

GlaxoSmithKline—one of the participants in Together Rx—also operates a separate discount card program. The income limits of the manufacturer cards vary, ranging from \$18,000 to \$30,000 for individuals and from \$24,000 to \$40,000 for couples. In terms of enrollment, Together Rx is the largest of these programs, reporting more than 1 million enrollees (as of September 2003). Enrollment for the other manufacturer card programs is reported to be more than 355,000 in the Pfizer card (as of May 2003), about 100,000 in the Eli Lilly card (as of October 2002), about 100,000 in the GlaxoSmithKline card (as of November 2002), and about 15,000 in the Novartis card (as of April 2002).

Many beneficiaries who might benefit from the Medicare prescription drug discount card program may currently be enrolled in or eligible for manufacturer card programs. We use the same uptake assumptions for these beneficiaries as for the general beneficiary population, since it is difficult to predict how both manufacturer card programs and beneficiaries currently enrolled in those programs will behave in terms of participation in the Medicare prescription drug discount card program. For example, it is unknown whether the manufacturer card programs will seek Medicare endorsement. If these programs do seek and obtain Medicare endorsement, their enrollees will be included in the enrollment count for the Medicare prescription drug discount card program. On the other hand, if manufacturer card programs do not seek Medicare endorsement, some beneficiaries may opt to enroll in both the manufacturer cards and a Medicare endorsed discount card program. For example, we would expect that many low-income beneficiaries currently enrolled in manufacturer card programs would likely also enroll in an endorsed discount card program to take advantage of the \$600 transitional assistance. In addition, since the manufacturer cards provide savings only on specific drugs and endorsed programs have a low annual enrollment fee, we believe that some beneficiaries, depending on the mix of prescription drugs they use and their income levels, may find it beneficial to enroll in both types of programs as well.

While we expect there will be a phase-in of beneficiary enrollment in the Medicare prescription drug discount card program, we believe that because of the recognition and acceptance of the Medicare name, the educational efforts undertaken, and the proration policy for the \$600 transitional assistance

discussed in this document, beneficiaries wishing to enroll will do so over a relatively short period of time. For the purposes of this impact analysis, we assume that the program is implemented beginning second quarter (April) 2004 and that all beneficiaries expected to enroll in 2004 do so at the program outset. For beneficiaries who become eligible for Medicare between April 2004 and December 2005, we assume enrollment at the time they become Medicare eligible.

2. Beneficiary Savings Assumptions

The Medicare prescription drug discount card program will generate two types of savings from the perspective of beneficiaries. First, beneficiaries enrolled in an endorsed discount card program will derive savings from discount card activities undertaken by endorsed sponsors, such as negotiating lower prices on prescription drugs and educating beneficiaries about generic equivalents. Second, for the subset of Medicare prescription drug discount card enrollees who qualify for the transitional assistance, they will also derive savings from the government funded \$600 transitional assistance. For ease of reference in the remainder of the regulatory impact analysis, we will refer to these two different types of savings as “savings from discount card activities” and “savings from transitional assistance,” respectively.

a. Savings From Discount Card Activities

An April 2000 study prepared by HHS entitled, “A Report to the President: Prescription Drug Coverage, Spending, Utilization and Prices,” indicated a significant price differential between individuals paying cash for prescriptions at a retail pharmacy versus individuals with insurance. This was true for both the Medicare and non-Medicare populations. According to the study, in 1999 the price paid by cash customers was nearly 15 percent more than the total price paid under prescription drug insurance, including the enrollee cost sharing. For 25 percent of the most commonly prescribed drugs, this price difference was higher—over 20 percent. Thus, in today’s market, individual Medicare beneficiaries without drug coverage and the related market purchasing leverage, not only face having to pay the full cost for medications from their own pockets, but ironically are also charged the highest prices. Furthermore, the HHS study did not include the effect of rebates on total prices paid. It did, however, note industry experts as indicating that insurers and employers typically receive

70 to 90 percent of the rebates negotiated for their enrollees. While currently, rebates in insured products may not necessarily reduce prices paid at the retail point of sale, the rebates do lower the per-prescription cost for plan sponsors, and thus tend to lower premiums or program costs for insured beneficiaries.

A March 2003 study by the Brandeis University Schneider Institute for Health Policy, entitled “PBM-Administered Prescription Drug Discount Cards: Savings for Uninsured Seniors,” examined administrative data on eight national drug discount card programs operated by 3 PBMs to analyze the level of discounts available through these types of discount programs. Looking at drugs most commonly used among individuals age 65 and over, the study found that on average the card programs provided discounts (over and above any other discounts uninsured individuals received at retail pharmacies) of 14 percent for brand drugs, 26 percent for generic drugs, and 15 percent overall.

We anticipate that the estimated savings for Medicare beneficiaries from discount card activities, such as negotiated prices and education about generic substitution, under the Medicare drug discount card program will be a first step toward the savings that could be achieved under an insurance product. Based on information on savings from insurance products and information on the current discount card market, we assumed that beneficiaries enrolling in the endorsed programs will save as a result of discount card activities, on average, between 10 and 15 percent of their total drug costs compared to their spending in the absence of this program. While savings of 10 to 15 percent are anticipated on total drug expenditures, the discounts on individual drugs will vary and may be substantially higher for certain products, particularly generics, due to their lower prices. If endorsed discount card programs rely heavily on the use of formularies, we expect that manufacturer rebates or discounts will be greater in response.

The beneficiary savings from discount card activities will be attributable to the combination of lower prices paid at the point of sale as a result of manufacturer and pharmacy discounts, as well as the effects of beneficiary education leading to greater use of generic drugs and more effective management of prescription drug expenses by beneficiaries. Because pharmacy discounts are increasingly available to beneficiaries through existing voluntary card programs, we expect that manufacturer rebates or