

their administrative expenses and may be able to charge a lower enrollment fee or pass greater savings onto their discount card enrollees.

J. Conclusion to Impact Analysis

In summary, more than 7 million Medicare beneficiaries are projected to enroll in the Medicare prescription drug discount card program. Savings to these beneficiaries from discount card activities are estimated to range from \$1.4 billion to \$1.8 billion in the last nine months of 2004, \$2.0 billion to \$2.7 billion in 2005, and \$0.4 billion to \$0.6 billion in the transition period in 2006. About 4.7 million of these beneficiaries are also expected to be enrolled in the transitional assistance program, with savings realized by these beneficiaries from transitional assistance estimated to be about \$2.4 billion in 2004, \$2.6 billion in 2005, and \$0.1 billion in the transition period in 2006.

The Medicare prescription drug discount card program is not expected to have a significant economic impact on a substantial number of small pharmacies and drug stores. On average, estimated savings from discount card activities represent at most 1.18 percent of retail prescription drug revenues. Results from the sensitivity analysis found that even in a hypothetical geographic area with a larger than average proportion of residents likely to enroll in the Medicare prescription drug discount card program, savings from discount card activities represented less than 3 percent (2.36 percent) of total retail prescription drug sales.

Furthermore, this economic impact will not be borne entirely by pharmacies, because endorsed sponsors will be required to obtain manufacturer rebates or discounts that will defray the cost of pharmacies providing discounts on retail drug prices.

Finally, the analysis of administrative costs and revenue demonstrated that endorsed discount card sponsors with varied levels of administrative costs, ranging from low to high, would be able to recoup all or almost all of their costs through enrollment revenue (a maximum \$30 enrollment fee in Years One and Two) alone. Furthermore, this analysis found that endorsed sponsors with lower administrative costs can easily collect sufficient enrollment revenue to cover their administrative expenses, and as a result may be able to charge a lower enrollment fee or pass greater savings onto their enrollees.

K. Alternatives Considered

Most of the provisions related to the Medicare prescription drug discount card program are statutorily specified;

however, there were a few policy areas where the Secretary was provided discretion and we considered alternatives to the proposed features. A number of the areas where we considered alternatives relate to applicant qualifications. The statute specifies that the Secretary may determine the types of non-governmental entities that are appropriate to act as endorsed sponsors, and these entities may include pharmacy benefit management companies, wholesale or retail pharmacy delivery systems, insurers (including insurers offering Medicare supplemental policies), and Part C plans. Although we have the authority to limit the types of entities that may act as endorsed sponsors, the only specific structural requirement for a sponsor is that it be a non-governmental, single legal entity doing business in the United States. We chose not to impose other structural requirements at this time because we believe our other conditions for endorsement ensure that applicants, either individually or through subcontracts, will have the necessary experience and integrity to act as endorsed sponsors. We did this to provide flexibility for a wider variety of applicants using combined capabilities to become card sponsors than are specifically identified in the statute.

Another provision of the statute related to applicant qualifications is that an applicant is eligible for endorsement under the Medicare prescription drug discount card program if the applicant by itself, or together with subcontractors, demonstrates experience and expertise in operating a drug discount card or similar program and meets certain requirements related to business stability and integrity. We considered alternatives for how to interpret this provision. As discussed earlier in this document, we decided to interpret this provision to mean that applicants, together with their subcontractors, must have certain qualifications. First, is the qualification of demonstrating 3 years of private sector experience in pharmacy benefit management, including adjudication and processing of claims at the point of sale, negotiating with prescription drug manufacturers and others for rebates and discounts on prescription drugs, and administration and tracking of an individual subsidy or benefit in real time. All of these administrative functions are features that must be performed as part of this program. We did consider both shorter and longer periods of experience. We believe, however, that the 3 years prior

experience strikes an appropriate balance to ensure that endorsed sponsors are able to quickly establish their endorsed programs, thereby promoting the statutory mandate to implement the Medicare drug discount card program within 6 months of enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. In addition, the 3 years prior experience requirement ensures that endorsed sponsors have the necessary experience and capacity to offer card enrollees quality discounts and customer service. Moreover, given the relative newness of the drug card industry and high market turnover, we believe requiring less than 3 years experience would create an untenable risk of having the Medicare name associated with less than stable and reputable organizations. Alternatively, requiring more than 3 years experience might be too limiting in terms of an applicant pool.

In addition to requiring 3 years of relevant experience, we decided to require that a single entity which is either the applicant or a subcontractor operate a pharmacy benefit program, a drug discount card, a low-income drug assistance program, or a similar program that serves at least 1 million covered lives. We decided not to link the 1 million covered lives requirement with the 3-year experience requirement in order to provide entities the flexibility to combine their capabilities. For example, an entity with the requisite experience may not have the enrollment capacity, but may acquire this capacity by contracting with another entity for purposes of administering the endorsed program. As discussed previously in this document, given the potential level of enrollment in this program, we believe it is necessary that endorsed sponsors have the capacity to accept a large volume of enrollees. Furthermore, our 6-month statutorily mandated implementation timeline necessitates that endorsed sponsors be able to quickly accommodate a potentially large influx of enrollees over a relatively short period of time. Current levels of covered lives provides evidence of an applicant's immediate capacity to do so. In examining our data on the number of covered lives served by a variety of organizations, we found that a standard of 1 million lives strikes a balance between ensuring a competitive marketplace with a number of different endorsed programs available to Medicare beneficiaries and ensuring that endorsed sponsors have the capacity to handle a large influx of card enrollees.