THE HENRY J. KAISER FAMILY FOUNDATION

MEDICARE DRUG DISCOUNT CARDS: A WORK IN PROGRESS

EXECUTIVE SUMMARY

Prepared for the Henry J. Kaiser Family Foundation

By

HEALTH POLICY ALTERNATIVES, INC.

JULY 2004

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The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) adds outpatient prescription drug benefits to the Medicare program, effective January 1, 2006. To assist Medicare beneficiaries with their outpatient prescription drug costs in 2004 and 2005, the MMA authorizes the establishment of the Medicare Discount Card Program as well as a Transitional Assistance (TA) Program for low-income beneficiaries.

According to the Centers for Medicare & Medicaid Services (CMS), about 3.9 million beneficiaries have signed up for a Medicare-approved discount card, including almost 1 million qualifying for TA. Nearly 2.3 million of those enrolling are members of Medicare Advantage (MA) plans who were auto-enrolled in a card offered by their plan. In addition, seven of the 31 states with state pharmacy assistance programs (SPAPs) have arranged to auto-enroll their recipients in a discount card. If the number of beneficiaries who were "auto-enrolled" by SPAPs is taken into account, the number of beneficiaries enrolling to date on their own initiative would likely be less than 1 million.

This report takes a first look at the Medicare Discount Card Program, with an emphasis on issues affecting beneficiaries. Part I of the report provides descriptive information on the requirements and characteristics of approved discount cards, their sponsors, the number of card choices, enrollment fees, covered drugs, drug pricing, pharmacy networks, and initial efforts by CMS, to educate beneficiaries about approved discount cards and the $600 TA credits.

Part II examines prices offered by card sponsors, and considers potential savings for enrollees. This analysis is designed to address several questions. Can beneficiaries who lack drug coverage realize savings by signing up for a discount card? Does choice of card really matter, in terms of monthly costs/savings? Have prices changed since the program was first implemented?

Our pricing analysis shows that some cards do offer good value when compared to full retail prices paid by cash customers. It also indicates that, after an initial period of price instability and unreliability, the drug prices quoted for these cards have remained relatively stable.

CHARACTERISTICS OF DISCOUNT CARD SPONSORS AND PROGRAMS

Card sponsors. Most of the entities that have been approved for card sponsorship are companies that describe themselves as pharmacy benefit managers (PBMs) or firms that perform some or all of the functions of PBMs. Of the 72 originally approved general national and regional card sponsors, 53% can be classified as PBMs. Other sponsors include a variety of businesses that have partnered with entities that have the capacity to manage pharmacy benefits. In addition, 84 MA organizations sponsor discount cards that are available solely to their enrollees ("exclusive cards").

Number and choice of discount cards. In all, 39 general card programs were originally approved by CMS to accept enrollment throughout the U.S. ("general national" cards); an additional 33 general cards were approved that serve one or more states ("general regional" cards). Little variation exists across the nation in the number of general card programs actually available to beneficiaries, ranging from the originally approved 39 to 43 where multiple regional options are available.

The range of real choices, however, is less than meets the eye. Five of the national card programs that were approved never became operational, reducing the number of general card options to 34. Moreover, many of the card programs are either offered by the same sponsor or utilize the same PBM or similar type of entity. When examined for actual variations in programs, drug prices, enrollment fees, and pharmacy networks, some cards appear to be different in name only.

Enrollment fees. Beneficiaries may be charged an annual enrollment fee of up to $30 per year. While most do charge a fee, just over half of the general national card programs (21 of the 39) charge the maximum $30 enrollment fee for 2004, compared to only three of the 33 regional discount card programs.

Drug lists ("formularies"). Formularies are important because they define the list of discounted drugs offered by a given card program. Card sponsors are required to offer a discounted price on at least one drug in each of 209 categories developed by CMS. In addition, sponsors must provide at least one generic drug in 95% of the categories for which a generic is available.

Analyzing the comprehensiveness of the formularies for each of the discount card programs is not easy. The Prescription Drug Assistance Program (PDAP) tool on the medicare.gov website only responds to queries about specific drugs, thereby making it extremely laborious to ascertain the universe of drugs included in any card's formulary. Sponsors vary, moreover, as to how they describe the products available at a discount through their programs. Some programs use adjectives such as "most" or "many" to describe drugs covered by their cards. Others provide beneficiaries with partial lists that contain those drugs that are most frequently prescribed and indicate that a complete list of discounted drugs and prices can be obtained from their toll-free telephone service and mailed upon request. We did find that certain high cost drugs are available from a more limited number of cards.

Drug pricing. A fundamental issue in the discount card program is the extent to which card sponsors are able to negotiate significant savings, and in turn, pass those savings along to consumers. All card programs are required to report the value of any discounts or price concessions to CMS, but they are not required to pass along the full value of discounts to their enrollees. Discount prices available to enrollees may change at any time, although the magnitude of any change is limited. Card programs may offer deeper discounts to certain enrollees based on income, but only some do.

Retail and mail order pharmacy access. Convenient access to prescribed drugs is important to beneficiaries who often have close relationships with their pharmacist or may be unable to travel significant distances to obtain prescriptions. Of the 19 national cards providing information on the size of their pharmacy network, 3 indicate that they have between 30,000 and 39,999 pharmacies, 12 have between 40,000 and 49,999, and 4 have 50,000 or more. Complaints have emerged that some pharmacies listed as participating in specific card programs may not, in fact, be doing so. Whether this is a data error or a failure of card sponsors to monitor network agreements could not be determined. Of the 34 general national card programs actively marketing in June 2004, at least 26 also offer a mail order option.

Other sources of assistance. Many pharmaceutical manufacturers sponsor patient assistance or discount card programs that provide free or discounted drugs to targeted populations. In response to the Medicare discount card program, some of these companies

have entered into agreements with Medicare-approved drug card sponsors to provide deep discounts on some of their drugs to all beneficiaries qualifying for TA after they have used their $600 annual credit. A few drug companies are also offering additional discounts to enrollees with incomes up to 200% of the federal poverty level.

Education and outreach. CMS has relied mainly on an Internet site displaying comparative information on discount card options and a toll-free telephone line with trained customer service representatives who can furnish similar information and mail printed copies of the data on request. Information is also available directly from each card program, although the content varies widely.

However, the sheer volume of relevant data and the complexity of drug pricing can be overwhelming. Despite the government's significant investment in decision support tools, beneficiary frustration and confusion have reportedly continued, and we too found the process far from user friendly. It is important to note, however, that CMS has reduced telephone waiting times and incorporated improvements to the Medicare.gov website that now make it easier and quicker for those who use these tools.

PRICING ANALYSIS

Our pricing analysis provides a preliminary assessment of the value of Medicare discount cards to beneficiaries who would otherwise buy at full retail price. While proponents of the discount card program have found that beneficiaries stand to save significant amounts of money using Medicare-approved cards, program critics have found that beneficiaries could do just as well or better buying their drugs from Drugstore.Com or through Canadian-based internet pharmacies. Because of the obvious benefit of the drug card program to beneficiaries receiving TA, we focused our pricing analysis on savings for Medicare beneficiaries with no prescription drug coverage who would not qualify for TA.

Methods and limitations. We tracked drug pricing on a weekly basis for a set of 10 drugs commonly prescribed for Medicare beneficiaries and seven discount card programs over the period May 10 through June 28, 2004, but ultimately dropped the first two weeks of this period because of concerns about data reliability. The seven card programs chosen were the ones initially offering discounts on all selected drugs at pharmacies in the locations we targeted --an urban and a rural community in Maryland. The card prices were compared to retail prices reported by the Maryland Attorney General's "Prescription Drug Price Finder" in these same communities (as posted through May 31, 2004), and to two companies that offer mail order service to the general public: Costco and Drugstore.com.

We also developed four 'prototype beneficiaries' to assess the relative value of the selected card programs for their retail pharmacy and mail order prices, both in an urban area (Baltimore) and a rural area (Kansas). The basket of drugs for these beneficiaries were developed to test prices on a variety of frequently prescribed brand and generic medications. (See Appendix for a discussion of our methodology.)

It is important to note that our pricing analysis – similar to findings in other recently reported studies – is limited in scope and subject to some uncertainty because researchers are unable to access the full underlying database for the discount card program, and because some of the available data on pricing and drug coverage has been inaccurate, incomplete, or changing.

Do Medicare-Approved Discount Cards Offer Savings for Beneficiaries?

The results of our pricing analysis are consistent with what card program proponents have said: at least some cards do provide savings when compared with the retail prices paid by cash customers. Drugstore.com also compares favorably with some cards for some drugs. We also found that, after an initial period of price instability and unreliability, card prices on the whole have not moved steadily downward, suggesting that competition between cards for enrollees has not resulted in widespread efforts by sponsors to "meet or beat" the prices of other cards.

Based on our review of the prices for 10 of the drugs most commonly used by Medicare beneficiaries, we found:

- All seven of the card programs had prices that were significantly less than those reported by the Maryland Attorney General (AG) as typical retail prices.
- A Medicare beneficiary purchasing at retail one of the 10 drugs sampled would save between 8% and 61% for a drug, with the precise level of savings dependent on the specific drug, card program, and location of the pharmacy.
- Savings on brand products were less in terms of percentages than generics but more in actual dollars. For example, the highest percentages in savings – 61% and 89% -- were for a generic, furosemide, which retails in urban Maryland at $9.04 to $10.89 for a 30-day supply.
- Using mail order provides significantly greater savings for the sample of drugs over the Maryland Attorney General's reported prices, providing savings of 23% to 89%, again depending on the product, the card program, and location, although most cards require the purchase of a 90-day supply rather than a 30-day supply.

Because prices and savings varied widely among the seven card programs for the ten drugs, we also analyzed the total price for the basket of all ten commonly used drugs, recognizing that this particular basket of drugs would not likely be taken by any one Medicare beneficiary.

For the basket of the ten drugs, we found prices for the card programs were:

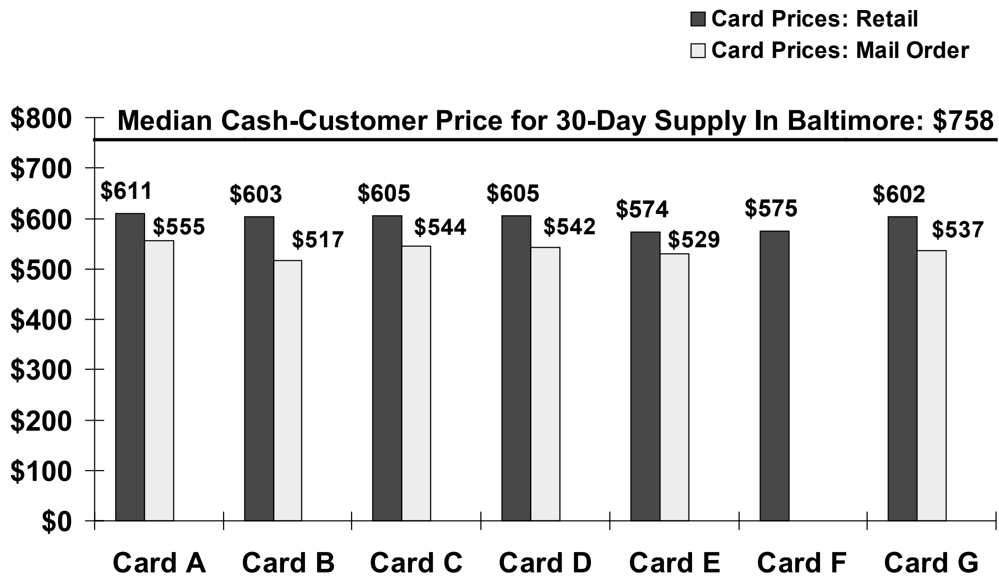
- 19% to 24% lower than the aggregate of the median prices reported by the Maryland Attorney General for the Baltimore area;
- 17% to 22% less than the Maryland AG prices in a rural area of Maryland; and
- 27% to 32% lower for mail order when compared to the median Baltimore prices. (See Figure ES1 on the following page.)

The savings reported above do not include any savings derived from switching from a brand to a generic equivalent product. It must also be emphasized that -- even in the absence of using a Medicare-approved discount card -- beneficiaries electing to move from a brand to a generic or from retail to mail order would experience significant savings from the Maryland Attorney General prices.

We also tested how these mail order prices compared to two companies that offer mail order to the general public: Costco and Drugstore.com. All six of the seven selected card programs that offered mail order had prices less than those offered by Costco, ranging from 5% less for the card with the highest mail order prices to 11% for the card with the lowest

mail prices. Drugstore.com, however, was competitive with the six cards. The Drugstore.com aggregate price for the ten drugs was 5% higher than the lowest priced card, but 2% less than the highest priced card.

Figure ES1



NOTES: Prices for a basket of 10 commonly prescribed drugs for Medicare-age population. Cash-customer prices reported by Maryland Attorney General. For purposes of comparison, mail order prices were adjusted to reflect a 30-day supply. Card F does not offer mail order.

In sum, our analysis shows significant savings for a subset of drugs and a subset of cards, compared to retail drug prices in two areas within one state. However, as others have noted, while these discounts do lower prescription drug costs, beneficiaries continue to face significant drug expenses. We do not know the extent to which the retail prices in Maryland as provided by the Maryland AG are indicative of retail prices in other areas and states. It also should be noted that the prices reported by the card programs on Medicare's website are their highest prices. Some of their participating pharmacies could offer lower prices, and thus produce greater savings for enrollees.

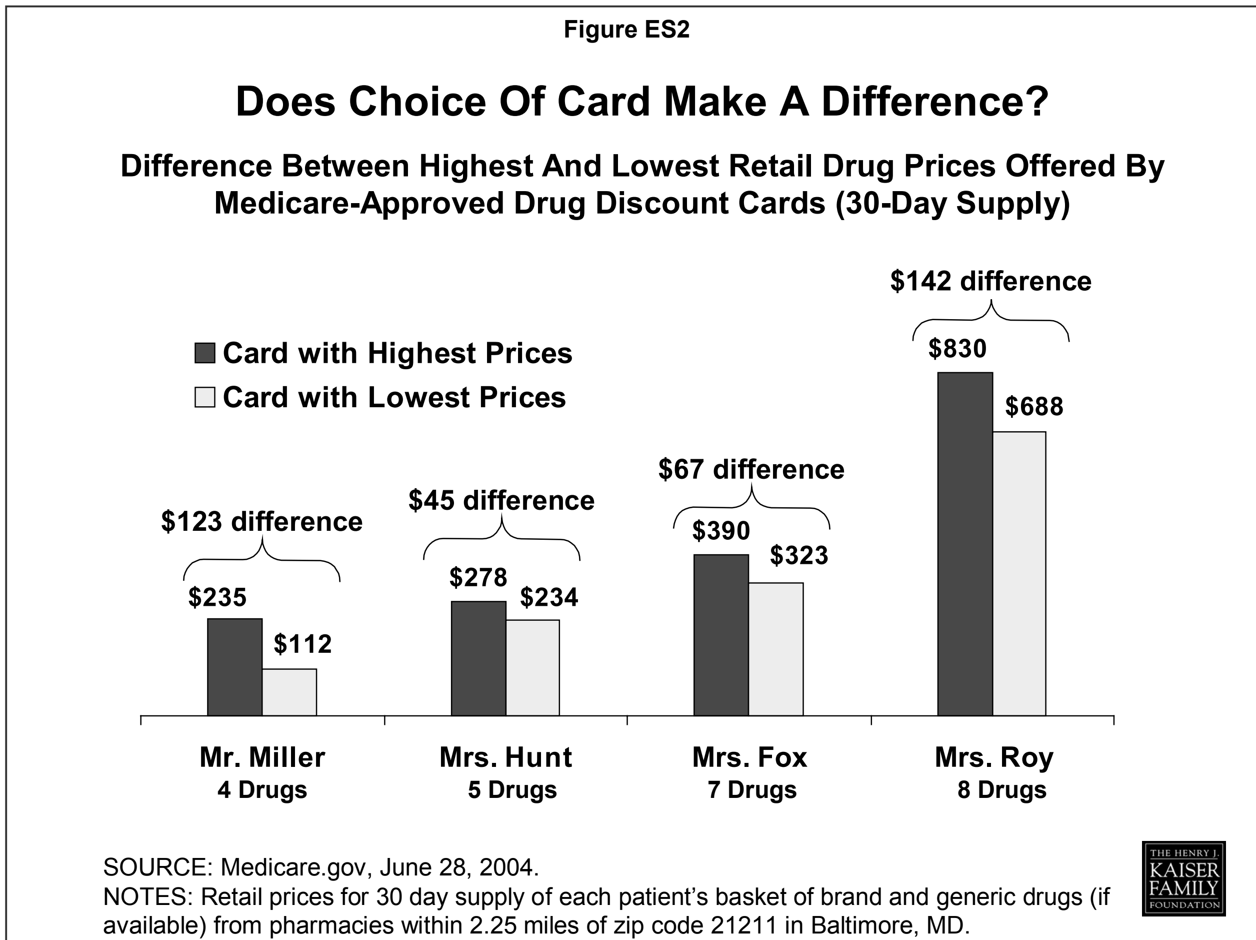
How Much Does Choice Matter?

We also sought to determine how the seven-selected Medicare-approved card programs compared with one another using four different baskets of drugs for four hypothetical beneficiaries. Price results were tracked from Medicare.gov for the seven selected discount card programs for the weeks of May 10 through June 28, 2004, again dropping the first two weeks of this period due to the unreliability of the data. In addition, we determined which of <u>all</u> of the general card program(s) (national or regional) displayed the lowest aggregate price for each of the four beneficiaries' basket of drugs (this almost always turned out to be a card

that was not one of our seven selected programs). For the last week, we also tracked which card program out of all options had the highest aggregate price.

From our analysis we found:

- For three individuals, the retail pharmacy cost of the basket of their drugs for the highest card was 19% to 21% more than the card with the lowest prices, when used at pharmacies in the same area.
- If our four prototype beneficiaries selected the card with the highest prices, over a card with the lowest prices, they would pay between $45 to $142 more per month. For example, Mr. Miller would pay $235 using the card that offered the highest prices, but only $112 using the card that offered the lowest prices, or a difference of $123 for a 30-day supply of his four drugs. (See Figure ES2.)
- An even greater difference existed when the cards with the lowest and highest mail order prices were compared for the four individuals: they would pay $174 to $646 more for a 90-day supply of their drugs.



In addition, we looked at the implications for these individuals of substituting generic alternatives when available. Our analysis shows that they would clearly save by electing that option, but again the amount of savings varied by drug, card, zip code, and whether purchased from a retail pharmacy or through mail order.

In short, our analysis illustrates that the choice of a card program may have significant financial implications for beneficiaries, based on their drug regimen, where they live, and how they prefer to purchase their drugs (pharmacy or mail order). This suggests the importance of careful comparison shopping before enrolling in a specific card program.

Have Discounted Prices Changed Over Time?

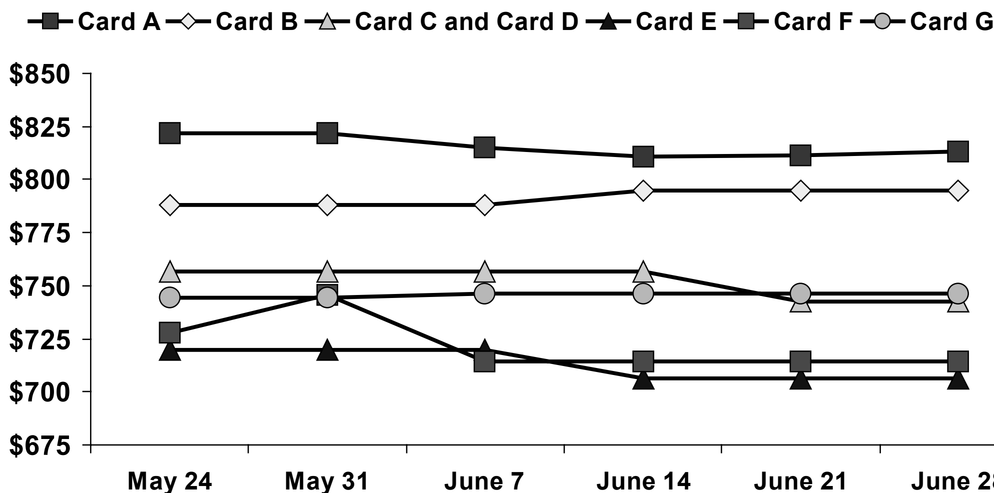
Beneficiary advocates have raised concerns about the potential for card sponsors to increase prices over time once enrollees are "locked-in" to their card choices. On the other hand, CMS has said that prices are likely to fall as a result of competition between the card programs for enrollment. To this point, CMS issued a press release on May 14, 2004 indicating that after the first week of posting prices on the Medicare.gov website, approved card programs had lowered their average discounted prices by approximately 11.5% for brand name drugs and 12.5% for generic drugs in selected zip code areas.

Because of the large amount of data errors we discovered in tracking prices at the beginning of the program (in early-mid May), we were unable to draw any conclusions about price changes during the first several weeks of the program. Over the subsequent six weeks, however (May 24-June 28), our analysis of the selected drugs and selected card programs showed that while there were a few changes up and down for selected drugs and cards, overall prices remained relatively stable. (See Figure ES3.)

Figure ES3

Have Medicare-Approved Drug Discount Card Prices Changed Over Time?

Prices Offered By Seven Selected Medicare-Approved Drug Discount Cards - Illustrative Example for Mrs. Roy



NOTES: Prices reflect mid-point in range of prices reported on Medicare.gov. Card A missing price data for June 7 and June 21, 2004; midpoint estimates used for missing weeks. Card C and Card D reported the same prices for this patient's basket of 8 drugs.

CONCLUDING OBSERVATIONS

Our report documents early experience with the Medicare discount card and TA programs. While we have observed a number of implementation challenges facing CMS and card sponsors, they largely reflect the relatively short time for implementation and the significant administrative and outreach tasks associated with these programs. We note that CMS has continued to make improvements in the quality, reliability, and accessibility of information posted to its website. The sheer volume of information, however, is likely to be overwhelming for many beneficiaries and others assisting them.

Critical to a successful implementation of the discount card program is getting clear and consistent information to beneficiaries and those agencies and individuals on whom beneficiaries rely for assistance and advice. Despite a significant investment by CMS in decision support tools, reports of beneficiary frustration and confusion have been widespread. Card sponsor descriptions of key program features, such as drug lists, pharmacy networks, and the availability of additional manufacturer discounts vary, thus making “apple-to-apple” comparisons problematic.

Our effort to determine the value of card programs for 10 commonly prescribed drugs showed that at least some cards do provide value compared to full retail prices. We also found that choice of card program can make a significant difference in the value to an individual beneficiary. The range of pricing differences for our four hypothetical Medicare beneficiaries suggests that card choice can have a significant impact on individuals with limited incomes. In contrast to predictions that market forces would continuously drive prices lower, we did not observe notable changes in reported prices after the initial start up period of the program. It will be interesting to see what happens to prices before the annual open election period in November when enrollees may change enrollment from one card to another.

Overall, the experience to date with implementation of the discount card program suggests some important implications for putting the new Medicare Part D drug benefit in place in 2006. While choice helps to ensure that beneficiaries can find a plan best suited to their individual needs, excessive choice produces confusion and may discourage enrollment. The majority of the 3.9 million enrollees so far have been auto-enrolled by their MA plans or their SPAPs. Direct enrollment by individual beneficiaries has been modest. Moreover, managing beneficiary education is especially challenging and costly for the Medicare population because of the need to use multiple means of disseminating complex information including the availability of trained counselors to provide individual assistance. Although the internet is a useful tool for beneficiary education – and holds great possibilities for increased drug pricing transparency – the need for more accessible “face-to-face” education cannot be overestimated. Most beneficiaries are not now using the internet; even their helpers are often finding the web-based information more perplexing than helpful. Lessons from the card program experience could help to make the transition to a Medicare drug benefit more beneficiary friendly.

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