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The Medicare Drug Discount Card: First Phase of a Market Revolution?

Grace-Marie Turner and Joseph R. Antos, Ph.D.

ROBERT E. MOFFIT, PH.D: When it comes to health policy, the intensity of opposition to a proposal is sometimes directly proportional to its potential for success. Given some of the heated congressional rhetoric on our topic, that appears to be the case with the Medicare prescription drug discount card. Today, we will examine the discount card program; how it works; what it delivers to seniors; and what it means for the Medicare program in particular—and what it may mean for consumers in the health care system.

Our first presenter today is Grace-Marie Turner, President of the Galen Institute. Grace-Marie is also the founder of the Health Policy Consensus group, an informal group of health policy analysts committed to the free-market–oriented, consumer-based reform of America's health care system. She's the editor of a series of essays on the subject, *Empowering Health Care Consumers Through Tax Reform,* published in 1999 by the University of Michigan Press. Previously, she served as Executive Director of the National Commission on Economic Growth and Tax Reform. For twelve years, Grace-Marie worked as an independent consultant in Washington, focusing primarily on health care policy and analysis. She also worked on Capitol Hill as the press secretary for Senator Pete Domenici (R–NM).

Our second speaker is Dr. Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute. Joe is also an adjunct professor of the School of Public Health at the University of North Carolina. Most of us in the

Talking Points

- The Medicare prescription drug discount card introduces incentives for consumer choice and genuine price competition into the Medicare program.
- The program is designed to provide help to those who need it most—low-income seniors. These seniors will secure the biggest savings.
- There are three levels of assistance: drug discount cards, a transitional cash assistance program for low-income seniors, and the drug companies' private assistance programs.

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(202) 546-4400 heritage.org

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health policy community knew him as the Assistant Director for the Congressional Budget Office (CBO)—a point man for CBO on Medicare policy. He specialized in health policy for six years at the CBO before joining the American Enterprise Institute. Earlier in his career, Joe was a staff economist at the President's Council of Economic Advisers and a Senior Economist at the Office of Management and Budget (OMB). Joe and his colleague Ximena Pinell are completing a major empirical analysis of the Medicare drug discount card for the American Enterprise Institute.

—Robert E. Moffit, Ph.D., is Director of the Center for Health Policy Studies at The Heritage Foundation

GRACE-MARIE TURNER: We are not yet halfway through the year and already there are three programs taking effect as a result of the new Medicare law. First, health savings accounts provide a rare example of the government being ahead of the private market. There is also new money in the new Medicare Advantage Program to provide seniors with expanded and upgraded private health plan options—options to secure comprehensive health care among plans of their personal choice. Then there is the new temporary drug cards to be activated on June 1st. This new program has been severely criticized by political leaders and others. Some are even saying that seniors should stay away from the program because it is too complicated and they are likely to get cheated somehow because of all these private plans operating in the Medicare program.

A Good Start

We think this is a good program, based upon good incentives. We will show you facts and figures about why it will work. That said, we are not here to say that this is the perfect program, nor that it is going to fix everything for all seniors. There is no such thing as a silver bullet in the health care sector. Yet it is a good start. It introduces incentives for consumer choice and genuine price competition into the Medicare program—no small feat. In addition, this is a program that is designed to help provide the most help to those who need it most—low-income seniors (primarily those without drug coverage). Many of us have been saying for years that this is where we really ought to be focusing the resources of government in providing a Medicare drug benefit. In this first program, at least, this is where they have begun. I would like to walk you through the structure of the program and some of the reasons that we believe that it is really a good program.

Levels of Assistance

First of all, the program does provide immediate drug discounts for all Medicare beneficiaries and especially generous assistance for low-income seniors. It also introduces private competition and negotiated pricing into Medicare.

There are three levels of assistance. The drug price discounts are only part of the story. There is a subsidy for poor seniors. The tremendous value of this $600 subsidy for low-income seniors—this year and next—is often missed in much of the analysis. Importantly, these new Medicare-approved drug discount cards also provide much easier access to the private patient-assistance programs. These often are much more generous than the negotiated discounts and help even more often than the $600 subsidy. Together, these different benefit features really make this quite a good program.

Drug Discount Cards

Let us start with the drug discount cards. As you know, they are to be activated on June 1. There are no penalties for delayed enrollment. People can join whenever they want to. However, those who join too late this year, who would otherwise be eligible for this $600 subsidy, will miss out on that because it is calculated per calendar year. The drug cards will be available to all Medicare beneficiaries except those on Medicaid. It is going to be most valuable to those who do not have other drug coverage. Yet anyone can participate: They can enroll in the plan of their choice—but only one card at a time. That is to allow the drug plan companies to negotiate decent prices. As of now, there are 39 national cards, five of them with zero enrollment fees. That is one of the first places you see competition—whether the card plans are going to charge the full $30 that they are allowed by law to charge

for participation, or whether they are going to use that as a negotiating tool to make their plans more attractive. One of them is $20; several are $30. There are different prices: Some are at zero. Each of the plans must provide at least one drug in all 209 therapeutic categories.

This is a new program, and already it is the subject of some intense academic and policy analysis. Studies of savings are all over the map: 11 percent to 95 percent are the ranges that I have seen. Some of you may have seen an even broader range of savings for seniors. In any case, there really are measurable savings available to seniors.

Transitional Cash Assistance Program

Let us turn now to the transitional cash assistance program for low-income seniors. It will be $600 (this year and next), and the subsidy is provided through the discount cards. The card will work like a debit card: The money will be associated with the card the seniors choose and will allow them to draw against that toward their drug purchases. There are specific categories: If you are under 100 percent of poverty level, you pay 5 percent of the price of the drug. If you are between 100 percent and 135 percent, you pay 10 percent and the rest of that is drawn down from the card account. The $600 is available to seniors that make $12,569 per year as individuals or $16,862 per year for a couple. This is the maximum. Small co-payments and the enrollment are free for those who are eligible for the $600. Importantly, any balance that is left over this December rolls over to the next year. That is a great incentive to use that money wisely and also to find the best deal.

Private Assistance Programs

Let's turn to the third piece of this program: the drug companies' private assistance programs and what they are doing to supercharge this Medicare drug discount card program. Pfizer is participating. Eli Lilly offers a similar program, participating in most cards. The drug companies have to negotiate with each one of the drug cards that are offered and sign contracts to associate their patient-assistance programs with that card. It is taking some time to get that done but they are working on it. Their goal is to get their assistance programs associated with each one of the drug cards. Merck has said that if you—as a senior—are eligible for the $600 subsidy, they are going to give you their drugs *free* (except for a dispensing fee for the pharmacist) after you use up your $600. Glaxo-Smith-Klein, Together Rx, and a number of other drug companies are offering their own discounts—in addition to the prices that they are offering to the drug plans through their patient-assistance programs for seniors who are in need.

State Assistance

Finally, the states are also participating in this. Medicare beneficiaries can join a drug discount program even if they are participating in the state pharmaceutical-assistance programs. The states are doing a lot to help educate their seniors about this program and are doing a lot of outreach to seniors. Several states are able to automatically sign up seniors who would be eligible for this $600 so that they don't even have to go through a technologically intensive decision process. States also can boost the subsidy program with some of their own contributions. They can help with co-payments and enrollment fees.

The National Council on Aging, the American Association of Retired Persons (AARP), and scores of organizations are already undertaking a major media and marketing campaign to try to help educate seniors about this new program. They would not be doing this if there weren't some real value in this program—especially for lower-income seniors.

Common Criticisms

However, this is a new program and there are a lot of criticisms. We have all heard them.

- **"All the drugs won't be covered."** The belief is that people will be stuck with this card. Yet critics often overlook the fact that if they don't like the plan that they're in for the next seven months, they can change at the end of the year to another one.
- **"They'll get stuck in a plan that doesn't offer their drugs."** In fact, the coverage is broad. The law requires the plans to cover at

least one drug in all of the 209 therapeutic categories. Therefore, the chances that somebody won't have a drug that they need made available to them through this program are relatively slim. In addition, lower-income seniors can still participate in drug-company patient-assistance programs even if they are not part of this Medicare program. They can do that separately. There are still a lot of options for people to get the drugs they need. However, this program is different than a government-run, centrally controlled program. In order for the plans to be able to drive market share and in order to get good discounts from the companies that the pharmaceutical companies are negotiating with, they have to be able to offer some level of volume. If every drug were covered by every plan, no one would be able to secure market share and the discounts would be less as a result. People will get the drugs they need and they can see in advance what drugs are available to them through these different plans. They have the choice of the plans they want and drugs in the 209 therapeutic categories will be covered.

- "**Sponsors will drop the drugs that seniors need most.**" This criticism makes no market sense. Most of these drug plans are spending millions—maybe tens of millions—of dollars getting these new drug card plans up and running. One of the reasons for this is because they need to begin to get participation by a large number of seniors and some consumer loyalty to their cards. So when the full Medicare drug benefit kicks in during 2006, they will already have a base of people in their particular plan. Why on earth would they want to trick seniors by putting some attractive drug on their list and then pulling it off? That would be senseless. Beyond that, it would not go over well with the officials at the Centers for Medicare and Medicaid Services (CMS) who are administering the new program. The same thing is true—by the way—with drug prices.
- "**They can change prices weekly.**" If you look at the new Web site (*www.medicare.gov*), what you find is that the prices are going *down* because the companies are negotiating and making better deals. If you say you have to stick with that price for good, they may not be able to provide the drug because they can't get it from the manufacturer. They have to have something that they can substitute and offer at the prices that the market will bear. Also, as I said, CMS is looking over their shoulders. They have a relatively narrow range and they have to justify those price increases. This is just a different way of looking at the world. You look at the numbers in Target or Wal-Mart ads: They are falling. The same thing can happen here—but not if the government says, "You just can't change this price for good."

Drug Price Increases

I'm sure you have seen some press reports that the drug companies have raised their prices so that the discounts will look better. These reports are all over the map and it really depends upon what the basis is for the comparative measurement and what drugs you look at. In fact, the consumer price index for pharmaceuticals increased at the compound annual growth rate of 2.8 percent from January 2003 to February 2004. Contrast that to overall medical inflation. It rose at an annual growth rate of 4.5 percent. Pharmaceutical prices were not rising faster than other sectors of the health economy: In fact, they were rising at a much lower rate. Other major categories of health services increased at a rate of 3.8 percent to 6.7 percent. Why do prices rise so much faster in the health sector than in other sectors of the economy? This is the subject of many other Heritage Foundation forums and doubtless many in the future. There are a million reasons for it, but simply comparing price increases in the pharmaceutical industry to increases in the consumer price index is akin to playing the old game of comparing apples and oranges.

This new Medicare drug discount card program offers new kinds of incentives for seniors to have a choice of private plans and incentives to shop wisely—especially for the seniors who have the opportunity to get $600. The basis of comparison should not be confined solely to brand name

drugs, either—Americans buy generics, too. A recent CMS study found that if seniors use generics, they could save 93 percent on their drugs. That's a huge savings. Competition is also going to force them to do the right thing for seniors. Additionally, Medicare officials are working hard to promote the program. CMS Administrator Mark McClellan said recently that they have increased the number of operators at *1-800-Medicare* from 400 to 2,000. They apparently had 400,000 calls in the first week. The average for the year has been 6 million calls. They are clearly being barraged.

Making It Permanent

The political battles over Medicare are going to continue. There are parts of this law that will lead to transformative changes. It is already starting and this temporary drug card is one of the mechanisms for this transformation. That is certainly one of the reasons that it is being criticized. Why? It signals a new way of doing business in the Medicare program.

Cost pressures throughout the health care sector of the economy and for drug prices will continue to drive political demands for change. Our recommendation is to allow the funded drug card to continue as an option in 2006. We would add more generous funding and private catastrophic coverage associated with it. If these card plans are attractive and the seniors like them, why should not they be able to keep them? Because these companies have spent so much money ramping them up, this could continue to be an option for seniors in the future. Ultimately, these seniors would be the winners.

DR. JOSEPH ANTOS: Grace-Marie just told us the truth about how the Medicare drug card program works and dispelled some of the confusions that are out there. I am going to focus on some numbers, but before I do that I want to re-emphasize something that Grace-Marie said: The Medicare drug discount card program is not the Medicare drug benefit. It is *immediate* assistance to get us to 2006—if we get there—to the point where there is a major Medicare drug benefit.

Therefore, the appropriate test for the program—"Is it good enough?"—should be on its own terms. It is not the biggest giveaway program that the government ever invented. It wasn't intended to be. You have to judge a program by its goals—not by some other goals that you did not achieve or were frustrated about because you didn't get your way in Congress. That might be an odd concept to some, but that would generally be considered fair in this country. The question really is: How good of a deal is it? How good of a deal is it for whom, in particular? That really is the issue. That is what's bugging everybody. While some may not be that comfortable with a program that simply helps poor people in Medicare, I think we should be proud of this program. This is one of the few acts of government—at least in Medicare—where we have actually, consciously sought to help poor people who need the help. Congress—those who voted for this—should be congratulated, at least for this part of the Medicare law.

A Managerial Accomplishment

Let us talk about this recent criticism of the Medicare officials, about how incompetent CMS has been at implementing the program. They have had a total of *four whole months* to put up the largest consumer information effort on health care options that the government has ever mounted. Quite honestly, it is a miracle that we can even talk about this today. Sure, mistakes have been made. They probably had to circumvent—I hope legally—government contracting rules in order to get this price-finder Web site up.

There has been a lot of criticism: how hard it is to use; it doesn't provide good information; and so on and so forth. I think it is a miracle that it even exists because it is a huge technological accomplishment. There are something like 60,000 different kinds of drug formulations. There are many thousands of zip codes. There are on the order of 50 to 70 discount card plans and then there are all those retail drug stores. It turns out that, in most cases, all the drug stores take all the cards. Therefore, they are mixing and matching all this information. It is absolutely amazing that the Web site is even up now and that it is as good as it is.

CMS—and Mark McClellan in particular—should be congratulated. They should not be criticized for trying to make it better.

Now they *can* be criticized for something. They should all be ashamed of themselves for not admitting during the first week of the program that things weren't "perfect." Instead, they mealy-mouthed it: They did not want to admit that the federal government couldn't be perfect right out of the box. Yet the federal government *wasn't* perfect right out of the box. The information now is pretty good. It will get better, but the fact is that they made a mistake by not owning up to the emerging problems that they were having because everybody else knew the problems they were having.

A Good Deal for Seniors

Is it a good deal? Yes. It is not just about drug discounts. It is not just about the discounts that everybody can get through this program. It is also about other possibilities. Everybody can also choose to go to mail order and that saves some money. It is surprising how many seniors want to go down to their local drug store and buy their drugs—even though it might cost them 10 or 15 percent more doing it that way. Yet that is an option and it is now an option that is available to every senior—not just seniors who are part of some organized retiree benefit program. In addition, for low-income people, there are two kinds of subsidies: one from the government and one from the private sector. And I want to emphasize that.

This program is going to be successful. It already *is* successful, in large measure because of the government contribution to poor seniors and because of the private-sector contribution. This could not work if you did not have a drug industry that was ready to step up to the bar. Again, this is something that CMS has not been very good at explaining to people.

This is not just another government program. If it were just another government program, it would work like another government program. This is better. As Grace-Marie said, there are, in many cases, tremendous price breaks available to seniors. Initially, even before the price-finder Web site was available, that information became available. We saw lots of erroneous newspaper stories telling us that the discounts were going to be lousy. I thought it was miraculous that some people would know this to be true even before the information about pricing was available. Yet they did find this out, even before that information became available. In fact, I was a little worried that Health and Human Services Secretary Tommy Thompson was believing some of this stuff himself because he was saying, "Oh, it's going to be a 17 percent discount." He got that from a recent article in *Health Affairs* projecting price discounts. Now that is a great study, but it has nothing to do with the real prices in this program.

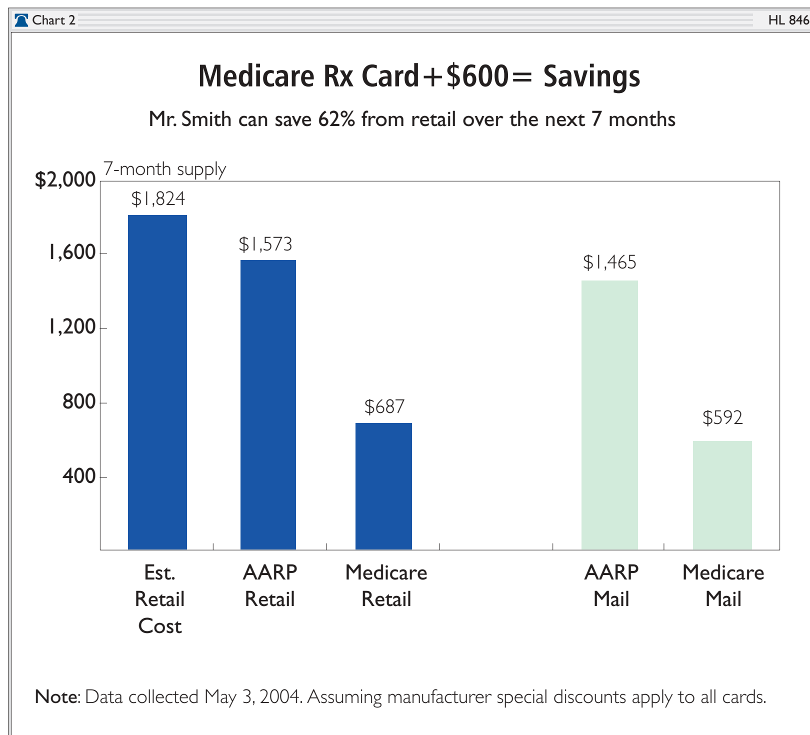
Eventually price data became available and we began to see other stories. Yet they said. "The discounts aren't good enough." Well, the discounts aren't good enough. Why? Because we chose to look at what it would cost to fill a 30-day prescription and that was it. We did not look at the rest of the program: We didn't consider the actual circumstances of the patients and we didn't consider the other possibilities that would provide easy access through this program. That seemed wrong. So, Ximena Pinell (my colleague at the American Enterprise Institute [AEI]), Grace-Marie Turner, and I decided that we were going to shed a little light on that. Look at Chart 1. We selected three hypothetical Medicare patients. These are not real living people, although if you think about what is wrong with Mr. Smith—the first one—you will recognize this as everyone's future.

The Case of Mr. Smith

Who is this guy? This is a guy who has spent 66 years watching TV, eating snacks, drinking his beverage of choice, and getting as much exercise as his thumb could stand.

These are three people who have typical types of conditions that Medicare beneficiaries often have. As I say, I think patient number one is probably "Mr. and Mrs. Medicare." These other two folks may have more serious problems and we had to pick a zip code, because in order to use this Web site you have to click in some information about where you live. Therefore, for the purposes of the analysis, we decided that we lived in Brooklyn. It is useful to know your income level.

To make it simple, we decided just to go with somebody below the poverty level. It doesn't have any real bearing on the results for people who are eligible for the $600 cash subsidy. For people who are not eligible—people who are above 135 percent of poverty— they obviously don't get the $600 and some of them might also not be able to take advantage of certain other private-sector programs. Anyway, we selected these patients. We selected a zip code and we went to work looking at what was the best deal in Medicare.



Then there are the drugs. We were able to compare two kinds of therapeutic strategies: one that relies more heavily on brand name drugs and one that relies more heavily on generic drugs. In many cases you can only get a brand name drug and in some cases you have some choices there. The typical Medicare patient who takes four or five drugs on a regular basis will typically take some brands and some generics. Again, we were trying to be as realistic as possible.

So we did a calculation. Focus on Mr. Smith here—and remember he is below the poverty level. Therefore, he is not only fully able to take advantage of the $600, but he is also eligible for some of these deep private-sector discounts. However, the best deal that he could get would be to enroll on the first day that anyone could sign up for the program. We did the best we could to avoid obvious data errors. We found plenty of them in the four or five days that we worked to investigate the Web site before we did the final runs. Anyway, we calculated the best deal that Mr. Smith could get in Brooklyn and what it would cost him over the next seven months. You add up all the seven months of his expenditure; you take into account the $600 that he is going to spend—that is a gift from you, the taxpayer; and then you also factor in (where it's available) very, very low prices that are available to him through senior discount card programs offered by pharmaceutical companies.

These private-sector programs are programs that are often available to low-income seniors—oftentimes at 200 percent of poverty or

Chart 1 HL 846

Who Are Our Hypothetical Patients?

Patient #1, **Mr. Smith**, is a 66-year-old man with modestly well-controlled diabetes, high blood pressure and cholesterol, and need for an occasional Viagra pill.

Patient #2, **Mrs. Jones**, is a 74-year-old woman with more problems—congestive heart failure, high blood pressure, osteoarthritis, and gastric reflux disease.

Patient #3, **Mr. Green**, is a 78-year-old man suffering from chronic lung disease (from years of smoking), a history of blood clots in his legs, seasonal allergies, hypothyroidism, and depression.

All 3 patients live in **Brooklyn** (zip 11201) and have annual **incomes below the federal poverty level,** or $9,310 for an individual.

Chart 4 HL 846

Generics: Mail Order Increases Savings

		Medicare's Best Deal	AARP*	PercentageSavings
Mr. Smith				
"Brand"	Retail	$686.58	$1,572.72	56%
	Mail	$592.31	$1,464.98	60%
"Generic"	Retail	$503.60	$1,370.21	63%
	Mail	$421.91	$1,280.74	67%
Mrs. Jones				
"Brand"	Retail	$1,887.49	$2,224.10	15%
	Mail	$1,599.53	$2,128.97	25%
"Generic"	Retail	$1,430.95	$1,952.29	27%
	Mail	$1,187.37	$1,867.17	36%
Mr. Green				
"Brand"	Retail	$775.26	$1,404.69	45%
	Mail	$649.22	$1,297.17	50%
"Generic"	Retail	$824.15	$1,333.64	38%
	Mail	$670.93	$1,235.15	46%

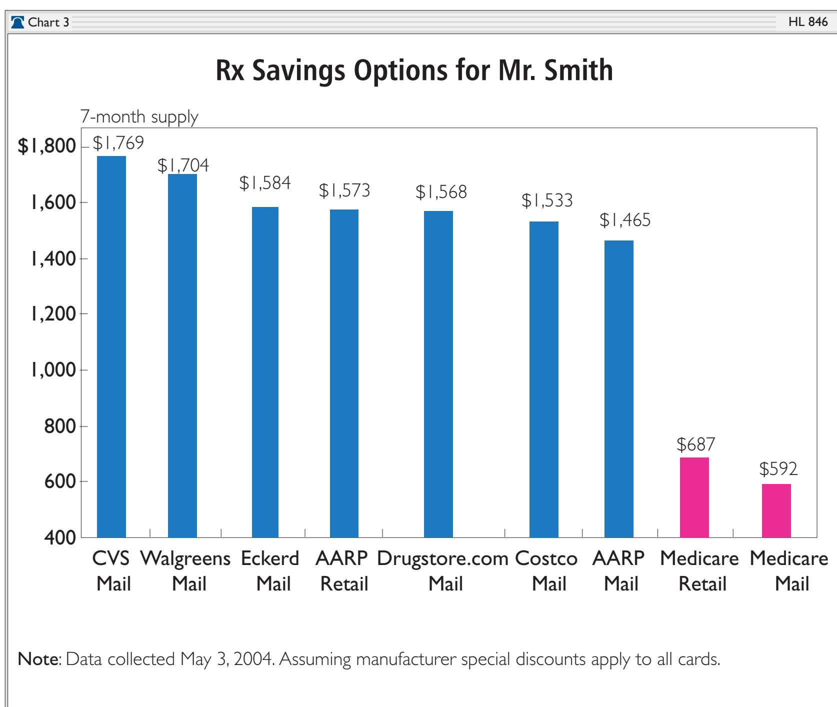
* Assumes discounts that manufacturers offer Medicare-endorsed cards do not apply to AARP.

Source: Author's calculations based on price data from *www.medicare.gov* and *www.aarppharmacy.com* (May 3, 2004).

below, which is better than the Medicare program; sometimes up to 300 percent of poverty. These are programs that do not require the beneficiary to jump through hoops to join them and there are various kinds of discounts depending on the card and depending on the products. Generally, these are programs where you can get your drugs at your local pharmacy if you want to.

There are other patient assistance programs, which are more narrowly restricted, and generally they require that you apply through your physician and get your drugs for free. However, you have to go to your doctor's office to get them. To make this simple, we are leaving aside those patient-assistance programs that are essentially free drugs, and in many cases, the Medicare price for that would be very close to zero. That's not really a fair comparison, so we are just looking at things that are generally available to seniors and generally available to more seniors than the Medicare $600 subsidy.

We also really wanted to have a retail price, but as you may know, there are no retail prices that are generally available. You can't find out. If you go to the drug store you can't find out if you ask. You have to try to buy the drug. Therefore, the best we could do was to get AARP retail prices. AARP has a very large discount card program. They say they get anywhere from 10 to 20 (or 15 to 20) percent discounts. So we looked at that.



Note: Data collected May 3, 2004. Assuming manufacturer special discounts apply to all cards.

However, CMS produced a report that allowed us to roughly estimate what the retail cost of Mr. Smith's drugs would be and we did a comparison with AARP and then raised that by about 16 percent. That is our rough estimate of the AARP discount off of retail prices for Mr. Smith's drugs. Therefore, you can see that compared to retail, Mr. Smith—including the $600 he is getting—gets a 62 percent savings over the course of the next seven months. (See Chart 2.)

Obviously, you can do better with mail order. You can do better with AARP mail order and you can do better with Medicare mail order. Yet in this case, at least, there does not appear to be much of a contest. We looked at a lot of different options

and we tried to make sure that we covered as many of the types of options that people have. We've got AARP retail and mail. There were no other Internet-available sites that would tell us retail prices or prices sold at the local pharmacy but we did pick up COSTCO mail order, CVS mail order, Walgreen's mail order, Eckerd's mail order, etc. We think we got a pretty good selection. We got *drugstore.com*, which is a legitimate Internet site. They will ship you safe and effective drugs. (See Chart 3.)

You could see that given all of these options, the best that Mr. Smith could do was to join the Medicare discount card program and get his $600 and take advantage of all the programs that will be made available to him. Now, if he didn't have the $600, would he still win? Sure, a pretty obvious fact.

Chart 5 HL 846

Other Studies Confirm Savings

	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5	Patient 6
1 month's savings [1]	17.3%	10.6%	12.8%	10.2%	11.7%	11.1%
7 month's savings [2]	42.0%	77.0%	42.8%	31.6%	58.7%	36.7%

Sample patients with:

	Diabetes	Diabetes, high BP	Diabetes, high cholesterol	Congestive Heart Failure, high BP	high BP
Annual savings [3]	48%	35%	38%	62%	88%

Total savings for seniors, 2004-05 [4] **$6.4 billion**

[1] Centers for Medicare and Medicaid Services, "Medicare-Approved Drug Discount Cards Provide Drug Prices Significantly Below Average Paid by Americans," May 6, 2004, at *www.cms.hhs.gov/media/press/files/rxcard_savings_analysis.pdf* (May 26, 2004).

[2] Centers for Medicare and Medicaid Services, "Medicare-Approved Drug Discount Cards Provide Additional Savings to Low-Income Medicare Beneficiaries," May 19, 2004, at *www.cms.hhs.gov/medicarereform/drugcard/reports/lowincomestudy5-19-04.pdf* (May 26, 2004). This research accounts for the $600 subsidy.

[3] The Lewin Group, "New Study on Discount Drug Cards Shows Average Savings will Top 20 Percent," May 26, 2004, at *www.lewin.com/Spotlights/Features/SF_Medicare_Drug_Discount_Cards.htm* (May 26, 2004). This reserach accounts for the $600 subsidy.

[4] Business Roundtable, "New Business Roundtable Study Estimates $24.1 Billion in New Drug Benefits to Seniors Who Enroll In Medicare Drug Program," May 20, 2004, at *www.businessroundtable.org/newsroom/document.aspx?qs=5866BF807822B0F1AD5468222FB51711FCF50C8.*

Now, we didn't stop with Mr. Smith. There are a lot of numbers here. When you calculate the percentage savings, you get quite a range. Depending on what drugs you take, you might not get much of a savings. Depending on the drugs you take and where you buy them, you might not get much of a savings or you might get tremendous savings. For example, look at Mrs. Jones. She is buying her set of brand-oriented drugs at the retail level and even with her $600, she's not really beating AARP by very much. She is saving 15 percent off of AARP, which would probably translate to 25 or 30 percent off of real retail. On the other hand, you can see that if Mr. Smith goes mainly generic and goes the mail order route through Medicare's best deal, he's going to save almost 70 percent. (See Chart 4.)

This is a pretty large range, but nonetheless, there are real savings here. Now, one might say that 15 percent doesn't look good. Well, it might be different today: This is a month old. Yet if 15 percent doesn't look good, it still beats what you can do out in the conventional market. Therefore, I think the real comparison is not, "Gee, I wish it could be different," but rather, " What are my realistic options?" That is a realistic option. I don't know any senior who would throw away several hundred dollars. No sensible person would do that. So it's a good deal. There are other studies that confirm this. At AEI, we were probably the first to come out with this kind of analysis.

We talked to some people at CMS and they eventually roused themselves to do that kind of analysis as well. We saw the same pattern. You see so-so price discounts, quite honestly. These are the average price discounts for selected patients in (more or less) randomly selected zip codes across the country. Ten percent doesn't look that good. And this is off of their estimate of retail prices—all the way up to 17 percent. That looks better. By and large, AARP can beat that. A lot of places can beat that: *drugstore.com* can beat that. That's true.

Yet you overlook the $600, and also overlook all of the other private-sector programs that would put money in the pockets of seniors. If you throw in the $600, suddenly the world changes and you see something interesting here. The patient who is getting the 10 percent price discount finds that they are saving 77 percent off of their seven-month spending because of the $600. Now that is partially because they're not spending a huge amount of money.

When you look only at price discounts, it is very confusing. A sensible senior would say, not "What's the discount," but rather "What is it going to cost me, compared to what it cost me today?" That is the relevant question. The Lewin Group finds similar, very large, savings. (See Chart 5.)

Aggregate Drug Savings

What about aggregate savings? It's not such a bad number. The Business Round Table hired a consulting firm and they estimated that over the next year-and-a-half that seniors will save roughly $6.4 billion if you take into account *only* the average, normal discount available through the discount card program (and not the special discounts and the $600). For the period 2004 and 2005, you save about $6.4 billion. I think that is a pretty good estimate. It reflects a reasonable assumption: The take up isn't going to be very good this year. People are legitimately confused about things. It is a new program and a lot of organizations are just now getting around to realizing that instead of bickering about politics, they could help seniors actually get a good deal. Therefore, it will be a little slow this year and next year it will pick right up. So $6.4 billion is maybe not an unreasonable estimate—although it might be a little bit low.

Where does this leave us? As Grace-Marie said, there have been a couple of studies out this week from Families USA and AARP. AARP is especially confusing because it is a drug card sponsor. Basically, AARP says it is not good enough and savings are being wiped out. But go back to the central point. If it was relatively easy to do, would you sign up for this program if it would save you some money—even if it wasn't a huge amount of money? The answer is yes.

Furthermore, both of these studies ignore the $600 subsidy. They ignore the larger discounts that are available. In fact, they don't even reflect general business practice in the pharmaceutical industry. One of them did not take into account that the actual average transaction price in this country is a lot lower than the so-called average manufacturer's price—which is a wholly made up number. Real transactions, on average, take place at a much lower level in this country. Therefore, their comparisons are skewed.

Again, the critics are missing the point: There is real value in this drug card program—not just for seniors, not just for low-income seniors, not just for seniors in general. There is real value in it for all of us. It is not what you would normally think. It is in this new CMS Web site. What is that? It is the first nationally accurate database of prices—actual prices that are available in the market for prescription drugs. There is no other source of information that is nationally representative and that actually tells you what it costs to buy prescription drugs. This, by the way, is a problem generally in health care in this country. It isn't a problem with gasoline prices; it isn't a problem with almost everything else we buy. Yet we cannot find out the price of anything in health care.

A Market Revolution?

How is this going to help us? There is a good chance that this is going to revolutionize all of marketing and sales in pharmaceuticals in the next four or five years. This price finder mechanism—now that the proverbial cat is out of the bag—is required for the discount card program. It is not required for the Medicare drug benefit. It will be there. Once you've done it, you can't back off. There will be prices on Web sites, now and forever.

The interest will spread. Employers, who pay for a lot of healthcare in this country, will begin to look at these prices. As competition really begins to grab hold—as I think we're going to see later this year and next year, as well—we are

going to see prices come down. At some point, we are going to see employers look at those prices and say, "Hey, what about me? I'm paying too much."

In the near term, there is going to be a lot of confusion. People are going to think, "Why can't I just get the lowest possible price available anywhere in the country—sort of like supermarkets?" It doesn't exactly work that way, but nonetheless, there is going to be tremendous pressure for price transparency. It is going to give consumers an ability to not only know what they are paying, but also to consider what the value of it is. Ultimately, that is going to be a great benefit to all of us.