

structure. We do not figure this into pricing the claims processing cost described here.

Some claims may be submitted on paper. Approximately one percent of all claims processed for a funded benefit are paper claims.¹⁴ In our estimates, we assume that any one endorsed sponsor will have to process one percent of their claims manually for their endorsed program. To process a paper claim, the endorsed sponsor must manually enter the information into the claims processing system. Cost estimates for processing paper claims range from \$1.00 to \$1.50 per claim.¹⁵ We used this same range of costs for our estimates of processing paper claims.

Section 1860D–31(g)(5) of the Act requires that transitional assistance through the endorsed sponsor be made available to beneficiaries who qualify for transitional assistance and reside in skilled nursing facilities and nursing facilities. These claims will be more difficult to process than electronic claims because they are likely to be submitted by pharmacies that are not in the endorsed sponsor's pharmacy network and with whom the endorsed sponsor may not have a formal relationship or electronic data exchange. We make this assumption because we believe that pharmacies in long-term care and skilled nursing facilities may not participate in an endorsed discount card program; institution-based pharmacies have less incentive than those in the community to join a discount card network.

To address the specific structure of the long-term care pharmacy market, this regulation provides for CMS to award a "special endorsement" to endorsed sponsors competing for the opportunity to process claims from long-term care pharmacies. This competition limits the processing of claims from pharmacies serving long-term care and skilled nursing facilities to a few endorsed sponsors who have experience processing such claims and who can garner economies of scale. We expect that endorsed sponsors receiving a special endorsement will have some pharmacies serving long-term care and skilled nursing facilities in their pharmacy network. For purposes of this analysis, we assume that two of the anticipated fifteen endorsed sponsors receive a special endorsement from CMS. For each of these two "special endorsed sponsors," we assume that they continue to enroll the average

number of enrollees in a card program: 431,865 in Year One, and 438,010 in Year Two and Transition Period, but that a sizable proportion of those enrollees is institutionalized.

We estimate that roughly 200 thousand institutionalized individuals will qualify for transitional assistance and use that transitional assistance at the pharmacy in their facility. This estimate is derived from the Medicare Current Beneficiary Survey (MCBS) and is used earlier in this document. We also estimate that this enrollment is split across the two special endorsed sponsors, thereby allocating 100 thousand enrollees to each special endorsed sponsor. This means that, roughly, one-quarter of the 430 thousand enrollees in a special card program are institutionalized. With regard to cost, we estimate that each of the special endorsed sponsors will receive about one-third of their claims for the institutionalized from long-term care pharmacies in their networks and that the cost per claim will be the same as processing any electronic in-network claim. Also, we assume that each card sponsor will achieve efficiencies in processing out-of-network claims from long-term care pharmacies. Without better estimates of the burden of processing out-of-network claims, we assume that the cost of processing such claims is similar to that for processing paper claims, between \$1.00 to \$1.50 per claim. In light of our assumption about available economies of scale, we assume a cost estimate of \$1.00 for processing claims from out-of-network long-term care pharmacies.

We make a base assumption that beneficiaries using a discount card will fill 27 prescriptions a year. We base this assumption on findings from CMS Office of the Actuary, which obtains data on prescription drug sales and prescription utilization from a variety of sources, including the National Prescription Audit conducted by IMS Health. These are the same numbers used in the Impact Analysis. In light of the nine-month operating period for Year One, we assume that discount card enrollees will fill an average of 20 prescriptions using their discount card in Year One. We assume they will fill all 27 prescriptions during Year Two and fill 5 prescriptions during the Transition Period.

For the purpose of claims submitted against transitional assistance for beneficiaries in skilled nursing facilities and nursing facilities, we estimate that institutionalized individuals will fill an average of nine prescriptions for Year One and eight prescriptions for Year Two. This assumes that their long-term

care pharmacy will only process claims against the balance of available transitional assistance. When the balance of transitional assistance becomes depleted for the year, we assume claims processing through the card program will cease. We derived nine and eight prescriptions by dividing \$600 by an average prescription cost of \$66 and \$72, which is an average total prescription price of \$46.99 (derived from self-reported beneficiary expenditures in MCBS 2000), adjusted to 2004 and 2005 dollars. We assume that institutionalized enrollees will not use their card during the Transition Period because they will have expended all of their transitional assistance in Year Two.

Twenty prescriptions for each non-institutionalized enrollee and nine prescriptions for each institutionalized care enrollee translates to a total of 129 million prescriptions in Year One, with each of the 13 endorsed sponsors processing 8.7 million prescriptions and each of the two special endorsed sponsors processing 7.6 million prescriptions. In Year Two, twenty-seven prescriptions per non-institutionalized enrollee and eight for institutionalized enrollees means a total of 174 million prescription across all beneficiaries, with each of the 13 endorsed sponsors processing 11.8 million prescriptions and each of the two special endorsed sponsors processing 10 million prescriptions. Five prescriptions for non-institutionalized enrollees in the Transition Period means a total of 32 million prescriptions for all enrollees will be processed, with each of the 13 endorsed sponsors processing 2.2 million prescriptions and each of the two special endorsed sponsors processing 1.7 million prescriptions.

We used the cost and prescription utilization estimates listed above to estimate costs for each of the 13 endorsed sponsors not processing claims from long-term care pharmacies. We assume that these endorsed sponsors only process in-network claims, both paper and electronic. For Year One, we estimate a per endorsed sponsor cost between \$542 thousand and \$1.4 million and a per enrollee cost between \$1.25 and \$3.24. For Year Two, we estimate a per endorsed sponsor cost between \$763 thousand and \$2 million and a per enrollee cost between \$1.74 and \$4.50. For the Transition Period, we estimate a per endorsed sponsor cost between \$149 thousand and \$386 thousand and a per enrollee cost between \$0.34 and \$0.88.

We used the costs and prescription utilization estimates discussed above to

¹⁴ Price Waterhouse Coopers. June 2001. *Study of Pharmaceutical Benefit Management*, CMS contract number 500–97–0399 Task Order 0097: 76.

¹⁵ *Ibid.*