Private Discounts, Public Subsidies

How the Medicare Prescription Drug Discount Card Really Works

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Introduction

Not good enough. Too complicated. A program that will benefit drug companies more than it will benefit seniors.

These charges have been leveled at the new Medicare prescription drug discount card program that began in June. That program, part of the $400 billion prescription drug benefit and Medicare modernization bill signed into law in December 2003, is a short-term measure to provide financial assistance to seniors and disabled Medicare beneficiaries for the purchase of their prescription drugs.[1] Despite the early criticisms, the program is already having a favorable impact on beneficiaries.

The drug discount card program is designed to bring the benefits of group purchasing to seniors, resulting in lower prices at the pharmacy. It also offers cash assistance to low-income seniors who have no other insurance coverage for prescription drugs. In addition, needy seniors benefit from special discounts offered by pharmaceutical manufacturers through the Medicare-approved card.

Many critics wasted no time in pronouncing the Medicare discount card program a failure. Some claimed the discounts under the program would be inadequate months before those discounts could be known:

- On December 10, just two days after the president approved the new Medicare legislation, Sen. Edward Kennedy (D-Mass.) complained that the discount card program would "put corporate profits ahead of patients' needs" because it did not impose government controls on the size of the discounts.[2]
- Six Democratic House members—John Dingell of Michigan, Henry Waxman and Pete Stark of California, Charles Rangel of New York, Sherrod Brown of Ohio, and Mike Ross of Arkansas—repeated this theme in January. They asserted that the "drug discount cards do not provide prices that are significantly lower than those already available to seniors."[3]

Others complained about the complexity of the new program. They argued that seniors would be confused by having to choose from too many Medicare discount card options:

- The *New York Times* in early February summarized the concerns of consumer advocates that seniors "will face a bewildering array of new government-approved drug discount cards."[4]
- In late February, Ron Pollack, executive director of Families USA, said "seniors all across the country are confused, bewildered, and perplexed by the new legislation and have a very

difficult time navigating the choices that are in their best interest."[5]

Were the critics correct? The Medicare drug discount card program began to enroll beneficiaries on May 3, and seniors began to use their cards on June 1. Rather than speculating about how the program might function, it is now possible to do an early assessment of the program based on its actual performance.

The card program should be evaluated on its own terms, not criticized because it does not do what it was not designed to do. Bear in mind that the Medicare discount card program is not the full Medicare drug benefit. It was intended by Congress to help Medicare beneficiaries only until the full benefit becomes available, with the greatest assistance to low-income beneficiaries without drug coverage. Seniors have almost nothing to lose by enrolling in the program—the annual enrollment fee is $30 or less—and potentially much to gain in reduced prescription costs. The program is temporary, however, and it cannot resolve every drug financing problem in Medicare.

Despite complaints that the Medicare prescription drug discount card program is inadequate, the program provides substantial help with the cost of prescriptions to millions of seniors and disabled beneficiaries. Discounts negotiated by the card sponsors are only part of the story. Low-income seniors without other drug coverage also receive a $600 annual cash subsidy and special discounts made available by pharmaceutical manufacturers. Beneficiaries who need the help the most could save between half and three-quarters of their prescription cost for the remainder of this year through this public-private partnership. The Medicare drug discount card program was designed by Congress primarily to help low-income seniors, and with private sector involvement, that is precisely what it achieved.

The influence of the discount card program is likely to extend well beyond temporary assistance for several million Medicare beneficiaries. Congress opened the door to competition among private plans through the drug discount card program. For the first time, consumers can compare pharmaceutical prices available through the card anywhere in the country and shop for the best value. Employers, insurers, and individuals who are not in the Medi care program also can compare Medicare's best prices with the prices they currently pay. That new price transparency ultimately could enhance competition and leverage change throughout the pharmaceutical industry, benefiting all consumers.

The new program has had growing pains—not surprising given the short six-month window allowed by Congress to have the program up and running. The consumer information campaign rolled out unevenly. Television advertising meant to build public support and awareness of the new drug benefit was slowed by criticisms from political opponents, who demanded an investigation by the General Accounting Office. An internet site containing information on drug prices available through each Medicare discount card had a rocky start, with complaints that some of the prices were inaccurate and hard to access. Early reports indicate slow growth in enrollment, although that is likely to pick up in the coming months with more aggressive outreach and consumer information efforts.

For many Medicare beneficiaries, the decision to enroll in the Medicare drug discount card program should be easy. They generally have many options, each of which offers similar savings. Complexity arises for beneficiaries who are eligible for pharmaceutical manufacturers' special discounts, available to low-income seniors who have no drug coverage. Those beneficiaries could select a Medicare card that provides some savings without much difficulty. They could save hundreds of dollars a month more through special manufacturers' discounts, but that would require greater efforts to find the best deal. The current failure to offer clear and accessible information on the coordination of the Medicare discount card and manufacturers' separate discount programs must be corrected if the new Medicare program is to live up to its full potential.

Origins of the Discount Card Program

It is commonly believed that seniors as a group pay the highest prices for prescription drugs. In fact, very few people at any age pay the full retail price for prescription drugs. Most seniors are enrolled in private or public health insurance plans—retiree health plans, Medicaid, or Medigap—that cover prescriptions. Those plans negotiate discounts with pharmaceutical manufacturers, and their beneficiaries are responsible for an out-of-pocket payment that is a fraction of the total negotiated price of the drug. Others without such coverage can cut their costs through discounts offered by many retail pharmacies, associations such as AARP, pharmaceutical manufacturers, and internet pharmacies. Perhaps 10 million Medicare beneficiaries currently have no prescription drug coverage. Many of them and others with only modest drug coverage have trouble paying their drug bills.

As the cost of pharmaceuticals rises, some seniors turn to Canada and other countries for their prescription drugs. The Food and Drug Administration, major pharmaceutical manufacturers, pharmacists, and others have raised concerns about the safety and effectiveness of drugs that reach consumers from those foreign sources.

The absence of a prescription drug benefit in Medicare is a significant gap in the program that has been widely noted since its beginnings in 1965. Congress enacted a drug benefit in the Medicare Catastrophic Coverage Act of 1988, but a storm of protest from seniors over the high cost of premiums led to its repeal in 1989. The issue was rejoined in 1999 when then-President Bill Clinton proposed a drug benefit costing $168 billion over ten years.

In an effort to give all Medicare beneficiaries the advantage of price discounts through group purchasing, President George W. Bush, on July 12, 2001, announced a new Medicare-endorsed prescription drug discount card program. That initiative, vigorously promoted by Thomas Scully, then administrator of the Centers for Medicare and Medicaid Services (CMS), was a stopgap measure intended to help seniors until a full prescription drug benefit could be passed by Congress. Unlike the current program, no funds were made available to subsidize the purchase of prescription drugs by low-income seniors.

Less than a week later, the National Association of Chain Drug Stores (NACDS) and the National Community Pharmacist Association filed suit in U.S. District Court to block that program on the grounds that any consumer savings would come straight out of the pockets of pharmacists. Subsequent efforts over several years to implement the discount card program without new legislative authority failed.

That same year a proposal for a funded discount card was advanced by policy analysts at the American Enterprise Institute and the Galen Institute.[6] That proposal was intended to be the vehicle for the full Medicare drug benefit, rather than serve as a temporary measure. It combined a discount card, a cash subsidy for low- and moderate-income seniors, and catastrophic insurance coverage offered as a package by competing private firms. Such an approach offered strong incentives to hold down unnecessary costs while providing financial support targeted to those who were most in need.

By 2003, a narrow consensus had formed in Congress that a Medicare drug benefit could and should be enacted. The Medicare Prescription Drug, Improvement, and Modernization Act was signed into law on December 8 of that year. According to the Congressional Budget Office (CBO), the new drug benefit will cost $409 billion between 2004 and 2013.[7] The Office of Management and Budget pegs the cost at $534 billion.

Controversy raged over the role of competition in a modernized Medicare program, but in the final bill, the drug benefit was to be delivered through competing private plans. That decision remains a sore point for many politicians.

Recognizing that a full drug benefit could not be implemented for several years, Congress created the Medicare prescription drug discount card program, including cash assistance for low-income beneficiaries, that operates today. Even though the Medicare prescription drug discount card program is temporary, it is a proving ground for the full drug benefit,

scheduled to begin in 2006. This temporary program also operates through competing private discount card sponsors, and as such, it has drawn considerable scrutiny and criticism from those who prefer a more traditional government-run benefit. Any failures in the discount card program will serve as evidence to critics that a competitive system does not work in Medicare.

Plan of the Study

Will the Medicare prescription drug discount card program be a success? We focus on how much beneficiaries might save over the remainder of 2004 by enrolling in a Medicare-approved discount card plan. Estimates are based on the prices of prescription drugs posted on the Medicare website www.medicare.gov as of June 1, the first day that discounts were available to seniors under the new program. Although prices are likely to change over the year, these data provide a reasonable early indication of how well seniors might do under a Medicare discount card compared to their other alternatives for discounted drug prices. This is the same information many seniors themselves are reviewing as they consider whether to enroll in the program.

As background to this analysis, the next section discusses discount and subsidy programs outside the Medicare program available to help seniors with the cost of their prescriptions. The section after that summarizes the provisions of the Medicare drug discount card program and briefly explains how the non-Medicare savings options dovetail with the Medicare program.

Then, we analyze the costs that three typical beneficiaries will pay for prescription drugs this year under the Medicare drug discount card program. Those individuals have health conditions that frequently occur in an elderly population, such as hypertension, diabetes, and congestive heart failure. We investigate several ways in which they can reduce their out-of-pocket spending for prescription drugs, including switching from brand-name pharmaceuticals to their generic equivalents and purchasing through a mail order service rather than at a retail pharmacy. We compare the amounts spent by each person under the Medicare drug discount card program with the spending they would incur using alternative discount and subsidy programs currently available to seniors. Our evaluation of the program, therefore, is against the discounts that a savvy shopper could obtain outside of Medicare.

The concluding section provides a broader assessment of the likely performance of the Medicare drug discount card program. Will the prices we see today remain relatively constant over the year, or will they rise sharply once seniors are locked into specific drug discount cards? Can seniors be sure that the drugs they use will remain available to them at low prices over the entire year? If the program is successful, will funded discount cards remain available after the full Medicare drug benefit begins in 2006? How might the Medicare drug discount card program affect the broader market for pharmaceuticals? Will Congress allow this program to succeed?

Discount and Assistance Programs Available Outside Medicare

Prescription drugs pose a large and growing cost to many seniors. Various options are available to seniors to make their drug bills more affordable, however. Lower prices are available through

- Discount programs sponsored by organizations other than pharmaceutical manufacturers. These can be administered by associations (such as AARP), pharmacies (such as Eckerd), pharmacy benefits managers (such as ExpressScripts), and online pharmacies (like Drugstore. com). Many of these programs offer mail order services that can increase savings to consumers.
- Senior discount card programs sponsored by pharmaceutical manufacturers. Low- and moderate-income seniors often can obtain very large savings through such programs.
- Patient assistance programs (PAPs) sponsored by pharmaceutical manufacturers. These programs make drugs free to low-income patients of all ages.
- State pharmacy assistance programs. Many state governments subsidize or obtain discounts on prescription drugs for their residents without drug coverage.

Most of the existing programs and purchasing options will remain available to seniors and other consumers now that the Medicare prescription drug discount card program is available. In many cases, seniors will be able to use a combination of programs with the Medicare discount card to get the best deal on their prescription drugs.

Discount Programs Sponsored by Organizations Other than Pharmaceutical Manufacturers

Many seniors without drug coverage continue to pay full retail price at their local pharmacy, and that price can vary widely across outlets. However, most could lower their costs through discount programs offered by retailers, membership organizations, pharmacy benefits managers, and internet pharmacies.[8] These programs offer discounts on prescription drugs from numerous manufacturers, but the level of savings can vary widely. Many of these programs are open to seniors regardless of their income.

A wide variety of options are available to consumers, including private discount cards and low-margin retailers. For a $20 annual enrollment fee, AARP's MembeRx Choice boasts average discounts of nearly 20 percent off retail prices. Major retail pharmacy chains like CVS also sponsor drug

discount programs. CVS's Health Savings Pass, a program for people age fifty and older, offers discounts on various health services, including prescription drugs. For an annual enrollment fee of $70 per couple, the drug discounts range from 5 to 50 percent off retail prices when no insurance is applied. Individuals can generally obtain even greater savings filling prescriptions through mail-order pharmacies than they could at retail outlets. Drugstore.com, an internet pharmacy that provides mail-order service, advertises average savings as high as 30 percent. Mail-order programs are widely available.

Senior Discount Card Programs Sponsored by Pharmaceutical Manufacturers

Most of the major pharmaceutical companies have sponsored senior discount programs in recent years to help low-income seniors without prescription drug coverage afford their medicines. Enrollment in these programs is typically free. Seniors who qualify for discount card programs can obtain sizable discounts on drugs manufactured by the card sponsor. For example, the GlaxoSmithKline Orange Card entitles eligible seniors to discounts on the order of 30 to 40 percent off retail prices for many GSK drugs, like the diabetes drug Avandia and the depression medication Paxil.

While the specific eligibility criteria vary among cards, the programs target individuals who are eligible for or enrolled in Medicare and have no prescription drug coverage, public or private. Medicare beneficiaries receiving prescription drug coverage through Medicaid, therefore, are excluded from these programs. The maximum incomes to qualify are generally 200 or 300 percent of poverty, a design that helps a segment of the elderly population financially strained by prescription drug costs but not covered by Medicaid.

The first senior discount card programs were launched in 2002 to help low-income seniors access their medicines until the Medicare program was expanded to cover prescription drugs. Consequently, when Part D begins in 2006, these programs no longer will be in play.

There are two models of drug discount card programs for seniors. One employs discounts off retail prices; the other charges a flat fee for a month's supply of a drug. See table 1 for program details on several discount cards. For both schemes, the price breaks apply only to drugs manufactured by the card sponsor. Under the first type of program, average discounts of up to 40 percent are extended to those eligible for Medicare with incomes as high as $30,000 for an individual (approximately 300 percent of the federal poverty line). The second type of program offers a month's supply of a medicine for a small administrative fee of $15 or less. These programs are typically offered only to individuals with incomes up to 200 percent of poverty.

Under both program models, pharmaceutical manufacturers partner directly with pharmacies to reimburse the discounts. Therefore, not all pharmacies necessarily participate, and the size of the discounts can vary among outlets based on the pharmacy's markup.

Discount card programs strive to be simple and accessible for seniors that qualify. Separate applications must be submitted for each program, but they can be fully completed by the patient and do not require physician approval. Forms are generally available at pharmacies, physician's offices, and company websites. Once seniors are enrolled, they simply present their discount card at the drugstore to receive the discount.

The Percentage Discount Cards. The first senior discount card programs were sponsored by individual pharmaceutical companies and covered only their own products. The only program that covers the products of several companies is the Together Rx card, formed in June 2002 by a coalition of drug manufacturers. The Together Rx card is jointly sponsored by seven pharmaceutical companies: Abbott, AstraZeneca, Aventis, Bristol-Myers Squibb, GlaxoSmithKline, Johnson &

TABLE 1
VARIOUS SENIOR DISCOUNT CARD PROGRAMS

	GlaxoSmithKline Orange Card	Novartis Care Card	Together Rx (7 companies)	Pfizer Share Card	LillyAnswers Card
Eligibility	Medicare eligibles; Income <$30,000 individual, $40,000 couple (~320% poverty); No drug coverage	Medicare eligibles; Income <$28,000 individual, $38,000 couple (~300% poverty); No drug coverage	Medicare eligibles; Income <$28,000 individual, $38,000 couple (~300% poverty); No drug coverage	Medicare eligibles; Income <$18,000 individual, $24,000 couple (~200% poverty); No drug coverage	Medicare eligibles; Income <$18,000 individual, $24,000 couple (~200% poverty); No drug coverage
Discount/ Fee	Discount: 25% off wholesale prices	Discount: 25% off wholesale prices	Discount: Each company sets discounts above a minimum 15% off wholesale prices	Fee: $15 for one 30-day supply	Fee: $12 for one 30-day supply
Scope of Coverage	All GSK drugs	All Novartis drugs	>170 drugs manufactured by participating companies	All Pfizer drugs	All Lilly drugs
Comments	GSK also part of Together Rx	Novartis also part of Together Rx			

Source: Pharmaceutical Research and Manufacturers of America, "Prescription Drug Discount Card Programs for Seniors," November 2003.

Johnson (and its subsidiaries Janssen and OrthoMcNeil), and Novartis. The program currently offers discounts on more than 170 prescription drugs. To avoid antitrust violations, each company individually sets the discounts off the wholesale prices of its products. Actual savings to consumers are expected to average 20 to 40 percent off retail prices and could be as high as 70 percent for some drugs. Above a certain minimum discount, firms can vary the level of savings they offer at any time. Nearly all retail pharmacies participate in the program. Discounts under Together Rx are also available for some generic drugs. In September 2003, program membership surpassed 1 million.

The Flat Fee Cards. Discount cards that offer drugs for a flat fee make their own drugs available to qualifying patients for an extremely modest monthly sum: $12 for Lilly medicines and $15 for Pfizer drugs. Such cards are considered by the sponsors to be patient assistance programs rather than discount cards. However, they differ from the broader class of PAPs in several important ways: They do not require a physician's approval, prescriptions are typically filled by retail pharmacies, and they are limited to Medicare-eligible patients.

Medicare enrollees with incomes as high as $18,000 for an individual (about twice the federal poverty level) are eligible for the Pfizer and Lilly cards. The Pfizer Share Card was launched in January 2002 and has enrolled more than half a million patients to date. LillyAnswers was introduced in April 2002, and several hundred-thousand people have benefited from the program since then.

Patient Assistance Programs Sponsored by Pharmaceutical Manufacturers

All pharmaceutical companies have long-standing programs that offer their drugs free of charge to individuals of any age without the means to pay for them. Member companies of the Pharmaceutical Research and Manufacturers of America (PhRMA) alone enrolled 6.2 million people in their patient assistance programs in 2003. They donated more than 17 million prescriptions valued at $3.3 billion. However, these programs are usually difficult to access, and some eligible seniors may prefer to forego the potential savings for a simpler alternative.

Pharmaceutical companies have traditionally strived to ensure that their medicines reach patients that could not otherwise afford them. As health care has grown increasingly reliant on pharmaceuticals, charitable efforts to assure access to them have evolved, too. While some PAPs date back to the 1950s, most were formalized in recent decades.

Each pharmaceutical company has its own standards in place to qualify individuals for its patient assistance program. To be eligible for a PAP, an individual cannot have any prescription drug coverage or must have already exhausted his drug benefit. Income limits to qualify vary among programs but are generally lower than they are for senior discount card programs. Part of the application for patient assistance programs usually must be completed by the patient's physician. Most often, the prescription is then mailed to the physician, who dispenses it to the patient. Other times, although far less frequently, the medicines are mailed directly to the patient or the patient is given a voucher to present at the pharmacy.

While PAPs are extremely generous, they are often faulted for being too cumbersome to access. Not only does each pharmaceutical company have a separate application, but each prescription refill requires a new application. Particularly for low-income clinics that rely on these programs, the process can be difficult to keep up with. This may have made sense in an earlier era when few patients had chronic need for high-cost medications, but that is no longer the case, in large part due to the development of successful new drugs. The enrollment process for PAPs by and large has not evolved to accommodate the increased need for such programs. However, the Merck company, in an effort to facilitate access to its program, has extended the enrollment period between applications to one year.

Efforts to increase public awareness of and access to patient assistance programs are underway. PhRMA recently launched an interactive website, www.helpingpatients.org, to help patients identify the programs for which they could qualify. After responding to a few brief questions about income, prescription drug needs, and insurance status, individuals are directed to the appropriate program websites and application forms. PhRMA is also working to streamline the application process with a dynamic form available on its website. Patients submit information in a general questionnaire, which is used to fill out the individual PAP applications of forty participating companies. The physician then completes the prescription information, and the patient submits the application to the program sponsor. While the dynamic form facilitates applying to *some* PAPs, not all program applications can be accessed by it. Moreover, the website itself may be challenging for seniors to navigate.

The pharmaceutical industry is also working to promote the visibility of its patient assistance programs so that more individuals that qualify actually enroll. Campaigns to publicize the programs are underway in several states.

State Pharmacy Assistance Programs

States also sponsor programs to help seniors afford prescription medicines. Twenty-nine states currently administer a state pharmacy assistance program (SPAP), and nine more have legislated their creation (see table 2). All SPAPs cover the elderly, and about half extend the benefit to the under-sixty-five disabled population as well. The income thresholds to qualify vary widely, from 100 percent of poverty in

TABLE 2
STATE PHARMACY ASSISTANCE PROGRAMS

State	Year Created	Type of Program	Pharmacy Plus Waiver
Arizona	2003	Discount	
California	1999	Discount	
Connecticut	1986	Subsidy	
Delaware	1981	Subsidy	
Florida	2000	Subsidy & Discount	Yes
Illinois	1985	Subsidy & Discount	Yes
Indiana	2000	Subsidy	
Iowa	2002	Discount	
Kansas	2000	Subsidy	
Maine	2000	Subsidy & Discount	
Maryland	1979	Subsidy & Discount	
Massachusetts	1996	Subsidy	
Michigan	1988	Subsidy	
Minnesota	1999	Subsidy	
Missouri	1999	Subsidy	
Nevada	1999	Subsidy	
New Hampshire	2000	Discount	
New Jersey	1975	Subsidy	
New York	1987	Subsidy	
North Carolina	1999	Subsidy	
Ohio	2002	Discount	
Oregon	2003	Discount	
Pennsylvania	1984	Subsidy	
Rhode Island	1985	Subsidy	
South Carolina	2000	Subsidy	Yes
Vermont	1996	Subsidy	
West Virginia	2000	Discount	
Wisconsin	2001	Subsidy	Yes
Wyoming	1988	Subsidy	

SOURCE: National Health Policy Forum, "The Basics: Medicare Prescription Drug Discount Card Programs," George Washington University, April 26, 2004, available at www.nhpf.org/pdfs_basics/Basics_DrugDiscountCard.pdf.

Louisiana to as high as 500 percent in Massachusetts. Some states offer the benefit to all income levels but adjust enrollee cost sharing according to an individual's means. Other states modify the eligibility requirements for patients with catastrophic drug spending. Most do not consider a person's assets in determining eligibility.

There is generally no enrollment fee for SPAPs, but all require some degree of patient cost sharing. Like senior discount card programs sponsored by pharmaceutical companies, state pharmacy assistance programs can follow two models. In most cases, the state subsidizes the cost of the medicine and the enrollee contributes a modest copayment, between $1 and $30. SPAPs can also function as discount programs, where enrollees obtain better drug prices through discount cards or the formation of purchasing pools. Some state programs employ both direct subsidies and discounts. Under both models, states negotiate directly with drug manufacturers for better deals on the drugs that seniors use most often. State programs cover most prescription drugs, but some lifestyle drugs and over-the-counter medications are excluded.

While state pharmacy assistance programs are typically supported by state budgets, four states receive federal Medicaid funds as well. Pharmacy Plus Waivers allow states to extend Medicaid prescription drug coverage to low-income seniors not otherwise eligible for Medicaid. Federal funds are used to insure SPAP enrollees with incomes below 200 percent of poverty.

The Medicare Prescription Drug Discount Card Program

The Medicare prescription drug discount card program offers immediate assistance to seniors and disabled Medicare beneficiaries until the full drug benefit goes into effect in January 2006. According to a recent U.S. Department of Health and Human Services study, prices for brand-name drugs under the discount card program could range from 10 to 17 percent below retail, about as good as other widely available discount programs.[9] Many Medicare drug discount cards also offer lower-cost mail-order service. Although the Medicare drug discount card is available to most Medicare beneficiaries, it is of greatest value to those who have no other source of prescription drug coverage regardless of their income.

Low-income seniors who enroll in a Medicare drug discount card program are eligible for a subsidy of $600 a year to help with their drug purchases if they have no other drug coverage. In addition, many of those beneficiaries are also eligible for special low prices offered by pharmaceutical manufacturers through senior drug discount programs and patient assistance programs. The Medicare drug discount card often can enable those eligible to take advantage of such special prices seamlessly, without requiring low-income seniors to juggle several discount cards to get the lowest possible price.

Medicare Drug Discount Cards

Enrollment in the Medicare drug discount card program is voluntary and open to all Medicare beneficiaries except those who have prescription drug coverage through Medicaid. Seniors who decide to enroll must select only one Medicare-approved card, but they also may use other discount cards that have not been endorsed by Medicare. Enrollment began on May 3 and will continue for the remainder of this year. Once beneficiaries have selected a card, they have only one opportunity in late 2004 to switch to another card for 2005. Discounts offered by the program became available June 1.

Medicare discount cards are offered by a wide array of private sponsors, including retail pharmacies, pharmacy benefits managers, and health plans operating under the Medicare Advantage (MA) program. Forty Medicare drug discount cards are available to beneficiaries nationally, and thirty-three other plans operate regionally. In addition, eighty-four discount card plans are available to members of MA plans.

Sponsors may charge an annual enrollment fee up to $30. That fee is waived for beneficiaries with incomes up to 135 percent of the federal poverty level. Most MA plans and five national sponsors offer

discount cards at no charge. Sponsors must assure that beneficiaries have ready access to their prescriptions through bricks-and-mortar pharmacies, and sponsors may also offer mail-order service.

Card sponsors may use formularies, or specific lists of discounted drugs, which are expected to result in deeper discounts for their enrollees. Those formularies must cover 209 categories of the pharmaceuticals most commonly used by Medicare beneficiaries. At least 55 percent of these categories must have a generic equivalent available, and pharmacists are required to notify beneficiaries if a lower-priced generic is available for the prescription they seek to fill. Card sponsors can add or drop drugs from their formularies as long as they keep at least one product in each of the 209 therapeutic categories.

Sponsors can change the discounts available on individual pharmaceuticals, but price increases cannot be arbitrary. Any price increases not reflecting changes in actual costs or price levels prevailing in the market can be rejected by the CMS. Moreover, the card sponsors are constrained by their own self-interest: They want to increase enrollment in their plans next year. Sponsors are likely to offer the full Medicare drug benefit in 2006 and want to retain as many of those beneficiaries as they can over the long term. Arbitrary price increases or changes in the availability of pharmaceuticals would only reduce their future prospects for commercial success.

The beneficiary education campaign mounted by the CMS faced some early difficulties, but most of those problems are easing as information systems mature. The CMS provides information on each Medicare drug discount card, including the prices of pharmaceuticals and their availability at retail locations and by mail order, at www.medicare.gov. That website also provides information about other prescription drug assistance programs that may be available to beneficiaries through state agencies, pharmaceutical companies, and other private organizations. A telephone hotline (1-800-MEDICARE) is also available, although the volume of calls has overwhelmed this system in the first month of the enrollment process.

Transitional Cash Assistance

A key part of the program is a cash subsidy for the cost of prescriptions, available to some low-income beneficiaries in both 2004 and 2005. The $600 subsidy is available only through a Medicare-approved discount card, which functions as a debit card to simplify access to the funds. The federal government also pays the annual enrollment fee for the drug discount cards for those eligible.

Individuals without drug coverage whose incomes are less than 135 percent of the poverty rate qualify for the cash subsidy. For singles, this means those making less than $12,569 per year; for married couples, it means those making less than $16,862 per year. Medicare beneficiaries who are also eligible to receive assistance for prescription drugs through Medicaid, TRICARE for Life,[10] or an employer group health plan cannot receive the cash subsidy.

Medicare beneficiaries eligible for transitional assistance receive the full $600 subsidy for 2004 even though the program did not begin until mid-year. Any balance left over from the $600 subsidy at the end of 2004 will be added to the 2005 allocation. This rollover provision could be particularly important for beneficiaries who enroll in the Medicare discount card program late and might not spend their entire subsidy by the end of this year.

Legislators decided that even low-income seniors should pay at least something for their drugs so that they would appreciate the value of the benefit. The new law establishes two categories of recipients for whom assistance will be offered:

- Those with incomes below 100 percent of the poverty rate would pay 5 percent of the cost of their prescriptions until they exhaust their cash subsidy, with the rest deducted from their Medicare account. That amounts to $30 in out-of-pocket payments for a beneficiary spending $600 for prescriptions.
- Those with incomes of 100 percent to 135 percent of the poverty rate would pay 10 percent of the cost until they exhaust their cash subsidy.

That amounts to $60 in out-of-pocket payments for a beneficiary spending $600 for prescriptions.

After the cash subsidy is spent, low-income beneficiaries are liable for the full discounted cost of their prescriptions. However, many beneficiaries can take advantage of deep discounts offered by pharmaceutical manufacturers through their senior discount card programs.

With the implementation of the Medicare discount card program, the special manufacturer-specific discounts are typically limited to seniors with incomes below 200 percent of the federal poverty level. Eligible seniors receiving the cash subsidy qualify for the larger discounts once they have spent the $600. For example, a prescription that retails for $75 might cost a higher-income senior who is not eligible for any special discount $60 a month through a Medicare discount card. The same medication might be obtained by a low-income senior for $15 or less after the beneficiary has exhausted his or her cash subsidy.

Several drug manufacturers contracted with most Medicare discount card sponsors to make their senior discounts available to low-income beneficiaries without having to enroll in a separate discount card program. Other companies adopted different marketing strategies. Pfizer, for example, appears to have contracted exclusively with the United U Share Card to offer its products to eligible beneficiaries for only $15 a month. Sponsors of the Together Rx card and the GSK Orange Card decided not to integrate their discount programs with the Medicare discount card. Instead, seniors have the option of using the Medicare-approved card or an alternative such as Together Rx or the Orange Card to get the greatest savings.

Some low-income seniors also are eligible for no-cost pharmaceuticals through patient assistance programs sponsored by the drug companies. As discussed previously, those programs require a special application process and are available only to people (of any age) who lack the resources to buy necessary medications. They typically distribute pharmaceuticals through physicians' offices rather than through retail pharmacies. Moreover, state pharmacy assistance programs may provide additional support to low-income seniors once the $600 federal subsidy has been spent.

Both the temporary discount card program and the $600 annual subsidy end in 2006, to be replaced by the full Medicare prescription drug benefit program, often called Part D. At that time, seniors can enroll either in one of the new subsidized Medicare Part D prescription drug plans or in a Medicare Advantage plan to receive drug coverage.

Finding the Best Deal

Much of the analysis of the Medicare prescription drug discount card naturally focuses on the size of the discounts that could be available under that program. Most studies compare the price of a thirty-day supply of a drug under the Medicare discount card with some measure of the retail price (perhaps obtained from a local retail pharmacy) or prices available through other discount card programs or internet sites. On the basis of these kinds of studies, some commentators concluded that discounts under the Medicare program are no better than discounts available elsewhere.

Such discount comparisons can be a misleading indicator of the savings available to seniors under the Medicare drug discount card program. The actual value of the new program to an individual over the course of the year depends on other important factors typically overlooked by studies that simply compare the prices of a few top-selling drugs. A senior might be eligible for the $600 cash subsidy depending on his or her income. Even a person who is not eligible for the government's subsidy may qualify for deeper discounts on specific manufacturers' products than found on the Medicare website.

Considering all savings options generally available to seniors, we find that the new Medicare program offers substantial savings to low-income seniors compared to the amount they would spend on their prescriptions at retail prices or through other widely available sources of discounted drugs. A significant portion of those savings is due to the $600 subsidy, but senior discount programs sponsored by pharmaceutical manufacturers that coordinate with the Medicare program also account for a sizeable share of the savings.

Higher-income seniors who do not receive the cash subsidy can also save using a Medicare discount card, depending on their specific prescriptions and whether they are already shopping aggressively for the lowest price. We found significant savings, even compared to the cost of prescriptions available from AARP and internet pharmacies, for seniors who use only the baseline discounts offered by Medicare cards to all beneficiaries.

The confusion caused by looking only at drug prices and not considering the cost of prescriptions over the year could lead many seniors astray. Critics assert that the Medicare discount card does not offer lower prices than Canadian pharmacies or the cost of drugs to the U.S. Department of Veterans Affairs (VA), at least on branded drugs. While prices for such drugs are generally higher through the Medicare program, that program also provides easier access to pharmaceuticals through thousands of retail pharmacies and other features that add to operating costs. Nonetheless, many low- and moderate-income seniors

TABLE 3
THREE HYPOTHETICAL BENEFICIARIES

	Age	Conditions	Prescription Drugs*
Robert Smith	66	Diabetes	Glucophage
		High blood pressure	metoprolol
		High cholesterol	Zocor
		Erectile dysfunction	Viagra
Mary Jones	74	Congestive heart failure	Lasix
		High blood pressure	metoprolol, Zestril
		High cholesterol	Lipitor
		Osteoarthritis	Vioxx
		Gastric reflux disease	Prevacid
Fred Green	78	Chronic lung disease	albuterol
		Blood clots	Coumadin
		Seasonal allergies	Allegra
		Hypothyroidism	Levoxyl
		Depression	Paxil

SOURCE: Authors' assumptions.

* These prescription drugs make up the "branded" basket of drugs used by our hypothetical seniors. Another set of drugs making greater use of generic substitutes was also considered (the "generic" basket); see the appendix.

without drug coverage could, in fact, save more money under the Medicare discount card program. By taking advantage of privately negotiated discounts and special manufacturers' prices, those seniors would pay much less over the course of the year than they could even with VA and Canadian prices.

Many seniors have a wide choice of Medicare-approved discount cards that offer savings at or very close to their best deal. The beneficiaries we analyzed had between thirteen and twenty Medicare card options within 5 percent of the lowest cost plan as reported on Medicare's website. However, low- and middle-income seniors without other coverage should check to see if pharmaceutical manufacturers' senior discounts are available to them. Under some circumstances, one card could prove to be a much better deal than any other, even if its baseline prices reported on the Medicare website are not the lowest.

There is no universal answer to how much seniors will save by enrolling in the Medicare drug discount card program. Actual savings depend on both what the Medicare card offers and what the individual has already done to reduce the cost of prescriptions. Some seniors prefer the familiarity of the local pharmacy, even though the price is higher than other options. They are likely to find that the Medicare drug card allows them to continue to shop locally at reduced prices. They probably could save more through a Medicare mail-order option or, for that matter, an internet pharmacy, but cost savings may not be their only consideration.

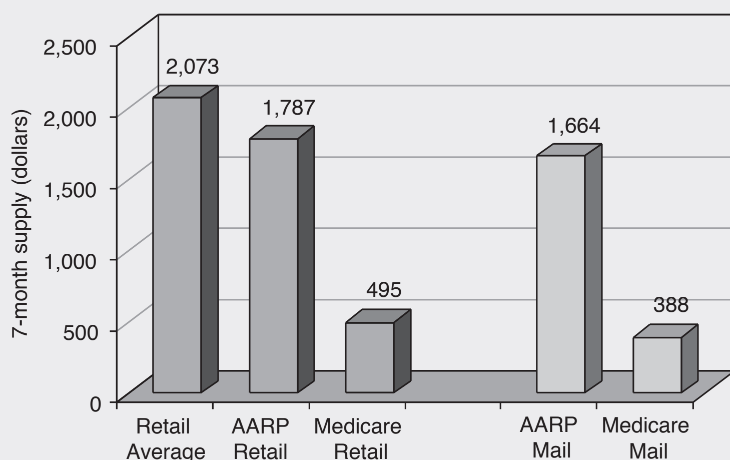
The new program will spur seniors to look more carefully at their options, and some may reconsider the way they currently purchase their prescriptions. Even if they do not enroll in the Medicare card program, some seniors are likely to find other alternatives that will save them money on their prescriptions compared to their current costs.

Three Typical Beneficiaries

To understand the full impact of the new program, we must put ourselves in the place of a typical senior. We developed three hypothetical patient profiles for seniors with arthritis, hypertension, high cholesterol, diabetes, and other health conditions common to an older population (see table 3). For each person, we identified medicines typically prescribed for his or her health conditions and identified generic drugs frequently substituted for brand drugs when appropriate.

Price information was current as of June 1, the first day Medicare beneficiaries could take advantage of discounts using the card. We determined

FIGURE 1
MR. SMITH CAN SAVE 75 PERCENT OVER THE NEXT SEVEN MONTHS



SOURCE: Authors' calculations. Data collected June 1, 2004.

the cost of pharmaceuticals prescribed for each of our beneficiaries under the Medicare discount card program and six other sources of low-priced drugs. Since subsidies and discounts depend on a beneficiary's income, we repeated the exercise for seniors at three different income levels:

- Up to 135 percent of the federal poverty level, no other drug coverage—eligible for the $600 subsidy and special manufacturers' discounts for some drugs.[11]
- Between 135 percent and 200 percent of poverty, no other drug coverage—eligible for special manufacturers' discounts for some drugs.
- Above 200 percent of poverty or any lower-income beneficiary *with* drug coverage—eligible for only the standard discounts reported on the Medicare website.[12]

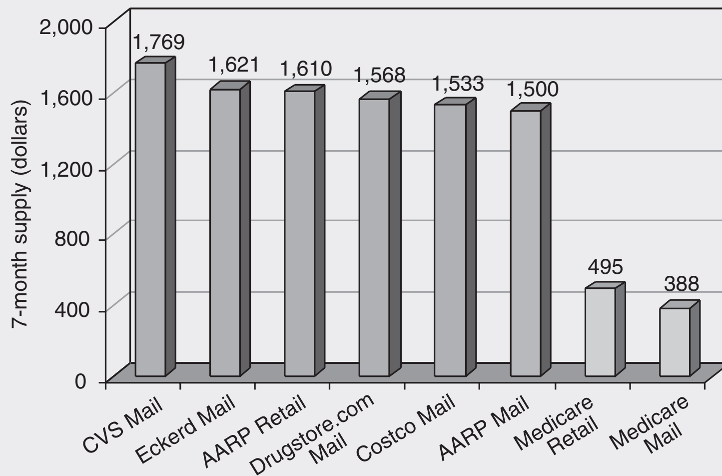
Savings were calculated over the seven months (June through December) that the new Medicare program will be in operation this year. The assumptions made in this study are more fully documented in the appendix.

Savings for Low-Income Seniors. Consider Robert Smith, a sixty-six-year-old man with modestly well-controlled diabetes, high blood pressure and cholesterol, and the need for an occasional Viagra pill. He also takes Glucophage (a branded drug for diabetes), metoprolol (a generic drug for hypertension), and Zocor (a branded drug for cholesterol) on a daily basis.

Mr. Smith is married, lives in Brooklyn, and has a family income of $16,000—just under 135 percent of the poverty level. He is a member of AARP and purchases his drugs through AARP's retail pharmacy program. Although he is eligible for senior discount programs offered by drug manufacturers, he has not applied for those programs. His monthly drug spending, with the AARP discount, comes to just over $255. Between June and December, he will spend $1,787 on prescription drugs. The retail price of those drugs would be even higher without the AARP discount, approximately $2,070 over the next seven months.[13]

Under the Medicare discount card program, Mr. Smith is eligible for the full $600 subsidy as well as special low prices offered by drug manufacturers' senior discount programs through the Medicare cards. For his medications, the best Medicare card option available to him on June 1 was the U Share Prescription Drug Discount Card. (The same Medicare discount card will not necessarily be the best buy for different people, depending on the drugs they take and where they prefer to fill their prescriptions.) Using that card and with all the other subsidies for which he is eligible, Mr. Smith can purchase his medicines at a retail pharmacy for $495 for the remainder

FIGURE 2
MR. SMITH'S BEST DEALS*



SOURCE: Authors' calculations. Data collected June 1, 2004.

* These package prices account for the regular low prices offered by each retailer plus any available manufacturers' discounts.

of this year, or about $70 a month. He could save even more if he purchased his prescriptions by mail order, which would cost about $388 for the seven months (see figure 1).[14]

Mr. Smith stands to save almost 75 percent off the cost of his prescriptions over the rest of this year compared to his current spending using the AARP discount. Just over half the saving, about $690, is the result of the discount prices and the price breaks from the drug company discount programs. The other $600 in savings represents the cash subsidy given to low-income seniors. Ignoring that subsidy and looking only at price discounts clearly understates the value of the program to someone like Mr. Smith.

Could Mr. Smith beat the savings from the Medicare discount card by just taking advantage of manufacturers' senior discount programs and shopping around? That is unlikely. If Mr. Smith were to enroll in those discount programs available to him, his cost through an AARP retail pharmacy would drop to $1,610. If he also switched to AARP's mail-order option for all his prescriptions, his cost would fall to $1,500, somewhat below what he is now paying but certainly not below his $388 cost under the best Medicare mail order service. Other mail order options—including Eckerd, Drugstore.com, and Costco—offer savings similar to AARP's for Mr. Smith (see figure 2).

This result is repeated in the other cases we examined. Table 4 shows the analysis for our three typical seniors using different assumptions about their incomes and eligibility for the $600 subsidy and special manufacturers' discounts. For each senior, we priced two drug baskets (one with mostly branded products, the other with more generics) at retail pharmacies and through mail order. We assumed that each senior takes advantage of all discounts available under both Medicare and private discount plans.

A typical low-income senior might save between half and three-quarters of his or her drug costs for the remainder of this year compared to the next best private alternative. Low-income seniors who are eligible for the cash subsidy almost certainly will save money through the Medicare discount card program compared to other legitimate sources of discounted pharmaceuticals.

Additional savings are possible if the beneficiary is willing to shift some prescriptions to generic formulations or purchase them through mail order rather than at a retail pharmacy. We switched some (but not all) of the branded drugs in our examples to generics. Our low-income seniors purchasing through the Medicare discount card program typically save around 10 percent compared to the cost of prescriptions that were mainly branded drugs. Greater savings are generally possible if more of a beneficiary's prescriptions are generic, although we

TABLE 4
MEDICARE SAVINGS OFF THE BEST PRIVATE DEAL

Low-income senior (at or below 135% of the federal poverty level*)		
"Brand"**	Retail	53–69%
	Mail	60–74%
"Generic"†	Retail	50–78%
	Mail	58–72%
Moderate-income senior (between 135 and 200% FPL)		
"Brand"	Retail	10–34%
	Mail	16–37%
"Generic"	Retail	10–38%
	Mail	16–29%
High-income senior (above 200% FPL)		
"Brand"	Retail	8–13%
	Mail	15–23%
"Generic"	Retail	6–23%
	Mail	14–24%

SOURCE: Authors' calculations. Data collected June 1, 2004.

* In 2004, the FPL is $9,310 for individuals, $12,490 for couples.

** "Brand" refers to a basket where branded drugs are generally included over generic alternatives.

† "Generic" refers to a basket where generic alternatives are generally substituted where they are available.

found some branded products are less expensive than generics if the beneficiary is eligible for an exceptionally generous manufacturer's senior discount program.

Mail order could save between 12 and 31 percent compared to retail purchases through the Medicare card program for our beneficiaries. However, one of our typical seniors would spend more on mail order than on retail purchase. Mail order generally requires that an individual buy a three-month's supply, which can delay when a manufacturer's senior discount goes into effect. The senior discounts apply after the $600 subsidy has been spent, but an individual could meet that limit partway through a three-month mail-order cycle and not immediately capture the discounts for which he is eligible.

Savings for Higher-Income Seniors. Seniors with higher incomes are likely to see modest but real savings under the Medicare drug discount card program, particularly if they have no other coverage for their prescriptions. Moderate-income seniors, with incomes between 135 percent and 200 percent of poverty, are eligible for manufacturers' senior discount programs through Medicare in addition to the baseline discounted prices posted on the Medicare website. In addition, the Together Rx card, the GSK Orange Card, and perhaps others continue to be available outside Medicare to some seniors without coverage.

High-income seniors, with incomes above 200 percent of poverty, can access only the baseline discounts offered by Medicare card sponsors. Discounts from Together Rx and the Orange Card also are available for seniors with incomes up to about 300 percent of poverty who have no insurance coverage for prescriptions. For our analysis, we assume that a high-income senior is eligible for only the baseline discounts under the Medicare-approved card.

Accounting fully for senior discount programs, the typical moderate-income beneficiaries in our analysis could save from 10 to 38 percent under the Medicare discount card program compared to their next-best private alternative. High-income seniors, who would pay the prices shown on the Medicare website for each card option, could save from 6 to 24 percent in our examples. Although those savings may not be viewed by some commentators as large enough, they are nonetheless real savings compared to what higher-income seniors without drug

coverage typically spend, even when they are careful comparison shoppers.

Those seniors can save more if they switch to generics or purchase through mail order under the Medicare discount card program. Moderate-income seniors might see additional savings of 2 to 17 percent by shifting to more generic drugs. Higher-income seniors would also save from that switch, particularly because they do not benefit from special manufacturers' discounts on branded drugs. In our examples, savings ranged from 6 to 16 percent.

Mail order also yielded significant additional savings, ranging from 9 percent to as much as 19 percent compared to retail pharmacy purchases for higher-income seniors. Once again, however, mail order could prove more costly than retail purchases for a moderate-income senior who is eligible for a generous senior discount card program because of the three-month purchasing cycles.

To test whether the baskets of drugs we identified for our typical seniors might give a false indication of savings, we also compared Medicare discount card prices for the ten top-selling pharmaceuticals with prices charged by other well-known discounters.[15] (Those prices were posted on June 5.) Medicare's best price for retail sales undercut AARP's discounted retail price in every case, with savings ranging from 7 to 35 percent. Medicare's best mail-order price was also best, ranging from 5 to 53 percent lower than the mail-order prices offered by five discounters. This confirms that the prices currently posted on the Medicare website are, in fact, highly competitive.

Medicare Card vs. VA and Canada. Senate minority leader Tom Daschle (D-S.Dak.) and his colleagues recently asserted that the new discount card program does not show real savings compared to Canadian pharmacies or the U.S. Department of Veterans Affairs (VA).[16] That statement confuses price with cost to the consumer. Despite higher prices on branded drugs, many seniors could pay less over the year through the Medicare discount card program than with VA or Canadian prices, particularly if they qualify for the $600 subsidy.

Prices for the top-selling branded drugs available through the VA and Canadian pharmacies are substantially lower than Medicare discount card prices. According to price data for May 24 from Families USA, the VA paid between 6 and 69 percent less than the Medicare discount card price (measured as the best price available through retail sales) for the top ten pharmaceuticals.[17] The Canadian prices used by Sen. Daschle were between 27 and 63 percent lower than the Medicare prices reported by Families USA.

Those price comparisons are not completely fair. They do not include generic drugs, which represent about half of pharmaceutical sales in the United States and offer substantial savings. They compare discounted retail prices under Medicare with prices not available at retail pharmacies in the United States. Americans who take advantage of Canadian prices generally purchase by mail order for obvious reasons, and the VA dispenses drugs through a limited number of facilities rather than through thousands of retail pharmacies, as Medicare card sponsors do. Other requirements of the Medicare program, including consumer hotlines and other information for seniors, may not be available through Canadian pharmacies. The VA tightly controls what drugs may be prescribed by their physicians, while there is no such restriction under the Medicare program. These differences add to the cost of the Medicare discount card program, but they also represent added value to seniors.

Low-income beneficiaries eligible for the subsidy and special discounts almost certainly would save more under the Medicare program than they could even at very low Canadian prices. Seven of the top ten drugs are available to those low-income seniors for $15 or less per month after they have spent their $600 subsidy. Even moderate-income seniors would save if they were eligible for those manufacturers' discounts. Higher-income seniors would pay a higher price under Medicare than Canadian or VA prices, but as we have seen, those prices are substantially below prices available through popular discounters in the United States.

Other Evidence of Potential Savings. The pattern of savings to Medicare beneficiaries by enrolling in the new drug discount card program that we found is broadly consistent with other studies, including a preliminary analysis we completed in early May and later studies by the Centers for Medicare and Medicaid Services (CMS) and the Lewin Group. Each of those studies documents the large savings possible for low-income seniors under the new program, with lesser savings available to seniors who are not eligible for the $600 subsidy. Unlike the CMS and Lewin studies, we explicitly account for the additional savings available to low- and moderate-income seniors through manufacturers' senior discount programs.

Our earlier study[18] followed the same three typical beneficiaries but estimated drug spending using prices listed on Medicare and other websites on May 3. More Medicare discount cards report prices on the Medicare website currently, and the prices of many drugs have come down since the first week in May. Savings for prescriptions filled between June and December of this year were calculated by comparing the best price under the Medicare program with the best available alternative outside Medicare. With that metric, savings for seniors below the poverty level ranged from 30 to 70 percent.[19] Savings percentages would have been somewhat higher if we had compared the cost under the Medicare discount card with the cost of prescriptions at full retail price.

A May 6 study by the CMS[20] reports the cost of a thirty-day supply of pharmaceuticals for six hypothetical beneficiaries living in different parts of the country and compares that with an estimate of the average national retail price. Price data were collected May 3. That study finds discounts ranging from 10 to 17 percent below retail, in line with our savings estimates for high-income seniors who are eligible only for the normal discounted prices found on Medicare's website. They found that the mail-order savings ranged from 4 to 13 percent below Drugstore.com or Costco.com for three Medicare-approved cards, but a fourth card charged about 20 percent more. A subsequent CMS analysis published May 24 (using prices from May 19) found savings from Medicare mail-order outlets ranging from 7 to 24 percent.[21]

In a May 19 study,[22] the CMS also looked at the savings possible to low-income seniors between June and December using the discount card and the $600 subsidy. Using prices available on May 17, the study found savings ranging from 11 to 19 percent below the national retail cost when taking only price discounts into consideration. These are somewhat lower prices than captured in the May 6 CMS study. Factoring in the $600 subsidy raises the net savings to eligible seniors to between 37 and 77 percent off the retail cost. Similar large savings are reported in the CMS analysis of twelve commonly prescribed drugs. None of these estimates accounts for additional savings possible through manufacturers' senior discounts, available through many of the Medicare-approved cards.

The Lewin Group[23] published preliminary findings indicating a wide range of savings under the Medicare discount card program, depending on the specific drug prescribed. They found little state-to-state variation in prices. Total savings for twenty-five commonly prescribed drugs ranged from 16 to 24 percent off retail. The study also examines the costs encountered by patients with eleven chronic conditions. Savings from price discounts alone ranged from 13 to 29 percent over a year; accounting for the $600 subsidy, savings ranged from 29 to 92 percent.

Choosing the Right Medicare Discount Card

How can seniors know whether they should enroll in the Medicare prescription drug discount card program? How important is it for seniors to choose their Medicare-approved card carefully?

For at least one group of seniors, the answer to the first question is easy. Those who are eligible for the $600 subsidy can access that money only through a Medicare-approved card. As the previous analysis demonstrates, those seniors stand to save much more than $600 by enrolling in the new Medicare program, and there is no cost to them since the enrollment fee is waived.

Most beneficiaries need information on the costs they will incur under a Medicare discount card

compared to the costs they will pay if they do not enroll. That means a pricing exercise similar to the one we performed in this study for our typical seniors. The exception to this rule is a beneficiary who is a member of a Medicare Advantage plan. Those plans typically integrate drug discounts with insurance coverage for prescriptions. MA plan members are automatically enrolled in their plan's approved prescription discount card program.

Other factors could sway a beneficiary's decision to select one Medicare-approved card over another. Some seniors may find that the lowest cost option does not include their favorite pharmacy, for example. Seniors living in institutional settings may face special requirements (such as the need for certain kinds of packaging) that may limit their choices. However, most beneficiaries gravitate to the lowest-cost plan—and for many, a large number of cards offer roughly equivalent savings.

Limited Price Dispersion. A striking result of our investigation into the cost of prescriptions under the new Medicare program is the large number of approved discount cards that offer prices very close to the best deal possible. This is relevant primarily to higher-income beneficiaries, who are not eligible for manufacturers' senior discount programs, many of which operate through the Medicare discount card. Because high-income seniors get no additional price breaks, the thirty-day or ninety-day supply prices available from the Medicare website represent the actual cost they will incur over those time periods.

We analyzed the baseline prices of Medicare discount cards available to our three typical beneficiaries, as reported on the Medicare website. Between thirteen and twenty Medicare-approved cards were within 5 percent of the cost of the card offering the best deal on retail purchases of prescriptions. Over the course of seven months, a card plan that was 5 percent more expensive would add between $45 and $120 to the cost paid by those beneficiaries. If a beneficiary could tolerate as much as a 10 percent increase in cost, between twenty-two and twenty-eight plans would be feasible for the three people in our examples.

This wide choice of competitive plans might be expected in a heavily urbanized area such as Brooklyn. But the previously mentioned CMS and Lewin studies confirm that the prices for specific pharmaceuticals do not vary much from place to place. We would expect therefore that most beneficiaries have a wide choice of card options that are similarly priced.

The majority of Medicare beneficiaries, who are not eligible for manufacturers' senior discounts, can easily determine from the Medicare website which of the approved discount cards makes the most sense for them. Lower-income beneficiaries must look more carefully.

Access to Manufacturers' Discounts. Seniors with incomes up to 200 percent of the federal poverty level (and in some instances, 300 percent) are eligible for senior discount programs offered by pharmaceutical manufacturers if they have no other coverage for drugs. Many of those special discounts are available directly through the Medicare discount card for seniors receiving the $600 subsidy. Moderate-income beneficiaries submit an additional application, but they too often get the benefit of the extra discount automatically with the use of their card.

There is, however, no general rule of thumb to guide seniors on what could result in very large savings to them. Some manufacturers plan to contract with every Medicare card sponsor to make this special discount available. Others are likely to contract with only a few sponsors. Pfizer, for example, apparently contracts with only one sponsor, United Healthcare's U Share card. At least two senior discount programs, the Together Rx plan and the GSK Orange Card, remain independent of the Medicare program. In addition, some of these programs give substantial discounts on all of a manufacturer's products, while others give discounts on only selected products.

Beneficiaries who are eligible for senior discount programs are provided only general guidance from the Medicare website, indicating whether a manufacturer has contracted with a card sponsor but giving

TABLE 5
THE TOP FIVE MEDICARE DISCOUNT CARD OPTIONS FOR MRS. JONES

Card	Monthly Retail Price*	Seven-Month Cost with Manufacturer Discounts
1. Preferred Prescription Discount Card	$353.95	$1,538.09
2. U Share Prescription Drug Discount Card	$355.94	**$994.79**
3. myPharmaCare	$356.20	$1,543.96
4. EnvisionRx Plus	$357.77	$1,561.62
5. Prescription Discount Card	$358.07	$1,546.07

SOURCE: Authors' calculations.
* Price is for the "branded" basket of drugs (refer to table 3) and applies no special manufacturer discounts or Together Rx prices.

little additional information. Not surprisingly, the website does not calculate prices for beneficiaries that take into account these special discounts. Although those discounts could be substantial and might be made available automatically, a beneficiary would have to call the Medicare-approved card sponsor to know whether that is the case.

The potential importance of selecting the best Medicare discount card is brought into sharp focus by our example of Mrs. Jones, who uses Lipitor to lower her cholesterol. Lipitor is a Pfizer product, so if her income were below 135 percent of poverty, Mrs. Jones would be eligible to purchase that drug for about $15 a month, but only if she enrolls in the U Share card. The Medicare website shows five drug cards available to Mrs. Jones that are nearly equivalent in cost, varying by less than $5 for a month's supply of all her prescriptions (see Table 5). The Preferred Prescription Discount Card is the lowest price, at $353.95 for a month's prescriptions filled at a retail pharmacy. The U Share card appears to come in second, at $355.94.

Many seniors would be tempted to go with the lowest-cost card, even if the savings are only a few dollars a month. That would be sensible for higher-income seniors not eligible for special discounts, but that would be a $540 mistake for Mrs. Jones over the next seven months.

It is essential that Medicare beneficiaries find out the details of special discount programs for the drugs they take that may be offered through approved discount cards. As Mrs. Jones's example illustrates, selecting the best card could bring substantial savings compared to the next best alternative.

Prospects for Success

The Medicare prescription drug discount card program was developed in remarkably little time. The Centers for Medicare and Medicaid Services published a regulation detailing the requirements of the new program in December, just two days after the Medicare legislation was signed by the president. That sparked a flurry of interest among firms seeking to participate in the program. By January, the CMS had received applications from 104 prospective card sponsors. A few months later, the CMS approved seventy-three discount card plans open to any Medicare beneficiary and another eighty-four plans open to beneficiaries in managed care plans operating in the Medicare Advantage program.

In contrast to this vigorous response from potential card sponsors, Medicare beneficiaries have been slow to enroll in the new discount card program. Initial reports indicated that 2.9 million people were enrolled in the Medicare prescription drug discount card program by the first week in June, far below the 7.4 million the CMS eventually expects to sign up. About 2.3 million of those beneficiaries were automatically enrolled as a result of being a member of a Medicare managed-care plan. Perhaps as few as 600,000 people signed up for a discount card on their own.

Is this an indication that seniors are not ready or not able to make decisions about their health care? Does this mean that competition cannot work even when competitors line up at the door?

The failure is more mundane. People at any age need time and information to adapt to changing circumstances. Congress required that the Medicare discount card program begin operating in only six months. The CMS has met that timetable, but consumer information efforts continue to be developed. Many seniors remain uncertain about the value of the program to them, and uncertainty breeds inertia.

Despite mounting evidence to the contrary, critics remain skeptical that the discount cards offer lower prices than seniors could find elsewhere. They argue that allowing card sponsors to set their own prices rather than having the government negotiate directly with pharmaceutical companies will lead to higher prices and greater cost to beneficiaries and taxpayers alike. Prices offered by card sponsors in early May may have been somewhat disappointing, seeming to give credence to those fears. Since then, better deals have become available to seniors, due at least partly to the entry of more competitive firms seeking to attract a large share of the Medicare market.

Critics also have charged that card sponsors could pull a bait and switch, raising prices and dropping expensive drugs after seniors are locked into plans that they cannot leave until January 2005. Although such changes are permitted, the

companies sponsoring Medicare drug cards are well-established firms that see the discount card program as an entry to the full drug benefit in 2006. Competition and the desire to build a customer base is likely to force prices down and improve customer service, not raise prices and drive beneficiaries away.

The Medicare drug discount card program introduced a new element of competition into a price-controlled government entitlement. The program is an unusual partnership between the federal government and the private sector, with a taxpayer-provided cash subsidy and privately negotiated discounts that together could substantially reduce the cost of prescriptions for millions of seniors. If that were the sole outcome of the program, it would be a runaway success.

There is even greater potential for good in this fledgling program. For the first time, anyone can learn the price of prescription drugs from a national database that is updated weekly. Over 40 million Medicare beneficiaries are now able to compare prices and get the best deal under the discount card program. The database is limited to prices available through Medicare discount card sponsors and does not include retail prices. Even that level of price transparency is unprecedented in the market for health services.

Consumers must know the price of a product before they can get the best value, and that information has been missing in health care until now. There is reason to hope that the Medicare discount card program could be a catalyst for larger changes in the way we buy health care in this country.

Encouraging Enrollment

It should not be surprising to anyone that enrollment in the Medicare drug discount card program has gotten off to a slow start. According to polls taken months after the Medicare provisions had become law, a sizeable fraction of seniors were only dimly aware of the new benefit provisions enacted by Congress. That speaks more to a lack of need rather than a lack of interest in the new program. Most seniors already have some type of prescription drug coverage, and many probably guessed that a discount card program would be of little value to them. Under those circumstances, a reasonable person would not work very hard to find out about the Medicare discount card program.

AARP's experience may have been typical. It reports receiving thousands of inquiries about Medicare drug discount cards in the weeks prior to June 1.[24] Despite that interest, only about 400 people enrolled in AARP's own Medicare-approved card program by the end of May.

The apparent lack of interest in the AARP-sponsored card points to another potential problem: Seniors may believe that they do not need a Medicare-approved card because they already have a private card under a similar corporate name. As we found in our analysis of three typical seniors, that error could cost low-income beneficiaries hundreds of dollars in savings this year.

The information available to beneficiaries from the CMS and other sources has improved greatly over the past several months, and more improvements are forthcoming. However, many beneficiaries are likely to decide whether to enroll, and which Medicare card to select if they do so, using incomplete information.

The Medicare website provides only limited information on manufacturers' senior discount programs that coordinate with many Medicare-approved cards. The card sponsors' websites provide some additional information but often not enough to tell a beneficiary what his actual costs will be with the special discounts. Telephone calls to several card sponsors may be the only way to accurately determine which of several card options is best for a beneficiary.

This problem conceivably could be resolved by collecting massive amounts of additional data from card sponsors and further complicating the way beneficiaries access that information. Most people want less complication, not more.

A newly formed coalition of organizations might hold the solution to this information problem. Chaired by the National Council on Aging, the Access to Benefits Coalition (ABC) is a group of sixty-eight

organizations serving seniors and persons with disabilities. Those organizations include aging and health care organizations (such as AARP and the Catholic Health Association), charities (such as Easter Seals), and disease-specific groups (such as the American Diabetes Association). The ABC has joined with the CMS to encourage low-income beneficiaries to enroll in the Medicare discount card program.

The ABC could become a clearinghouse for consumer-friendly information. In addition to promoting awareness of the new program, the ABC will soon offer on its website a consumer's guide to discount card plans, possibly including a summary rating. Some ABC members also might make recommendations on which card sponsors may offer the best deal to a beneficiary with particular health needs. Even though such advice would not pinpoint the single best option for a specific individual, advice that cuts through the thicket of technical detail would be welcomed by many.

Competition vs. Regulation

The role of private competition in Medicare has been a major point of contention in Congress. The Medicare drug discount card is the latest field on which this battle is being waged. Those who favor a government-run system assert that competition will not hold down costs. On the contrary, Medicare discount cards undercut the prices offered by private competitors from the outset. They also fear that card sponsors could raise prices indiscriminately without direct government controls. That problem is unlikely to materialize because most of the sponsors have a longer-term interest in the success of the Medicare prescription drug program.

Competition and Better Card Options. Skepticism about the effectiveness of competition in keeping down drug costs was heightened by the CMS's release of the first pricing information in late April and early May. The early offers by Medicare-approved card sponsors were not dramatically lower than competitors, prompting federal officials to respond that prices would come down in subsequent weeks. That has been borne out.

We examined the lowest-priced Medicare discount cards (not accounting for any special discounts) available to our typical beneficiaries on May 3 and again on June 1. The number of cards reporting prices on the CMS website increased significantly over that period. For example, our Mrs. Jones of Brooklyn had fourteen Medicare card options for her drug set when the price finder was launched on May 3. A month later, she had thirty-three cards to choose from. The surge of new cards that have become available to seniors has already bred competition and driven down prices. The best Medicare cards for our three Brooklyn seniors in June were on average 3.5 percent lower than their best options in early May.[25]

Seniors are already getting better deals than our first look at prices, one month ago, suggested. This is a result of competition among Medicare drug cards *and* the influx of new plans that offer deeper discounts.

The initial pricing decisions by card sponsors reflected the substantial costs and uncertainty associated with the new Medicare market. Although many sponsors have experience with private discount card programs, the requirements of the Medicare program are more costly and less familiar to them. Greater customer support is necessary, for example, and sponsors must develop secure ways of administering the cash subsidy component of the program. Those requirements add significantly to the cost of operating the card plan. Sponsors may charge an annual enrollment fee (which can be no higher than $30), but that revenue offsets only a small part of the cost. The remainder must be recouped through higher prescription prices.

Uncertainty about how competitors would price their cards also contributed to prescription prices judged by some as too high initially. We should begin to see card sponsors competing for enrollment by more aggressively bidding down prices and offering better customer service (which might simply mean offering more pharmaceuticals at discounted prices). Some consolidation may be

expected as less successful sponsors drop out of the Medicare market after 2004, and their increased market shares may give the remaining plans additional leverage with pharmaceutical companies on the cost of their products.

Bait and Switch. Critics argue that card sponsors could raise prices sharply once beneficiaries have enrolled. Beneficiaries must remain with the discount card plan that they first enroll in for the year, with one opportunity to switch plans for 2005. That could place beneficiaries at a disadvantage if plans change their discounts or drug lists after the open enrollment period.

Few, if any, card sponsors are likely to pursue a bait-and-switch strategy, where they advertise prices that are too good to be true, then raise prices after seniors are locked into the plan. Safeguards built into the program limit price increases to a limited range that reflects increases in the drug's average wholesale price or changes in the card sponsor's cost of operation. In addition, prices are posted on the CMS website, and drugs cannot be dropped from company drug lists without notifying the CMS in advance. The threat of public disclosure can be a significant deterrent to inappropriate business practices.

The risk of bait-and-switch tactics would be greater if drug card sponsors had only a short-term interest in the Medicare program, so that the loss of market share after the first year would be of little consequence. But most, if not all, prospective sponsors of the Medicare discount card are well-established firms with reputations to protect, and the majority of them are considering continued involvement with Medicare through the Part D benefit. For such sponsors, bait-and-switch practices would be bad business, placing them at a competitive disadvantage.

Catalyst for Change

The Medicare prescription drug card program is clearly a work in progress, and much more needs to be done to make the program known and accessible to seniors, especially low-income seniors, who have the most to gain from it. If public- and private-sector outreach and consumer information efforts are successful, perhaps 7 million beneficiaries will receive substantial assistance with their prescription costs. We may well approach that enrollment target by the end of this year.

The discount card program is a significant departure from the way Medicare typically functions. The program is not a health benefit in the traditional sense but an assistance program. It does not guarantee federal payments for health services, but it gives seniors access to lower prices and, for many, some cash assistance. Enrollees in the discount card program have a strong incentive to find the lowest-cost product that works for them, since in fact they are spending their own money. Those without other insurance coverage who are eligible for the $600 subsidy have always had a strong reason to economize on their prescriptions. That has not changed, but now they have more funds to help with their expenses.

The extent of private sector involvement in this program is also a departure from the Medicare norm. Low-income seniors benefit from a federal subsidy and savings from privately negotiated discounts on pharmaceuticals. Perhaps half the benefit that those seniors receive is the result of private actions rather than government expenditures or mandated prices. Already, some evidence suggests that competition among card sponsors will drive down the cost of prescriptions under this program.

The Medicare drug discount card program was designed as a temporary measure to help those who need the help until the full drug benefit becomes available. The full benefit is a more complex and expensive undertaking than the discount card program. Implementing that benefit in only two years is ambitious and perhaps unrealistic.

If more time is needed, Congress may have an option: Extend the discount card program into 2006 and broaden eligibility for the cash subsidy to moderate-income beneficiaries. Some of the money that would have been spent during the first year of a delayed Medicare drug benefit could be used to give more people cash assistance. An extended and

enhanced drug discount program could give the CMS an additional year to implement the more complex drug benefit.

Policymakers are appropriately focusing their attention on how well the Medicare drug discount program will work for seniors. But the impact of this small program could be much wider. Actions that already have been initiated in the drug discount program ultimately could leverage change in the pharmaceutical market as a whole.

The catalyst for that change is the much-maligned price information posted on the Medicare website. Despite its limitations, this database of pharmaceutical prices is a unique resource. Although there are private sources of information on drug prices, that information is closely held. Medicare now provides such information from Medicare card sponsors freely to anyone with access to the internet. That could be the beginning of a broader move toward price transparency in the market for prescription drugs.

Secrecy over prices is not news in health care. Unlike any other item bought and sold in this country, health care products and services are routinely provided to consumers who do not know what they cost. Without knowing the price, the consumer can hardly be expected to purchase wisely.

Price transparency could revolutionize the pharmaceutical industry. Once prices can be compared with little difficulty, consumers inside and outside Medicare will begin to ask whether they are getting their money's worth.

Moreover, Congress will also ask whether the taxpayer is getting *his* money's worth, and therein lies a danger. The price information that can fuel smart shopping by consumers could just as easily be an invitation to the government to fix prices. There is clearly strong sentiment on Capitol Hill and around the country for such a policy, even though the long-term consequences of federal price controls could be less innovation and fewer effective pharmaceuticals to treat the diseases of an aging population.

We are nearing a crossroad: One path leads to a market catering to consumers, the other to a market dominated by bureaucrats. Congress favored a consumer-oriented approach in the Medicare Modernization Act but by only a slim margin. If the Medicare prescription drug discount card program matures successfully, there is reason to hope that Congress will continue down that path.

Appendix

Measuring Prescription Costs and Savings

Savings available to Medicare beneficiaries under the new prescription drug discount card program depend on the drugs they use, how they choose to purchase those drugs, and their income levels. We began by developing clinical profiles for three hypothetical seniors having chronic conditions commonly seen in aging populations (see table A1).

We identified drugs frequently prescribed for each of these patients, as well as generic equivalents where available (see table A2). Since most people with chronic conditions take a mix of brands and generics, we identified a combination of prescriptions that were more heavily weighted toward brands and another combination more heavily weighted to generics.

We tracked the costs each person will incur for their prescriptions from June through December 2004 under the lowest-cost Medicare-approved card and under other well-known sources of discounted pharmaceuticals (see table A3). Price information was current as of June 1, the first day Medicare beneficiaries could take advantage of discounts available under the card program. By necessity, we assumed that those prices would hold throughout the remainder of 2004. However, it is reasonable to expect that drug prices generally move in tandem between the Medicare discount card program and the broader pharmaceutical market.

Information was collected for people living in Brooklyn, New York, but our conclusions generalize to the rest of the country. Pharmaceutical prices offered by a Medicare-approved card sponsor do not seem to vary much from place to place (although prices between sponsors may differ considerably). A

Table A1
Three Typical Beneficiaries

Robert Smith, 66 years old	Diabetes, high blood pressure, high cholesterol, erectile dysfunction (ED)
Mary Jones, 74 years old	Congestive heart failure, high blood pressure, high cholesterol, osteoarthritis, and gastric reflux disease
Fred Green, 78 years old	Chronic lung disease, a history of blood clots in his legs, seasonal allergies, hypothyroidism, and depression

Source: Authors' assumptions.

Note: All three patients live in Brooklyn (zip code 11201). Because of the large number of available retail pharmacies, a 1-mile search radius was used in the price finder on www.medicare.gov.

TABLE A2
PRESCRIPTION DRUGS USED BY OUR BENEFICIARIES

Mr. Smith	
“Brand”*	Glucophage 500 mg (2/day†), metoprolol 50 mg (2/day), Zocor 40 mg, Viagra 50 mg (8/month)
“Generic”**	metformin 500 mg (2/day), metoprolol 50 mg (2/day), Zocor 40 mg, Viagra 50 mg (8/month)
Mrs. Jones	
“Brand”	Lasix 40 mg (2/day), metoprolol 50 mg (2/day), Zestril 40 mg, Lipitor 20 mg, Vioxx 12.5 mg, Prevacid 30 mg
“Generic”	furosemide 40 mg (2/day), metoprolol 50 mg (2/day), lisinopril 40 mg, Lipitor 20 mg, Vioxx 12.5 mg, Prevacid 30 mg
Mr. Green	
“Brand”	albuterol 95 mcg (1 vial/month), Coumadin 2.5 mg, Allegra 180 mg, Levoxyl 125 mcg, Paxil 40 mg
“Generic”	albuterol 95 mcg (1 vial/month), warfarin 2.5 mg, Allegra 180 mg, Levoxyl 125 mcg, Paxil 40 mg

SOURCE: Authors’ assumptions.

* “Brand” means branded drugs are generally included over generic alternatives.

** “Generic” means generic alternatives are generally substituted where they are available.

† Standard is 1 tablet per day; exceptions noted.

recent analysis by the CMS suggests that prescription prices may be fairly consistent in different regions of the country.[26]

Low-income seniors have more opportunities to save under the Medicare drug discount card than higher-income people (see table A4). Everyone is eligible for the baseline discounts negotiated by card sponsors and posted on the Medicare website.[27] Additional discounts on some manufacturers’ drugs may be available through the Medicare card program to beneficiaries with incomes up to 200 percent of poverty. Not all Medicare cards offer the same manufacturers’ discounts, and some manufacturers’ senior discount cards (such as Together Rx, which offers discounts to people with incomes to 300 percent of poverty) remain available outside the Medicare program.

The amount of extra savings from manufacturers’ senior discounts depends on the specific drugs prescribed for the individual and his or her income level. Beneficiaries eligible for the $600 subsidy must generally spend that amount before receiving the larger discount. Since they have received a government grant, these beneficiaries are no worse off than moderate-income seniors who are eligible for only the manufacturers’ senior discounts.

We identified nine prescription drugs for our three typical beneficiaries that could be obtained using these special discounts (see table A5). Note that Pfizer is phasing out its Pfizer Share Card but extending those discounts to beneficiaries enrolling in United Healthcare’s U Share discount card. Where applicable, we attributed those same manufacturers’ discounts to purchases made through non-Medicare sources of discounted pharmaceuticals.

We did not consider additional savings that might be available to some seniors through patient assistance programs operated by pharmaceutical manufacturers and some states. Manufacturers’ PAPs are charity programs that donate drugs to needy patients at no cost to them. These programs do not operate in the same way as the discounts available through the Medicare discount card, and they must be applied for outside the Medicare program. State PAPs are not available nationally and could not be incorporated into our analysis. However, PAPs can be an important source of savings for Medicare beneficiaries who are eligible for them.

New information required one significant change between our May analysis[28] and the current study. In the earlier study, we assumed that Merck offered a senior discount card program similar to that of Pfizer and other companies. As with the

TABLE A3
PRESCRIPTION DRUG DISCOUNTERS

Membership Organization	AARP—retail and mail order
Pharmacy Chains	CVS, Eckerd's*—mail order only
General Merchandiser	Costco—mail order only
Internet Pharmacy	Drugstore.com—mail order only

SOURCE: Authors' assumptions.

* Our analysis of prices on May 3 included Walgreen's pharmacy. However, we were unable to capture Walgreen prices in our June 1 price survey because its website was not functioning that day.

other senior discounts, we applied the generous terms of the Merck program to AARP and the other discount purchasing options outside Medicare. We subsequently found that the Merck program operates as a patient assistance program, requiring a physician's approval and delivering the product directly to the physician's office or to the patient's home rather than through a retail pharmacy. Since we do not attempt to incorporate the savings possible through PAPs in this study, we no longer apply the Merck PAP terms to non-Medicare discount purchasing options. However, Merck has modified its program for low-income Medicare beneficiaries who enroll in the Medicare discount card program, allowing them to purchase their prescriptions at retail pharmacies (who may charge a small fee). Thus, the Merck program operates within the Medicare discount card program like other companies' senior discount programs. For that reason, we continue to apply Merck's terms to eligible beneficiaries in the Medicare card program. That has the effect of raising the savings possible through the Medicare program compared to other alternatives.

One point of comparison—the cost of prescriptions at full retail price—is difficult to measure with any precision. Retail prices are generally not available. Discounts offered by pharmaceutical companies, pharmacies, membership organizations, and other sources are often couched in terms of reductions from the average manufacturer's price (AMP) rather than the retail price. The retail price might vary considerably from the AMP, depending on what discounts the retail pharmacy itself can negotiate with pharmaceutical manufacturers and on the local retailer's markup.

The CMS has used a proprietary database from IMS Health to estimate the national retail cost of a thirty-day supply of certain commonly prescribed drugs for six beneficiaries.[29] We calculated the cost of those same drugs available from the AARP retail discount program and computed the average discount over the six people to be 16 percent. The measure used in our study for the retail cost of drugs is simply the AARP price increased by 16 percent. This is, at best, a crude approximation.

The cost of each basket of prescriptions for our three typical seniors under the Medicare discount card and the best private alternative is presented in tables A6–A8. We repeated the pricing exercise for seniors at three income levels, accounting for all subsidies and discounts normally available to seniors through Medicare or private vendors. As previously discussed, the Medicare approved card offering the best deal varies from patient to patient; that is also true for the best private alternative.

TABLE A4
SAVINGS AVAILABLE UNDER MEDICARE DISCOUNT CARD BY INCOME LEVEL

Income	$600 Subsidy	Baseline Discounts under Medicare Card	Manufacturers' Senior Discounts	Mail Order
Low income: <135% federal poverty level ($12,569 individual/ $16,862 couple)	X	X	X	X
Moderate income: Between 135% and 200% FPL		X	X	X
High income: >200% FPL ($18,620 individual/ $24,980 couple)		X		X

SOURCE: Authors' analysis.

TABLE A5
MANUFACTURERS' SENIOR DISCOUNTS AVAILABLE TO LOW-INCOME BENEFICIARIES IN THE STUDY

	Discounts Offered *through* Medicare Card Sponsors	Contracts with Medicare Card Sponsors (no.)	Discounts Offered *outside* Medicare Card
Mr. Smith			
Zocor, Merck	$15/mo. after $600 subsidy exhausted*	23	
Viagra, Pfizer	$15/mo. after $600 subsidy exhausted *only under U Share card*	1	Phase-out: $15/mo. for June, July, and August only
Mrs. Jones			
Lasix, Aventis	–	N/A	$18/mo. under Together Rx**
Zestril, AstraZeneca	$15/mo. after $600 subsidy exhausted†	7	
Lipitor, Pfizer	$15/mo. after $600 subsidy exhausted *only under U Share card*	1	Phase-out: $15/mo. for June, July, and August only
Vioxx, Merck	$15/mo. after $600 subsidy exhausted	23	
Mr. Green			
Coumadin, Bristol-Myers Squibb	–	N/A	$20/mo. under Together Rx
Allegra, Aventis	–	N/A	$65/mo. under Together Rx
Paxil, Glaxo-SmithKline	–	N/A	$74/mo. under Together Rx

SOURCE: Communications with pharmaceutical companies.

NOTE: Many manufacturers of branded drugs offer senior discount programs, but generic manufacturers do not.

* Merck provides drugs at no cost. Pharmacies may charge a fee, assumed to be $15 but could be lower. Outside of the Medicare program, Merck offers only a patient-assistance program.

** Together Rx will remain an independent option, but many of its sponsors are negotiating contracts with Medicare card sponsors.

† AstraZeneca has contracted with the U Share card to offer its products to low-income seniors for free or at low cost, here assumed to be $15.

Table A6
How Much Can Low-Income Seniors Save on a Seven-Month Supply of Their Medicines?

Assume incomes are below 135% of the federal poverty level.

	Medicare's Best Deal		Best Private Deal		Percentage Savings	
	Retail	Mail	Retail	Mail	Retail	Mail
Mr. Smith						
"Brand"*	$494.66	$387.54	$1,609.62	$1,499.77	69%	74%
"Generic"**	$311.68	$369.02	$1,407.10	$1,306.85	78%	72%
Mrs. Jones						
"Brand"	$994.79	$876.80	$2,280.13	$2,218.75	56%	60%
"Generic"	$970.11	$788.33	$1,952.26	$1,867.11	50%	58%
Mr. Green						
"Brand"	$622.91	$450.62	$1,318.85	$1,217.31	53%	63%
"Generic"	$569.36	$390.77	$1,271.84	$1,149.55	55%	66%

Source: Authors' calculations. Data collected June 1, 2004.

* "Brand" refers to a basket where branded drugs are generally included over generic alternatives.

** "Generic" refers to a basket where generic alternatives are generally substituted where they are available.

Table A7
How Much Can Moderate-Income Seniors Save on a Seven-Month Supply of Their Medicines?

Assume incomes are between 135 and 200% of the federal poverty level.

	Medicare's Best Deal		Best Private Deal		Percentage Savings	
	Retail	Mail	Retail	Mail	Retail	Mail
Mr. Smith						
"Brand"*	$1,054.61	$947.49	$1,609.62	$1,499.77	34%	37%
"Generic"**	$871.63	$928.97	$1,407.10	$1,306.85	38%	29%
Mrs. Jones						
"Brand"	$1,554.74	$1,436.75	$2,280.13	$2,218.75	32%	35%
"Generic"	$1,530.06	$1,348.28	$1,952.26	$1,867.11	22%	28%
Mr. Green						
"Brand"	$1,192.91	$1,020.62	$1,318.85	$1,217.31	10%	16%
"Generic"	$1,139.36	$960.77	$1,271.84	$1,149.55	10%	16%

Source: Authors' calculations. Data collected June 1, 2004.

* "Brand" refers to a basket where branded drugs are generally included over generic alternatives.

** "Generic" refers to a basket where generic alternatives are generally substituted where they are available.

Table A8

How Much Can High-Income Seniors Save on a Seven-Month Supply of Their Medicines?

Assume incomes are above 200% of the federal poverty level.

	Medicare's Best Deal		**Best Private Deal**		**Percentage Savings**	
	Retail	Mail	Retail	Mail	Retail	Mail
Mr. Smith						
"Brand"*	$1,574.58	$1,321.76	$1,787.48	$1,664.32	12%	21%
"Generic"**	$1,364.93	$1,140.35	$1,584.94	$1,480.01	14%	23%
Mrs. Jones						
"Brand"	$2,460.43	$2,116.73	$2,662.45	$2,477.30	8%	15%
"Generic"	$2,193.17	$1,872.15	$2,326.42	$2,167.62	6%	14%
Mr. Green						
"Brand"	$1,224.23	$990.62	$1,404.66	$1,283.31	13%	23%
"Generic"	$1,027.81	$930.77	$1,333.65	$1,221.99	23%	24%

Source: Authors' calculations. Data collected June 1, 2004.

* "Brand" refers to a basket where branded drugs are generally included over generic alternatives.

** "Generic" refers to a basket where generic alternatives are generally substituted where they are available.

Notes

1. The Medicare prescription drug discount card is available to all Medicare beneficiaries, regardless of age, except for those who receive drug benefits through Medicaid. Temporary cash assistance under the program is available to certain low-income beneficiaries without other drug coverage, also without regard to age. As a shorthand in what follows and when the context is clear, we refer to *seniors* even though the program is available to both seniors and people under age 65 who are eligible for Medicare because of disability.

2. Robert Pear, "Medicare to Monitor Prices in New Drug Plan," *New York Times*, December 11, 2003.

3. Robert Pear, "Drug Discount Cards Give the Elderly Small Savings," *New York Times*, January 4, 2004.

4. Milt Freudenheim, "Drug Discount Card for Elderly May Confuse as Well as Help," *New York Times*, February 6, 2004.

5. Vicki Kemper, "Prescription Drug Law Leaves Seniors Perplexed," *Los Angeles Times*, February 26, 2004.

6. A funded drug discount card is part of the Prescription Drug Security Plan proposed by Joseph Antos and Grace-Marie Turner in 2001. For more information, see www.galen.org/pdrugs.asp?docID=608. See also Joseph Antos and Grace-Marie Turner, "What Congress Should Do about Prescription Drugs for Seniors," *AEI on the Issues*, September 1, 2002, available at www.aei.org/publications/filter.all,pubID.14231/pub_detail.asp.

7. The CBO estimated the net cost of the entire bill at $395 billion over ten years, reflecting other provisions that reduce federal outlays. See Douglas Holtz-Eakin, "Estimating the Cost of the Medicare Modernization Act," testimony before the House Committee on Ways and Means, March 24, 2004, available at www.cbo.gov/showdoc.cfm?index=5252&sequence=0.

8. A good resource on prescription drug assistance programs is the Medicare Rights Center. A listing of programs is available at www.medicarerights.org/rxframeset.html.

9. See Centers for Medicare and Medicaid Services, "Medicare-Approved Drug Discount Cards Provide Drug Prices Significantly below Average Paid by Americans," May 6, 2004, available at www.cms.hhs.gov/media/press/files/rxcard_savings_analysis.pdf.

10. TRICARE for Life is the health insurance program for military retirees and dependents.

11. We do not include manufacturers' or state patient assistance programs in what follows, although those programs can provide substantial additional savings to eligible beneficiaries.

12. Some manufacturers, including those sponsoring the Together Rx card, extend their senior discounts to people with incomes up to 300 percent of poverty. We assume in what follows that high-income seniors are not eligible for any manufacturers' senior discount programs.

13. Retail drug prices generally are not published. We approximated the retail cost Mr. Smith's prescriptions by adding back the estimated 16 percent discount offered by the AARP retail discount program.

14. Note that the out-of-pocket costs for a senior with an income between the federal poverty level and 135 percent of poverty are $30 greater than an individual whose income is below the poverty level. This is the result of having to pay 10 percent of the cost of his drugs until the $600 cash subsidy has been spent, rather than 5 percent if his income were lower.

15. The list of top-selling drugs is from Families USA, *Sticker Shock: Rising Prescription Drug Prices for Seniors*,

June 2004, available at www.familiesusa.org/site/DocServer/Sticker_Shock.pdf?docID=3541.

16. Deborah B. Berry, “Dems Blast Medicare Cards,” *Newsday*, June 3, 2004.

17. Authors’ calculations based on Families USA, “Price Comparison: The Department of Veterans Affairs and the Medicare Discount Card,” June 2, 2004, available at www.familiesusa.org/site/DocServer/Top_20_and_VA_comparison.xls?docID=3601. That document reports seemingly higher percentage savings compared to VA but only because they divided the price difference by the lower VA price.

18. Joseph R. Antos and Grace-Marie Turner, “New Drug Plan: There’s More for the Poor,” *Wall Street Journal*, May 6, 2004.

19. We made a change in estimating beneficiary savings between our May analysis and the current study, which has the effect of increasing the savings estimates for low-income seniors. See the appendix for more details.

20. CMS, “Medicare-Approved Drug Discount Cards Provide Drug Prices Significantly below Average Paid by Americans,” May 6, 2004, available at www.cms.hhs.gov/media/press/files/rxcard_savings_analysis.pdf.

21. CMS, “Medicare-Approved Drug Discount Cards Continue to Show Significant Savings—Including for Mail-Order/Internet Prescriptions,” May 24, 2004, available at www.cms.hhs.gov/medicarereform/drugcard/reports/online_comparison_report.pdf.

22. CMS, “Medicare-Approved Drug Discount Cards Provide Additional Savings to Low-Income Medicare Beneficiaries,” May 19, 2004, available at www.cms.hhs.gov/medicarereform/drugcard/reports/lowincomestudy5-19-04.pdf.

23. The Lewin Group, “New Study on Discount Drug Cards Shows Average Savings Will Top 20 Percent,” May 26, 2004, available at www.lewin.com/Spotlights/Features/SF_Medicare_Drug_Discount_Cards.htm.

24. Robert Pear and Milt Freudenheim, “Drug Discounts Beginning Tuesday, but Sign-ups Lag,” *New York Times*, June 1, 2004.

25. Interestingly, several of the best cards in June posted substantially higher prices in May, suggesting that they reduced their prices to meet the competition. This calculation compares the retail cost of the branded drug baskets in May and June.

26. See the previously cited CMS report of May 6, 2004.

27. Drug prices on the Medicare website are guaranteed by the sponsor to be available at participating retail pharmacies and mail-order services, but the actual price could be lower. See Mark B. McClellan, “Statement on Improvements to 1-800-MEDICARE and www.medicare.gov,” May 20, 2004, available at www.cms.hhs.gov/cmedia/press/release.asp?Counter=1060.

28. Antos and Turner, “New Drug Plan.”

29. See the previously cited CMS report of May 6, 2004, p. 3 and table 1.

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