MEDICARE DRUG DISCOUNT CARDS: A WORK IN PROGRESS

Prepared for the Henry J. Kaiser Family Foundation

By

HEALTH POLICY ALTERNATIVES, INC.

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TABLE OF CONTENTS

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EXECUTIVE SUMMARY

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.

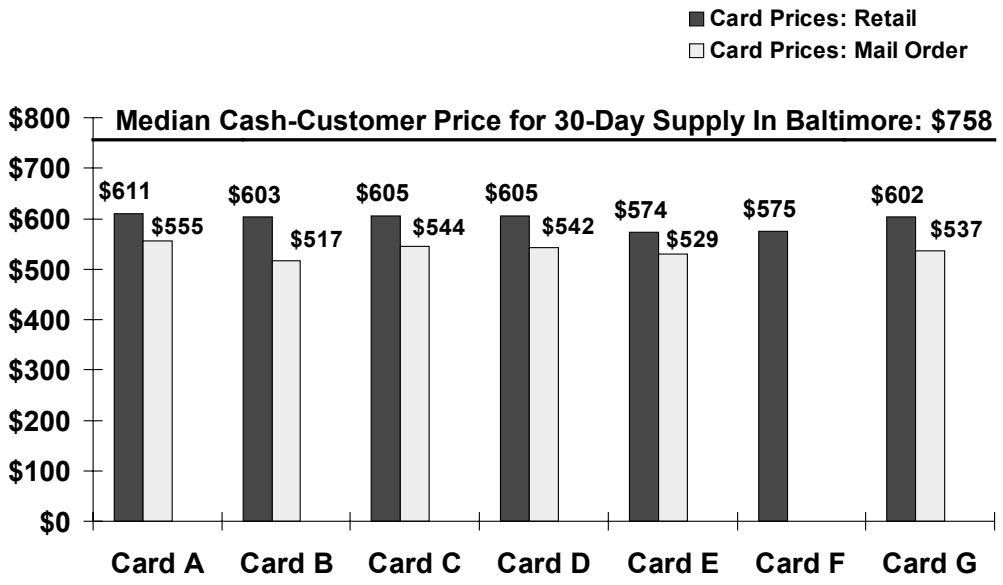
We also tested how these mail order prices compared to two companies that offer mail order to the general public: Costco and Drugstore.com. All six of the seven selected card programs that offered mail order had prices less than those offered by Costco, ranging from 5% less for the card with the highest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

Do Medicare-Approved Drug Discount Cards Offer Savings?

Comparison Of Medicare-Approved Drug Discount Cards And Cash-Customer Prices



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.

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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 all 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.

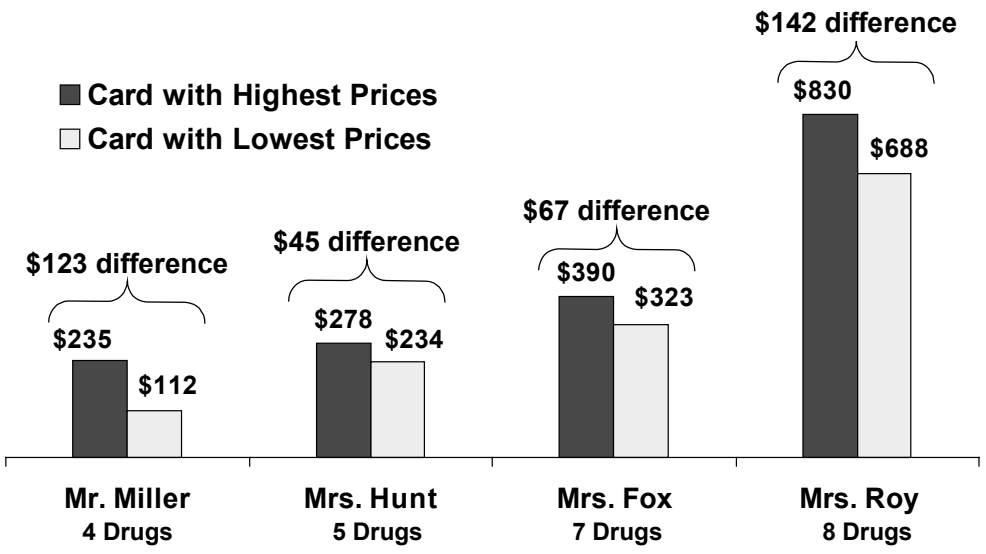
From our analysis we found:

- 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.

Figure ES2

Does Choice Of Card Make A Difference?

Difference Between Highest And Lowest Retail Drug Prices Offered By Medicare-Approved Drug Discount Cards (30-Day Supply)



SOURCE: Medicare.gov, June 28, 2004.
NOTES: Retail prices for 30 day supply of each patient's basket of brand and generic drugs (if available) from pharmacies within 2.25 miles of zip code 21211 in Baltimore, MD.

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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?

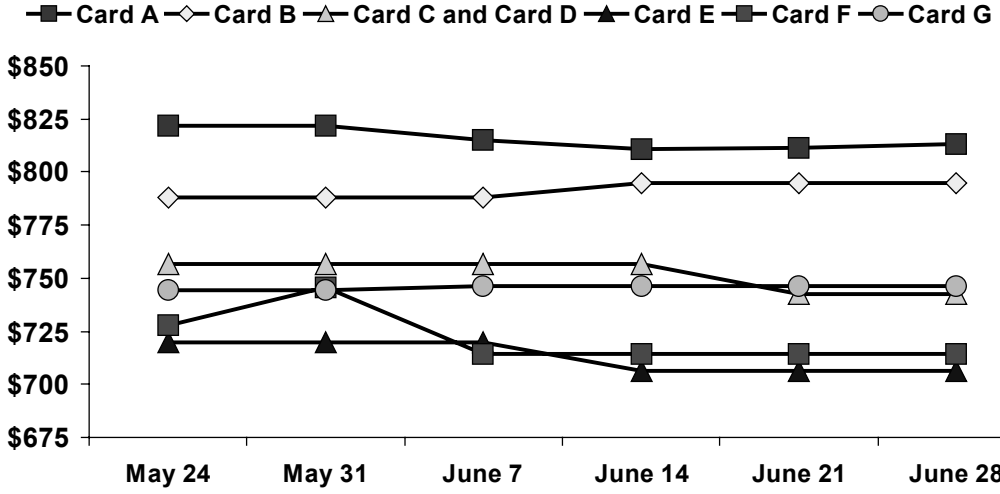
Beneficiary advocates have raised concerns about the potential for card sponsors to increase prices over time once enrollees are "locked-in" to their card choices. On the other hand, CMS has said that prices are likely to fall as a result of competition between the card programs for enrollment. To this 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.

INTRODUCTION

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), signed into law on December 8, 2003, adds outpatient prescription drug benefits to the Medicare program, to be effective January 1, 2006. To assist Medicare beneficiaries with their outpatient prescription drug costs in the interim period, 2004-2005, the MMA authorizes the establishment of the Medicare Discount Card Program as well as the Transitional Assistance (TA) Program for low-income beneficiaries. These programs became available to Medicare beneficiaries June 1, 2004.

All Medicare beneficiaries, except for those who receive prescription drug coverage through Medicaid, are eligible to enroll in one of the approved Medicare discount cards. The cards are intended to reduce the price that many Medicare beneficiaries otherwise pay for their prescription drugs either because they have no or very limited drug coverage. Under the TA program, beneficiaries in families with incomes that do not exceed 135% of the federal poverty level ($12,569 for single individuals/$16,862 for couples in 2004), who do not have prescription drug coverage other than Medigap or Medicare Advantage, are eligible to receive $600 for each year, 2004 and 2005, to use through a drug discount card to purchase prescription drugs. Although the card programs may limit the drugs for which they provide discounts, TA may be used to purchase any drug product that falls under the definition of covered drugs for the discount card program.

The Henry J. Kaiser Family Foundation contracted with Health Policy Alternatives, Inc. (HPA) to report on the implementation of the Medicare endorsed discount card program, primarily from the perspective of Medicare beneficiaries. Are the cards providing good value to beneficiaries? What is the federal government doing to promote the program and educate beneficiaries and those who advise them about the program? To what extent is there coordination with other sources of prescription drug assistance for Medicare beneficiaries? Are any major problems developing in the marketplace related to the sale of the discount cards?

As part of this effort, we monitored the implementation of the “Medicare-Approved Drug Discount Card Program” as it officially is called by the Centers for Medicare & Medicaid Services (CMS), the agency with responsibility for implementing the program. This involved monitoring the internet site (www.Medicare.gov) that has been established to help Medicare beneficiaries choose the card program that best meets their needs. (The specific tool on this website that was developed to help beneficiaries compare card options is known as the Prescription Drug Assistance Program tool or PDAP.) We also tracked prices on a set of specific drugs for a subset of the card sponsors. CMS staff were helpful in addressing numerous questions about details of the program and its implementation. In addition, we analyzed program regulations, guidance, and related information; tracked national and trade press stories; and reviewed the many reports and studies evaluating the Medicare discount card program and the prices obtainable using the various card options.

Part I of this report begins with a description of the basic requirements and features of the Medicare-approved Discount Card Program and the cards that are being offered nationally, regionally, and through the Medicare Advantage plans. Following that is a discussion of the role of CMS in promoting it and the additional help available to qualified low-income beneficiaries. We also address how the discount cards interact with State Pharmacy Assistance Programs and manufacturer patient assistance and discount card programs. This

part concludes with a description of the major safeguards against fraud and abuse that have been established through law and regulation.

Part II presents the results of a pricing analysis we conducted of selected card programs for a selected set of prescription drugs. The results of our analysis are consistent with other studies that have reported savings for beneficiaries associated with these cards. We discuss the range of savings that might be achieved by beneficiaries in various circumstances and the factors that affect the magnitude of savings. We also find, however, that for the specific drugs and card programs studied, prices have so far remained relatively stable. This finding contrasts with suggestions by CMS that competition between the card programs would drive prices significantly downward. A detailed discussion of the methodology for the pricing analysis is presented in the Appendix to this report.

PART I. THE MEDICARE-APPROVED DRUG DISCOUNT CARD PROGRAM: STRUCTURE, OPERATION, AND CURRENT STATUS

APPROVED CARD SPONSORS: REQUIREMENTS AND CHARACTERISTICS

Basic Requirements

Under the MMA, Medicare discount cards may only be offered by nongovernmental entities, known as sponsors, with which the government has contracted. The regulations specify that card sponsors must have 3 years of private sector experience in pharmacy benefits management and, at the time of application, operate a pharmacy benefit, discount card, or similar program that serves at least 1 million covered lives. The sponsor must also demonstrate fiscal stability and business integrity, quality customer service and a process for handling complaints.[1]

Medicare discount cards may only be offered by nongovernmental entities known as sponsors. Sponsors can contract to provide cards nationwide (general national cards) or within specific states (general regional cards).

Sponsors can meet these requirements by combining the capabilities of different entities. For example, a group of pharmacies can team up with a pharmacy benefit manager (PBM) or third party administrator (TPA) to sponsor one or more card programs. Sponsors can contract to provide discount cards nationwide (general national cards) or within specific states (general regional cards). A state is the smallest service area permitted. By law, the Secretary is required to contract with at least two different general discount card programs in each state. As discussed below, the minimum number of card program options approved for all fifty states far exceeds this statutory minimum.

Although the MMA permits CMS to limit the number of approved card programs, CMS decided to approve all card programs of qualified applicants. CMS first previewed an initial list of approved discount card program sponsors in late March, 2004, both for the general national and regional cards. It also announced the sponsors for the exclusive cards for Medicare Advantage (MA) health plans.[2] Additional card sponsors were designated for "special endorsement" for nursing home residents and Native Americans.[3]

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[1] *Federal Register,* vol. 68, no. 240, December 15, 2003, p. 69839-69927.

[2] U.S. Department of Health and Human Services, CMS Public Affairs, News Release: *HHS Gives Seal of Approval to Medicare Drug Discount Cards,* March 25, 2004. In testimony to Congress,

At the time of the March announcement, a number of applications from potential card sponsors were still being reviewed by CMS, and some applicants that had been initially turned down by CMS requested reconsideration. In June, 2004, CMS posted on its website a "master list" of approved card sponsors, their product names, service areas, annual enrollment fees, and contact numbers. Summary data on card program totals are presented in Table 1.

Table 1. Medicare-Approved Drug Discount Card Programs (June 2004)

General national cards	39
General regional cards	33
Exclusive cards	84
Special endorsement cards	
Long-term care	3
Indian health	3
U.S. territories	4
Source: www.cms.gov., as of June 16, 2004.	

Card Program Sponsors

Most of the entities that CMS identifies as general card sponsors are companies that describe themselves as pharmacy benefit managers (PBMs) or use somewhat less specific language such as a pharmacy benefits solutions company. Of the 72 originally approved general national and general regional card sponsors, 53% can be classified as PBMs (see Figure 1 on the following page). Such companies, especially the larger national companies, are well positioned to offer discount cards because they already had in place the administrative infrastructure to run a program, as well as the established processes to obtain drug manufacturer and pharmacy discounts. About 28% of the 72 sponsors identify themselves as third party administrators (TPAs) or pharmacy benefit administrators, commercial discount card companies, various forms of medical technology and information technology companies, and an alliance of retail and chain pharmacies.

The nine managed care organizations that are identified as sponsors of general card programs either operate their own PBM (e.g. Wellpoint) or contract with a PBM or TPA to run the card programs. A few of these programs have partnered with companies that operate

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Michael McMullan of CMS indicated that the 28 general card sponsors were selected out of 55 general applications considered. 27 potential sponsors were rejected based on failing to satisfy completely fundamental requirements of the CMS solicitations. CMS approved 43 of the 44 exclusive card applications. Secretary Thompson was quoted later as saying that those cards that did not pass muster with CMS had problems in one or more areas: insufficient reserves, or the information they gave was not satisfactory; they didn't have the capacity to offer drugs in all 209 categories; they did not have a broad enough network of pharmacies, or (4) their past history with drug discount cards was insufficient. Card applicants had until April to appeal the determination. *Drug Card Management Report,* April 16, 2004.

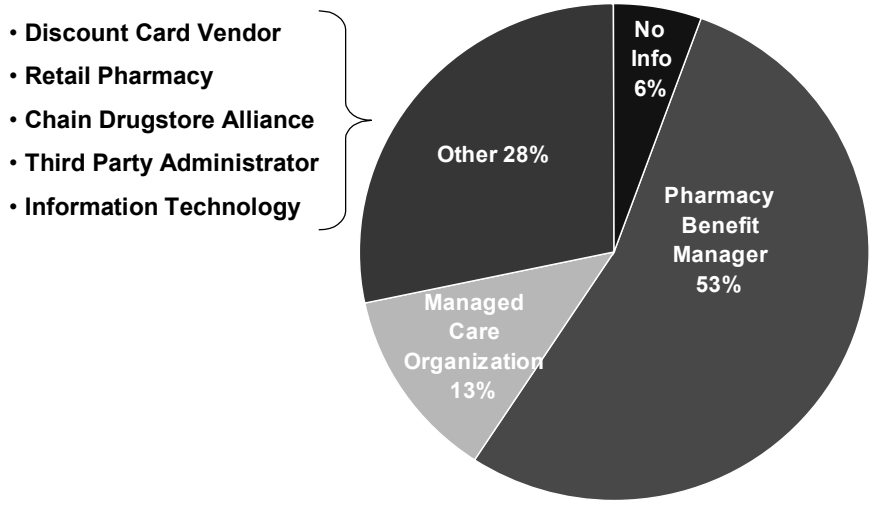
[3] Many nursing homes restrict which pharmacies may supply drugs and pharmacy services to their residents. These pharmacies may or may not participate in the various Medicare-approved discount card programs. CMS has provided a special endorsement to three card programs to serve long-term care pharmacies. Institutionalized beneficiaries eligible for TA will be able to obtain it through these cards. However, these cards are not expected to become operational until later in 2004. The delay is in part due to the need to work out how these endorsed card programs work in states where nursing homes are required to permit their residents to go outside of their nursing homes for their outpatient prescription drugs. (Centers for Medicare and Medicaid Services, Drug Card Sponsor Questions & Answers, Last updated 5/6/2004, p. 57-58 (www.cms.gov); CMS Open Door Conference Call, June 10, 2004.)

commercial drug discount card programs. Wellpoint's partner, for example, Nation's Health, is a discount card vendor.

Figure 1

Types Of Sponsors Of Medicare-Approved Drug Discount Cards

Total = 72 General National and Regional Card Sponsors



SOURCE: CMS, May 21, 2004.

Some of the card program sponsors have disclosed partnerships with other entities, such as grocery stores, insurers, or big box stores. Those that are not partnered with PBMs or TPAs nonetheless mostly have contracts with a PBM or TPA to administer at least some aspects of their card programs.

Card Program Choices

Little variation exists among states in the number of general card programs that were originally approved for sale to beneficiaries. In addition to the 39 card programs that were approved to be marketed nationwide, beneficiaries in all but nine states also have at least one general regional card program serving their area. In five states, beneficiaries have a total of 43 card options.

The large number of card choices is considered by some as the best way to facilitate consumer choice and by others as "daunting, confusing, and downright unattractive to many beneficiaries."

The large number of card choices available to any card-eligible Medicare beneficiaries is viewed by some as the best way to facilitate consumer choice

and by others as "daunting, confusing, and downright unattractive to many beneficiaries."[4] As indicated above, CMS decided to approve card program proposals for all qualified sponsors instead of selectively contracting with a subset of qualified applicants. CMS may have done this to expedite the approval process or possibly to maximize both the choices for beneficiaries and the competition between card programs so as to encourage the best price discounts. But in so doing, CMS may have overly complicated the decision process for beneficiaries.

Moreover, the number of true competitors is fewer than meets the eye. First, not all approved card options are actually available. Some of the general national cards originally listed by CMS are not, in fact, available (and pricing information is not available on the PDAP). This is true for the two Nation's Health cards, two Express Scripts cards, and the Wellpoint Precision Discounts Option B card program. According to CMS, although these programs applied for and received Medicare approval, the sponsors elected not to market them. The subtraction of these five card programs means that 34 general national card options were being actively marketed as of the end of June, 2004.[5]

Second, while it is generally true that a beneficiary has at least the 34 general national card programs to select from and, in most states, some regional card options as well, the real number of options depends on the type of prescriptions needed and the distance the beneficiary is willing to travel to a pharmacy (noting that mail order is an option for many card programs). But even for a given list of commonly prescribed drugs, the number of options is fewer than 34 when looked at in terms of actual variations in programs, drug prices, enrollment fees, and pharmacy access. This is because many of the card programs are either offered by the same sponsor or work through the same PBM or TPA. Although different combinations of partners ("co-branders") may be involved, some cards appear to be different in name only.

The number of true competitors is fewer than meets the eye. Some cards appear to be different in name only.

To illustrate, a beneficiary living in McLean, Virginia seeking prices on three commonly prescribed brand name drugs, would find prices for 33 card programs on the PDAP website (July 5, using the maximum allowed 7-mile pharmacy radius).[6] Two regional cards were included in the list of options. Out of the 33 options listed, six (all connected with AdvancePCS or Caremark which, as of March 2004, are the same company) offered identical price ranges and the same number of pharmacies, and two cards for each of four other associated card sponsors showed the same price ranges and numbers of pharmacies in their networks, bringing the real number of choices

[4] Senator Max Baucus, U.S. Senate. Committee on Finance, Hearing, *The Medicare Drug Discount Card: Delivering Savings for Participating Beneficiaries*, June 8, 2004.

[5] The five 5 nationwide cards not being actively marketed were sponsored by organizations that have relationships with other cards. Express Scripts is a partner with the Pharmacy Care Alliance, a card that is reportedly drawing relatively high enrollment. Nation's Health is a partner with Wellpoint. Had Express Scripts and Nation's Health marketed their own branded cards, they would have been competing against themselves for enrollment. Whether this is why they withdrew their branded products has not been determined.

[6] The drugs were: Fluoxetine, Nadolol and Celebrex. Information on one card, MedAdvantage Sav-Rx, was listed as not available. As of this date, one of the 34 national general cards – ScriptSave Plus -- had dropped off of the PDAP altogether. According to CMS, it remains, however, a card option. Personal communication with CMS, July 15, 2004.

down to 24. The only obvious differences would be, in some cases, the enrollment fee and, in at least one instance, the availability of a mail order option.[7]

Because so many of the card sponsors use the same PBMs or Third Party Administrators (TPA) to administer all or some aspects of their card programs, we also looked to see whether the presence of the same PBM or TPA resulted in the same prices, list of covered drugs, and pharmacy networks.

Using data on card program TPAs provided by CMS,[8] we found that AdvancePCS provides TPA services to 14 national and regional cards; Anthem is both the sponsor and the TPA for 10 general regional card programs. Express Scripts, which was approved to offer two general cards of its own but decided not to market them, serves as the TPA for seven other general cards. SXC Health Solutions is providing TPA services to seven general card programs. (See Figure 2 on the following page.)

To determine whether common PBMs/TPAs resulted in common card features, including prices and pharmacy networks, we again checked the PDAP for the price of three drugs in one zip code, 62959.[9] For the cards where AdvancePCS is listed as the TPA, we found the same price ranges for the bundle of the three drugs for all five cards available in that zip code (American Prescription Plan, BD Advantage, RxSavings, RxSavings distributed by Mennonite Mutual Aid Association, RxSavings distributed by Reader's Digest). For the cards associated with Express Scripts, however, the price ranges were within $2 of each other (AARP, Pharmacy Care Alliance Option A, and Pharmacy Care Alliance Option B).[10] For Health Trans, we found the same price range for their associated cards, Aetna and ScriptSave Premier. Finally, for SXC Health Solutions, we found the same prices for two cards (Community Care and Criterion), similar prices for two (SXC Health and Public Sector Partners) and one (PBM Plus Senior) that was $50 more for the bundle of the drugs than the others.

Even if cards share the same PBM/TPA, they may charge somewhat different prices, have similar if not the same pharmacy network in a given area, and charge different enrollment fees.

These findings complicate any generalization about PBMs and TPAs. It appears that even if the cards share the same PBM/TPA, they may charge somewhat different prices, have similar if not the same pharmacy network in a given area, and charge different enrollment fees.

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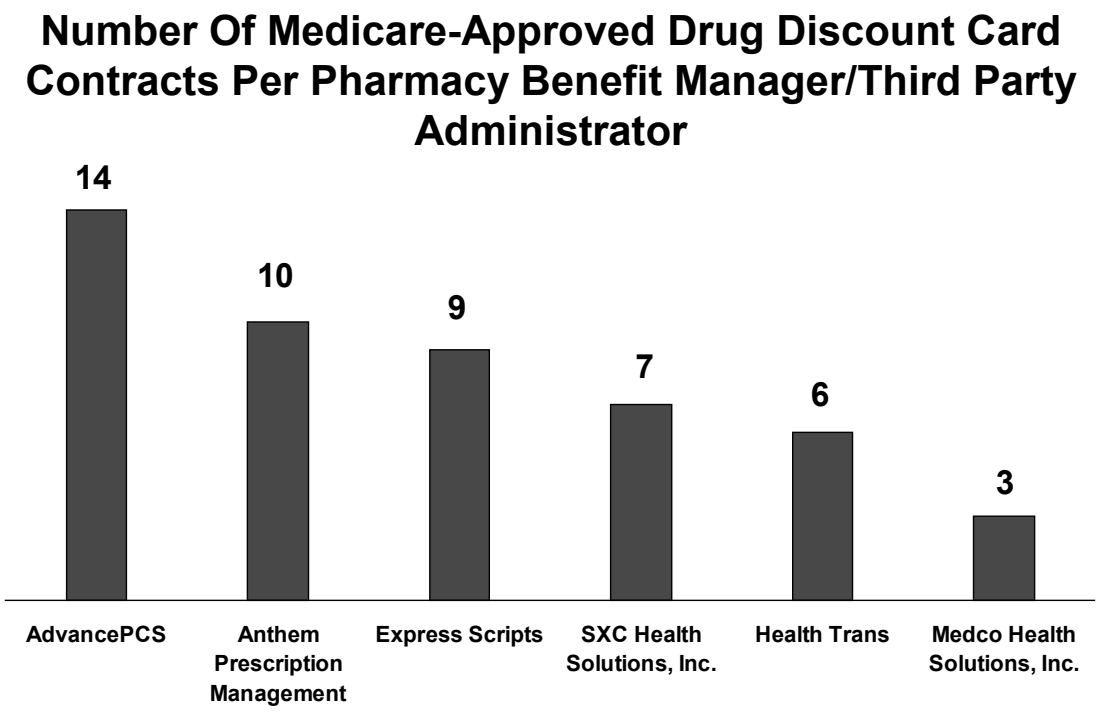
[7] CMS has confirmed that "some cards are the same except for branding." However, "because these are separate cards, going forward they do not necessarily have to stay the same." Personal communication with CMS, June 21, 2004.

[8] The "TPA" label, used by CMS in its data compilations, may be misleading. In some instances, the organization referred to as a TPA is really a PBM, which may be providing the entire range of cost management and administrative services, including negotiating discounts with drug manufacturers, utilization review, claims processing, and the provision of mail order. Or, it may contract to provide a more narrow range of services, such as claims processing. In some instances, the PBM makes it possible for the card sponsor to offer a mail order option, but the card sponsor handles in-house or through yet another contractor the other functions needed to operate the Medicare-approved card program. In other instances, the entity referred to as a TPA may only be providing claims administration and other administrative services. It may not be negotiating rebates or performing other cost management functions.

[9] Furosemide, Spironolactone, Zocor. The zip code is for Marion, Illinois.

[10] Pharmacy Care Alliance Option B (recommended for people with two or more prescriptions per month) charges one dollar more per prescription than Pharmacy Care Alliance Option A. The enrollment fee for option A is $19.00; for option B, it is $30.

Figure 2



SOURCE: CMS unpublished data, June 2004.
NOTES: PBMs and TPAs linked to fewer than three sponsors and contracts with exclusive card programs not shown. CMS data on PBM/TPA affiliation missing for six card programs.

THE HENRY J. KAISER FAMILY FOUNDATION

The Enrollment Process

Each Medicare discount card program is responsible for collecting enrollment forms from applicants. There are two standard enrollment forms developed by CMS: 1) for general enrollment in a discount card program; and 2) for enrollment in a card program and for eligibility determinations for TA. Card sponsors may use these or their own forms subject to approval by CMS; however, they must accept the standard CMS forms. Implementing regulations from CMS did not provide for standard enrollment forms, but pressure from beneficiary advocates for a uniform application resulted in the release of standard CMS forms.

For beneficiaries who are not applying for TA, the application must be verified by CMS to determine that the applicant is enrolled in Part A and/or Part B of Medicare and does not have drug coverage under a state Medicaid program. The sponsor may also require that the application include the enrollment fee or an authorization for charging a credit card.

General enrollment may be accomplished by mailing or faxing an enrollment form to the card sponsor, or over the Internet, by telephone, or, in at least the case of one card sponsor, at a participating pharmacy. Applicants must be furnished a written explanation if they are not accepted for enrollment and informed of the procedures for reconsideration of an adverse determination. Enrollment is not effective until a card sponsor is notified by CMS that the applicant is a Medicare beneficiary who is not enrolled in Medicaid. Medicaid enrollment

records for each state are matched against card applicants to identify any covered individuals.

Enrollment for Transitional Assistance (TA)

As noted above, the MMA provides a program for TA to Medicare beneficiaries with incomes below certain levels who do not have any other drug coverage (except for Medigap or through MedicareAdvantage plans). Beneficiaries must have annual incomes at or below 135% of the federal poverty line level ($12,569 for single individuals/$16,862 for couples in 2004). Beneficiaries enrolled in any state Medicare Savings Program (MSP)[11] are deemed to meet the income criteria. Eligible individuals are entitled to an annual $600 credit toward the purchase of any covered drug. Beneficiaries must submit a signed application to a card sponsor for TA that attests to their income and states they are not covered by TRICARE, FEHBP, or a private group health insurance plan. The application requires verification by CMS with assistance from the Social Security Administration and the Internal Revenue Service. Balances in the TA credit account may be carried over for an eligible individual's use in the second year. CMS estimates that 7.2 million Medicare beneficiaries will be eligible for the $600 credit in 2004, and that 4.7 million (65%) of those individuals will apply.[12]

Individuals who qualify for TA will receive a $600 credit on their discount card in 2004 regardless of when in 2004 they apply. They will receive another $600 credit in 2005. For those first applying for TA in 2005, the $600 will be prorated based on the calendar quarter in which they apply (e.g., those applying in April will receive $450). The $600 is administered in a manner similar to a debit card. The cost of an enrollee's prescription purchases, less the required coinsurance, is deducted from the $600 until it is exhausted. Individuals with incomes at or below the poverty level are required to pay 5% coinsurance out-of-pocket; other transitional assistance individuals with higher incomes are required to pay 10% insurance.

Beneficiaries who qualify for TA are eligible for a $600 credit on their discount card in 2004 and another $600 credit in 2005.

Medicare beneficiaries who are enrolled in certain state pharmacy assistance programs (SPAPs) may be auto-enrolled in a drug card program, and the SPAP may also apply for TA on behalf of members if all eligibility conditions are satisfied. (Auto-enrollment by SPAPs is discussed in great detail below.) Because low-income Medicare beneficiaries have been slow to enroll in programs offering assistance with Medicare cost-sharing (the so-called Medicare Savings Programs (MSPs), there has been considerable discussion about whether auto-enrollment can be permitted on a broader basis. The MMA includes provisions that "deem" any individual enrolled in a state MSP as meeting the income requirements for TA. However, the statute also requires a signed attestation that the applicant does not have other prohibited government or private health coverage. This requirement has complicated consideration of auto-enrollment since a signed application by the enrollee of his/her legal representatives must be submitted.

Moreover, there are significant challenges in designing an auto-enrollment protocol that is fair to beneficiaries and card sponsors. For example, it is important to preserve the voluntary

[11] The Medicare Savings Program (MSP) includes Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), and Qualified Individuals (QIIs).

[12] Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medicare Program; Medicare Prescription Drug Discount Card; Interim Rule and Notice," *Federal Register*, Vol. 68, (December 15, 2003), p. 69891. Referenced hereafter as: *Federal Register,* December 15, 2003.

nature of the program by providing an opportunity to opt out of enrollment or to select a card of the individual's choice within some reasonable time following auto-enrollment. At the same time, it is important not to advantage or disadvantage competing card programs as a result of the auto-enrollment process.

CMS has announced that auto-enrollment is under consideration for beneficiaries who are enrolled in Medicare Savings Programs. It is unlikely that a decision will be announced until there is more information on the number of beneficiaries who have applied for TA on their own. It appears at this juncture, however, that in the absence of auto enrollment, a relatively small number of TA-eligible individuals will actually receive the $600 credits. As noted below (see "Current Enrollment Numbers"), early enrollment figures indicate that not many people are enrolling on their own.

Enrollment Fees

The law allows card sponsors to charge an annual enrollment fee of up to $30 for 2004 and then again for 2005. A free (i.e., no fee) card program is permitted. Any enrollment fee must, however, be uniform across enrollees in a state. The sponsor, and not Medicare, is responsible for collecting it.[13] Almost all nationwide cards charge the same fee across all states; the fees for two of the regional card sponsors vary some by state.[14] Figure 3 on the following page shows the distribution of fees for the general national and regional card programs. The majority of the general national card programs are charging the maximum $30 enrollment fee for 2004 compared to only 3 of the regional card programs.[15]

Current Enrollment Numbers

As of July 12, 3.9 million beneficiaries have enrolled in a card program, including almost 1 million who have qualified for TA. Most have been auto enrolled.

As of July 12, CMS reported that 3.9 million beneficiaries have enrolled in a card program, including almost 1 million who have qualified for TA. However, in early June, CMS Administrator McClellan indicated that nearly 2.3 million enrollees were members of Medicare Advantage plans with exclusive card programs who were auto-enrolled. Information on the number of beneficiaries who have enrolled outside of a Medicare Advantage plan or a state pharmacy assistance program is not available, but published reports from some card sponsors suggest direct enrollment has been slow.

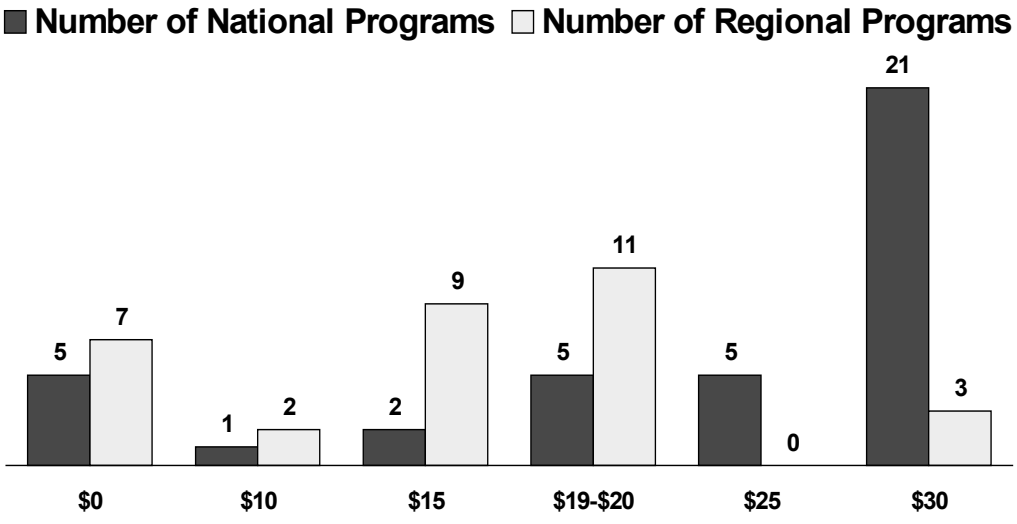
[13] *Federal Register*, Dec. 15, 2003, p. 69922

[14] One national card (ArgusRx) charges a lower enrollment fee for enrollees living in two states; two regional cards (Priority Plus and PrimeScript) charge lower enrollment fees for enrollees living in certain states. Centers for Medicare and Medicaid Services, *Approved General Cards*, www.cms.gov [for web posting_master_approved-generalsponsors-by product_06022004.xls]

[15] Discrepancies in enrollment fee amounts have occurred between the various documents posted on www.cms.gov, the individual card program websites, and the Medicare.gov PDAP, probably due to data errors. A spokesman for CMS says that card fees have not changed and that the PDAP has the correct amounts. Personal communication with CMS, July 15, 2004.

Figure 3

Annual Enrollment Fees For Medicare-Approved Drug Discount Cards



SOURCE: Centers for Medicare & Medicaid Services (CMS).
NOTES: Current as of July 11, 2004. Some regional card programs charge different fees in different states.

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Covered Drugs and Formularies

The MMA requires that Medicare-approved discount card sponsors offer enrollees discounts on "covered drugs". The law applies the same definition of covered drugs for the discount card program as for the new Part D drug benefit that becomes effective in 2006, which is basically the same definition that is applied under Medicaid, with minor exceptions. Generally, the definition includes all FDA approved drug and biological products available only by prescription, and necessary supplies for the injection of insulin. Drugs currently covered under Medicare Part B continue to be reimbursed under Part B and are not considered Part D covered drugs. Table 2 presents a complete list of those categories of drugs that are excluded.

Table 2. Categories of Drugs Excluded from Coverage under Medicare-Approved Drug Discount Card Programs
Barbituates
Benzodiazepenes
Cosmetic drugs
Drugs covered under Part A or Part B
Drugs that relieve coughs or colds
Fertility drugs
Over-the-counter drugs or drugs that do not require a prescription*
Vitamins (except prenatal)
Weight-related drugs
*Card sponsors are permitted to offer discounts on these types of drugs. However, the $600 TA credit cannot be used for over-the-counter drugs, except insulin.

The regulations allow endorsed discount card sponsors to establish formularies, i.e., lists of drugs for which discounts are available within the overall universe of drugs that fall within the definition of covered drugs. The preamble to the regulations notes that "while clinical appropriateness must be foremost in the development of a formulary, a properly designed formulary can also promote lower costs for beneficiaries as pharmaceutical manufacturers compete using, among other things, rebates, volume discounts, and generic drugs to supply the drugs that meet the formulary requirements at the lowest price."[16] Card sponsors are required to offer a discounted price on at least one drug in each of 209 categories developed by CMS and published in the regulations. In addition, sponsors must provide at least one generic drug in 95% of the categories for which a generic is available (55% of the 209 categories). The categories specified in the regulations were developed by CMS through a contractor by reviewing data on the drugs most commonly used by Medicare beneficiaries.

While a sponsor is required to meet the general formulary requirement of one drug in each of the 209 categories, it may decide to provide discounts on all FDA approved drugs or a subset of drugs. A card sponsor can change its discounted drug list or the discounted prices at any time. Such changes have to be published on the sponsor's website and updated weekly on the Medicare.gov website.

This formulary flexibility has troubled beneficiary advocacy groups who fear that beneficiaries drawn to a particular card program on the basis of an initial drug list may subsequently find that the list of discounted drugs has changed. Such drug list modifications may be more problematic in 2005 when the selection of a card generally "locks-in" the beneficiary for a full twelve months (exceptions are possible for special circumstances). The CMS has responded to this concern asserting that drug plan sponsors have a strong incentive to maintain a stable drug list (formulary) for the following reasons: (1) sponsors need a lot of enrollees (i.e., "covered lives") to negotiate good deals for enrollees and to cover their card program operating costs; (2) satisfied enrollees are more likely to remain in 2005; (3) satisfied enrollees will be more likely to stay with a sponsor if it offers a Part D drug plan in 2006; and (4) sponsors need experience of Medicare beneficiaries' utilization under the drug card program to help them anticipate costs and risks under the Part D benefit.[17]

There is no practical way to analyze the extensiveness of the formularies of each of the discount card sponsors. The PDAP only responds to drug-specific queries, thus making it extremely laborious to ascertain the universe of drugs included in a card's formulary. Card sponsors vary as to how they describe on their own websites or in their brochures the products available at a discount through their programs. Some programs claim to offer a discount on all products that meet the Medicare definition of covered drugs. Others use adjectives such as "most" or "many" to describe drug availability through their program. Many programs 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. Most of the programs offering a more limited list of discounted drugs suggest that the enrollee show their physicians the list of discounted drugs to improve the likelihood that the physician will prescribe a drug on that list.

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[16] Federal Register, December 15, 2003, page 69852.

[17] Centers for Medicare and Medicaid Services, FAQs: What are the rules for drug card sponsors to drop drugs from their formularies? http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_cat_lvl1=77&p_cat_lvl2=78

Beneficiaries who use very high cost drugs may need to be especially vigilant in checking the availability of their drugs at a discount under the specific card options. Drugs that are used to treat various forms of cancer, rheumatoid arthritis, HIV/AIDS, and multiple sclerosis, for example, can cost thousands of dollars a month. Some of these products are biologics, however, and require special handling. They may not be obtainable at local pharmacies, or through mail order, or the card program may not include them at all. Using the Medicare.gov PDAP, we tested how the card programs would treat eight of these high priced drugs for a beneficiary living in Baltimore (21211). As shown in Table 3, this beneficiary would have a maximum of 34 general national and regional card programs from which to choose for lower-cost, frequently prescribed medications. For these high-priced drugs, however, prices were available for three of the drugs for all 34 cards, but they were only available for 24 of the cards for the Multiple Sclerosis drug, Avonex. More but not all card programs offered prices on Thalomid, Humira, Avonex, and Tracleer. Similar results were found for a rural California county (93635). Our results suggest that beneficiaries needing these types of drugs may have to check with the specific card programs about both availability of the drugs and their prices.

Beneficiaries who use very high cost drugs may need to be especially vigilant in checking the availability of their drugs at a discount under the specific card options.

Table 3. Availability of Discounts from General National and Regional Medicare-Approved Drug Discount Cards for Selected High-Cost Drugs

Baltimore, Maryland 21211 – Retail pharmacies within a 2.25 mile radius

Use	Drug Name	Dosage/30-day	# cards (out of 34) with drug	# cards for which prices are not available for the drug
AIDS drug	Epivir	150 mg	34	--
Anti-cancer-myeloma	Thalomid	100 mg	25	9
Breast Cancer	Tamoxifen	10 mg	34	--
Rheumatoid Arthritis	Humira	2@40mg/.8mL	31	3
CMV Retinitis/AIDS	Valcyte	450 mg	34	--
Multiple Sclerosis	Avonex	4@30/.5ML kit	24	9
Pulmonary Hypertension	Tracleer	62.5 mg	32	2

Source: www.Medicare.gov. PDAP. Data are for the week of July 5, 2004.

The implications of the extensiveness of a formulary for a discount card program are less significant than they will be for the Part D drug benefit. The discount cards are not insurance; the enrollee remains responsible for paying the entire cost of prescriptions (although TA enrollees do receive the $600 per year subsidies). Enrollees pay the lower of the pharmacy price or their card's discounted price. They are free to not use their card if they can find lower prices for certain drugs at other retail outlets or with discount card programs that are not endorsed by Medicare. Moreover, the law provides that enrollees receiving TA may use those funds for any prescription, regardless of whether a discounted price is available through their card program. Under the Part D benefit program, plans may structure formularies so that there is no coverage for drugs not on the formulary (unless they are found necessary upon appeal), or to require higher out-of-pocket cost-sharing for drugs that do not have "preferred" status. Thus, the choice of drug plan may have much greater financial consequences for the enrollee, and beneficiaries will need to be more thorough in analyzing the formularies associated with their Part D plan choices.

Drug Pricing

Negotiated prices. Medicare-endorsed discount card programs are required to obtain "negotiated prices" on the prescription drugs they cover. The regulations define negotiated price as "the discounted price for a covered discount card drug offered by an endorsed sponsor, including any dispensing fee, which takes into account negotiated price concessions, such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations." [18] Sponsors are required to pass through to enrollees some of these price concessions, but no minimum quantitative standard is established. [19] In explaining this decision not to establish any minimum standard for passing through discounts, the preamble to the regulation states that "doing so would have the unintended effect of undercutting market competition as endorsed sponsors might cluster their drug prices around that threshold."[20]

Reporting of price concessions. Drug card sponsors are required to disclose to the Secretary of HHS the percentage of pharmaceutical manufacturer price concessions or rebates passed through to enrollees. The law requires that this information be protected as proprietary pricing information in the same way drug price reporting is protected under the Medicaid statute. CMS will not release any non-aggregated data in a format that discloses the identity of any particular drug rebate, manufacturer, or wholesaler.

*Price changes***.** Card sponsors are allowed to change the price of drugs at any time. However, because enrollees are generally "locked-in" to their enrollment in a particular program for a calendar year, any price increases cannot exceed an amount proportionate to the change in the drug's average wholesale price (AWP) and/or an amount proportionate to changes in the sponsor's cost structure (e.g., rebates, discounts, etc.) for the product. CMS has indicated that it is hiring a contractor to monitor price changes in order to enforce this requirement.[21] As of July 1, 2004, the identity of the contractor had not been announced.

*Medicaid "best price" exception***.** The MMA excepts prices negotiated by Medicare discount card programs with pharmaceutical manufacturers from the Medicaid law requirement that pharmaceutical manufacturers provide Medicaid programs with the lowest price (i.e., "best price") available from a manufacturer to any wholesaler, retail pharmacy provider or managed care organization. The exception is expected to allow card program sponsors to negotiate prices which in some cases will be less than paid under Medicaid.

Enrollees pay the lower of the pharmacy or their card's discounted price. They are free to not use their card if they can find lower prices for drugs at other retail outlets or with discount card programs that are not endorsed by Medicare.

Prices paid by beneficiaries. The drug prices quoted by card programs reflect the total cost to the consumer, including both the price for the pharmaceutical ingredients and the pharmacy dispensing fees. Card programs are required to ensure that the pharmacies participating in their program charge an enrollee no more than the lesser of the card program price, or the pharmacy's usual and customary price. Therefore, a card program enrollee is never to be penalized and pay a

[18] *Federal Register*, December 15, 2003, p. 69916
[19] Only one card, Public Sector Partners Prescription Discount Card, claims to be passing on "100% of its discounts" to enrollees. www.publicsectorpartners.com/programs/summary.cmf, June 14, 2004
[20] *Federal Register*, December 15, 2003, p. 69861
[21] McClellan, Mark, Testimony before the U.S. Senate. Committee on Finance, June 8, 2004.

higher amount because of participation in an approved card program. Network pharmacies must inform enrollees of any differential between the price of their prescribed drug and the lowest priced generic equivalent available at the pharmacy. This information is to be provided at the time of purchase, or in the case of mail order, at the time the drug is delivered (presumably through a package insert). It is unclear, and the regulations do not clarify, if the generic price information is to be provided before the prescription is actually filled, so that the enrollee has the option to obtain the lower priced generic, or whether the requirement can be fulfilled by providing the information with the filled prescription, so that any change to the generic version could not occur until the prescription is refilled.

Deeper discounts. Card sponsors are allowed to vary prices and formularies among categories of enrollees, such as by income or disease status. The preamble to the regulations states that such flexibility will promote access to lower prescription drug prices for populations for whom prescription drug expenses are a significant burden.[22] While most of the card programs indicate that prices may vary by enrollee characteristic, the only characteristics by which prices appear to vary is income and that is true for some but not all cards. One card program, Public Sector Partners Drug Discount Card, says that it "passes 100% of discounts to PSP card members."

While most of the card programs indicate that prices may vary by enrollee characteristic, the only characteristics by which prices appear to vary is income and that is true for some but not all cards.

Some discount card programs indicate on their websites that they have negotiated "additional" or deeper discounts with certain manufacturers on certain products. Treatment of these programs on the Medicare.gov PDAP has evolved, and as of mid-July, PDAP now links each card program to a page showing "Special Features," including whether the program has such manufacturer agreements. More information is provided below (see: "Drug Manufacturer Discount Card and Patient Assistance Programs").

Pharmacy Access

Card sponsors must demonstrate that enrollees will have convenient access to covered drugs at a discounted price by securing the participation of a sufficient number of pharmacies that dispense drugs (other than solely by mail order) directly to card enrollees. By regulation, "convenient access" is defined to mean that, in urban areas, at least 90% of card enrollees live within 2 miles of a contracted network pharmacy, in suburban areas, at least 90% of enrollees, on average, live within 5 miles of a contracted network pharmacy, and in rural areas, at least 70% of enrollees live within 15 miles of a network pharmacy.[23] The endorsed sponsor's retail pharmacy network may be supplemented by a mail order.

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[22] *Federal Register,* December 15, 2003, p. 69862

[23] *Federal Register*, December 15, 2003, p. 69918. These access standards are defined by statute and are based on the pharmacy access standards under the Department of Defense TRICARE program. Because of CMS concerns that these standards may be difficult to meet in some very rural areas, CMS requires only "that sponsors meet these standards at the program level, that is, across all of the states that comprise the sponsor's service area. Therefore, sponsors that wish to include rural states may need to also include more densely populated stated in their program's service areas in order to meet the statutorily defined access requirements." CMS also observes that drug card sponsors may offer mail order which "may provide a particular convenience for beneficiaries in rural areas." CMS, Drug Card Sponsor Questions & Answers, Last updated 5/6/2004, p. 25. www.cms.gov

There are about 57,500 retail pharmacies in the United States.[24] Of the 19 general 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.[25] Many card sponsors provide a tool on their websites enabling the user to identify all or a sample of participating pharmacies in a zip code or state. (Some permit the user to identify pharmacies that offer 24-hour service.) Other card sponsors do not include specific pharmacy information on their website, but indicate that they will make their pharmacy list available upon request.

Card programs generally caution that pharmacy networks may change at any time.

Card programs generally caution that pharmacy networks may change at any time. Regional card programs appear to have somewhat smaller pharmacy networks, an observation that has not, however, been examined systematically. Complaints have emerged that some pharmacies listed as participating in specific card programs may not, in fact, be doing so. This may be a problem for some beneficiaries who base their choice of card programs on that program's list of pharmacies.[26]

To test whether pharmacy networks vary for urban and rural areas, we looked at the number of pharmacies offered by seven selected card programs for four hypothetical beneficiaries in Baltimore and rural Kansas (Ellsworth). It is not surprising that beneficiaries living in Baltimore have a larger number of pharmacies to select from and that are closer to home as measured by radius from the beneficiary's home zip code.[27] Whereas the number of pharmacies offering the card for Baltimore ranged from 11 to 22 for the different card programs (with the median being 22), the number for Ellsworth ranged from 7 to 15 (with the median being 14).[28] For some of the selected card programs, the number of network pharmacies changed from the first to the sixth week but the change was typically no greater than the addition or subtraction of one pharmacy. Whether this is because of actual changes or data corrections is not known.[29] This tentative finding does suggest the importance of tracking this question over a longer time period than six weeks.

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[24] Health Policy Alternatives, Inc. *Prescription Drug Discount cards: Current Programs and Issues.* Kaiser Family Foundation, February 2002, p. 11.

[25] Information was sought from the card sponsor's website. In a few instances where the website was not yet operational, information was obtained by calling the sponsor's toll-fee telephone number.

[26] This problem "seems to stem in large part from the way in which drug card sponsors developed their list of participating pharmacies. Many drug card sponsors used 'passive acceptance agreements' to identify participating pharmacies. Under these agreements, unless a pharmacy specifically told the sponsor that they would not be participating – and have no intention of participating – with drug card sponsors, [they] are listed as participants on the Medicare web site." Letter to Secretary Thompson from Representatives Henry Waxman and Louise Slaughter, July 6, 2004.

[27] The Medicare.gov PDAP requires the user to indicate, for the zip code selected, the distance ("radius") for which it should display pharmacies for the available card options. Because of the large number of pharmacies in urban areas, we used 2.25 miles for Baltimore (21211). For Ellsworth (67439), we began with 11.75 miles but needed to increase the radius to 37.5 miles to capture the seven selected card programs.

[28] Note that the pharmacy totals for the seven selected card programs for each of our beneficiaries varied somewhat, presumably because some pharmacies within a network might not supply a specific drug.

[29] We did not check to see whether the change was simply in the totals or whether the specific pharmacies also listed in the network also changed.

Of the 34 general nationwide card programs actively marketing in June 2004, at least 26 offer mail order. Sometimes the mail order option is provided through the same organization such as a PBM; sometimes it is a separate entity. For example, some contract with Medco, Express Scripts, or Caremark-AdvancePCS, three of the nation's largest PBMs that operate mail order pharmacies. A few, however, contract with Drugstore.com. A mail order option may be especially useful for Medicare beneficiaries who are home-bound or live in areas where pharmacies are few and far between, especially for medications used on an ongoing basis. Depending on the card program, mail order also may provide for greater savings and convenience, a reason why many people use it even when neighborhood pharmacies are nearby.

A mail order option may be especially useful for Medicare beneficiaries who are home-bound or live in areas where pharmacies are few and far between, especially for medications used on an ongoing basis.

Some mail order options can be used for 30-day supplies; most tend to offer the best prices for 90-day supplies. Information on whether a card sponsor offers a mail order option can usually be found on the card sponsor's website. In addition, the PDAP allows the user to specify whether the display for their zip code and set of drugs includes card sponsors that offer a mail order option. The Medicare-approved discount card programs build in any shipping costs for normal deliveries to the drug price; enrollees are not charged a separate shipping charge for using the mail order option unless they request expedited delivery.

Some card program sponsors that do not offer mail order (and at least a few that do) indicate that discounts on 60- or 90-day supplies are available at their participating retail pharmacies. For these sponsors, it is likely that this option is included to help retail pharmacies -- who may also be partners in the card program -- retain customers not only for the prescription medications but for the other items sold by the pharmacy.

Medicare Advantage Plans and the Medicare Discount Card Program

Organizations with Medicare contracts under Part C (Medicare Advantage (MA) risk plans as well as plans with cost contracts and PACE programs) are eligible to offer general Medicare-endorsed discount card programs (including administration of TA for eligible enrollees). In general, Part C organizations must comply with the rules established for all discount card program sponsors. However, some special provisions apply for those MA plans that wish to offer programs exclusively to their Medicare enrollees (called exclusive drug cards). Other types of Part C plan organizations (e.g., private fee-for-service plans) that meet the discount card sponsor qualifications must make their endorsed programs available to all eligible individuals in their service area(s).

If an MA plan offers an exclusive discount card program, plan enrollees are only allowed to enroll in the plan's discount card program. Since the program is voluntary, MA organizations must allow their Medicare enrollees to decline enrollment, but if they do decline, they may not enroll in any general card program. If an MA organization does not offer an exclusive card program, their enrollees may participate in any general endorsed card program available to them in their area of residence. The same rules apply regarding the lock-in to one program and the ability to change card programs only during the annual coordinated election period or special election periods.

If an MA plan offers an exclusive discount card program, plan enrollees are only allowed to enroll in the plan's discount card program.

The Medicare discount card requirements that are waived for all exclusive card programs include:

- having at least a statewide service area;
- offering enrollment to all Medicare beneficiaries;
- pharmacy access standards if the plan operates a network that is not limited to mail order and meets provider access standards applicable to managed care plans;
- having a minimum one million covered lives; and
- the requirement that TA only be applied towards covered drugs (Part C plans are allowed to apply TA funds to cost-sharing requirements for their pharmacy benefits).

As of June 16, 2004, 84 organizations had been approved to offer exclusive discount card programs to enrollees in 457 Medicare managed care plans. In only 38 of the MA plans is payment of an enrollment fee for the discount card required: 29 plans charge $30 and in 9 the fee is $29. The fact that most of the plans do not require an enrollment fee is likely due to the fact that MA organizations are allowed to provide coverage of the discount card enrollment fee as a benefit in fulfilling any extra benefit requirements under their MA contract and must report such as part of their adjusted community rate filings.

The original CMS application solicitation for Part C organizations interested in offering discount cards indicated that the exclusive card program sponsors could request a waiver of the requirement that formularies and drug pricing information be made available on the PDAP website. In fact, however, the exclusive card programs were completely excluded from PDAP, and no comparative pricing information for these exclusive card programs is available on the PDAP website.

MA plan sponsors choosing not to offer a Medicare-endorsed discount card may have done so for a number of reasons. Some organizations already provided their enrollees with pharmacy discount cards and did not perceive sufficient advantage to having their cards receive Medicare endorsement. Other organizations may have been deterred by the short time frame and complicated application process. Others chose to partner with a general card sponsor and/or offer to pay all or part of the enrollment fee in a general card program as a more efficient way to provide members with access to discounted prices.

Coordination with State Pharmacy Assistance Programs

State Pharmacy Assistance Programs (SPAPs) are state-sponsored programs that provide senior citizens and, in some states, individuals with disabilities, increased access to affordable outpatient prescription drugs. Generally funded exclusively by state dollars, these programs have been increasing both in number and expenditures. As of July 2004, 31 states had programs in operation, and eight additional states had enacted laws to establish them but had not yet implemented them.[30]

[30] National Health Policy Forum: *The Basics*. *State Pharmacy Assistance Programs,* April 26, 2004, www.nhpf.org; National Conference of State Legislatures, *State Pharmaceutical Assistance Programs*, www.ncsl.org

Most of the states have direct-benefit programs where they subsidize a significant share of the prescription drug costs of their enrollees. Six states offer discount cards but no direct subsidy program. Eligibility levels vary but most SPAPs target low-income individuals who are not eligible for Medicaid, are 65 or older, or are disabled. Income thresholds range from 100% of the federal poverty level (Wyoming) to as high as 500% (Massachusetts). Some SPAPs offer benefits regardless of an individual's income, but with higher cost-sharing as income rises. Most SPAPs cover most drugs in a therapeutic class through the use of open formularies; a small number, however, use closed formularies. A majority of the states offering direct benefit programs also offer discount programs.[31]

The SPAPs, with their widely varying eligibility criteria and benefits, are taking their own paths in the precise manner in which they coordinate with the Medicare discount card program.

Medicare beneficiaries who are enrolled in an SPAP (other than those funded under Medicaid waivers) may also enroll in a discount card program.[32] If a beneficiary establishes eligibility for TA, he or she receives the $600 credit and then the SPAP typically wraps its coverage around the TA credit. This means that the beneficiary will first buy her drugs using the TA credit. The SPAP may fill in the required cost-sharing and help with the cost of drugs once the credit is exhausted. The SPAPs with direct benefits stand to save significant amounts of money as a result of the TA program. Whether these savings are used to expand eligibility or benefits remains to be seen. At this juncture, it appears that the SPAPs, with their widely varying eligibility criteria and benefits, are taking their own paths in the precise manner in which they coordinate with the Medicare discount card program.

The value of the Medicare discount card program to lower-income individuals who are not eligible for TA but who are enrolled in a SPAP is also likely to vary by state. In some states, there may be few or no enrollees with incomes above that needed to qualify for TA; in others, with higher income eligibility thresholds, there are significant numbers of enrollees who will not be eligible for TA. Often, non-TA eligible enrollees can get drugs at lower out-of-pocket costs through their SPAP than they could through the Medicare discount card program. For this reason, many SPAPs are advising enrollees not to obtain a Medicare discount card.[33]

SPAPs and Auto-Enrollment. One of the major issues initially facing states has been whether they would be permitted to enroll automatically Medicare beneficiaries who participate in their SPAPs in specific discount card programs. The major rationale for doing this is to better coordinate the SPAP with the TA credit and the Medicare discount cards and accrue savings for these states. CMS has decided to allow states to do this, known as "auto-enrollment," or "auto application" but only if the state is the individual's authorized representative. Auto-enrollment is permitted for all beneficiaries enrolled in an SPAP, not just those qualifying for TA.

Beneficiaries who are auto enrolled into a card program must be given the opportunity to decline the card or to switch to a different card program. Before the auto-enrollment occurs, states electing this procedure are required to send a notice to SPAP enrollees explaining what is happening, the consequences of auto enrollment, whether enrollment in the card is

[31] National Health Policy Forum, April 26, 2004.
[32] Enrollees in state AIDS Drug Assistance Programs (ADAP) are also eligible to participate in the discount card program and to apply for transitional assistance (if they meet the income eligibility criteria). CMS. Drug Card Sponsor Questions & Answers, updated 5/6/2004, p. 47.
[33] Testimony of Kimberly Fox, Center for State Health Policy at Rutgers University, to the State Pharmaceutical Assistance Transition Commission, July 7, 2004.

required for participation in the SPAP; how the individual can opt out, and whether there is a card program enrollment fee. (The fee would apply only to non-TA enrollees, but most states are not auto-enrolling them.)[34]

If the state is not the individual's authorized representative, the state is permitted to send a letter to its SPAP enrollees seeking permission from the beneficiary to apply for TA on the person's behalf (or take other appropriate steps as provided under state law). Once the person's permission is obtained, then the state can do auto-enrollment. States are also permitted to facilitate enrollment in a specific drug card program and to apply for TA by completing the form on behalf of the individual, and providing the form to the individual to return it (signed) to the card sponsor.[35]

As of June 10, 2004, SPAPs in seven states (CT, ME, MA, MI, NJ, NY, and PA) had arranged with CMS to auto-enroll their recipients in a drug card and the TA program. In addition, Ohio and Rhode Island had provided enrollees with applications that were already filled out and required only the beneficiary's signature. SPAPs in CT, ME, MA, NJ and Ohio cover both the aged and the under-65 disabled; NY, PA, and RI only cover those 65 and older. As of the same date, the other SPAPs did not have plans to do auto-enrollment. CMS has given SPAPs the permission to exclusively contract with a Medicare-approved discount card program. Pennsylvania's PACE, for example, is exclusively contracting with First Health, which has served as PACE's TPA.[36] One state, Connecticut, chose to implement auto-enrollment with several cards instead of using an exclusive arrangement.

As of June 10, 2004, SPAPs in seven states (CT, ME, MA, MI, NJ, NY, and PA) had arranged with CMS to auto-enroll their recipients in a drug card and the TA program.

Drug Manufacturer Discount Card and Patient Assistance Programs

Many pharmaceutical manufacturers sponsor programs that provide free or discounted drugs to targeted populations. Information on these patient assistance programs is linked to the Medicare.gov website.[37] Many of the larger drug companies also sponsor and/or have partnered with other companies to offer drug discount cards. GlaxoSmithKline, for example, sponsors the "Orange Card;" Eli Lilly sponsors the "LillyAnswers" card; Novartis sponsors the Novartis CareCard; and Pfizer sponsors the "Share Card." The "Together Rx" card program was founded by a consortium of 8 drug manufacturers, including Eli Lilly, GlaxoSmithKline, Novartis and Pfizer. Drug companies established these discount card programs for their drugs in 2001-2002 in the heat of debate over the Medicare drug benefit and targeted them largely to low-income Medicare beneficiaries who lack insurance coverage for prescription drugs.

How will these programs work with the Medicare discount cards? The Pfizer Share Card program has announced that it will end on August 31, 2004, but through Pfizer's participation

[34] CMS, Drug Card Sponsor Questions & Answers, updated 5/6/2004, p. 51.
[35] CMS, Drug Card Sponsor Questions & Answers, updated 5/6/2004, p. 51.
[36] Presentation of Thomas Snedden, Pennsylvania PACE, National Health Policy Forum meeting, May 14, 2004.
[37] In May 2004, Wisconsin introduced a new website (www. Rx4Wisconsin.org) to help connect qualified low-income residents connect with discount drugs, through drug manufacturer patient assistance programs. Such information can also be obtained from the ABC Rx Coalition's website: http://www.accesstobenefits.org/Find%20Rx%20Savings/.

in the Medicare-approved "U Share Prescription Drug Discount Card," Pfizer will continue to make available most of its drugs to enrollees at $15 per 30-day supply.[38] Eli Lilly announced in January 2004 that it would offer the "LillyAnswers" discount to low-income enrollees below 200% of the federal poverty level in all Medicare-approved discount card programs. Lilly drugs would be available for only a $12 fee for a 30-day supply. Lilly also indicated that it would provide discounts on Lilly medications for approved card program enrollees with incomes greater than 200% of the federal poverty level.[39] Lilly, like Pfizer, is also a cosponsor of the U Share Prescription Drug Discount Card Program. Together Rx says on its website that it plans to continue to assist cardholders until 2006, when the drug benefit becomes available. "Together Rx is structured to allow each member company to make individual decisions as to whether to continue its participation, the savings that it offers, and its product offerings, which can be periodically modified."[40] It is not known whether the other companies with discount card programs will respond like Pfizer's "Share Card" and be transitioned to a Medicare-approved card or, like Together Rx, continue to operate outside the Medicare-approved card program through the end of 2005.

Transitional Assistance Enrollees. As of mid June 2004, CMS indicated that seven pharmaceutical manufacturers had agreements with Medicare-approved discount card sponsors to provide additional discounts to TA individuals once they exhaust their $600 credit. This information has been gradually updated and is now described on the PDAP as the "Expanded Medicare Assistance Programs."[41] (See also Figure 4 on the following page.) For each of these manufacturer programs, there is a different list of sponsors with which they have agreements, and the programs vary on whether the enrollee is required to pay anything for the drugs that are included in the agreement. For example, Novartis and AstraZeneca are providing prescription drugs free to TA-eligible Medicare enrollees after they exhaust the $600 credit, except that enrollees are "responsible for any pharmacy fees, such as a dispensing fee, negotiated by your card sponsor." An earlier Novartis announcement estimated these to be $5 to $10 for most medications.[42] Under the Eli Lilly agreement, once the $600 is spent, the TA-eligible enrollee will be charged $12 for a 30 day supply of a specific set of Lilly drugs, plus any pharmacy fees, such as a dispensing fee, as negotiated by the card sponsor." With Merck's program, once a TA enrollee has exhausted the $600 credit, the person will be able to purchase Merck medications for the rest of the year, paying only a pharmacy dispensing fee. As noted above, Pfizer has indicated that it will allow beneficiaries to purchase medications for a flat monthly fee of $15 (30-day supply) for those participating in the Medicare-approved "U Share Card" program.

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[38] http://www.pfizersharecard.com/homenew2.asp?cardImageOver=8&cod=2, July 6, 2004

[39] If this is the case, then some card programs have not yet indicated on their websites the availability of these discounts on Lilly drugs. For the announcement, see: http://www.lillyanswers.com/en/news/pr_1.html, July 6, 2004.

[40] http://www.togetherrx.com/faq.html, July 6, 2004

[41] The PDAP page that lists the approved discount card programs for a beneficiary in a zip code includes information for some card programs on how their programs interact with manufacturer patient assistance programs. This list has tended to lag behind the actual number of manufacturer agreements. A "master list" now appears on the cms.gov website. Although the PDAP shows the actual price a TA enrollee would pay for each drug for each card (for each pharmacy) before he or she exhausts the $600 credit, it does not show the extra savings from the manufacturer discounts.

[42] *Health Care Daily*, Novartis to Offer Free Medications to Low-Income Seniors With Drug Cards, April 15, 2004; *Health Care Daily*, Merck Offers Free Medications For Some Low-Income Senior Citizens, February 17, 2004.

Some manufacturers have also entered into arrangements with certain card sponsors to offer additional discounts to enrollees who are at income levels that disqualify them for transitional assistance. In some instances, it is not clear from the card sponsor's website when such additional discounts are available and to whom. For others, it is clearly indicated that the additional discounts are available for enrollees who fall below certain income thresholds for some drugs manufactured by a named company. For example, Wellpoint's Precision Discount Card (Option A) provides additional discounts for Lilly drugs for enrollees who have $18,000 to $24,000 in household income. Income information is requested on the enrollment form as an optional question. Community Care Rx and Criterion Advantage, sponsored by Computer Sciences Corporation, indicate that they will provide additional discounts for lower-income enrollees for selected drugs of certain manufacturers. Again, optional income information is solicited on the cards' enrollment forms.

Seven pharmaceutical manufacturers have agreements with Medicare-approved discount card sponsors to provide additional discounts to TA individuals once they exhaust their $600 credit.

Figure 4

Availability Of Assistance For Low-Income Beneficiaries After Exhaustion Of $600 Credit

Agreements Between Drug Manufacturers and Medicare-Approved Drug Discount Card Programs to Provide Additional Discounts

Drug Manufacturer	Number of Agreements
Abbott	4
Astra Zeneca	6
Eli Lilly and Company	27
Johnson & Johnson	12
Merck	27
Novartis	20
Pfizer	1

SOURCE: www.cms.hhs.gov/medicarereform/drugcard/mfragreements.asp, July 6, 2004.
NOTES: On July 7, 2004, Pfizer announced that it will give access to many of its drugs for a flat fee of $15 per prescription for low-income beneficiaries who are enrolled in any Medicare-approved drug discount card. Press release, www.pfizer.com.

BENEFICIARY OUTREACH, EDUCATION AND SAFEGUARDS

Critical to a successful implementation of the Medicare drug discount card program is getting clear and consistent information to beneficiaries and those agencies and individuals on whom beneficiaries rely for assistance and advice. Educating beneficiaries has proved to be a significant undertaking because of the large number of card options, and the challenge of communicating with over 40 million seniors and people with disabilities. The Medicare.gov PDAP alone includes information on nearly 60,000 drug products and 75,000 pharmacies, according to CMS Administrator Mark McClellan.[43] Choosing the card that offers the best value for an individual requires consideration of a large amount of comparative data and the availability of tools to support informed decision making.

Educating beneficiaries has proved to be a significant undertaking because of the large number of card options . . . . The Medicare.gov PDAP alone includes information on nearly 60,000 drug products and 75,000 pharmacies.

The challenge of mounting an outreach and education effort on the scale required to reach all beneficiaries cannot be over stated. A survey sponsored by the Kaiser Family Foundation in April 2004 found that nearly one-half of Medicare beneficiaries held an unfavorable impression of the MMA. Fifty-four percent of survey respondents reported that they didn't know enough about the MMA to say whether it included a Medicare drug discount card program. And, three quarters of surveyed beneficiaries said they did not know whether cash subsidies were available for some with a Medicare discount card. These results illustrate both the need for an aggressive educational effort and the magnitude of the challenge. [44]

CMS Education and Outreach

The MMA directs the Secretary of HHS to undertake a number of specific information and outreach activities to ensure broad dissemination of program features, eligibility rules, and comparative information. In response, HHS through CMS has initiated a broad range of information and enrollment-related activities to inform Medicare beneficiaries about their card options and assist them in enrolling in the card program of their choice. In addition, the agency is working with a large number of private and public agencies to provide beneficiaries with the opportunity to talk directly with trained volunteers about the details of the card program.

The 1-800 toll-free telephone line with trained customer service representatives and the CMS.gov and Medicare.gov websites displaying comparative information on the approved card options, enrollment fees, pharmacy networks, prices for the drugs covered under the program, and enrollment applications has been a major undertaking. As noted above, the PDAP found on medicare.gov was built on an existing site offering detailed information on state pharmacy assistance programs and patient assistance programs sponsored by some drug manufacturers.

Staffing for the 1-800-Medicare information line has been progressively increased over the last several months as the volume of calls has increased. Inquiries can be handled in English or Spanish, but there is only limited availability of other language support and no capability to

[43] Mark McClellan,Testimony before Senate Finance Committee, June 8, 2004.
[44] Kaiser Family Foundation, 2004, *Selected Findings on the New Medicare Prescription Drug Law, Health Poll Report Survey* (conducted April 1-5, 2004), www.kff.org.

communicate in Asian languages. Nearly 2,800 customer service representatives at six call centers were handling as many as 150,000 inquiries per day in early June.[45] Waiting times for customer service representatives are being reduced, and now it takes less than 2 minutes on average to speak with a customer service representative, down from 14 minutes on average a month ago.[46]

The comparative information on card programs presented on the PDAP is in a format intended to assist beneficiaries in choosing a card. CMS has continually refined the tool and made it simpler to use. Still, in order to obtain a list of specific drug prices for cards accepted by pharmacies near a beneficiary's residence, it is necessary to enter the appropriate zip code, and a list of drugs taken with the strength and frequency. Following the complete PDAP inquiry process also requires the individual to enter income and insurance coverage data, which are used to determine whether the beneficiary is eligible for general enrollment and for $600 in transitional assistance. The PDAP also can provide prices for generic alternatives to brand name drugs (although it does not provide brand names if the person enters the generic) or expand the range of card and pharmacy choices by asking for a report on cards in a wider geographic area.

Beneficiaries may also request this same information by calling the Medicare toll-free number and requesting a printed copy of comparative information be mailed to them. However, to use the phone for this purpose a beneficiary must be prepared to answer specific questions about the drugs they are taking, the strength and frequency of dosing, which pharmacy or pharmacies they wish to use, and whether they want information on mail order options and generic drugs. Some beneficiary counseling centers offer help in assembling the information necessary to make a complete and accurate inquiry.

Of those beneficiaries who use the Internet, just 2% had visited the main government website designed for beneficiaries (www.Medicare.gov).

While the PDAP and the toll-free telephone service can help to identify a card program offering the best value for a beneficiary, the volume of information on available cards and participating pharmacies can be overwhelming. Printed reports on card options in many areas can run over 50 pages depending on the number of drugs and the size of the geographic area included in a beneficiary's request. Media reports suggest delays in reaching operators at 1-800-Medicare are also a source of significant frustration for many beneficiaries, although this problem appears to be subsiding.

An April 2004 survey sponsored by the Kaiser Family Foundation (KFF)[47] shows that use of the Internet by seniors is growing but overall remains low. About 70% of those age 65 or over report never using the Internet. Of those who do go online, just 2% had visited the main government website designed for beneficiaries (www.Medicare.gov). Internet use also varies significantly by income. For those with annual incomes below $20,000, only 15% have ever visited the Internet, while 65% of beneficiaries with incomes above $50,000 have gone online. These results suggest that direct decision support for beneficiaries through the Internet is still quite limited, although it may be available to individuals through family members.

[45] Leslie Norwalk, Orlando Sentinel, June 1, 2004.
[46] Mark McClellan, Testimony before the Senate Special Committee on Aging, July 19, 2004; testimony before the Senate Finance Committee, June 8, 2004.
[47] Kaiser Family Foundation, *Selected Findings on the New Medicare Prescription Drug Law*, 2004.

HHS has also taken a number of other steps to acquaint beneficiaries with the approved drug card programs:

- Print, radio, and television advertisements have been prepared and placed in major media outlets—television time for just two ads totals $18 million.
- The Secretary sent a mailing to all Medicare beneficiaries in February 2004 with an enclosed "Fact Sheet" previewing the upcoming card program and the drug benefit scheduled for 2006.[48]
- In April 2004, HHS mailed to all beneficiaries a three-page introduction to Medicare-approved discount cards highlighting the beginning of the enrollment period on May 1 and the availability of $600 in TA for beneficiaries below the statutory income ceilings.
- In April 2004, CMS sponsored a conference to train state and voluntary agency staff on the policies and enrollment procedures for card programs.
- The Social Security Administration in April mailed a letter to low-income beneficiaries with information on how to access TA benefits.
- Finally, HHS prepared a guide to choosing a discount card and a briefer "tip sheet" to aid in the enrollment process – both of which are available upon request or at Medicare.gov and from organizations partnering with HHS to assist beneficiaries with their card decisions.

In addition to these outreach efforts, funding for the state health insurance assistance programs (SHIPs) was increased from $12.5 million in 2003 to $21.1 million this year. These organizations provide personal assistance to Medicare beneficiaries regarding all of their health coverage options. Recently, HHS announced an additional $4.6 million in grant funds for community-based organizations to target assistance to low-income beneficiaries. Members of the Access to Benefits Coalition (ABC)[49] are among the eligible recipients in 30 targeted urban communities across the country where approximately 70% of low-income beneficiaries reside. Another $2 million is being made available to Area Agencies on Aging to help enroll low-income beneficiaries in the transitional assistance benefits. Additional funds ($200,000) have been allocated to the Indian Health Service for similar activities.[50]

Congress authorized HHS to spend an additional $1 billion on activities related to launching the card program and the Part D prescription drug benefit. While a total figure on funds for education and outreach activities in support of the card program is not currently available, published expenditures for some of the activities noted above are nearly $50 million. Additional funds have been used to support contracts with Abt Associates for an evaluation of the card program and with another contractor to monitor and identify excessive price fluctuations in specific card programs.

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[48] Critics of this mailing requested a Government Accountability Office (GAO) opinion on whether it was purely informational or contained "publicity or propaganda" in violation of statutory prohibitions. GAO concluded that the mailing did not violate the law, but contained "notable omissions and other weaknesses." GAO. *Medicare Prescription Drug, Improvement and Modernization Act of 2004. Use of Appropriated Funds for Flyer and Print and Television Advertisements*, March 10, 2004(B-302504), p. 2-3.

[49] ABC includes over 68 organizations such as the AARP, the Salvation Army, the National Senior Citizens Law Center, and the American Hospital Association.

[50] DHHS Press Release, *HHS Announces New Collaborative Enrollment Initiative to Help Low-Income Medicare Beneficiaries Sign Up for Drug Discount Card*, May 27, 2004.

Card Sponsor Education and Marketing

Sponsors of drug cards are required to engage in specific education and enrollment activities. Among other requirements, sponsors must prepare information on covered drugs and prices, participating pharmacies, other products or services offered under the endorsement (e.g., discounts on over the counter medications), and enrollment fees for distribution in print and through the Internet. They must also maintain a toll-free telephone number to respond to inquiries and to advise enrollees with TA benefits of the current balance in their accounts. Current information on the balance in TA accounts must also be available at all network pharmacies at the time drugs are dispensed to an enrolled card member. Sponsors must also require their participating pharmacies to advise all card enrollees of the difference in price between a brand name drug and a generic product if available when prescriptions are dispensed.

Card sponsors may market their card options in a variety of ways including print and broadcast media, sales presentations upon request, flyers, and response cards. Sponsors are prohibited from any door-to-door solicitation or telemarketing approaches. Sponsors may also compensate others for their assistance in enrolling beneficiaries in a card program such as pharmacists subject to certain limits under the fraud and abuse laws (see below).

CMS regulations include a specific listing of the content for sponsor materials that must be available before and after enrollment of an eligible beneficiary. Among these items are:

- Details on covered drugs and prices and enrollment procedures;
- Availability of transitional assistance;
- Details on additional services such as drug utilization reviews and product alerts that are provided are no additional cost;
- Grievance procedures;
- The toll-free information telephone number;
- List of participating pharmacies;
- Enrollment fee and cost-sharing (if applicable);
- Notice that discount prices are subject to change; and
- Privacy protections.

Targeted outreach by HHS/CMS to physicians and pharmacists consists of making informational guides and other printed material available to providers upon request. Most card sponsors are also distributing materials for enrollment to participating pharmacies where beneficiaries are expected to seek information and advice.

Consumer Protections Against Fraud and Abuse

Law and Regulations. The MMA authorizes the Secretary to impose sanctions on sponsors of Medicare-endorsed discount cards for violations of program rules, including those pertaining to fraud and abuse.[51] These include: (1) civil money penalties (CMPs) of up to $10,000 for actions that the sponsor knows or should know violates a requirement of the discount card program; (2) other intermediate sanctions (such as suspension of outreach activities or enrollment of new beneficiaries); and (3) termination of participation in the discount card program.

[51] Section 1860D-31(i)(3) of the Social Security Act (42 U.S.C. 1395w-141(i)(3))

Regulations implementing this authority identify the following forms of potential fraud and abuse that are subject to these sanctions:

- misrepresentation or falsification of information in outreach materials and comparable materials that a provided to beneficiaries and other persons;
- charging an enrollee in violation of the terms of the endorsement contract (e.g., charging for services the sponsor is required to provide without charge);
- charging an enrollment fee exceeding $30;
- charging a TA enrollee any enrollment fee;
- using TA funds in any manner inconsistent with their intended purpose;
- charging TA-qualified enrollees any coinsurance, and charging coinsurance in excess of 5% for enrollees below 100% of poverty or 10% for those between 100% and 135% of poverty;
- substantial failure to provide enrollees with negotiated prices consistent with information reported for the drug comparison website (medicare.gov);
- substantial failure to assure that any drug price increases do not exceed the increase in a sponsor's costs for the drugs; and
- substantial failure to comply with information and outreach guidelines (e.g., inclusion of information on products not directly related to discounted prescription drugs or to discounted over-the-counter drugs in marketing materials.[52]

Other laws enacted before the MMA also apply to fraud and abuse in the card program. The Office of the Inspector General (OIG) of the Department of Health and Human Services has made it clear that the anti-kickback laws[53] for Medicare and federally-funded State health care programs apply to the program. On April 8, 2004, it issued guidance indicating that payments by drug card sponsors to pharmacies for education and outreach activities could violate the anti-kickback laws if the payments result in steering Medicare beneficiaries to a particular discount card. The most obvious example of this would be basing such payments on the number of beneficiaries selecting the sponsor's card.[54]

Although the OIG has not identified other behavior in connection with the drug card program that could violate the anti-kickback laws, presumably it could also apply in other contexts, such as offering beneficiaries coupons or discounts on pharmacy services outside of the discount card endorsement.[55] Violations of the anti-kickback laws are a felony and are

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[52] *Federal Register*, December 15, 2003, p. 69863-64, 69869-70, 69877-78, 69918-19, 69922, 69925-26; Department of Health and Human Services, Office of the Inspector General, "Medicare and State Health Care Programs; Fraud and Abuse; OIG Civil Money Penalties Under the Medicare Prescription Drug Discount Card Program; Interim final rule and comment period", *Federal Register*, May 19, 2004, p. 28842-46.

[53] Section 1128B(b) of the Social Security Act (42 U.S.C. 1320a-7b(b).

[54] Office of the Inspector General, "Education and Outreach Arrangements Between Medicare-Endorsed Discount Drug Card Sponsors and Their Network Pharmacies Under the Anti-Kickback Statute," April 8, 2004(available at www.oig.hhs.gov/fraud/docs/alertsandbulletins/2004/FA040904.pdf). It should be noted that, although the anti-kickback laws generally prohibit the waiver of Medicare cost-sharing, the MMA made a specific exception that permits pharmacies to waive coinsurance for beneficiaries qualifying for transitional assistance if certain conditions are met.

[55] CMS has offered somewhat ambiguous guidance on this issue. In its December 2003 interim final rules on the discount card program, it indicated that the "Forthcoming information and guidelines"

punishable by fines of up to $25,000 and imprisonment for up to five years. Violations are also subject to CMPs of up to $50,000.

In addition, a 1988 law prohibits the use of words and symbols related to the Medicare program to give the false impression that an item is approved, endorsed, or authorized by Medicare. Violations are subject to CMPs of up to $5,000 or $25,000 violations consisting of a broadcast or telecast.[56]

Oversight and Monitoring. The program is in its early days and there have been no reports of enforcement actions taken against discount card sponsors beyond removing inaccurate pricing information from the program's price comparison website (www.Medicare.gov's PDAP). The only specific report of fraud to surface to date has involved persons misrepresenting themselves as Medicare officials or as representatives of Medicare-approved discount cards in an apparent effort to obtain personal information from beneficiaries that could be misused for other purposes. In April, before the program commenced operations, CMS reported that "some Medicare beneficiaries across the country (Alabama, Georgia, Idaho, Maryland, Nebraska, New York, Rhode Island, Virginia) have already received calls as well as in-person solicitations from individuals/companies posing as Medicare officials attempting to gain personal information from beneficiaries with the intent to scam the beneficiaries." [57]

There have been no reports of enforcement actions taken against discount card sponsors beyond removing inaccurate pricing information from the program's price comparison website.

In press releases and regulatory guidance, CMS and OIG have indicated that they are taking a number of steps to prevent and detect fraud and abuse. They include:

- Requiring card sponsors to submit all marketing and outreach materials for agency review prior to their use. The purpose of this review is to identify any false or misleading information, as well as the improper inclusion of prohibited information on products and services that are outside the scope of the card endorsement.[58]

- Monitoring the week-to-week changes in drug prices offered by card sponsors in order to detect "bait and switch" tactics (i.e., initially offering enrollees low prices and then raising them once the beneficiary has selected a card and is "locked in" for a period of time). According to CMS Administrator Mark McClellan, this monitoring will initially be done by CMS, but only until the agency has selected an outside contractor to conduct it.[59]

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would provide that card sponsors "may not …provide cash or other monetary rebates (for example. coupons on pharmacy products and services) as an incentive for enrollment. (*Federal Register*, December 15, 2003, p. 69868). However, in its publication on "Drug Card Sponsor Frequently Asked Questions" (as of June 15, 2004), it indicates that sponsors can offer nominal ($15 or less) coupons or gifts to offset enrollment fees as long as they are "not a form of inducement to enroll…in the card program." (Question 25).

[56] Section 1140 of the Social Security Act (42 U.S.C. 1320b-10).

[57] CMS, "Fact Sheet: Medicare Beneficiaries Warned About Drug Card Scams" (April 22, 2004) (http://cms.hhs.gov/media/press/release.asp?Counter+1018). In addition, a June 1, 2004 report issued by the Center for American Progress suggested that the discount card company may be susceptible to fraud because 20 card sponsors have been involved in fraud charges in the past.

[58] *Federal Register*, December 15, 2003, p. 69868-69, 69872.

[59] CMS, " Medicare Implements New Steps to Prevent Drug Card Fraud," (April 22, 2004) (http://www.cms.hhs.gov/media/press/release.asp?Counter=1017) ; *Washington Healthbeat*, Stop

- "Mystery shopping" of the toll-free call centers card sponsors are required to maintain in order to identify false, misleading, or otherwise prohibited information practices. Although the precise meaning of the term "mystery shopping" is not defined, presumably this involves a caller who represents herself or himself as a Medicare beneficiary in order to determine the types of information a card sponsor actually conveys to beneficiaries.[60]

- Reviewing grievance logs that card sponsors are required to maintain as a condition of participating in the program.[61]

- Taking complaints and tips about fraud over the phone at 1-800-MEDICARE and the OIG's fraud hotline (1-800-447-8477).

- Issuing fraud alerts for use by publications read by seniors. For example, in response to anecdotal reports of persons falsely representing themselves as Medicare officials or agents of Medicare-approved drug discount cards, CMS issued a fact sheet on April 22, 2004 warning beneficiaries to "NEVER share personal information such as their bank account number, Social Security number or health insurance card number (or Medicare number) with any individual who calls or comes to the door claiming to sell ANY Medicare related product." [62]

Only additional experience will tell whether fraud and abuse will prove to be a significant problem under the discount card program.

PART II. DISCOUNT CARD PRICING ANALYSIS

To what extent do the Medicare-approved discount cards provide value to Medicare beneficiaries who otherwise buy their prescriptions at the full retail price? Do some cards provide better value than others?

Others have sought to answer this key question by comparing prescription drug prices obtainable using the Medicare-approved discount cards with prices that could be obtained through other means, including Canadian sources and the Federal Supply Schedule that is applicable to drugs obtained through the Department of Veterans Affairs.[63] Some analyses have factored in savings achievable for TA-eligible beneficiaries (including the $600 credit available in each of 2004 and 2005) as well as the extra discounts that may be available from some pharmaceutical manufacturers for some drugs through side agreements with the drug card sponsors.[64] Other analyses have focused on the prices obtainable by the Medicare

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Dissing Discount Cards, Grassley Tells Dems, June 8, 2004.

[60] *Federal Register, December 15, 2003,* p. 69877; CMS, " Medicare Implements New Steps to Prevent Drug Card Fraud," April 22, 2004.

[61] *Federal Register, December 15, 2003,* p. 69877.

[62] CMS, "Fact Sheet: Medicare Beneficiaries Warned About Drug Card Scams," April 22, 2004.

[63] U.S. House. Committee on Government Reform, Minority Staff, *New Medicare Drug Cards Offer Few Discounts*, Washington; D.C., April, 2004; *Medicare Drug Card Prices Remain High*, Washington, D.C., June 2004.

[64] For example, see Antos, Joseph and Ximena Pinell, *Private Discounts, Public Subsidies. How the Medicare Prescription Drug Discount Card Really Works*, The AEI Press, Washington, D.C., June,

beneficiary who either does not qualify for TA or fails to apply for it.[65] CMS itself has generated almost weekly reporting of how the Medicare-approved drug card programs are faring on the pricing front and Administration officials have asserted that competition among the Medicare-approved card programs will drive prices steadily downward, gradually enhancing the value of a card to the beneficiary.[66]

While proponents of the discount card program have found from their analyses that beneficiaries stand to save significant amounts of money using the discount cards, program critics have found that beneficiaries could do just as well or better buying their drugs from Drugstore.Com or, better yet, through Canadian-based internet pharmacies. If a consensus exists at all, it is with regard to the TA program, where the savings for qualified beneficiaries are obvious because of the $600 annual government subsidies. Results from these conflicting studies are generally not comparable, however, because their authors have analyzed different sets of drugs, different areas of the country, different sources of retail or approximated retail prices (i.e., what the cash customer would pay), and different analytic techniques. All of these studies have had to be conducted without the benefit of having access to the underlying drug price database that makes up the Medicare.gov PDAP tool.[67]

The actual savings for any one beneficiary will depend on his or her ability and willingness to "maximize" the potential savings, which may require switching from brand to generic drugs, from one community pharmacy to another, or from a community pharmacy to mail order.

We too sought to determine whether the Medicare-approved discount cards were providing value in terms of providing savings to a beneficiary who would otherwise be paying the full retail price. Like everyone else, our inability to access the full underlying database for the discount card part of the PDAP limited the scope of the inquiry and, as such, our ability to generalize from our results. (See Appendix for a discussion of our methodology.) Because the PDAP's comparative pricing information is available only on a drug- and zip code-specific basis, it is not possible to do a comprehensive evaluation of the savings achievable using the various approved card programs. Moreover, the actual amount of savings achieved by any one beneficiary will depend on his or her ability and willingness to "maximize" the potential savings, which may require switching from brand to generic drugs, from one community pharmacy to another, or from a community pharmacy to mail order. Nor is it certain that the same beneficiary could not have achieved the same savings by using some of the commercial discount cards that were being heavily marketed prior to the implementation of the Medicare discount card program.

These cautions noted though, the results of our pricing analysis are consistent with what some card program proponents have said: at least some of the cards do deliver good value when compared with the retail prices paid by cash customers. As indicated above, for

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2004; Centers for Medicare & Medicaid Services, *Medicare-approved Drug Discount Cards Provide Additional Savings to Low-Income Medicare Beneficiaries*, Washington, D.C. May 19, 2004.

[65] Health Care Leadership Council, *Medicare Prescription Drug Discount Cards. Immediate Savings for Seniors*, analysis prepared by the Lewin Group, May 2004. http://www.hlc.org/html/medicare.html

[66] For example, see Centers for Medicare & Medicaid Services, *Medicare-approved Prescription Drug Discount Cards Provide Drug Prices Significantly Below Average Paid by Americans,* May 6, 2004, http://www.cms.hhs.gov/medicarereform/drugcard/; Press Release, *Medicare-approved Prescription Drug Discount Cards Show Significant, Sustained Discounts*, May 28, 2004. http://www.cms.hhs.gov/default.asp?

[67] CMS will not provide the data base on the grounds that it includes proprietary information. Personal communication with CMS, May 17, 2004.

beneficiaries with TA, there is no question that some Medicare-approved discount cards are well worth having; even those that deliver little in price savings are better than going bare because the beneficiary pays no enrollment fee, gets the $600 annual credit applicable to all covered prescription drugs and not just those that are discounted, and – depending on the card -- may allow access to additional manufacturer savings on certain drugs once the credits are exhausted. Because of this, we focused our pricing analysis on savings for Medicare beneficiaries with no prescription drug coverage who do not qualify for TA.

Nonetheless, our inquiry also confirmed the findings of card program critics that the process of trying to use the Medicare.gov website to determine which card program(s) is the best buy is far from being user friendly and is likely to discourage many beneficiaries or even their more computer-savvy helpers. We spent countless hours trying to produce consistent and meaningful results, especially in the first few weeks that card-specific pricing data were available from the Medicare.gov PDAP website. To the credit of CMS, website improvements have made the PDAP steadily more reliable and user friendly. And like some card program critics who have doubted the likelihood of continuously declining prices, we found that prices have remained relatively stable. The details on our specific findings follow.

We first compare prices for ten specific drugs using a sample of seven approved discount cards with retail prices that would be paid by a beneficiary paying full retail prices. We then examine the cost implications of using various discount cards for four hypothetical beneficiaries. We further compare the implications for each individual if they lived in an urban versus a rural area of the country.

The process of trying to use the Medicare.gov website to determine which card program(s) is the best buy is far from being user friendly and is likely to discourage many beneficiaries or even their more computer-savvy helpers.

Do Medicare-Approved Discount Cards Save Beneficiaries Money Compared with Retail Prices?

We tracked the pricing on a weekly basis for a set of 10 drugs commonly prescribed for Medicare beneficiaries and seven Medicare-approved discount card programs over the period May 10 and June 28, 2004, ultimately eliminating the first two weeks of this period because of concerns about data reliability. We compared these prices to retail prices reported by the Maryland Attorney General's "Prescription Drug Price Finder," which tracks prices paid by cash customers for the 25 most commonly used drugs in Maryland. (See Appendix for an explanation of the Price Finder as well as our rationale for the selected drugs and card programs.)

We found that all seven of our selected card programs had prices that were significantly less than those reported by the Maryland Attorney General (AG). Table 4 (on the following page) summarizes the range of savings provided by the seven card programs. A beneficiary purchasing any one of the 10 drugs sampled would save between 8% and 61% for a drug, depending on the specific drug, card program, and location of the pharmacy. Savings on brand name products were less in terms of percentages than for generics, but more in actual dollars. For example, an enrollee in one of the seven card programs in Baltimore ("urban") would pay between $159.41 and $166.05 at a network pharmacy for a 30-day supply of

We found that all seven of our selected card programs had prices that were significantly less than those reported by the Maryland Attorney General (AG).

Celebrex, compared to the median Maryland AG retail price of $198.99, for a 17% to 20% savings. An enrollee would pay between $4.27 and $6.45 for the generic drug furosemide at a card program network pharmacy, compared to the median Maryland AG retail price of $10.89, for a savings of between 41% and 61%.

Savings on brand name products were less in terms of percentages than for generics, but more in actual dollars.

Because the rural pharmacy prices reported to the Maryland AG are generally lower than those reported for the Baltimore zip codes, the percentage savings in the rural area are slightly less than in the urban area (card programs are required to report the highest price an enrollee will pay for a drug using their card, so although the price might be lower in some pharmacies, there was no way for us to include such differences in our analysis).

Table 4. Savings for Selected Drugs and Selected Card Programs Compared with Retail Prices in Two Maryland Areas

Drug Name	Brand or Generic	Maryland AG Median Price (Urban)	% Savings (Urban Retail*)	Maryland AG Median Price (Rural)	% Savings (Rural Retail**)	% Savings (Urban Mail order***)
Celebrex	Brand	$198.99	17-20%	$198.99	17-20%	28%
Fosamax	Brand	$87.49	17-28%	$80.63	8-21%	33%
Furosemide	Generic	$10.89	41-61%	$9.99	35-57%	81%
Hydrochlorothiazide	Generic	$8.87	38-54%	$6.33	13-36%	89%
Lipitor	Brand	$85.99	18-21%	$78.03	9-13%	30%
Norvasc	Brand	$76.99	19-22%	$76.84	18-22%	31%
Plavix	Brand	$147.12	17-22%	$155.60	21-26%	28%
Premarin	Brand	$36.99	12-26%	$36.43	10-25%	36%
Toprol XL	Brand	$34.99	31-39%	$31.21	23-31%	46%
Xalatan	Brand	$69.27	22-25%	$64.30	16-20%	34%
Total Price (10 Drugs)		$757.59	19-24%	$738.34	17-22%	27-32%

* Savings off of highest and lowest prices for seven selected Medicare discount card programs compared to the median Maryland Attorney General reported price for Baltimore zip codes 21201, 21202, and 21211.

** Savings off of highest and lowest prices for seven selected Medicare discount card programs compared to the median Maryland Attorney General reported price for Maryland zip codes 21811, 21842, 21851, and 21863.

***Mail order price for a 90 day supply from the selected card with the lowest mail order price was compared to three times the Maryland Attorney General reported price for a 30 day supply in the Baltimore area.

Six of the seven discount card programs studied offered a mail order option, and all six of the programs provide lower prices for each of the 10 drugs through mail order. Most of the card sponsors require that a minimum 90-day supply be filled through mail order, instead of the 30-day supply that can be obtained at the retail pharmacy, therefore making mail order primarily an option for established maintenance medications that are taken over long periods of time. Using the mail order options would provide significantly greater savings relative to full retail prices for our sample of drugs, providing savings of 23% to 89%, again depending on the product, the card program, and location. For example,

Using the mail order options would provide significantly greater savings relative to full retail prices for our sample of drugs, providing savings of 23% to 89%, again depending on the product, the card program, and location.

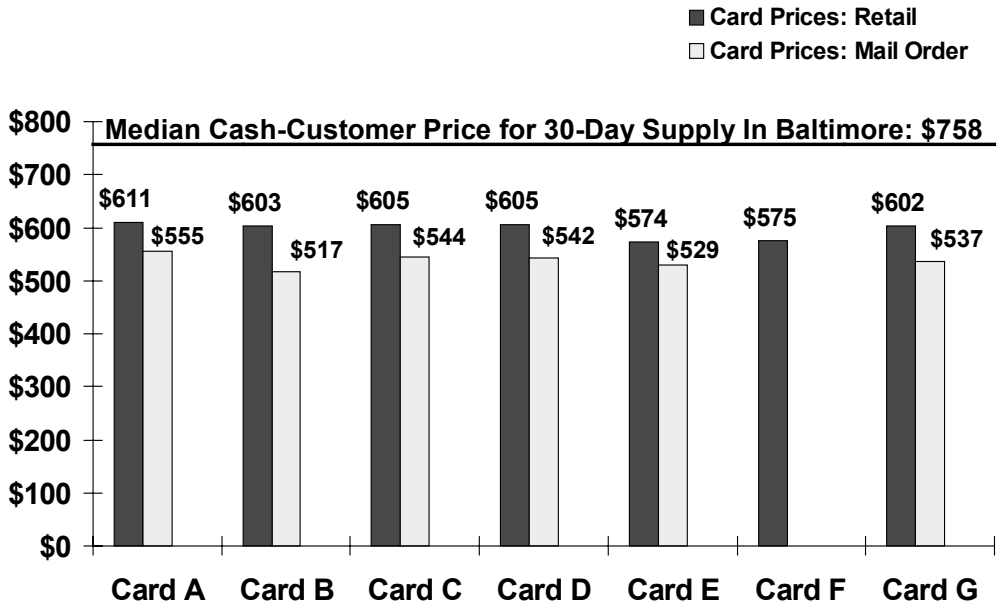
an enrollee could increase their savings on Celebrex to as much as 28% by using mail order, instead of the 17% to 20% savings that are available by purchasing from one of the seven card programs' network pharmacies.

Because prices and savings varied so much among the seven card programs for the ten drugs, we also analyzed the total price for the basket of all ten drugs, recognizing that our basket of 10 drugs is unlikely to be taken by one person. For the week of June 28, 2004, a beneficiary living in Baltimore electing the discount card with the lowest prices would have paid about $184 (24%) less than the full retail price for a 30-day supply ($758). Using the card with the highest prices, the beneficiary would have paid about $147 (19%) less. Overall, in terms of aggregate prices, the prices for the card programs were 19% to 24% lower than the aggregate of the median prices reported by the Maryland AG for the Baltimore area, and 17% to 22% less in the rural Maryland area. Mail order savings for the aggregate of the ten drugs when compared to the median Baltimore prices ranged from 27% to 32%. (See Figure 5. To allow comparisons, prices for mail order were adjusted to 30-day supplies.)

In terms of aggregate prices, the prices for the card programs were 19% to 24% lower than the aggregate of the median prices reported by the Maryland AG for the Baltimore area, and 17% to 22% less in the rural Maryland area.

Figure 5

Comparison Of Medicare-Approved Drug Discount Cards And Cash-Customer Prices



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.

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In sum, our analysis shows meaningful 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 are indicative of retail prices in other areas and states. Moreover, we cannot generalize about whether the same level of savings would be available for other drugs, in other areas of the country, and for the other Medicare-approved discount card programs. As indicated above, the prices reported by the card programs are their highest prices. Some of their participating pharmacies could offer lower prices, and thus produce greater savings to enrollees.

While there is a clear price advantage to mail order through one of the discount card programs compared to purchasing drugs at retail prices from a community pharmacy, we wanted to test how these mail order prices compared to companies that offer pharmacy mail order to the general public. To do this, we obtained prices for the same ten drugs from Costco and Drugstore.com. Figure 6 (on the following page) shows the prices for a 90-day supply of the basket of 10 drugs for our sample card programs with the lowest and highest prices compared to Costco and Drugstore.com.[68] All of these six sample card programs had prices less than those offered by Costco for the 90-day supply of the 10 drugs ($1,745) ranging from 5% less for the card with the highest mail order prices ($1,664) compared to 11% for the card with the lowest mail prices ($1,552). Drugstore.com, however, was competitive with the six cards. The Drugstore.com aggregate price ($1,624) was about 5% higher than the lowest priced card, but about 2% less than the highest priced card. Drugstore.com is advertising that it accepts most of the Medicare discount cards and that its everyday prices are competitive with Medicare card prices at 20% to 30% off retail. We do not know if Drugstore.com lowered its prices as a competitive response to the Medicare discount card program or whether it offered this level of discounts before the card program was launched.

The Drugstore.com aggregate price was about 5% higher than the lowest priced card, but about 2% less than the highest priced card.

Does Choice of Discount Card Make a Difference?

We also sought to determine how the seven selected Medicare-approved discount cards compared with one another. To do this, for one urban location (Baltimore City, 21211) and one rural one (Ellsworth, Kansas, 67439), we tracked prescriptions for four hypothetical beneficiaries with varying prescription drug needs: (1) Mr. Miller, a 50 year-old disabled man; (2) Mrs. Hunt, a 65 year-old healthy woman; (3) Mrs. Fox, an 80 year-old frail woman; and (4) Mrs. Roy, an 82 year-old frail woman. Information on the rationale and methodology for developing these hypothetical beneficiaries is provided in the Appendix. Also presented in the Appendix is the list of the prescriptions taken by each of these beneficiaries.

Drug price results were tracked from the PDAP for eight weeks (May 10 through June 28, 2004) for the seven selected card programs. In addition, we determined which of all 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

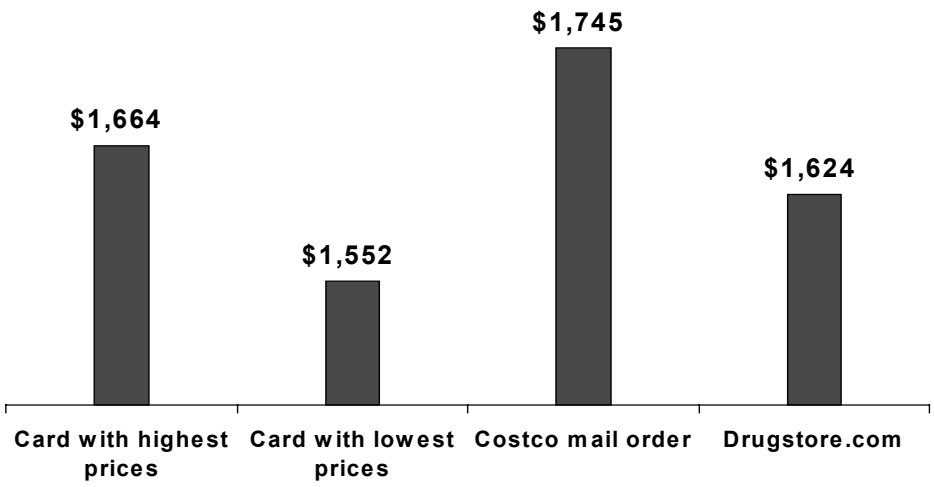
[68] One of the seven card programs does not have a mail order option.

program out of all available card options had the highest aggregate price. Pricing data for the weeks of May 10 and May 17 were eliminated because of concerns about their reliability.

Figure 6

Prices Offered By Medicare-Approved Drug Discount Cards Compared With Costco Mail Order And Drugstore.com

Mail Order Prices (90-Day Supply)



NOTES: Prices for a basket of 10 commonly prescribed drugs for Medicare-age population. Costco price assumes purchaser has a Costco membership; drugs are available without membership for an additional 5%.

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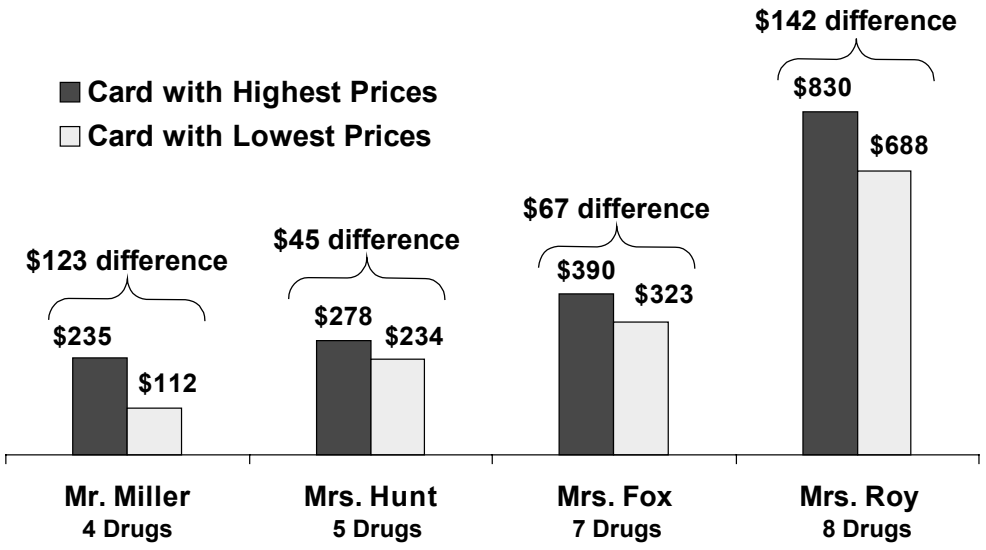
Our analysis illustrates that the choice of a card program may have significant financial implications for a Medicare beneficiary, based on their drug regimen, where they live, and how they prefer to purchase their drugs (pharmacy or mail order). Figure 7 on the following page shows, for the four individuals in our study, the difference between the highest and lowest price of their basket of drugs among all of the card programs available to them (that had prices available for all of their drugs). We compared prices for each basket with brand and generics, when available, at the retail pharmacy and through mail order. Where prices varied by pharmacy within a program, we used the price at the extreme, i.e., the lowest priced pharmacy for the lowest cost card and the highest pharmacy price for the highest priced card. For three of our individuals, the highest card was 19% to 21% more than the lowest priced card at the retail pharmacy, or a cost to the beneficiary of $45 to $142 a month. For Mr. Miller, the highest priced card was $123 more (110%) than the lowest priced card. There was an even greater difference when the cards with the lowest and highest mail order prices were compared for these individuals. The cards with the highest mail order prices were $174 to $406 (26% to 36%) higher for a 90 day supply than the lowest priced mail order cards for the three women; the price difference for Mr. Miller was $646 (159%) for a 90 day supply.

The choice of a card program may have significant financial implications for a Medicare beneficiary, based on their drug regimen, where they live, and how they prefer to purchase their drugs (pharmacy or mail order).

Figure 7

Difference Between Highest And Lowest Drug Prices Offered By Medicare-Approved Drug Discount Cards
(30-Day Supply)



SOURCE: Medicare.gov, June 28, 2004.
NOTES: Retail prices for 30 day supply of each patient's basket of brand and generic drugs (if available) from pharmacies within 2.25 miles of zip code 21211 in Baltimore, MD.

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Drug-specific prices. The prices for individual drugs in each of the four hypothetical beneficiaries' baskets did change some for some cards. For example, the price of Prozac (used by Mr. Miller) increased by about 5% for all of the selected cards as well as for the lowest priced of all cards, although the week during which the price increase occurred varied. Subsequent inquiry would be needed to determine whether this price change is due to changes in manufacturer prices or other factors.

Savings on Generics. We also looked at the implications of substituting generic alternatives when available. Some of our individuals were already taking generic products. Therefore, we looked at the implications of substitution for the brand drugs that they were taking. Only two of our four individuals were taking brand drugs for which there were lower cost generic alternatives.

Our analysis shows that these individuals would clearly save by electing the generic option, but the amount of savings would vary by drug, card, zip code, and whether purchased from a retail pharmacy or through mail order. Mr. Miller, living in Baltimore, using the generics for Glucophage (metformin) and Prozac (fluoxetine) could save anywhere from about $125 to $195 for a 30-day supply, depending on which card program he selected. Mrs. Fox, living in Baltimore, would also experience a savings by asking for generic prices. Her doctor had already prescribed a generic blood pressure medication (Benazelpril), and the only other drug in her basket for which a generic substitution is possible is Coumadin (Jentoven). The

maximum savings for Mrs. Fox would be about $40 using the best card's retail pharmacy price. Both Mr. Miller and Mrs. Fox would experience similar levels of savings from the substitution of generics through mail order. It should be noted that our analysis of generic prices was hampered by problems with the PDAP data. Sometimes the PDAP would give prices for baskets of drugs where generic alternatives were factored in incorrectly. Improvements have now been made so the pricing differences are clearer, although occasional glitches continue.[69]

Have Discounted Prices Changed Over Time?

On May 14, 2004, CMS issued a press release 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, "lowering their prices to become more competitive".[70] Our analysis did not show that prices were continuously dropping.

Our analysis of the selected drugs and selected card programs showed that while there were a few changes up and down for selected products and cards, overall prices remained relatively flat.

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 this period. However, over the subsequent six weeks (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 products and cards, overall prices remained relatively flat. Figure 8 on the following page displays the price variation for the basket of seven drugs taken by Mrs. Roy over the six week period for the seven selected card programs. For example, using Card B, the aggregate price would have increased by about $7.00 over the six-week period; with Card G, it would have increased by about $2.20. Using Card F, however, it would have declined by about $13.80. Results for the other three hypothetical individuals were similar. No card's aggregate prices changed more than 4%.

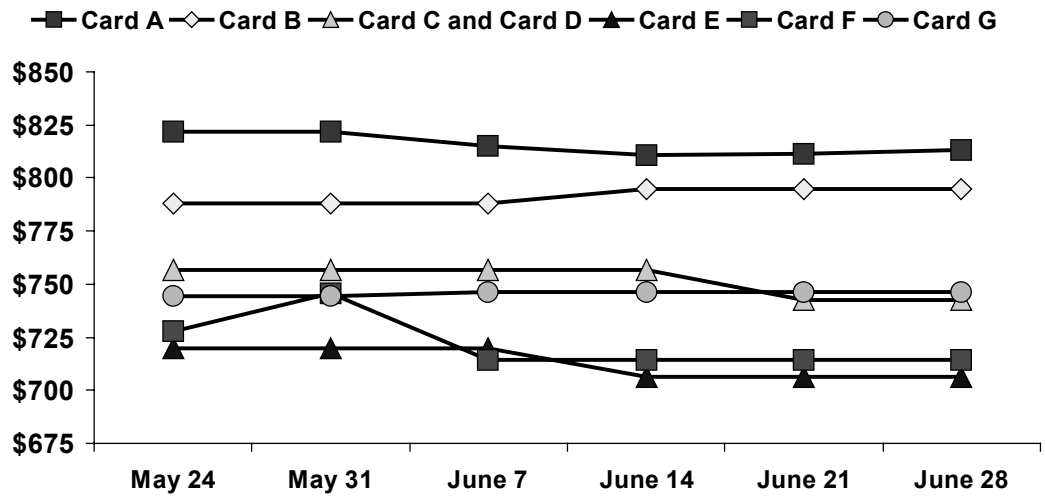
[69] Improvements could still be made, however. Many users of Medicare.gov's PDAP will not know whether a specific drug is a brand or generic. If the user initially enters a generic, and still requests generic alternatives, the software does not identify the generic as such. The price of the generic drug is displayed under the "brand" column.

[70] CMS Press Release, *Medicare Drug Discount Cards Continue to Drop Prices and Offer Better Savings*, May 14, 2004 Press release. Cms.hhs.gov/media/press/release.asp?Counter=1049.

Figure 8

Prices Offered Over Time 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.

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CONCLUDING OBSERVATIONS

Our report documents key elements of the Medicare discount card program and the transitional assistance program. While we have observed a number of implementation challenges facing CMS and card sponsors, for the most part they reflect the relatively short time for implementation and the significant administrative and outreach tasks associated with these programs. We have noted 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 those who assist them.

Critical to a successful implementation of the discount card program is getting clear, consistent and accessible information to beneficiaries and those agencies and individuals on whom beneficiaries rely for assistance and advice. Educating beneficiaries has proved to be a significant undertaking because of the large number of card programs, the challenge of communicating with over 40 million individuals, and the lack of knowledge about this new program. Despite a substantial investment by CMS in decision support tools, reports of beneficiary frustration and confusion have been widespread. And while the websites and brochures of the individual discount card programs contain some common elements, key program features such as drug lists (formularies), pharmacy networks, the availability of

additional manufacturer discounts, and the description of the available discounts vary and may be inaccurate

Our effort to determine the value of the card program in terms of savings 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 was large enough to create significant financial implications based on card choice. Finally, we did not observe notable changes in reported prices over our study period of six weeks, which excluded the initial two weeks of pricing data because of concern about its reliability. It will be interesting to see what happens to prices before the annual open election period in November when enrollees will have the opportunity to change enrollment from one approved discount card to another.

Overall, the experience to date with implementation of the discount card program suggests several important implications for putting the new Medicare Part D drug benefit in place in 2006. First, 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 tradeoff of too many choices may be indecision, which may be a major reason why so few beneficiaries have signed up directly for the cards. The majority of the 3.9 million enrollees so far have been auto-enrolled by their Medicare Advantage plans (2.3 million) and their State Pharmacy Assistance Programs.

Second, 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 support. The administrative and oversight investment required to assure the integrity of the discount card program will likely be the same or greater for the new Medicare drug benefit. Although the internet is a useful tool for beneficiary education – and holds out great possibilities for increased drug pricing transparency -- the need for more accessible “face-to-face” beneficiary education cannot be underestimated. Most beneficiaries are not comfortable using the internet; and even their helpers are likely to find 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.

APPENDIX – PRICING ANALYSIS METHODOLOGY

In response to the Kaiser Family Foundation's interest in a "first look" analysis of the Medicare Discount Card and Transitional Assistance Program, we requested from the Centers for Medicare and Medicaid Services (CMS) the data base that underlies the Medicare-approved discount card portion of the Prescription Drug and Other Assistance Programs (PDAP) tool, located on the Medicare.gov website. Because CMS considers the database proprietary, this request was not approved. As a result, we were limited to using the publicly available PDAP to do our pricing analysis.

Ideally we would have reviewed all drug prices for all Medicare-approved discount card programs. However, because the PDAP tool is designed to produce data for specific individuals, obtaining summary data is extremely cumbersome and time consuming. As a result, we were only able to examine a small subset of drugs for a limited number of zip codes. The weakness of this approach was that it limited our ability to generalize our findings; its strength is that we were able to experience the Medicare.gov website and the PDAP in the same way as beneficiaries and others working to assist them.

In doing a pricing analysis of the Medicare-approved discount cards, we hoped to answer the following major questions: Would prescription drug prices be less expensive using the Medicare cards than if the beneficiary paid full retail prices? Would the drug prices achieved by the different card options change over time? Would there be, as some have predicted, a significant price reduction over time as the Medicare-approved discount card program sponsors competed for enrollees? How would the discount cards compare with one another? Would one or more cards prove to deliver better discounts than the others?

Our first set of questions required us to identify a practical measure of the full retail price – a benchmark against which to compare the prices obtainable using the discount cards. Some researchers have used the Average Wholesale Price (AWP) for this purpose. However, the AWP is not a good measure of what cash customers – those paying the full retail price -- actually pay. (They may, in fact, pay AWP plus an additional amount.)[71] Other researchers have surveyed pharmacies in specific areas for the prices on specific drugs, a labor intensive approach if the goal is to obtain prices from more than a few areas.

For our source of retail prices, we elected to use the Maryland Attorney General's (AG's) "Prescription Drug Price Finder."[72] This web-based tool was recently established to enable residents of Maryland to comparison shop among Maryland pharmacies. It provides the usual and customary price, described as comparable to the prices paid by cash-customers without insurance.[73] The strength and dosage of each drug are also presented. Prices initially posted were surveyed for the period March 1, 2004 through April 1, 2004. The website was subsequently updated to reflect prices through May 31, 2004.

A major limitation of the Maryland AG's Price Finder is that it only provides prices for 25 of the most commonly used drugs in Maryland, as reported by the state's Medicaid program.

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[71] U.S. Department of Health and Human Services, *Prescription Drug Coverage, Spending, Utilization, and Prices*, Report to the President, Washington, April 2000, chapter 3.

[72] www.oag.state.md.us/drugprices/

[73] Prices are reported to the state "by each pharmacy each time a pharmacy filled a prescription for a drug in the survey. "www.oag.state.md.us/drugprices/

Obviously, another limitation is that prices are available only for Maryland and are updated on a less frequent basis than the Medicare.gov PDAP.

To obtain a set of drugs for which comparable prices (i.e., the same drug, strength, and dosage) could be tracked for both the Medicare discount cards and Maryland pharmacies, we selected the first ten drugs (including strength and quantity per month) that appeared on both the Maryland AG's Price Finder and on AARP's list of the top 250 brand or generic prescription drugs. The AARP list is based on the number of prescriptions adjudicated by the AARP Pharmacy Service in 2003. Individuals who use this service (i.e., AARP members) are ages 50 and older (including, therefore, both Medicare disabled and 65 and older Medicare beneficiaries). The AARP list reflects utilization by about two million individuals, and includes both brand and generic drugs.[74] The resulting set of drugs used for our price tracking is displayed in Table A-1.

Table A-1. List of Prescription Drugs in the Pricing Analysis

Drug	Strength	30-day supply
Celebrex (brand)	200 mg	60
Fosamax (brand)	70 mg	4 (1 per week)
Furosemide (generic)	40 mg	30
Hydrochlorothiazide (generic)	25 mg	30
Lipitor (brand)	10 mg	30
Norvasc (brand)	10 mg	30
Plavix (brand)	75 mg	30
Premarin (brand)	0.625 mg	30
Toprol XL (brand)	50 mg	30
Xalatan (brand)	0.01% solution	2.5 ml

Second, we needed to select a manageable number of Medicare-approved discount cards for which we could track prices. As noted above, monitoring prices for all of the approved general card programs was not practicable because of the PDAP's design. Consequently, we selected a set of cards that appeared to meet a few basic criteria (based on early monitoring of the PDAP and individual card program websites). Cards were selected if they were: (1) general national cards, (2) had their own active and relatively complete websites; (3) appeared to provide discounts on all of the drugs needed by our prototype beneficiaries; and (4) more broadly seemed to provide discounts on most if not all covered drugs (as defined by the MMA for the card program). Seven card programs met these criteria:

- AARP Prescription Discount Card
- aClaim Rx Savings Club
- Aetna Rx Savings Card
- ArgusRx
- Preferred Prescription Discount Card
- Rx Savings distributed by Reader's Digest, and
- ScriptSave Premier.[75]

We were also interested in comparing Medicare discount card and Maryland retail pharmacy prices to the prices available using major U.S. based internet pharmacies that sell to the

[74] Personal communication with staff of AARP, May 7, 2004.
[75] We later determined that ScriptSave Premier and Aetna, which use the same PBM/TPA, and quoted the same retail pharmacy prices, although different mail order prices.

general public. For this purpose, we used Costco.com and Drugstore.com. Both provide drug-specific pricing on relatively user friendly websites. For Costco, we needed to adjust the dosage units for a few of the selected drugs so that they were the same as used for the Maryland Price Finder and the PDAP.

Third, we needed to select areas for which we would track the discount card and Maryland AG prices. Like the PDAP, the Maryland Prescription Drug Price Finder displays drug-specific prices by pharmacy within a specific zip code. We selected one urban zip code (Baltimore City, 21211) and one rural one (Pocomoke, Maryland 21851) to track the Maryland retail prices. Because Maryland AG prices were not available for all drugs for the two selected zip codes,[76] we had to expand the urban area to two additional zip codes (21201 and 21202) and the rural one to three more zip codes (21811, 21842, and 21863). For the seven selected Medicare-approved discount cards, we tracked prices in urban Baltimore (21211) and Pocomoke Maryland (21851). We did not, however, confirm that the selected pharmacies actually accepted each of the seven discount cards.[77]

To compare the prices quoted by the different Medicare discount cards, we identified four prototype Medicare beneficiaries (one pre-65 disabled and three seniors) and collected information on the specific drugs that they would typically use for their health conditions. The specific drugs for the four prototype beneficiaries were suggested by a previous study.[78] (See Table A-2 on the following page.) Because we also wanted to check whether geography affected the availability of card programs, pricing and pharmacy access, we located each of these four beneficiaries in an urban area (Baltimore, Maryland 21211) and a rural one (Ellsworth, Kansas 67439).

With these established data sources, selected discount cards, prototype beneficiaries, and target locations, we began our data tracking process. We tracked prices from the Medicare.gov PDAP for each of the seven selected discount cards as well as the prices shown for whichever of <u>all</u> available general national and regional card(s) displayed the lowest prices. We did this for the four prototype beneficiaries' specific basket of drugs, collecting both the bundled and drug-specific prices. In addition, we obtained the card prices for generic alternatives, if any and mail order prices, if available. For the last week of our tracking, June 28, we also recorded which Medicare card program(s) of <u>all</u> available cards in the beneficiary's area quoted the highest price. This too was done for the generic alternatives as well as for mail order options.

[76] Because during its survey period, not all pharmacies fill prescriptions for all 25 drugs, there are a significant number of drugs for which prices are not available for a given pharmacy.

[77] According to an investigation by the minority staff of the House Committee on Government Reform, "numerous pharmacies listed on the [Medicare] website are listed as participating members of drug card networks when, in fact, they are not participants." Letter from Representatives Henry Waxman and Louse Slaughter to Secretary Tommy Thompson, July 6, 2004, obtained from www.InsideHealthPolicy.Com, July 9, 2004.

[78] Synder, Rani E., Thomas Rice and Michelle Kitchman, The Cost Implications of Health Plan Options for People on Medicare, Kaiser Family Foundation, January, 2003, www.kff.org/medicare/upload/14361_1.pdf

Table A-2. Prescription Drugs for Four Hypothetical Medicare Beneficiaries		
Disabled male (Mr. Miller)	**Strength & Dosage Per Day (pd)**	**Common Therapeutic Purpose**
Glipizide	20 mg, 1pd	Used to treat diabetes mellitus type II.
Glucophage/metforman	500 mg, 1 pd	Used to treat type II diabetes.
Macrodantin nitrofuranoin	100 mg, 1 pd	Antibiotic used to treat cystitis and other urinary tract infections.
Prozac/Fluoxetine	40 mg, 1 pd	Antidepressant. Also used to help people with obsessive compulsive disorder, eating disorders, panic disorder, post-traumatic stress.
Healthy female 65 (Mrs. Hunt)		
Benazelpril	20 mg, 1 pd	Used to lower blood pressure (hypertension).
Lipitor	20 mg, 1 pd	Used to lower blood cholesterol.
Levothyroxine	100 mcg, 1 pd	Used to treat thyroid problems such as hypothyroidism.
Fosamax	10 mg, 1pd	Reduces amount of calcium lost from bones; increases the density of bones. Used to treat patients with Paget's disease or postmenopausal osteoporosis.
Prempro	.45-1.5 tabs/day	Used to relieve symptoms of the menopause and also help to prevent the onset of osteoporosis.
Frail female 80 (Mrs. Fox)		
Benazelpril	20 mg, 1 pd	Used to lower blood pressure (hypertension).
Lopressor	50 mg, 1 pd	Used to lower high blood pressure (hypertension). Generic tablets are available, but in extended-release
Glyburide	2.5mg, 1pd	Used to treat type II diabetes mellitus.
Aricept	10 mg, 1 pd	Used to treat the symptoms associated with Alzheimer's disease or dementia.
Celexa	20 mg, 1pd	Used to treat depression and other related problems.
Coumadin/Warfarin sodium	3 mg, 1pd	An anticoagulant, helps to treat/prevent clots in veins, arteries, lungs, or heart.
Frail Female, 82, restricted (Mrs. Roy)		
Celebrex	200 mg, 2 pd	Used to relieve some symptoms caused by arthritis, such as inflammation, swelling, stiffness, and joint pain.
Diovan/HCT	80/12.5 tabs, 1 pd	Used to lower blood pressure.
Prevacid DR	30 mg, 2pd	Prevents the production of acid in the stomach, reducing symptoms/preventing injury to the esophagus, stomach, or intestines. Used to treat active ulcers.
Zoloft	100 mg, 1pd	Antidepressant; also used to help people with obsessive compulsive disorder, panic attacks, post-trauma stress, or social anxiety.
Zocor	40 mg, 2pd	Used to help lower blood cholesterol.
Furosemide	40 mg, 1pd	Diuretic, used to treat high blood pressure (hypertension) and to reduce swelling and water retention caused by heart, liver, or kidney disease.
Spironolactone	25mg, 1pd	A diuretic, used to treat hypertension without depleting potassium.

The Maryland AG's Price Finder and the Medicare.gov PDAP were checked each week for the eight weeks beginning May 10, 2004 and ending June 28, 2004. We excluded the first week for which the PDAP had data, a time when a variety of glitches and data errors suggested that the results might not be reliable. We ultimately decided also to exclude the

weeks of May 10 and 17 from our analysis because of the persistence of website problems. For those two weeks, data were especially spotty, with individual drug and bundled price data unavailable for some cards and incorrect or incomplete bundled price range data (prices for generics were especially problematic). Although price changes were only supposed to occur weekly (new prices are posted each Monday morning at 12:01 AM), prices for four of our selected card programs frequently experienced midweek price changes or showed miscalculated bundled prices if they were there at all. While some of these problems continued for several additional weeks, price data were overall more stable after the week of May 17. Throughout the study period, however, there were weeks for which prices for some cards were unavailable because they did not appear on the PDAP.[79]

Using these PDAP, Maryland AG, and internet pharmacy data, we performed the analyses needed to address the research questions identified above. The analyses presented in the report comparing the prices for the subset of ten drugs to the Maryland AG's retail prices, as well as the comparisons of prices among the seven selected cards for the prototypical individuals, are based on prices obtained in the last week of our data collection.

To assess discount card price fluctuations over time, we analyzed the PDAP prices both for the ten selected drugs and the individuals' basket of drugs for each of the six weeks, May 24 through June 28. As we report using the example of Mrs. Roy, there were small price variations for specific drugs and specific cards, both up and down, but there was no consistent downward trend.

[79] For those weeks, website users were instructed that “Currently no information is available. Please check back later.” This problem persisted throughout the study period.

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