Backgrounder

Published by The Heritage Foundation

No. 1752
April 26, 2004

Fixing the New Medicare Law #3: How to Build on the Drug Discount Card

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Starting this June, America's senior citizens will begin to see the first tangible benefits of the new Medicare law. Medicare beneficiaries will be able to start using new Medicare-approved prescription drug discount cards that are expected to produce discounts of up to 25 percent. Additionally, subsidies of $600 a year will be available to low-income seniors to help with their drug purchases.

This Medicare Prescription Drug Discount Card and Transitional Assistance Program already has sparked intense interest among companies seeking to participate. In January, the Centers for Medicare and Medicaid Services (CMS) received 104 applications from prospective card sponsors, and in March, it approved 71 of them. The CMS rejected 29 applications that did not meet its standards.

Medicare beneficiaries will be able to enroll beginning in May 2004 and can start using the cards and subsidies in June. The Administration expects more than 7 million seniors to participate.

This is a temporary program that is designed to provide interim help until the full drug benefit program begins in 2006. However, both the level of interest in this program and its rational structure suggest that it could provide the basis for a permanent program. Such an arrangement could feature privately negotiated drug discounts and fixed subsidies for the purchase of routine medications. It could also offer protection against catastrophic drug expenses.

Critics have raised four major concerns about the temporary drug card program:

Talking Points

- Senior citizens may find that they can save money by enrolling in both the Medicare drug discount card program and one or more card programs offered by private vendors. Seniors can participate in only one Medicare-approved program at a time, but there is no limit on their participation with other, non–Medicare-approved drug discount programs.
- If the transitional drug discount program were improved and made permanent, seniors would have the power to save for future drug needs and would have more control over spending to get the drugs they need—whether generic or brand-name.
- Involving consumers in their own health care spending decisions will be the next revolution in health care reform in the United States. By structuring the drug benefit so that consumers direct their own spending, Congress could, for once, keep Medicare abreast of the times and give seniors the power and resources to shape the pharmaceutical marketplace around their needs, both today and in the future.

This paper, in its entirety, can be found at:
www.heritage.org/research/healthcare/bg1752.cfm

Produced by the Center for Health Policy Studies

Published by The Heritage Foundation
214 Massachusetts Avenue, N.E.
Washington, DC 20002–4999
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1. A single drug card may not cover all the drugs a Medicare beneficiary uses.
2. After senior citizens have signed up for the card, card sponsors may drop particular drugs those seniors need.
3. Card plans can change drug prices weekly even though beneficiaries are locked into their plans for up to a year.
4. Rising drug prices may erode savings from the Medicare card.

To answer the first point, this is a discount program, not a drug benefit. By design, the cards cannot cover every drug and still provide meaningful savings. The card plans will obtain discounts from manufacturers by shifting consumer demand from one product in a particular drug class to another in order to concentrate purchasing power. If the drug cards were required to cover every drug in every category, discounts would be minimal, defeating the purpose of the program.

Second, the program offers beneficiaries protection against the loss of discounts on drugs they need. Drug card plans are required to cover at least one drug in all therapeutic categories to ensure that seniors will be able to get the drugs they need.

Third, price increases will be monitored and limited to ensure that any increases reflect prevailing market costs. Arbitrary price increases or formulary changes would be highly unpopular with beneficiaries and federal overseers alike, and there will be strong market pressures on the card plans both to keep prices as low as possible and to provide as many choices as feasible. Most sponsors are well-established firms with reputations to protect, and a majority of them plan to offer a Medicare Part D benefit. Consequently, those sponsors will try to make their cards as attractive as possible to seniors. While some card sponsors might find short-term gains from dropping drugs and/or raising prices, in the longer term, they would lose enrollment and could face expulsion from the program.

Finally, early reports indicate that pharmaceutical companies are offering very generous discounts on the drug card plans while still coupling their existing patient assistance programs with the cards. Health and Human Services (HHS) Secretary Tommy Thompson says card sponsors are vying with each other to negotiate the lowest prices on drugs in order to gain the largest numbers of enrollees. Seniors will be able to compare the individual drug prices offered by each card by visiting the new Web site at *www.medicare.gov* or by calling 1-800-Medicare.

A new study by researchers from Harvard University estimates that the drug discount cards will save seniors who do not have other drug coverage an average of 17.4 percent off current retail prices—for a total of as much as $1 billion a year in savings. The researchers predict that sicker beneficiaries will see slightly higher savings and poorer beneficiaries will save somewhat more than wealthier beneficiaries. They also say that low-income beneficiaries "will see the largest reductions in out-of-pocket drug spending relative to their income" and also will benefit from an annual $600 subsidy that is not included in the study's savings estimates.[1]

What the New Medicare Law Says

Title I of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), enacted on December 8, 2003, creates the new prescription discount drug card and transitional assistance program.

Drug Discount Cards

The law requires the Department of Health and Human Services to implement a new program of Medicare-approved prescription drug discount cards. Senior citizens who participate in this voluntary program will receive access to discounts negotiated by the private card sponsor they select. HHS anticipates that those who use the drug discount cards will see savings of 10 percent to 25 percent on their prescription drug purchases,[2]

1. Juliette Cubanski, Richard G. Frank, and Arnold M. Epstein, "Savings from Drug Discount Cards: Relief for Medicare Beneficiaries?" *Health Affairs* Web Exclusive, April 14, 2004.
2. Centers for Medicare and Medicaid Services, "Overview: Medicare Prescription Drug Discount Card and Transitional Assistance Program," at *www.cms.hhs.gov/discountdrugs/overview.asp*.

although some drug-card sponsors believe they can offer even larger discounts, especially for direct-mail purchases and generics.

Congress specified that the discount card program would take effect no later than six months after the date of enactment of the legislation. On December 10, 2003—two days after the legislation was signed—HHS published an "interim final rule" for the Medicare Prescription Drug Discount Card Program to notify prospective sponsors about the rules of participation. Seniors will be able to start using the Medicare-endorsed drug discount cards on June 1, 2004.

The cards are intended primarily for beneficiaries, regardless of income, who currently do not have outpatient prescription drug insurance. Medicare beneficiaries are eligible for the drug discount card program if they are enrolled in Parts A or B and as long as they are not receiving outpatient drug benefits through Medicaid.

Transitional Cash Assistance

A key part of the program is a cash subsidy of $600 per year for eligible lower-income beneficiaries to use in purchasing prescription drugs. The funds will be provided through the particular drug discount card program selected by the beneficiary. The provision was designed to provide immediate help for certain seniors and disabled people on Medicare until the new Medicare drug benefit is implemented on January 1, 2006.

Individuals whose incomes are less than 135 percent of the poverty rate may qualify for the cash subsidy. For singles, this means those making less than $12,569 per year; for married couples, it means those making less than $16,862 per year.[3] Medicare beneficiaries who are also eligible to receive assistance for prescription drugs through Medicaid, TRICARE for Life,[4] or an employer group health plan may not receive the cash subsidy.

For those eligible for this transitional assistance, the federal government will pay the annual enrollment fee for the drug discount cards and also will provide a subsidy on the drug discount card of $600 each year in 2004 and 2005.

The new law establishes two categories of recipients for whom assistance will be offered:

- Those with incomes below 100 percent of the poverty rate would be responsible for prescription drug co-payments of 5 percent.
- Those with incomes of 100 percent to 135 percent of the poverty rate would have 10 percent co-payments.

Legislators decided that even low-income seniors should pay at least something for their drugs so that they would appreciate the value of the benefit. Therefore, after selecting the drug discount card program of their choice, seniors will pay 5 percent or 10 percent of the costs of their medicines, depending upon their income category. The balance, or the remaining 95 percent or 90 percent of the discounted drug costs, will be subtracted from their $600 allowance.

Medicare beneficiaries currently without prescription drug insurance would pay about $1,400, on average, to purchase their drugs in 2004, absent the prescription drug card program. HHS concludes that the $600 subsidy, coupled with the drug discounts, will be of substantial help to them.[5]

Those eligible for transitional assistance will receive the full $600 subsidy for 2004 even though the program does not begin until mid-year. Significantly, any balance left over from the $600 subsidy at the end of 2004 may be added to the 2005 allocation. However, the legislation stipulates that both the temporary discount card program and the $600 subsidies will end in 2006, to be replaced by the full Medicare Prescription Drug Benefit program. At that time, seniors can enroll either in one of the new subsidized Medicare Part D Prescription Drug Plans or in a Medicare Advan-

3. U.S. Department of Health and Human Services, "The Facts About Upcoming New Benefits in Medicare," at *www.medicare.gov/Publications/Pubs/pdf/11054.pdf*.
4. TRICARE for Life is the health insurance program for military retirees and dependents.
5. Centers for Medicare and Medicaid Services, "Overview: Medicare Prescription Drug Discount Card and Transitional Assistance Program."

tage plan to receive drug coverage.

Additional Assistance Through Private Programs

Most pharmaceutical companies plan to continue their existing discount programs, which provide drugs to low- and moderate-income seniors at lower prices, in conjunction with the transitional Medicare program. Many companies are working on initiatives that will enhance the value of the Medicare drug card to beneficiaries. For example:

- Merck announced in February that it will provide its medicines free of charge for low-income Medicare beneficiaries who exhaust their $600 transitional assistance allowance (although there may be a fee to the pharmacist to dispense the drugs).[6]
- Eli Lilly announced in January that it would make discounts available through its LillyAnswers program to lower- and moderate-income seniors using Medicare-endorsed drug cards. The Lilly program allows seniors with incomes below 200 percent of poverty without prescription drug coverage to pay a flat fee of $12 for a 30-day supply of any Lilly medication.[7]
- Pfizer will continue its Share Card program, which charges $15 a month to fill any prescription for single Medicare beneficiaries who do not have drug insurance and who have incomes below $18,000, and for couples without drug insurance making less than $24,000. Pfizer will also partner with a Medicare drug card sponsor.
- Other programs, such as the GlaxoSmithKline Orange Card and the Together Rx card offered by an affiliation of eight major drug companies, will continue to offer discounts of up to 40 percent on their medications to qualifying seniors.

Senior citizens may find that they can save money by enrolling in both the Medicare drug discount card program and one or more card programs offered by private vendors. While seniors can participate in only one Medicare-approved program at a time, there is no limit on their participation with other, non–Medicare-approved drug discount programs. Seniors who qualify for the $600 transitional assistance subsidy must sign up for a Medicare-approved drug discount card in order to receive this money.

Some of these private programs may provide savings superior to the Medicare-approved drug cards. For example, once their $600 subsidy is exhausted, seniors may decide to transfer back to those pharmaceutical company drug card programs that operate independently of the Medicare-approved drug cards. Getting a month's supply of Pfizer's Lipitor for $15, for example, is likely to be a better deal than the discounted price seniors would get through a Medicare-approved drug discount card. The $15 fee basically covers dispensing fees and program administration costs, with little or no payment for the drug itself. Therefore, charges from the private pharmaceutical company plans are likely to be lower than those from the Medicare discount card prices.

Enrollment

Beneficiaries will first select the discount card program of their choice when enrollment begins on May 3, 2004. Enrollment is voluntary. As mentioned earlier, the legislation specifies that beneficiaries may enroll in only one Medicare-approved drug discount card program at a time.

The legislation details the application processes for drug card programs, including a standard enrollment form for beneficiaries, and allows the sponsor to collect annual enrollment fees of up to $30. The beneficiary will fill out the enrollment form with basic information about his or her Medicare and Medicaid status.

If the beneficiary wants to participate in the $600 subsidy program, he or she will be required to submit information about income and other retirement and health benefits. HHS will verify information on beneficiary eligibility for the subsidy.

Medicare Administrator Mark McClellan says his agency is taking action to make it easier for low-

6. Merck Corporate News, "Merck to Provide Free Medicines to Low-Income Medicare Beneficiaries Who Exceed Discount Card Cap," February 12, 2004, at *www.merck.com/newsroom/press_releases/corporate/2004_0212.html*.
7. Eli Lilly and Company, "Lilly Unveils Participation in Medicare Prescription Drug Discount Program," January 21, 2004, at *www.prnewswire.com/cgi-bin/micro_stories.pl?ACCT=916306&TICK=LLY&STORY=/www/story/01-21-2004/0002093050&EDATE=Jan+21,+2004*.

income Americans to receive the $600 benefit. Some states will be able to automatically enroll low-income seniors in the Transitional Assistance Program, provided their laws allow state officials to sign enrollment forms on seniors' behalf. Medicare also will provide a standard enrollment form for the program on its Web site, eliminating the need for dozens of different low-income application forms for each drug plan.

Beneficiaries generally can switch to another approved plan only during the open enrollment period between November 15 and December 31, 2004.

Card Sponsors

Card sponsors can be pharmacy benefit management companies, wholesale and retail pharmacies, insurers, Medicare Advantage health plans, and partnerships of the above. In March, HHS approved 71 Medicare drug discount card applications. Of these, 28 were general card sponsors who will offer their discounts to beneficiaries enrolled in fee-for-service Medicare, either on a national or regional basis. Another 43 sponsors represent Medicare Advantage health plans that will offer the discount cards to their members.

The major pharmacy benefit managers (PBMs), such as Advance PCS Health, LP, Caremark Advantage, Inc., Express Scripts, Inc., WellPoint Pharmacy Management, and Medco Health Solutions, Inc., will participate, along with major health plans such as Aetna Health Management, LLC, Humana Insurance Company, and United Healthcare Insurance Company.

CMS rejected 29 applications, demonstrating its prudence in protecting Medicare beneficiaries. The applications were rejected primarily because the companies seeking approval did not have adequate financial resources, because they did not offer drug discounts in all 209 therapeutic categories, or because their networks did not meet CMS's criteria for operating in a sufficient number of pharmacies.

Discount card sponsors must have sufficient participation by bricks-and-mortar pharmacies in the regions where they are offering the cards, in addition to offering mail-order services to enrollees. Express Scripts said in February that it already had signed up more than 40,000 pharmacies nationwide to participate in its card program. Seniors in a given area must have a choice of at least two discount card programs, offered by different sponsors. With at least 17 drug cards approved nationally, that legislative criterion was easily met.

Other service area specifications stipulate that 90 percent of Medicare beneficiaries living in urban areas must have a participating pharmacy within two miles of their homes (five miles in suburban areas) and that 70 percent of those living in rural areas must have a participating pharmacy within 15 miles of where they live.

Drug card plans are required to cover at least one drug in each of 209 therapeutic categories. At least 55 percent of these categories must have a generic available, and pharmacists are required to notify beneficiaries if a lower-priced generic is available for the prescription they are seeking to fill. Card sponsors will be able to add or drop drugs from their formularies, and sponsors will be able to change the discounts available on individual pharmaceuticals. Price increases will be limited, however, ensuring that beneficiaries will face only those price increases prevailing in the market or that result from increases in the card plan's cost of operation.

Critics have charged that there will be mass confusion for seniors trying to sort through the offers, claims, and prices of so many discount cards. Indeed, it will be a challenge for companies to market their cards to customers and to distinguish their plans from their competitors' in such a short time frame once enrollment begins in May.

The CMS is planning to help by establishing a hotline (1-800-MEDICARE) and a Web site with information about the cards, including comparative pricing information on each drug for each card. The Web site will be updated weekly.

Impact of the Drug Card Provisions

Controversy continues to swirl around the new Medicare law, particularly with regard to the structure of the permanent prescription drug benefit, including the "doughnut hole,"[8] whether government should "negotiate" drug prices, and questions about potential participation in 2006 both by seniors and by stand-alone prescription drug plans. This contrasts with the early acceptance and interest in the transitional drug discount card and the $600 subsidy.

Many companies that have applied to participate see the $600 subsidy as an attractive lure to enroll Medicare beneficiaries in their programs. These sponsors plan to market their cards actively and, in the process, educate seniors about this new assistance program.

The temporary discount card program may well turn out to be so popular that Congress could decide to extend it beyond 2005. As both the government and private sector gain more experience with the program, it could serve as a model for a larger Medicare drug benefit program. The $600 subsidy is essentially a defined contribution that gives seniors an incentive to get the best value for their money. Further, by participating in the discount card program, the money will go further than it would if seniors were paying the full retail price—as many without drug coverage currently do.

Reducing Prices and Maintaining Broad Access to Pharmaceuticals

The drug discount card program and the broader Part D benefit that becomes available in 2006 are designed to promote competition among private drug-only plans and comprehensive health plans (such as HMOs and PPOs) that offer a drug benefit to their members. The private plans will have an incentive to negotiate low prices from pharmaceutical manufacturers, which would be passed on to beneficiaries in the form of lower premiums and out-of-pocket costs. In addition to making their benefits financially attractive to potential enrollees, card sponsors and drug plans will offer customer conveniences, including a broad retail network of pharmacies, mail order service, telephone consultations, and the like.

The size of the discounts available to seniors who enroll in the Medicare drug discount card program depends on the ability of the plan sponsors to shift consumer demand from one product in a drug class to another. Pharmacy benefit managers have been successful in negotiating low drug prices for private insurance plans by using multitiered formularies that require lower copayments for preferred drugs and generics. A similar kind of financial incentive is possible for the Medicare discount card program, with sponsors of the discount cards offering larger discounts where they have negotiated better prices.

Using Private Competition to Deliver the Medicare Drug Benefit

The role of private competition has been a major point of contention in Congress. Critics of a competitive system argue that it could place beneficiaries at a disadvantage if plans change their formularies or discounts after the open enrollment period. Critics also assert that the government should exploit its market power and negotiate drug prices directly with manufacturers, and that drugs should be imported from Canada to keep prices low for everyone.

Bait and Switch. First, let us consider the concern that plans might bait and switch—advertising prices that are too good to be true and then raising prices after seniors are locked into the plan. HHS anticipated this possibility and built safeguards into the regulations. It will monitor price changes and allow them only within a limited range that reflects increases in a drug's average wholesale price or changes in the card sponsor's cost of operation.

Another requirement is that discounts, rebates, or other price concessions from pharmaceutical manufacturers or pharmacies must be accounted for in any proposed price increase to beneficiaries. In addition, HHS must be notified if the sponsor proposes to drop a drug from its formulary. HHS will then post the prices and formulary changes on its Web site.

Card sponsors clearly recognize that arbitrary price increases or formulary changes would be highly unpopular with beneficiaries and federal overseers alike. Card plans that do not meet reasonable consumer expectations will lose enrollment and could face expulsion from the program.

The risk of bait-and-switch tactics would be greater if drug card sponsors had only a short-term interest in the Medicare program, so that the loss of market share after the first year would be of little con-

8. Beneficiaries would have 75 percent of their drug spending covered by Part D for the first $2,250 after satisfying a $250 deductible. Those spending more than $2,250 would receive no additional reimbursement until they have spent $3,600 out of pocket. The gap in coverage is called the "doughnut hole."

sequence. But most, if not all, prospective sponsors of the Medicare discount card are well-established firms with reputations to protect, and the majority of them are considering continued involvement with Medicare through the Part D benefit. For such sponsors, bait-and-switch practices would be bad business, placing them at a competitive disadvantage.

The Impact of Private Negotiations on Drug Prices. There is heated controversy over whether the government should be allowed to "negotiate" prices with pharmaceutical companies since, the argument goes, the government would be able to obtain lower drug prices than private firms. But government doesn't negotiate.[9] It is a monopsony purchaser that dictates prices because it controls such a large customer base: Seniors consume about half of all prescription drugs sold in the United States.

Government would surely dictate prices that would shrink payments to pharmaceutical companies—payments that fund their investment in research and development, estimated to be more than $800 million for every new drug that comes to the market.[10] The result would be less money, a less hospitable business climate for research, and fewer new drugs.

Further, Congressional Budget Office Director Douglas Holtz-Eakin wrote a letter on January 23, 2004, to Senate Majority Leader Bill Frist (R–TN) concerning the provision in the Medicare law that prohibits the government from negotiating prices with drug companies.[11] The CBO concluded that:

> striking that provision would have a negligible effect on federal spending … because CBO estimates that substantial savings will be obtained by the private [drug] plans and that the [HHS] Secretary would not be able to negotiate prices that further reduced federal spending to a significant degree.

Drug Importation from Canada. Some critics of the new Medicare law argue that it would be better and cheaper simply to allow seniors to import drugs from Canada, where price controls prevail. The temporary drug card program provides a much safer and legal alternative for seniors than importing drugs from Canada or other countries. The Food and Drug Administration has found numerous safety problems involving prescription drugs sent to customers who order over the Internet from the United States.[12]

If wholesale importation were permitted, retail prices paid in the U.S. would decline only modestly because manufacturers would limit sales to Canadian wholesalers, and middlemen would eat up much of any price differences that arose. If importation occurred on a large scale, supply disruptions in other countries could threaten the worldwide distribution of pharmaceuticals.[13]

Using the legal route of privately negotiated drug discounts from reputable, government-approved firms, with the added benefit of the $600 subsidy, is a much safer alternative for seniors.

How to Improve the Medicare Drug Card Provisions

Every Congress for years to come will be forced to address Medicare and, particularly, the prescription drug benefit. Senate Minority Leader Tom Daschle (D–SD) and others already have introduced legislation that would significantly amend the MMA. For example, they want to permit U.S. residents to purchase medica-

9. Gail Wilensky, "How to Curb Spending on Drugs," *The Washington Post*, February 15, 2004, p. B7.
10. Tufts Center for the Study of Drug Development, "Tufts Center for the Study of Drug Development Pegs Cost of a New Prescription Medicine at $802 Million," November 2001.
11. Douglas Holtz-Eakin, Director, Congressional Budget Office, letter to the Honorable William H. Frist, M.D., Majority Leader, United States Senate, regarding the CBO's estimate of "the effect of striking the 'noninterference' provision…as added by P.L. 108–173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003," January 23, 2004, at *ftp://ftp.cbo.gov/49xx/doc4986/FristLetter.pdf*.
12. Letter from Mark B. McClellan, Commissioner of Food and Drugs, to Diane C. Gorman, Assistant Deputy Minister, Health Products and Food Branch, Health Canada, February 12, 2004.
13. John E. Calfee, "The Grim Economics of Pharmaceutical Importation," American Enterprise Institute *Health Policy Outlook*, November 2003.

tions from Canada; to allow the federal government to "negotiate" lower drug prices; to fill the "doughnut hole" in the new Medicare drug benefit; and to restrict or eliminate the pilot test in which private health plans would compete against traditional, fee-for-service Medicare in six areas of the country beginning in 2010. Such proposals would be ineffective, costly, and damaging to health care innovation, and would shorten the time frame within which Medicare's financial crisis can be solved.

Conservatives will continue to be on the defensive against these and other initiatives unless they have ideas of their own to propose. They should start by calling for the temporary drug card program to be made permanent. They should also consider improving the benefit available in a permanent drug card program and allowing Medicare Advantage plans greater flexibility in offering a drug benefit to enrollees.

Proposal #1: Make the Drug Card Permanent for Beneficiaries Who Want It

The drug discount card program, and particularly its $600 subsidy for lower-income seniors, should not expire at the end of 2005 but should be allowed to continue. The funded drug card provides an excellent model for delivery of the drug benefit.[14] Providing part of the benefit through a cash subsidy creates a defined contribution that gives government certainty over at least some of its program costs and rewards seniors for making prudent drug purchasing decisions.

Early experience with consumer-directed health benefit programs has demonstrated that consumers are more careful in their spending on health care needs when they are purchasing medical goods and services from a dollar-denominated account, particularly if they are allowed to roll over any savings to subsequent years.[15] The rollover provision for the temporary drug card could be a particularly good incentive if the card program were to continue: Instead of the use-it-or-lose-it benefit structure under current Medicare, seniors could roll over unspent balances in their $600 account, giving them the opportunity to conserve resources for the future.

However, because the program is temporary, there is little incentive for seniors to save and every incentive to make sure they drain every dollar from the account. This occurs every December when workers, who have put pre-tax wages into a Section 125 flexible spending account, purchase designer prescription sunglasses or whatever other items they don't really need in order to make sure they don't just lose the money. Congress could avoid repeating this mistake by making the funded drug card a permanent program and allowing rollover of the balance in a senior's account from year to year.

One reason such a large number of companies applied to participate in the drug discount and transitional assistance program is that they want to establish a customer base for the full drug benefit in 2006. They will have made a significant investment in creating their temporary drug card programs and, if they find that the funded drug card is appealing to consumers, should have the option of continuing to offer the permanent benefit based upon a similar structure.

Proposal #2: Improve the Permanent Drug Card Option

The Medicare drug discount card program offers a limited benefit from which low-income seniors derive the greatest benefit and that was intended to serve only as a temporary bridge to a more generous benefit in 2006. If the drug discount program were to be made permanent, it would not be attractive compared to the more generous Part D benefit. But improvements could be made that would make a permanent funded discount drug card program a realistic option for more beneficiaries.

It is reasonable to give seniors the choice of a subsidized discount card account. The added resources available in 2006 could allow the account to be funded more generously and to be coupled with private catastrophic insurance.

The subsidy could be increased above the cur-

14. The funded drug discount card is part of an idea proposed by the authors in 2001, called the Prescription Drug Security Plan. For more information, see *www.galen.org/pdrugs.asp?docID=608*.

15. "Consumer Choice Health Care: Reports from the Field," a congressional briefing sponsored by the Galen Institute's Center for Consumer Driven Health Care, February 11, 2004, at *www.galen.org/ccbdocs.asp?docID=601*.

rent $600 limit and could be extended to middle-income seniors who are not currently eligible for any subsidy in the discount card program. Seniors at higher income levels also could be allowed to participate, possibly with more modest subsidies to their card accounts than would be provided to low- and moderate-income seniors, but with the provision that they could make their own tax-deductible contributions to the accounts.

The funded drug card also could be coupled with private catastrophic drug insurance to make sure that seniors are protected against large drug expenses—something the temporary program lacks. To avoid attracting only the healthiest seniors into the permanent drug card program, subsidies could be adjusted for risk, and high risks could be pooled across all private plans (including Part D plans).

Seniors should be given the opportunity to continue to participate in this funded discount card program if they prefer it to the permanent Medicare drug benefit program.

Proposal #3: Integrate the Drug Card Into the Medicare Advantage Program

Beginning in 2006, the new Medicare Advantage health plans can incorporate the permanent prescription drug benefit created by the legislation into their benefit structures. The legislation gives the new plans limited leeway, however, in how they structure the drug benefit. Although they may want to build a benefit on the model of the temporary drug discount and assistance program, the legislation as currently drafted does not provide the needed flexibility. Congress could fix this. Seniors who prefer a funded drug card should be able to have it as an integral part of their overall health plan.

It is important to bring drug and medical benefits into the same plan. When health plans and drug plans are separate, there can be an incentive to push costs onto the other payer, potentially compromising patient care. An integrated plan can weigh the full costs and benefits of different treatment strategies rather than focusing on only part of the treatment. That reduces the chances that treatment decisions will be biased by the way benefits are financed.

Conclusion

Congress has provided a good start on a properly structured drug benefit through its transitional drug card program with funding for certain low-income beneficiaries. Drug discounts will be privately negotiated by competing drug plans, and seniors will have a wide range of plans from which to choose, each offering different menus of drugs.

Establishing a fixed contribution on the drug discount card enables government to know its costs while the prices—and savings—on drugs are visible to seniors. Experience with consumer-directed health plans shows that participants are likely to be more cost conscious when they are purchasing drugs from a cash account. Consumers also are more likely to consult with their doctors about how they can get the best value from their drug spending.

If the transitional drug discount program were improved and made permanent, seniors would have the power to save for future drug needs and would have more control over spending to get the drugs they need—whether generic or brand-name.

Involving consumers in their own health care spending decisions will be the next revolution in health care reform in the United States. By structuring the drug benefit so that consumers direct their own spending, Congress could, for once, keep Medicare abreast of the times and give seniors the power and resources to shape the pharmaceutical marketplace around their needs, both today and in the future.

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