FactSheet from Families USA

The New Medicare Prescription Drug Discount Card: A Very Flawed Program

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Background: The new Medicare prescription drug legislation creates a temporary drug discount care program that is projected to start in June 2004 and end by January 1, 2006 (at which point the permanent drug benefit will be established). This drug discount program is the only meaningful new assistance America's seniors and people with disabilities will receive during the next two years.

Seniors and people with disabilities on Medicare will be able to purchase a drug discount card for $30 per year. Those with incomes below 135 percent of the federal poverty level ($12,123 in annual income for an individual or $16,362 for a couple) who do not have Medicaid drug coverage will be able to get a discount card for free. They will also receive a credit worth $600 per year on the card (like a prepaid telephone card) to be used for the purchase of drugs (although they will have to make copayments of 5 to 10 percent of the cost of each drug purchased).

Two days after President Bush signed the new Medicare prescription drug bill, the Department of Health and Human Services (HHS) published an interim final rule establishing the regulations that will govern these discount cards. [1]

Drug discount cards will be offered by sponsoring private companies (sponsors)—such as pharmacy benefit management companies, insurance companies, or pharmaceutical manufacturers. Each sponsor's card will have to be approved—or "endorsed"—by HHS. Seniors and people with disabilities will only be allowed to sign up for one card and, when they do, they will be locked into that card for one year. Each discount card offered by a sponsor will enable an enrolling cardholder to obtain a discount for at least one drug in each of the groups defined by the regulations, [2]but the selection of those discounted drugs, and the size of the discounts, will be determined by the sponsor.

Overview of the Flaws in the Drug Discount Card Program: The regulations promulgated by HHS reveal a number of significant flaws in the drug discount card program. Four of these flaws are likely to cost seniors and people with disabilities a substantial amount of money:

1. Neither the new law nor the regulations specify the "base prices" to which discounts will be applied. Any discount will be meaningless if the base price is undefined—especially if the base price continues to rise very substantially. It would be like a department store marking up prices on products so that it can later offer them "on sale" at tremendous "savings."
2. Under the discount card program, sponsors are required to pass on to cardholders only an undefined "share" of the rebates they secure from drug manufacturers—and they can keep the remaining savings as profit. The regulations do not require sponsors to reveal to cardholders the real size of the rebates secured from pharmaceutical manufacturers, *and* they do not require disclosure about what portion of those rebates are kept by the sponsors and *not* passed on to cardholders. This will cause a real conflict of interest that may result in higher costs for cardholders: Since sponsors can get larger rebates for the most expensive drugs, they are more likely to include the most expensive drugs on their discount formularies. This will increase sponsor profits *but will also increase cardholders' drug costs*.
3. The regulations foster "bait and switch" schemes by sponsors. Seniors and people with disabilities will be lured into selecting a specific discount card based on information they receive about the drugs that will be discounted and the expected size of the discounts. They will then sign up for a specific discount card, and *they will be locked into that one Medicare card and can only change cards once*, during an annual enrollment period between November 15 and December 31, 2004. Sponsors, however, are explicitly

authorized to switch the drugs that are on the discount list and the size of the discounts *every seven days*—and cardholders are unlikely to be informed of those switches. As a result, cardholders will only learn when they go to a pharmacy that the drug prescribed for them, which they thought would be discounted through their card, is no longer on the discount list.

4. The $600 credit for low-income seniors and people with disabilities will only be provided to those who are certified as meeting the low-income test. However, the certification process is so cumbersome that millions of people who need the subsidy will never receive it.

These four concerns are discussed in greater detail below.

Discounts Don't Help If Base Prices Are High and Continue to Skyrocket: Neither the statute nor the regulations creating the new discount card program contain any rules concerning the base prices to which discounts will be applied. *There are also no rules that prevent base prices from increasing substantially and quickly.* Currently, drug prices vary dramatically, and there is no such thing as a "standard price" for any drug.

For each year during the past decade, the prices of the top-50 drugs prescribed for seniors have increased at rates that are significant multiples of inflation. From January 2002 to January 2003, for example, the prices of those top-50 drugs rose by almost three-and-one-half times the rate of inflation. [3]As the base prices continue to rise, seniors and people with disabilities may wind up with precious little savings.

The Regulations Create a Clear Conflict of Interest That May Result in Higher Profits for Card Sponsors and Bigger Costs for Cardholders: The statute and regulations allow card sponsors to negotiate rebates, discounts, or other price concessions from drug manufacturers—*but, according to the regulations, the sponsors are not required to pass on any specified portion of these savings to cardholders*. The regulations only require that sponsors pass on "a share" to cardholders; [4] the regulations do not define what constitutes "a share." Moreover, neither the statute nor the regulations require any transparency in this process: When selecting a card, seniors and people with disabilities will be unable to see the actual price the sponsor negotiated for a drug and the percentage of any negotiated savings the sponsor plans to pass along to cardholders.

The only limit on the selection of drugs subject to a cardholder discount is that card sponsors must include one drug in each drug group, and a generic drug must be available at a discount price in 55 percent of the drug groups. [5]

As a result of the regulations, card sponsors will have a very real, not just an apparent, conflict of interest. Sponsors will have every financial incentive to select the drugs for which they receive the largest dollar rebates in each drug group—often the most expensive drugs—and to retain the largest possible share of the rebates they negotiate. The larger the rebate and the smaller the share of the rebate passed on to cardholders, the greater the profits for the sponsors. This could result in cardholders purchasing the most expensive drugs in a drug class, which will result in *higher* drug costs for seniors and people with disabilities.

Cardholders May Face "Bait and Switch" Tactics by Sponsors: The regulations creating the new drug discount card program allow sponsors to engage in misleading and potentially harmful "bait and switch" tactics—first offering a card with an attractive list of covered drugs at good prices, and then changing those terms once the cardholder is locked into the card.

Under the regulations, cardholders will only be able to sign up for one Medicare-sanctioned drug discount card.

[6]Once cardholders sign up for a card, they will be locked into that card for approximately one year: Cardholders can only switch cards once between 2004 and 2006 during a short open enrollment period. [7]

The regulations, however, allow sponsors to change the drugs covered by the discount card as often as every seven days. [8]Sponsors need only provide "periodic" reports to the Centers for Medicare and Medicaid Services (CMS) about changes to covered drugs and discounts shared with cardholders. [9]The regulations do not require sponsors to notify cardholders or to update their Web sites about these changes. The only requirement is that a sponsor must post the date when it last updated its Web site and provide a disclaimer that the information on the Web site is not up-to-date. [10]Thus, seniors and people with disabilities who signed up for a specific discount card based on the drugs prescribed for them may find that the drugs they need are no longer covered by their cards.

Similarly, sponsors can change prices every seven days. The regulations only require that sponsors provide CMS with notice of, and the rationale for, changes in prices. [11]The only limit in price changes set forth in the regulations is that the prices cannot change more than an amount proportionate to changes in a drug manufacturer's Average Wholesale Price (AWP). [12]

This limitation in price changes is virtually meaningless and gives sponsors great leeway to change prices substantially and frequently. Tying changes in discount card prices to a drug's AWP does virtually nothing to protect cardholders from dramatic price increases. The term "AWP" is very misleading: It is a figure set by drug manufacturers that is neither the wholesale price nor the average of anything. It is merely a list price, and AWP prices change significantly and frequently. For example, over the past five years, the AWP for Claritin changed 13 times; the AWP for Premarin, an estrogen replacement, changed 10 times (for a nearly 90 percent cost increase); and the AWP for Synthroid, a thyroid agent, changed 10 times (for an increase of more than 60 percent). [13]

Millions of Low-Income Seniors and People with Disabilities Eligible for a $600 Drug Subsidy Will Not Receive It: The application process for the low-income drug subsidy is unusually cumbersome and is built on an untried application infrastructure. As a result, millions of low-income people eligible for needed help will not receive it. Indeed, CMS estimates that—among 7.2 million low-income Medicare beneficiaries eligible for the subsidy—only 4.7 million will receive it.

[14] A review of the application process set forth in the regulations suggests that even this low, projected participation rate is overly optimistic.

Individuals applying for the $600 in drug assistance will apply for this help through the discount card sponsor. Because these sponsors have no capacity to make determinations of low-income status, they are instructed to forward the low-income applications to CMS. [15] CMS, however, has never made determinations of low-income status for any programs and does not have staff trained for this function. Moreover, since CMS only has a main office in Baltimore and 10 regional offices, it will not have geographic proximity to applicants.

Low-income applicants who are eligible for partial Medicaid benefits may be presumed income eligible for the drug card's low-income assistance. [16]For low-income beneficiaries who are not in this category, the regulations make it clear that a signed declaration of income—even though made under risk of penalty for false statements—is not sufficient to establish income eligibility. [17]CMS may ask the Internal Revenue Service (IRS) to check tax returns to verify these applicants' low-income status. However, approximately two out of five seniors do not file tax returns (generally because their incomes are too low to result in tax consequences) [18]and, therefore, many of the people likeliest to need—and be eligible for—low-income assistance cannot be income certified by IRS. These applicants will be required to submit yet another round of paperwork to prove their income. [19] Not surprisingly, therefore, there are no specified time frames established in the regulations to determine eligibility for low-income assistance. Many seniors, therefore, will not be certified at all, or in a timely manner, for the drug subsidies.

Endnotes

1. A press release with a narrative overview and the interim final rule were posted on the Centers for Medicare and Medicaid Web site on December 10, 2003 (www.cms.hhs.gov/discountdrugs). All page references in this document refer to the interim final rule or, where indicated, the overview.
2. The regulations define more than 200 drug "groups" based on the medications frequently used by Medicare beneficiaries (pages 82-94 of the comments to the interim final regulations).
3. Dee Mahan, Out of Bounds: Rising Prescription Drug Prices for Seniors (Washington: Families USA, July 2003).
4. See page 419 of the regulations.
5. See pages 418-19 of the regulations.
6. See pages 436-442 of the regulations.
7. See pages 436-442 of the regulations.
8. See page 4 of the regulatory overview.
9. See page 426 of the regulations.
10. See pages 423-424 of the regulations.
11. See pages 426-27 and 463 in the regulations.
12. See pages 427 and 463 of the regulations.
13. Dee Mahan, op. cit.
14. See page 267 of the comments.
15. See pages 433-39 in regulations.
16 See page 434 of the regulations
17. See page 435 of the regulations
18. John Gist, A Profile of Older Taxpayers (Washington: AARP, September 2002)
19. See page 435 of the regulations