

assist with covering the costs of their covered discount card drugs obtained during the transition period. Therefore the costs reflected for this period include claims processing, account maintenance, customer service and call center operations, and responding to discount card enrollee complaints and grievances. We adjust all costs incurred in this period for an average enrollment length of two and one-quarter months, which is the same assumption made earlier in the beneficiary impact estimates to reflect declining enrollment in the Medicare prescription drug discount card program as individuals move to Part D.

We assume that all endorsed sponsors, or at least one of their contractors, are experienced in pharmacy benefit management and have the infrastructure in place to implement this program. The applicant, or one of its subcontractors, at the time of application for endorsement must have three years experience in adjudicating and processing claims at the point of sale, negotiating with prescription drug manufacturers and others for rebates and discounts on prescriptions drugs, and administering an individual enrollee health care subsidy or benefit in real time. Further, the applicant, or at least one of its subcontractors, must serve at least 1 million covered lives. For this reason, some requirements of this program are part of standard business practices for administering a prescription drug benefit or assistance program and are associated with negligible additional costs.

Activities already conducted as standard business practice include creating typical reports on discounts, pricing, and utilization for the client, providing counseling on generic substitution, establishing a pharmacy network, reimbursing network pharmacies for drugs covered by transitional assistance, drug utilization review, formulary management, and negotiating manufacturer and retail rebates. We assume marginal cost incurred for these activities, if any, will be captured in our estimates for account maintenance. Further, we believe that endorsed sponsors will be compliant with HIPAA because their other lines of business require such compliance. Regarding the HIPAA security rule, which is not enforceable until 2005, based on our discussions with potential endorsed sponsors, we assume they are already in compliance with these provisions under the privacy rule and are preparing to complete compliance with the security rule 2005 deadline for their other lines of business.

We assume that total program enrollment is equal to 100 percent of the number of beneficiaries that the impact analysis estimates will be enrolled in each year of operation: 7.3 million in Year One, and 7.4 million in Year Two and the Transition Period. We used a growth estimate of 1.4 percent to estimate enrollment in Year Two, which is the estimate for growth in Medicare Part B enrollment. Part E of this section discusses estimated program enrollment in greater detail. For some of our enrollment application, and information and outreach estimates, we assume that new enrollment in Year Two consists of those individuals the impact analysis anticipates enrolling in the program in Year Two and those individuals switching card programs. With regard to the latter, we assume that roughly 10 percent of enrollees will disenroll during Year One. As a simplifying assumption, we also assume that this same number re-enrolls in a different card in Year Two. We chose 10 percent as a modification of the 2001 Medicare managed care disenrollment rate of 13 percent because the rate reflects a continuous open enrollment policy. Our regulations limit enrollment to one endorsed program each year, with the option to elect another endorsed programs during the Annual Coordinated Election Period.

Exclusive card sponsors are Medicare managed care organizations that limit their card program membership to their health plan membership. We have chosen not to present separate cost estimates for exclusive card sponsors for two reasons. First, we assume that we will largely be endorsing existing card programs already in operation by these organizations for their Medicare enrollees. Second, we believe that the costs for exclusive card sponsors will be lower than those incurred by other endorsed sponsors. Exclusive card sponsors can group enroll their Medicare managed care organization enrollees, a known population. They also will have lower costs for information and outreach since they already engage in marketing activities for their plan and can achieve efficiencies by including their discount card information with other outreach efforts. Since the costs of enrollment, and information and outreach are some of the highest cost components in Year One, we expect exclusive endorsed sponsors will have costs substantially lower than the maximum \$30 enrollment fee.

We estimate that 812,637 individuals will be enrolled in a discount drug card offered by an exclusive card sponsor in 2004, and 824,201 individuals will be

enrolled in an exclusive card program in Year 2005 and the Transition Period. We derived this estimate by applying the proportion of individuals enrolled in a Medicare managed care plan (that is, Section 1876 cost plans, M+C plans, and preferred provider and most other managed care demonstrations) in the Medicare population, 12 percent, to the number of individuals estimated to enroll in this initiative who are not enrolled in Medigap, 6.8 million in 2004 and 6.9 million in 2005. Because we are not estimating costs for endorsed sponsors that are also managed care organizations, we removed these individuals from all enrollment assumptions made in this analysis.

Throughout the discussion of individual costs, we present estimated costs for the whole program, by discount card enrollee, and for the average fee-for-service (FFS) endorsed sponsor (meaning a endorsed sponsor whose enrollment is made up mostly of beneficiaries in the original Medicare program) whose average enrollment is based on the total enrollment level calculated above divided by the number of FFS programs we expect will apply and meet the requirements for endorsement, as described below. In part, this is because our research on administrative costs suggests that experienced administrators of prescription drug benefits have comparable per discount card enrollee and per prescription variable costs for programs of different sizes that meet minimum endorsement requirements. However, endorsed sponsors have the option of proposing a program for a service area as small as a State.

The remainder of this analysis examines the impact on endorsed sponsors that must comply with all components of this regulation and serve primarily beneficiaries in fee-for-service. This includes the few organizations that we expect may choose to offer a card for all Medicare beneficiaries rather than limit enrollment to their health plan membership. Only the latter are exclusive endorsed sponsors. Having removed individuals in exclusive card programs, we estimate per endorsed sponsor costs based on an average endorsed sponsor enrollment of 431,865 in Year One and 438,010 in Year Two and the Transition Period. We derived these numbers by dividing estimated enrollment less our estimates for exclusive card program enrollment by 15, or 6,477,973 divided by 15 in Year One, and 6,570,150 divided by 15 in Year Two. In 2001, we received 28 applications, with approximately one-half appearing to meet all of the