

information and outreach materials, eligibility determination and enrollment processing of beneficiaries, processing claims for retail and mail-order prescriptions, operation of a customer service call center, account maintenance, and logging and responding to beneficiary complaints and grievances. This analysis provides a range for each cost component, from low to high, that reflect possible endorsed sponsor differences in the level of technical efficiency and business investment decisions for offering the discussed initiative. For purposes of this analysis, estimated benefits are limited to the legislated enrollment fee, a maximum of \$30 per year in 2004 and 2005. This analysis demonstrates that a maximum annual enrollment fee of \$30 can cover all or almost all administrative costs over the life of the program. Finally, we believe that the low costs estimated in this analysis maybe more accurate because CMS received many applications from potential card sponsors during our previous attempts to enact a fairly comparable program, suggesting that these organizations believed expected returns to be positive.

2. Sources of Administrative Cost Estimates

We used several sources in estimating administrative costs for this analysis. First, CMS has extensive experience pricing and contracting for some of the activities we require of endorsed sponsors, specifically call center operations for the Medicare population and producing and mailing printed information and outreach materials. We thoroughly explored internal sources to estimate costs for information and outreach, and for call center and customer service activities.

Early this year, 2003, as the President's plan for Medicare reform was being considered by Congress, CMS contracted for research of discount drug card call center operations to better inform our understanding of endorsed sponsor customer service and possible impacts on 1-800 Medicare.⁵

Other administrative costs of this program, such as account management and claims processing costs for pharmacy benefit management services, are not publicly available in a standardized format. In part, this is due to a general lack of transparency in the financial reporting of the pharmacy benefit management industry. Administrative cost information is

considered proprietary by the industry and is not clearly itemized in financial reports.

Of the information that is available, most is not standardized, and therefore, not readily compared across discount card programs. A pharmacy benefit management firm's administrative costs are unique to its business structure. The structure of pharmacy benefit management contracts also reduces the standardization of cost information. When bidding on a Request for Proposal by an employer or health insurer to provide pharmacy benefit management services, pharmacy benefit management firms typically offer a package of administrative costs, negotiated pricing for reimbursing drug costs, and rebate-sharing arrangements. The package approach often includes a comprehensive administrative fee that covers many bundled services, the content of which vary by organization and proposal. The multifarious rebate-sharing arrangements unique to each pharmacy benefit management firm and other revenue flows mask the cost of some activities, contributing even more to reduced comparability. In short, payments for costs taken from multiple pharmacy benefit manager contracts cannot be readily compared. For example, a recent investor report by Credit Suisse First Boston demonstrates the impact of rebate-sharing arrangements on administrative costs. The authors cite variation in per claim processing costs paid by purchasers of \$0.0 to \$0.70.⁶

In order to best estimate these administrative costs, CMS contracted with an independent, management-consulting firm to provide technical support in developing estimates of administrative costs.⁷ For each of the major activities required to implement the Medicare prescription drug discount card program, we identified seven categories of economic costs that potential endorsed sponsors might incur in implementing this program. These costs are discussed in detail later in this analysis and presented in Table 9.

The consulting firm's analysis is based on interviews with officials representing State senior discount card programs and commercial organizations representing various categories of firms that provide drug card program administration, throughout the United

States. These organizations include pharmacy benefit management firms (independent and owned by managed care organizations) and other commercial discount card program operators. In addition to conducting interviews, the consulting firm also consulted industry experts on purchasing pharmacy benefit management services.

The consulting firm interpolated costs from more generalized cost information gathered in interviews about required labor and resources, in some instances, in order to estimate specific, comparable costs for all activities. This was necessary, in part, because commercial organizations were cautious about sharing costs and uncertain about the programmatic requirements of this regulation, which were not publicly available at the time that these interviews were conducted. Also, States and other purchasers did not always have the specific costs of components included in bundled administrative fees.

3. General Assumptions, Limitations, and Scope

This program has two full operational years beginning in April 2004 and ending mid-May 2006. Although the program does not start in January, we estimate costs for each calendar year of operation because calendar years correspond to the source of revenue, the annual enrollment fee, and to the coordination of the enrollment process with the Annual Coordinated Election Period for Medicare. We refer to the first nine months of 2004 as Year One, to 2005 as Year Two, and to the first four and one-half months of 2006 as the Transition Period. For Year One estimates, we adjust the costs associated with ongoing program operations, including claims processing, account maintenance, and responding to discount card enrollee complaints and grievances, to reflect the nine-month operating period.

The four and one-half month transition period is a carryover period during the initial open enrollment period for the new Medicare Part D prescription drug benefit. During this period, no new enrollment is allowed in the Medicare prescription drug discount card program, no new transitional assistance is available, and endorsed sponsors may not charge an annual enrollment fee. Current discount card enrollees retain access to negotiated prices and transitional assistance enrollees may, in most instances, use the balance of transitional assistance funds not expended in Year Two to

⁶ Berg, Kevin and Noah Yosha. July 14, 2003. *Pharmacy Benefit Managers and Specialty Pharmacies*. Credit Suisse Equity Research for First Boston: 5.

⁷ Booz, Allen, and Hamilton. December 2003. *Discount Card Administrative Costs to Support the Medicare Drug Discount Card Program*. CMS contract number 500-97-0437, Task Order 2006.

⁵ The Health Strategies Consultancy LLC. Call Center Parameters and Regulatory Authority for Drug Discount Cards. May 20, 2003.