Backgrounder

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# The Truth About the Medicare Drug Discount Card

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America's senior citizens, for the very first time, are being given an opportunity to compare drug prices in a newly created consumer-driven market. The Centers for Medicare and Medicaid Services (CMS) has launched a cost comparison database on its Web site (*www.medicare.gov*) that will allow seniors to compare the price of the prescription drugs they take and see how big a discount they would get if they enrolled in various Medicare Discount Drug Card (MDDC) programs.

This transparency in drug prices is the first of its kind and is an excellent first step toward empowering consumers. Given the lack of price transparency and direct consumer decision-making that characterizes so much of the health care sector of the American economy, this is an historic achievement.

However, certain prominent Members of Congress and special-interest groups that claim to speak for America's senior citizens have come out strongly against the creation of this new forum for consumer-driven pricing. Even before the program has taken effect, these congressional and other critics have disparaged not only the card program, but also seniors' ability to understand how it works or comparison shop for discounts.

For example, Edward Coyle, head of the Alliance for Retired Americans, recently told Reuters that "No one in their right mind can make sense of how these cards are going to work, what drugs will be offered and where by what plans, or what paltry savings might be recognized."[1] According to Representative

## Talking Points

- The Medicare Drug Discount Card program can serve as a concrete test of price transparency in pharmaceuticals. Federal officials already project that seniors can save an estimated $3.8 billion to $5.1 billion through December 2005.
- While some seniors will spend more and many much less, the vast majority of low-income seniors without drug coverage will see significant savings from the new drug discount card program. Any unused portion of the $600 low-income subsidy will be rolled over to 2005, thus increasing potential savings in 2005.
- If done properly, the changes in the MDDC would eliminate the need for the full-blown Medicare drug entitlement that is set to take effect in 2006. An effective and expanded Medicare drug discount card program would lessen the fiscal strain on Medicare and reduce the burden of present and future taxpayers, who are scheduled to pay trillions of dollars just for the drug entitlement.

This paper, in its entirety, can be found at:
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Fortney "Pete" Stark (D–CA), ranking member of the House Ways and Means Subcommittee on Health, "The cards provide maximum confusion and minimal savings."[2] And Morton Kondracke, executive editor of *Roll Call*, reports that "House Minority Leader Nancy Pelosi (D–Calif.) and others, as part of a general effort to discredit the Medicare law, are urging seniors not to acquire them."[3]

On the other hand, John Rother, national director of the American Association of Retired Persons (AARP), told *Roll Call* that Democratic critics "have gone off the extreme end. The cards give poor seniors a $600 credit on their cards, giving them drugs almost for free. You'd think Democrats would want to help this constituency."[4] Continuing, "Rother said that while there 'are problems' getting the discount card system started, seniors should be able to get a 30 percent discount, 'which is almost what they'll save by going to Canada.'"[5]

Congress can improve the program in several ways. It can make it permanent and intensify the competition. Federal officials can encourage active state participation in supplementing subsidies to low-income seniors, as well as the active participation of seniors' organizations and others in the evaluation and ratings of competing drug card plans.

Meanwhile, the Medicare drug discount card program can serve as a concrete test of price transparency in pharmaceuticals. Federal officials are already projecting that seniors can save an estimated $3.8 billion to $5.1 billion through December 2005.[6]

## What the Medicare Drug Discount Card Can Do

Based on preliminary assessments, it is clear that the Medicare drug discount card program holds significant promise for seniors in improving access to affordable drug coverage. Specifically:

**1. The program will provide significant help for low-income beneficiaries.**

The CMS estimates that Medicare recipients without drug coverage will spend about $1,400 in 2004.[7]

The new Medicare drug discount card program will carry with it a $600 subsidy for seniors with incomes of up to 135 percent of the federal poverty level (FPL): $12,569 a year for an individual and $16,862 for a couple, which will greatly reduce the out-of-pocket spending for millions of low-income seniors. Low-income seniors who have incomes of up to 100 percent of the FPL will be responsible for a co-pay of only 5 percent on their prescriptions, with the remaining 95 percent paid out of their $600 subsidy.

For seniors with incomes up to 135 percent of the FPL, a 10 percent co-pay is required, with the subsidy covering the remaining 90 percent. Seniors with incomes up to 135 percent of the FPL will have their MDDC enrollment fee, which ranges from $0 through a legal maximum of $30 per year, paid for by Medicare, saving them even more money.

Currently, 78 percent of seniors have some type of drug coverage.[8] The authors of a recent study

1. Susan Heavy, "US Offers Seniors Drug Cards Amid Criticism," Reuters, May 3, 2004, at *www.reuters.com/financeNewsArticle.jhtml?type=bondsNews&storyID=5020845*.
2. Robert Pear, "Agency Sees Withholding of Medicare Data from Congress as Illegal," *The New York Times*, May 4, 2004.
3. Morton M. Kondracke, "Drug Reimportation Can Kill Americans. We Can Do Better," *Roll Call*, May 6, 2004.
4. *Ibid.*
5. *Ibid.*
6. Centers for Medicare and Medicaid Services, *Savings from New Medicare-Approved Drug Discount Cards*, White Paper, May 2004.
7. "Medicare Prescription Drug Discount Card and Transitional Assistance Program," Centers for Medicare and Medicaid Services, March 26, 2004, at *www.cms.hhs.gov/media/press/release.asp?Counter=990*.
8. "Medicare Beneficiaries' Links to Drug Coverage," Joint Economic Committee, April 10, 2003, at *http://jec.senate.gov/_files/MedicareLinks.pdf*.

published in *Health Affairs* estimated that seniors without drug coverage who choose to enroll in the MDDC program will save 17.4 percent over retail prices.[9] The percentage of the discount differs greatly between generic and brand-name drugs; seniors are estimated to save an average of 41.1 percent on generic drugs and an average of 14 percent for brand-name drugs.[10]

Based on CMS drug spending estimates for Medicare beneficiaries, by applying the average percentage savings from the drug discount card (17.4 percent) and the $600 low-income subsidy, the average low-income senior without drug coverage will save $843.60, or roughly 60 percent. In other words, instead of spending an average of $1,400, low-income Medicare beneficiaries would be spending only $556.40 annually.

According to an even more recent study by officials at the CMS, low-income Medicare beneficiaries "could save 29.4–77.0 percent on prescription drug purchases over a 7-month period, depending upon geographic area and mix of drugs." The seven-month period would start on June 1, 2004, when the new program begins, and would end on December 31, 2004.[11]

Independent analyses are confirming the significance of Medicare beneficiary savings. For example, a preliminary release of a study by the Lewin Group, commissioned by the Healthcare Leadership Council, reflects that researchers found average savings of 20 percent.[12] Some examples from the preliminary estimates for seniors in Illinois show major savings on medications used to treat common diseases. For example, an Illinois senior who suffered from diabetes and hypertension and qualified for the $600 subsidy could realize savings of 35 percent. That same senior with congestive heart failure and hypertension could realize savings of 62 percent. (See Table 1.)

While some seniors will undoubtedly spend more and many much less, the vast majority of low-income seniors without drug coverage will see significant savings from the new drug discount card program. Any unused portion of the $600 low-income subsidy will be rolled over to 2005, thus increasing potential savings in 2005.

**2. The program holds enormous promise for broad public–private partnership in assisting seniors.**

Major drug companies like Astra Zeneca, Eli Lilly and Company, Merck, Novartis, Pfizer, and Wyeth have already announced their intention to offer their products either at no charge or for a very small fee once low-income seniors spend their $600 subsidy.[13] A little-known fact is that most pharmaceutical companies already offer deep discounts on their products, up to and including free drugs, to low-income seniors who need them.[14]

Beyond direct financial assistance, the new drug card program could also serve as a forum for consumer organizations, senior citizens' organizations, disease-related groups, and religious and faith-based groups to monitor, evaluate, and rate competing drug discount card programs not only on

9. 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, at *http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.198v1.pdf*.

10. *Ibid.*

11. Centers for Medicare and Medicaid Services, *Medicare-Approved Drug Discount Cards Provide Additional Savings to Low-Income Medicare Beneficiaries*, White Paper, May 19, 2004, at *www.cms.hhs.gov/medicarereform/drugcard/reports/lowincomestudy5-19-04.pdf*.

12. "New Study on Discount Cards Shows Average Savings Will Top 20 Percent; Seniors With Chronic Conditions Will Save Hundreds of Dollars on Drug Regimens," Healthcare Leadership Council press release, May 13, 2004, at *www.hlc.org/html/may132004pr.html*.

13. Centers for Medicare and Medicaid Services, *Medicare-Approved Drug Discount Cards Provide Additional Savings to Low-Income Medicare Beneficiaries*.

14. For more information on this option, seniors should talk to their physicians or contact the manufacturers of their prescription drugs directly.

Table 1 B 1766

## Savings for Low-Income Beneficiaries Eligible for $600 Credit, by Disease

| | | Brand / Generic | Annual Cost Without Discount | Savings with Card ($) | Savings with Card and Credit ($) | Savings with Card (%) | Savings with Card and Credit (%) |
|---|---|---|---|---|---|---|---|
| **Diabetes Combination Therapy I** | | | 3,099.23 | 753.59 | 1,353.59 | 24% | 44% |
| Drug A | Sulfonylurea | G | | | | | |
| Drug B | Biguanides | B | | | | | |
| Drug C | Insulin Sensitizers | B | | | | | |
| **Diabetes Combination Therapy II** | | | 2,209.48 | 468.53 | 1,068.53 | 21% | 48% |
| Drug D | Biguanides | G | | | | | |
| Drug E | Sulfonylurea | B | | | | | |
| Drug F | Insulin Sensitizers | B | | | | | |
| **Diabetes with Hyperlipidemia I** | | | 3,846.63 | 825.87 | 1,425.87 | 21% | 37% |
| Drug B | Biguanides | B | | | | | |
| Drug C | Insulin Sensitizers | B | | | | | |
| Drug G | HMG-CoA Reductase Inhibitor | B | | | | | |
| **Diabetes with Hyperlipidemia II** | | | 3,430.75 | 696.55 | 1,296.55 | 20% | 38% |
| Drug E | Sulfonylurea | B | | | | | |
| Drug F | Insulin Sensitizers | B | | | | | |
| Drug H | HMG-CoA Reductase Inhibitor | B | | | | | |
| **Diabetes and Hypertension** | | | 2,646.56 | 332.24 | 932.24 | 13% | 35% |
| Drug R | ACE Inhibitors | B | | | | | |
| Drug F | Insulin Sensitizers | B | | | | | |
| Drug G | HMG-CoA Reductase Inhibitor | B | | | | | |
| **Hypertension Combination Therapy** | | | 956.78 | 243.50 | 843.50 | 25% | 88% |
| Drug M | Calcium Blocker | B | | | | | |
| Drug N | ACE Inhibitors | G | | | | | |
| Drug O | Thiazides | G | | | | | |
| **Congestive Heart Failure, Hypertension** | | | 1,788.46 | 511.42 | 1,111.42 | 29% | 62% |
| Drug O | ACE Inhibitors | G | | | | | |
| Drug P | Alpha-Beta Blockers | B | | | | | |
| Drug Q | Diuretics | B | | | | | |
| **Known Coronary Artery Disease** | | | 2,637.83 | 505.91 | 1,105.91 | 19% | 42% |
| Drug T | Beta Blockers | B | | | | | |
| Drug R | ACE Inhibitors | B | | | | | |
| Drug U | HMG-CoA Reductase Inhibitor | B | | | | | |
| **History of Atrial Fibrillation** | | | 429.21 | 99.69 | 396.26 | 23% | 92% |
| Drug V | Inotropics | B | | | | | |
| Drug W | Anticoagulant | B | | | | | |
| **Osteoporosis, Osteoarthritis, and Chronic Allergies** | | | 3,001.98 | 509.82 | 1,109.82 | 17% | 37% |
| Drug I | Anti-Histamines | B | | | | | |
| Drug J | Cox-2 Inhibitors | B | | | | | |
| Drug K | Bone Density Reg, Other | B | | | | | |
| **Multiple Chronic Conditions** | | | 5,948.06 | 1107.14 | 1,707.14 | 19% | 29% |
| Drug X | Cox-2 Inhibitors | B | | | | | |
| Drug Y | Bone Density Reg, Other | B | | | | | |
| Drug Z | Proton Pump Inhibitors | B | | | | | |
| Drug AA | Leukotriene Agents | B | | | | | |
| Drug BB | Anti-depressants | B | | | | | |
| Drug CC | Beta Blockers | G | | | | | |

**Note:** Preliminary estimates based on savings in Illinois.

**Source:** Reprinted with the permission of The Lewin Group and the Healthcare Leadership Council.

price, but also on the quality and service of these plans in providing ease of access to prescription drugs. Already, a coalition of 68 organizations, many of which opposed the passage of the Medicare bill itself, are pushing for higher enrollment, aiming for 5.5 million low-income seniors as opposed to the 4.7 million that the CMS estimates will enroll.[15]

There is agreement among these groups that the MDDC can and will make a difference to enrollees and that their outreach will only increase enrollment, allowing more help to reach those in need. Randal L. Rutta, senior vice president of Easter Seals, a coalition member, has said that "We could not support the Medicare bill last fall, but we will certainly reach out to low-income beneficiaries to make sure they take advantage of the assistance now available."[16] According to Stephen R. McConnell, senior vice president of the Alzheimer's Association, another coalition member, "The best part of the new law is what it can do for low-income people. We intend to go out and get them enrolled."[17]

These and similar organizations can perform an immeasurable service, both by reaching and educating seniors in need and by playing a strong intermediary role in providing guidance and solid information for seniors and their families.

This provision of information on health plans to enrollees from a variety of trusted sources has been routine practice in the Federal Employees Health Benefits Program (FEHBP) for more than four decades. For federal retirees, for example, the National Association of Retired Federal Employees annually compares and rates health plans for federal retirees. There is no reason why a similar dynamic should not emerge in a robust drug discount card program.

**3. The program, if made permanent, could control Medicare drug costs.**

The CMS estimates that the MDDC will cost just $2.3 billion in 2004 and $2.8 billion in 2005.[18] These modest expenditures are in sharp contrast to the coming costs of the full-blown Medicare drug entitlement, which is scheduled to start in 2006.

While the entitlement is set to begin and the MDDC is set to end, the CMS estimates that the premium subsidy for the drug entitlement alone will cost $24 billion.[19] Add to that the estimated $5.5 billion in reinsurance costs that accompany the drug entitlement, the $3.9 billion in employer subsidies (an incentive to stop employers from dumping currently covered retirees[20]), and $16.4 billion for the low-income premium subsidy, and taxpayers will pay out $49.8 billion that first year. The government is expected to recoup an estimated $6.4 billion from the states, thus bringing the total expenditure for the drug entitlement to $43.7 billion for the first year alone.

This is, of course, only the beginning. Estimates for each of the above-listed categories rise every year thereafter and are expected to represent a net increase in federal expenditures of $114.3 billion in 2013.[21] Whether this estimate is accurate can be known only in the future; but

15. Robert Pear, "Coalition Promoting Drug Discount Cards," *The New York Times*, May 24, 2004.

16. *Ibid.*

17. *Ibid.*

18. *2004 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, Table IV.A1, p. 157, at *www.cms.hhs.gov/publications/trusteesreport/2004/tr.pdf*.

19. *Ibid.*

20. For more information, see Edmund F. Haislmaier, "How Congress's Medicare Drug Provisions Would Reduce Seniors' Existing Private Coverage," Heritage Foundation *Backgrounder* No. 1668, July 17, 2003, at *www.heritage.org/Research/HealthCare/bg1668.cfm*, and Derek Hunter, "More Taxpayer Subsidies Will Not Correct Congress's Medicare Miscalculation," Heritage Foundation *WebMemo* No. 357, October 27, 2003, at *www.heritage.org/Research/HealthCare/wm357.cfm*.

21. *2004 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, Table IV.A1, p. 157, at *www.cms.hhs.gov/publications/trusteesreport/2004/tr.pdf*.

if history is any guide, the cost will be significantly higher.[22]

In the second decade, when the baby boomers start retiring in huge numbers, the new drug entitlement costs (as so many analysts have continually warned Congress) will explode. The Medicare Trustees report that the Medicare drug entitlement will ensure that future generations are forced to pay for an additional $8.1 trillion of Medicare's already monstrous unfunded liability.

The money to pay for this unfunded liability—a technical term for the cost of promised future benefits over and above the revenue projected to pay for them—will almost certainly come from major future tax increases. In the near term, the growing pressures could well result in the repeal of President Bush's tax cuts.[23]

Permanent adoption of the new drug card as an alternative to the flawed entitlement program would help Congress to avoid this explosion in Medicare drug spending. Even if the low-income subsidy on the MDDC were doubled and/or expanded to subsidize those with incomes of up to 200 percent or 300 percent of the FPL, costs would be significantly lower than the cost of the planned Medicare drug entitlement that is scheduled to start in 2006.

Members of Congress should rethink killing the potentially successful and cost-effective drug discount card program and replacing it with the massive and hugely expensive drug entitlement.

**4. The program's transparency will mean lower prices through competition.**

For the first time, Medicare beneficiaries and the general public will have access to the prices of drugs from competing suppliers, either through the new database located at *www.medicare.gov* or by calling 1-800-MEDICARE. Although people shop throughout the economy for goods and services at various outlets based on prices, this is an option that generally has been lacking in health care. Now, with the new database as well as other Web-based drug price search engines such as *www.destinationrx.com*, consumers will be able to see where they can find the best prices for needed medications, thus introducing competition that has the real potential to drive down prices for everyone.

Even congressional critics of the program have inadvertently reinforced this simple point of basic economics. Representative Henry Waxman (D–CA) recently asked members of the minority staff of the House Committee on Government Oversight to look into how much of a discount, if any, seniors would see under the MDDC program. The original paper released by the minority staff, while critical of the new program, nonetheless helped to illustrate with precision what price transparency and real market competition can do to the price of drugs.

The initial results of the minority staff's examination, limited as they were, showed that seniors could get even better prices on some drugs from sellers outside the MDDC plan. Only two weeks later, drug prices from plans participating in the MDDC program dropped significantly. Markets are dynamic: Transparency and competition have begun to lower prices even before the new drug discount card program has gone into effect. (See Charts 1–3.)

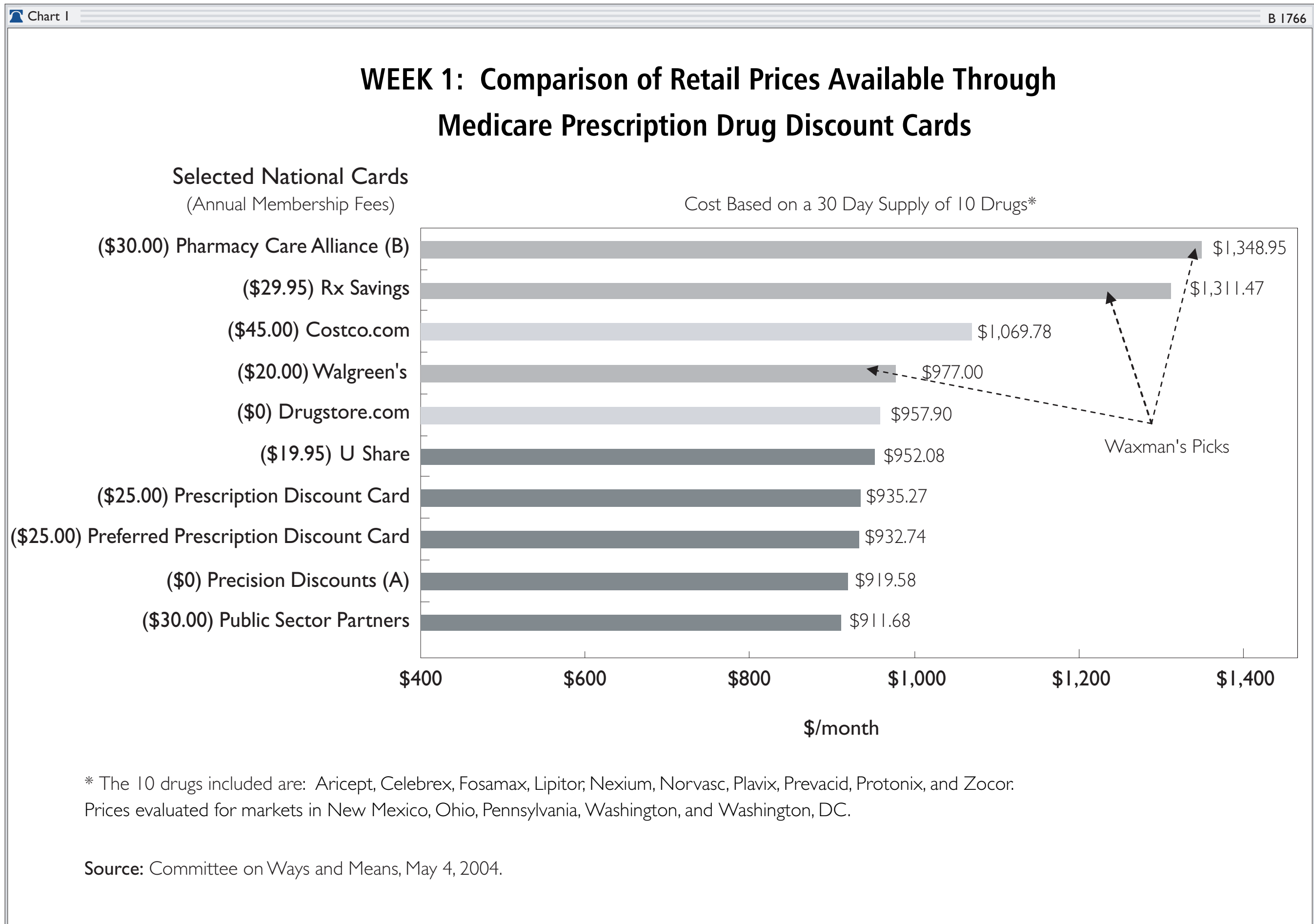
**5. The program expands seniors' personal freedom and control.**

This is true for all seniors; but it is especially true among lower-income seniors, who can roll over unspent funds from the subsidy. All enrolling low-income seniors who qualify for the $600 subsidy will get the full amount for the year even though the MDDC does not start until June 1, 2004. That will aid them greatly in the purchase of drugs for the rest of 2004.

However, any unspent amount can be rolled over and applied to 2005 along with another $600

22. See Derek Hunter, "The Sky's the Limit: Medicare's Upwardly Mobile Drug Cost Projections," Heritage Foundation *WebMemo* No. 326, August 12, 2003, at *www.heritage.org/Research/HealthCare/wm326.cfm*.

23. For more information, see Daniel J. Mitchell, "Medicare: A Ticking Time Bomb for Tax Increases," Heritage Foundation *WebMemo* No. 462, March 31, 2004, at *www.heritage.org/Research/HealthCare/wm462.cfm*.




subsidy for that year. Allowing the rollover of unspent funds gives seniors more freedom and, potentially, a significant amount of money to help them cover drug costs if they are healthy in 2004 and get sick in 2005.

## How to Make the Drug Discount Program Work Better

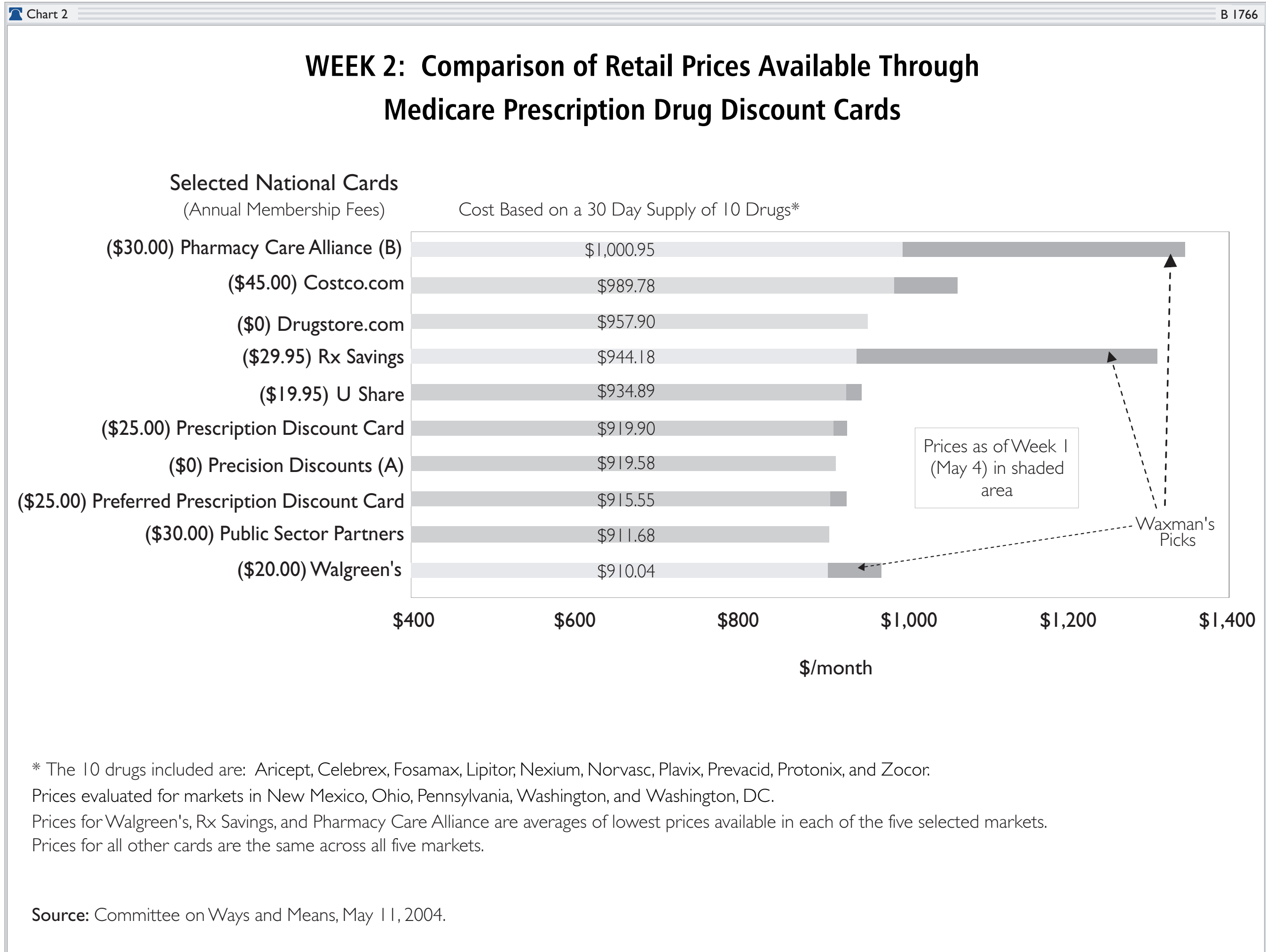
While the MDDC will provide significant savings to seniors without drug coverage, three specific improvements would increase choice and savings for enrollees as well as taxpayers.

**IMPROVEMENT #1: Congress can make the Medicare drug discount card program permanent.**

Even though the Department of Health and Human Services—particularly the staff at the CMS—is spending a great deal of time and effort to create a new infrastructure of drug price transparency, choice, and free-market competition, the program is designed by law to expire in 2006.

Congress should extend the life of the MDDC indefinitely. If market forces are allowed to take hold in the MDDC plan, competition will cause prices to fall and seniors will reap the benefits. Congress should not take away these valuable benefits and substitute what is certain to be a costly, bureaucratic, and unpopular drug entitlement that reduces the level and quality of drug coverage that many seniors now enjoy.

Extending the drug card will empower seniors to make their own choices as consumers of medicine, but replacing the entitlement with the drug card program will also free their children and grandchildren, present and future taxpayers, from the imposition of a huge portion of the




unfunded liability that Medicare has already incurred.

**IMPROVEMENT #2: The federal government can work with states to encourage coordination through state pharmaceutical assistance programs to further benefit seniors.**

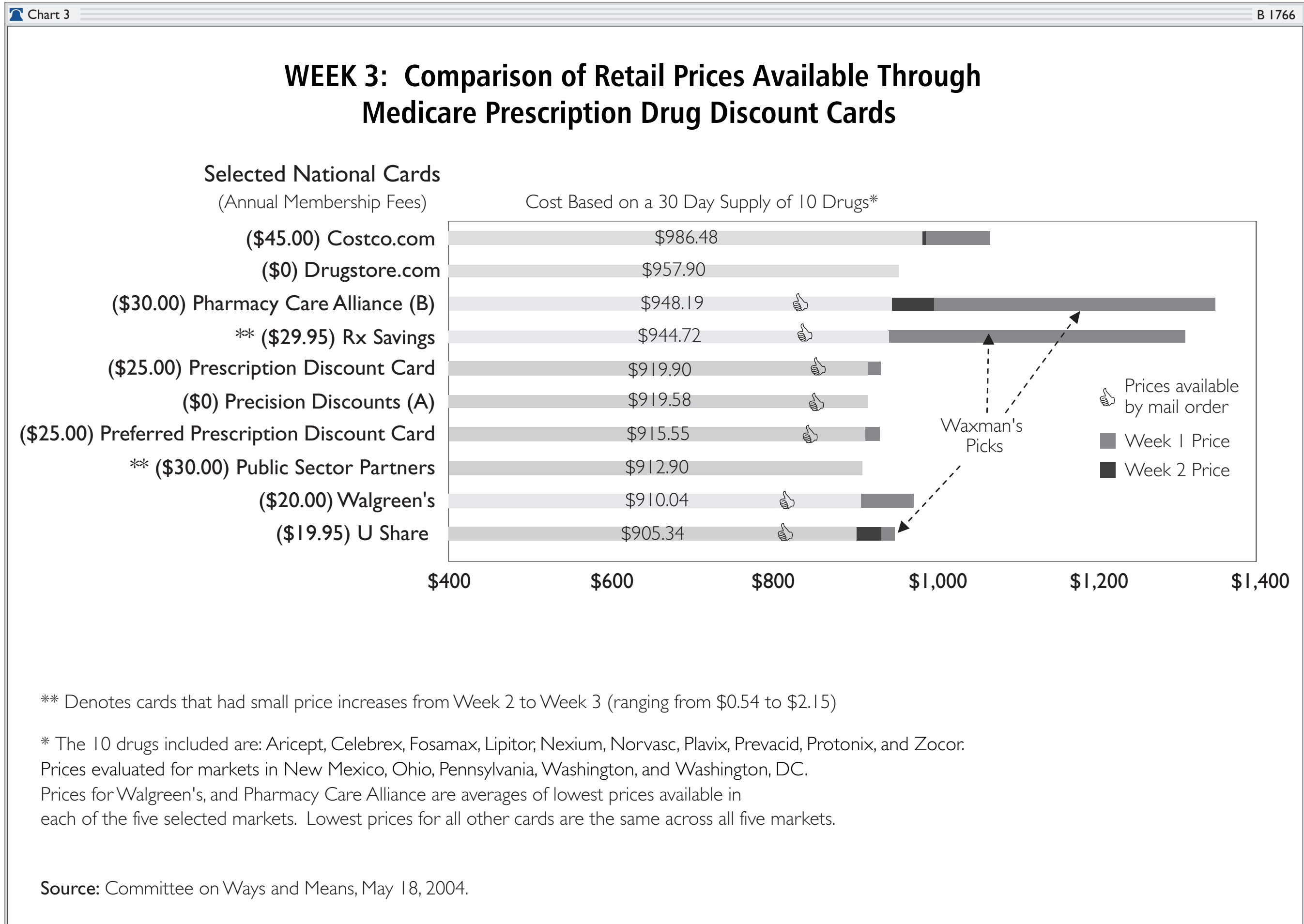
Indiana recently changed its HoosierRX Drug Card state pharmaceutical assistance program to complement the MDDC. Indiana's low-income seniors who qualify for the $600 annual subsidy will also receive $1,200 in additional benefits through HoosierRX through December 2005, essentially doubling the amount of the subsidy available to low-income seniors.[24]

The HoosierRX Drug Card used to cover 50 percent of qualifying seniors' drug costs, but starting June 1, 2004, the first day of the MDDC, that will change to 75 percent, up to a maximum of $1,200 over the next 19 months.[25] Seniors will have to spend their Medicare subsidy before they can start spending their HoosierRX money, but the average savings will nonetheless be significant.

If the federal government would encourage all states to follow suit, low-income seniors

24. Mike Smith, "State Makes Changes to Prescription Drug Program," Associated Press, May 7, 2004.

25. *Ibid.*




** Denotes cards that had small price increases from Week 2 to Week 3 (ranging from $0.54 to $2.15)

* The 10 drugs included are: Aricept, Celebrex, Fosamax, Lipitor, Nexium, Norvasc, Plavix, Prevacid, Protonix, and Zocor. Prices evaluated for markets in New Mexico, Ohio, Pennsylvania, Washington, and Washington, DC. Prices for Walgreen's, and Pharmacy Care Alliance are averages of lowest prices available in each of the five selected markets. Lowest prices for all other cards are the same across all five markets.

**Source:** Committee on Ways and Means, May 18, 2004.

would realize significant savings on out-of-pocket costs while taxpayers would see future tax burdens shrink.

**IMPROVEMENT #3: Congress can intensify free-market competition.**

The CMS approved 72 applications for participation in the MDDC, giving seniors a wide range of choices depending on their individual needs. As with any market, while one supplier may offer the lowest price for one or many drugs, it may not offer the lowest price on all the drugs a particular senior needs.

This is clearly the case with prescription drugs. *The Washington Post* reported recently that some commonly prescribed drugs were actually cheaper through alternative vendors such as *drugstore.com* and *Costco.com*, which do not offer the MDDC.[26] While the new government database will allow all seniors to see what their drugs will cost them through the plan of their choosing, those eligible for the annual $600 subsidy will be able to use that subsidy only if they purchase through that plan. Seniors will not be able to use the subsidy to offset drug costs if they find the drug at a cheaper price through another source.

While this subsidy restriction is not a major problem, it is likely to mean that the resulting drug price competition will be somewhat less robust than it otherwise would be in the absence of such a restriction. Drug card plans are barred from raising their prices arbitrarily without incur-

26. Bill Brubaker, "Web Still Helps the Medicine Go Down," *The Washington Post*, April 30, 2004, p. E1.

ring increases in their own costs, but they can still drop drugs from their lists as long as they maintain at least one drug in each class. Seniors, on the other hand, can change MDDC plans only once a year.

It should be noted that changing this policy does not imply that seniors should also be free either to enroll in more than one MDDC plan at the same time or to opt out of the MDDC system completely while still receiving the $600. Such changes in current law would undermine the basic MDDC program.

However, eligible seniors should be allowed to take their subsidy money to suppliers outside of the card system if they find a lower price for one of more of their prescriptions. Not only will this intensify the competitive pressures on drug card plans to seek the lowest prices for all drugs, but it will also permit low-income seniors to make the most of their subsidy dollars. The principle is simple: Money should follow the beneficiaries.

If seniors found a prescription they needed from an alternate vendor for $10 less per month than the price offered through their chosen MDDC plan, making the cost $40 per month instead of $50, low-income seniors would still be more likely to purchase the prescription through their MDDC plan because doing so would entail a lower out-of-pocket cost. Although it is natural to want to spend less of one's own money, over a year a low-income senior will have forfeited $120 that otherwise could have been used to purchase needed prescriptions because the low-income subsidy is tied exclusively to the senior's choice of MDDC.

## Conclusion

The Medicare Discount Drug Card program holds great promise, both for seniors and for taxpayers generally. It introduces transparency to drug prices while also empowering consumers with the freedom to choose those options that are best for them. The facts already show that the new experiment in a competitive market can significantly reduce the price of drugs. These personal savings are not, as some Members of Congress claim, "paltry" or "minimal."

Meanwhile, federal officials can work with the states to increase assistance to seniors who need the most help and to encourage robust private-sector participation, not only in the provision of assistance, but also in the provision of information on and evaluations of competing drug plans. There is an enormous supportive role in the program for consumer organizations, seniors' organizations, and religious and faith- based organizations.

Congress should not take this program away from seniors in 2006; rather, it should make it permanent and build on it for the future. Congress also could make a few adjustments in the program to increase its market efficiency and ensure its success.

If done properly, the changes in the MDDC would eliminate the need for the full-blown Medicare drug entitlement that is set to take effect in 2006. An effective and expanded Medicare drug discount card program would lessen the fiscal strain on Medicare and reduce the burden of present and future taxpayers, who are scheduled to pay trillions of dollars just for the drug entitlement.

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