House of Cards: New Medicare Drug Cards Built on Rickety Assumptions

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Hold on to your hats! The new Medicare-approved Drug Discount Cards that are scheduled to become available in June 2004 will not only entitle Medicare beneficiaries to lower drug prices but will also send the drug industry on a wild ride over the next 18 months.

I don’t like being a cynic, but if you read the rules of this program, whether you are a cynic or a formulary manager, the first thing you will want to do is go out and buy a crash helmet and strap it on tight. The card program is fraught with potential pitfalls.

When the Bush administration originally proposed a drug card program two years ago, the intent was that the cards would guarantee senior citizens a discount of 25% or so on their medications. When Congress passed the Medicare reform bill last year, it specified a card program with some rules that the Bush folks hadn’t requested. So when Tom Scully, the former head of Medicare, issued a press release in December 2003 announcing the interim final rules for the card program, he said that annual discounts per enrollee would be 10% to 15%. For that benefit, the beneficiaries would pay $30 a year and would be able to obtain access to a limited number of drugs whose prices might or might not be discounted and whose prices would be able, legally, to change from week to week. Whoopee!

None of the program’s rules require a card sponsor to do anything more than offer one discounted drug in any of 209 therapeutic categories and one generic product in 55% of those categories. Furthermore, there is no minimum cost reduction from the manufacturer’s price for that one “discounted” drug. Thus, if Pfizer sells Lipitor® (atorvastatin calcium) to a card sponsor for a “discounted” price of $300 for a 90-day supply of 80-mg tablets, a discount of $100, the card sponsor can pass along $1 or $100 of that discount to the beneficiary. It is up to the sponsor.

In the main, the Centers for Medicare & Medicaid Services (CMS) expects competition among manufacturers, who want to sell drugs, and among card sponsors, who want to attract customers, to result in deep discounts. These discounts would be passed along to senior citizens with just minor erosion for administrative costs. That is the theory, according to the way in which pharmacy benefit managers (PBMs) have worked in the past.

In addition, card sponsors would be able to have various formularies for different groups of people. For example, one formulary might be for enrollees receiving “transitional assistance” (i.e., payments of $600 a year) and another formulary might cover higher-income enrollees. Again, each formulary must have at least one discounted drug in each of 209 categories, and that drug might differ from formulary to formulary within the same card family.

The level of discount might also differ among formularies, and these variations would undoubtedly result in lower prices for beneficiaries who are eligible for the transitional assistance formularies. This means that a couple earning less than $16,362 a year could be charged $50 for 90 days of 80-mg Lipitor® and that a couple earning $20,000 could be charged $500 for the same 90 tablets—with the same Drug Discount Card.

As for drug costs, card sponsors would be able to change the prices once a week; the changes would be posted on a Medicare Web site and would also be available through an 800 telephone number.

As an example, a Medicare beneficiary decides to compare the cards in his or her geographical area, picking one based on the prices for the four or five drugs customarily used. Two weeks later, the prices may have changed, and the inter-card comparison of two weeks ago might now be worthless. Unfortunately, the beneficiary cannot switch to another card until November 15.

Peter Ashkenaz, a Medicare spokesman, says that the agency will be policing price changes very carefully and that card rules prevent a card sponsor from increasing a drug’s price more than an amount proportionate to the change in the drug’s average wholesale price (AWP), and/or an amount proportionate to the changes in the endorsed sponsor’s cost structure, including material changes to any discounts, rebates, or other price concessions the endorsed sponsor receives from a pharmaceutical manufacturer or pharmacy.

I am confident that Medicare’s intentions are good; however, it will be impossible for the agency to do the weekly math to fulfill its policing promise. For that task, Medicare would need approximately 1,000 accountants.

There is a real danger that Medicare drug cards are being oversold. The Pharmaceutical Care Management Association (PCMA) greeted the CMS’s interim final rule by saying that the cards “set the stage for seniors to reap substantial savings on the cost of prescription drugs.” The CMS itself admits that the annual savings per beneficiary would be in the range of 10% to 15%—if the card program works as CMS and Congress hope it will.

To an outside observer, a 10% discount, if we are lucky, seems to be “much ado about nothing.” The pity is that the cards will not be covering over-the-counter drugs, because the complexity of the new program is likely to stimulate more aspirin consumption.