

of the total hypothetical area's population will not participate in the program, including both Medicare beneficiaries and non-Medicare beneficiaries.

To estimate the impact of the program on prescription drug revenues in the hypothetical locality, we estimated the per capita drug spending for program participants and non-participants in the hypothetical area. We estimated per capita drug spending to be \$2187 for participants and \$1039 for non-participants in the hypothetical locality in 2004. These figures differ from per capita estimates for participants and non-participants at the national level due to the skewed demographic composition of the hypothetical area (which would have a large Medicare population and have beneficiaries with Medigap drug coverage comprising a slightly greater share of drug discount card program participants than at the national level). The per capita spending estimates for both participants and non-participants include individuals without drug expenditures.

For participants in the Medicare prescription drug discount card program, the per capita value consists of the estimated total spending for enrolled transitional assistance eligible beneficiaries, plus estimated total spending for enrolled beneficiaries not eligible for transitional assistance who do not have drug coverage, plus the share of spending for the Medigap enrollees that is purchased through the program, divided by the total number of participants.

For purposes of calculating the per capita spending for non-participants in the Medicare prescription drug discount card program, we used prescription drug spending data from the National

Health Accounts and estimates from the MCBS to develop per capita drug spending estimates for the non-Medicare population and for the Medicare population not participating in the program. These two per capita values for non-participants were then weighted relative to the population distribution they represented in the hypothetical area's non-participant population to create a per capita drug spending estimate for non-card participants.

We then adjusted per capita drug spending for non-participants to include participants' drug spending that was not purchased through the Medicare prescription drug discount card program (that is, the portion of drug spending covered by Medigap plans) to yield an estimate of total drug spending outside of the program. Consequently, this inclusion of the Medigap covered drug spending means that the per capita drug spending figure for non-participants is this adjusted per capita (including the Medigap related spending) for the hypothetical area rather than the actual per capita for the non-participant population in the hypothetical area. For purposes of the sensitivity analysis calculation of the impact of the program, we used the upper bound figure of all drug spending being effected by the program as a high-end assumption.

The results of the sensitivity analysis are shown in Table 8. For the hypothetical area that is skewed to have a large Medicare beneficiary population with a large share of that beneficiary population having characteristics making them likely to enroll in this program, the negative impact on prescription drug revenues reached 2.36

percent, still below the HHS measure for significant economic impact of 3 to 5 percent of revenues. Furthermore, as noted above, not all of the 2.36 percent will be borne by the pharmacy, since discount card sponsors will be required to obtain manufacturer rebates or discounts and pass those through to beneficiaries and pharmacies in order to receive Medicare endorsement. In addition, part of the savings also comes as a result of beneficiary use of lower cost generic drugs. Similar to the additional analyses performed earlier in this document looking at how varying the uptake assumptions by 15 percent would affect the impact on national retail prescription drug spending, we performed additional analyses here further skewing enrollment in this hypothetical area to assume 15 percent higher uptake rates among beneficiaries. Even under those assumptions, the economic impact on prescription drug revenues in the hypothetical area would still be below the HHS standard for significant impact of 3 to 5 percent of revenues.

We recognize that reliance of the sensitivity analysis on nationally calculated per capita averages weighted for different demographic compositions has limitations, and pharmacies may have customer populations with per capita drug spending levels that differ from the population specific averages calculated at a national level. However, lacking such pharmacy level data, this sensitivity analysis represents our best estimate of the maximum potential effect of the program on small pharmacies and drug stores in a hypothetical area with substantially higher than average program enrollment.

TABLE 8.—NATIONAL AVERAGE VERSUS SENSITIVITY ANALYSIS—HYPOTHETICAL EXAMPLE

2004	Discount card participants (percent)	Discount card Non-participants (percent)	Total population (percent)
National Average for Comparison Purposes:			
Percent of Total Population .....	2.49	97.51	100.00
Percent of Total Prescription Drug Sales .....	7.84	92.16	100.00
Estimated Beneficiary Savings From Discount Card Activities as a Percent of Drug Sales	15.00	0.00	1.18
Hypothetical Example:			
Percent of Total Population .....	8.15	91.85	100.00
Percent of Total Prescription Drug Sales .....	15.73	84.27	100.00
Estimated Beneficiary Savings From Discount Card Activities as a Percent of Drug Sales	15.00	0.00	2.36

5. Reporting, Recordkeeping, and Other Compliance Requirements for Small Pharmacies

Requirements related to reporting, recordkeeping, and other compliance activities for small pharmacies under

this program are minimal. There are only two requirements of this type for pharmacies that participate in an endorsed discount card sponsor's network. Pharmacies are required to notify the beneficiary at the point of sale

of the differential between the price of the drug to the beneficiary and the lowest priced generic covered drug under the program that is therapeutically equivalent and bioequivalent and available at the