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Before the
Health Subcommittee
Committee on Ways and Means

On

Medicare Drug Discount Card Program

April 1, 2004

Summary: Consumers Union Testimony on Discount Drug Cards

Consumers of all ages are in dire need of relief from the high cost of prescription drugs. The discount drug card program that is about to begin may offer modest relief to some low-income Medicare beneficiaries, but Congress needs to do much more to provide meaningful discounts for Medicare beneficiaries and relief for non-beneficiaries as well. Ten of Consumers Union's concerns about the program are outlined below.

1. Seniors and the disabled will be confused about how to choose – and whether to choose – a discount drug card.
2. One of the lessons from the ***medigap*** market in the 1970's and 1980's is that complicated choices in the health insurance marketplace can result in fraudulent schemes that victimize a vulnerable population.
3. Congress must provide resources and make a commitment to help consumers sort out the confusion. The need for this is demonstrated by the fact that even the federal government is providing "guidance" that could lead to some beneficiaries enrolling in programs that do not offer the most savings for them.
4. The Centers for Medicare and Medicaid Services (CMS) must be vigilant in curbing marketplace behavior that complicates the market and creates financial burdens for beneficiaries who choose the "wrong" discount drug card.
5. The CMS should aggressively ***expand*** the role of generics in the marketplace, and police against discount drug cards that steer beneficiaries toward brand name drugs.
6. The CMS should compare the discounts available from all discount drug cards with a standard drug-pricing basis such as the federal supply schedule to help consumers compare cards.
7. The CMS and Congress should pay particular attention to the use of formularies (drug lists) by the discount drug cards.
8. The CMS and Congress should apply additional lessons (e.g., the reliance on evidence-based, scientific findings; changing coverage, changing prices; harm due to consumer lock-in) to refine and improve the Medicare prescription drug benefit scheduled to begin in 2006.
9. The government should aggressively reach out to all those eligible for the $600 subsidy to assure that all who are eligible receive the subsidy, when that's the best deal for them.
10. In light of the fact that high prescription drug prices are denying millions of Americans access to needed prescription drugs and contributing significantly to the high cost of health insurance, Congress should take steps to lower prescription drug prices for all, including those not eligible for Medicare.

Introduction

American consumers are desperate for relief from the high prices they are charged for prescription drugs. Consumers Union[1] is not optimistic that the new discount drug card program enacted as part of the Medicare Modernization Act will provide the level of relief needed. Indeed, it seems like a missed opportunity. We are concerned that Medicare beneficiaries will be confused by the new program and will be at risk of being victimized by companies who will seek to take advantage of their confusion. Even some of the government's efforts to educate consumers could deepen the level of confusion. We urge Congress to take further steps to achieve meaningful relief for all consumers, to police against market practices that could harm consumers, and to study and apply lessons from the discount drug program to the Medicare prescription drug program that begins in 2006.

The potential for savings from the discount drug program are limited. CMS estimates that only 19% of Medicare beneficiaries will enroll, and about two thirds of enrollees will do so largely to get the $600 subsidy.

We believe that the challenge of making prescription drugs affordable for all consumers deserves immediate focus by Congress. The costs of failing to do so are high. Recently, there were reports in the press that 23 million Americans do not take statins to lower their cholesterol level – even though they are recommended for them – because they cannot afford them. These press reports came about in the light of new research that shows the high effectiveness (in terms of reduced heart attacks and mortality) of using cholesterol reducing medicines. If just five percent of those unable to afford statins suffer negative health consequences (and I believe this figure is an underestimate), then more than one million consumers in this country will be the victims of our failed health care policies. Because these are "statistical" health consequences and deaths – and not discrete events – they have not captured the attention of policymakers and the public. But we urge you to consider the reality that medicines that are unaffordable do mean dire consequences for those who cannot take them. This crisis demands your attention.

In our testimony below, we explore ten key areas of concern regarding the discount drug care program.

1. Seniors and the disabled will be confused about how to choose – and whether to choose – a discount drug card.

We don't need elaborate surveys about discount drug cards when we are able to poll our mothers and senior friends to quickly discover that there is already a high degree of confusion and anxiety about choices that they will soon face regarding discount drug cards. Should I get a discount drug card? Which one is best for me? Will I still be able to use other discount drug cards? Will the prices change? Will the drugs that I need continue

to be covered? What if I want to change to a different card? These are not easily answered questions, especially in light of the possibility that prices and drugs on the list could change as often as once a week, but beneficiaries will be locked into the card that they select. A further complication is uncertainty about how the discount drug cards will work with existing state discount programs and existing prescription drug company subsidy programs.

It is important to remember the characteristics of the population that will be eligible for a discount drug card. These are not federal employees who are used to annual open enrollment decisions, with assistance from human resources staffs and Washington Checkbook. Instead, they are people 65 and over, and younger adults with disabilities. The Kaiser Family Foundation estimates that 36 percent of Medicare enrollees need assistance with at least one activity of daily living. An estimated 23 percent have cognitive impairments. The challenges of sorting out the best discount drug card for those who are cognitively impaired, for those who may have difficulty reading fine print, may be overwhelming. Yet the importance of making the right choice could be of great importance to them.

We have questions about whether the modest anticipated discounts (especially compared with other options that Congress has rejected) justify this program which will be confusing for beneficiaries and will require a huge resource commitment by senior health insurance counselors in order to help beneficiaries make a decision that will provide very short-term benefits for them.

2. One of the lessons from the *medigap* market in the 1970's and 1980's is that complicated choices in the health insurance marketplace can result in fraudulent schemes that victimize a vulnerable population.

As you know, the CMS has expressed concern about recent illegal activities. Individuals are incorrectly indicating that they are offering government-approved discount drug cards. Apparently, scam artists have made telephone calls and went door-to-door in Alabama, Georgia, Idaho, Nebraska, Oklahoma, New York, Rhode Island, and Virginia, peddling phony discount drug cards while indicating they were from the government.[2] They tried to obtain personal information.

Recently, according to SCAMS -- Senior Counselors Against Medicare Swindlers -- the California Medicare Patrol Project, the consumer complaint Web site, http://ripoffreport.com/ reported having received 700 e-mails complaining about a website called pharmacycards.com that claimed to offer 80 percent drug discounts, listing an address in British Columbia. This company was withdrawing cash from checking accounts from people who had never even heard of the site. While this scandal may be unrelated to the discount drug card issue before you today, it is a reminder that the lure of

deep drug discounts, the increasing use of the Internet, and the potential to tap into seniors' checking accounts, can combine to set the stage for possible abuses in the future.

Members of this committee may remember similar problems that arose in the Medicare supplement insurance (medigap) market in the 1970's and 1980's, prior to the landmark reforms of OBRA 1990. Insurance agents preyed on the fears of vulnerable seniors (and sometimes represented that they were affiliated with the Medicare program) and this often resulted in abuses such as selling one person multiple duplicative policies. When seniors – many of whom have visual or cognitive impairments – are confused and overwhelmed with the choices that they face, this opens the door to predators in the marketplace who are out to make a quick buck at the expense of the vulnerable victim. It is important the CMS aggressively police against this type of preying on the nation's seniors and disabled.

3. Congress must provide resources and make a commitment to help consumers sort out the confusion. The need for this is demonstrated by the fact that even the federal government is providing "guidance" that could lead to some beneficiaries enrolling in programs that do not offer the most savings for them.

Will CMS educational materials be part of the solution or part of the problem? Recent materials offered as part of the CMS educational campaign raise serious concerns. On January 8, 2004, CMS released a document called: "Better Benefits – More Choices: Good News about the Medicare Prescription Drug, Improvement and Modernization Act of 2003!"[3] The sheet explains how the Medicare Endorsed Prescription Drug Discount Card will help those who need it most. The final bullet provides this example:

> Beneficiary A needs to fill a prescription for Celebrex. In 2002, an estimated retail price for 30 tablets of Celebrex (200 mg) was $86.28. For a low-income senior, the Act could mean a savings of nearly $22 a month off the retail price and this could be covered by the $600 in assistance. This example is based on a 20% discount off the retail price.

Unfortunately, there are several problems with this advice:

- The government is making no attempt to help people compare the Medicare card savings against other discount options like the Pfizer Share card, for which anyone eligible for the low-income assistance would qualify. In effect, by encouraging beneficiaries to sign up for the discount drug card coverage (instead of other discount programs), the government is benefiting drug companies (who will have lower costs for their subsidy programs) at the expense of taxpayers (who will be bearing the cost of the $600 subsidy).

- In addition, by failing to provide information about lower cost drug alternatives, the government is missing an opportunity to encourage consumers to consider lower-cost non-brand options. The state of Oregon recently conducted an in-depth evidence-based drug review for non-steroidal anti-inflammatory drugs (NSAIDSs) for arthritis and pain. The review concluded that "all of the medicines listed [list includes Ibuprofen, Celebrex, and Vioxx] are **equally effective** in treating arthritis.[4] The monthly cost of Celebrex was estimated (by AARP) to be $104, while the monthly cost of Ibuprofen (generic) $19.[5] We believe that CMS should help consumers identify lower cost alternatives that are equally effective.

4. The CMS must be vigilant in curbing marketplace behavior that complicates the market and creates financial burdens for beneficiaries who choose the "wrong" discount drug card. CMS must guard against "bait and switch" or other market manipulation.

As you know, companies that offer discount drug cards will be allowed to change both the prices they charge for various medications and the list of drugs that are offered as often as once a week. At the same time, consumers are locked into the card that they select, and are allowed to switch cards only once (during a short period at the end of 2004). This raises the troubling possibility that a diligent consumer will carefully complete worksheets comparing their savings from various discount drug cards, will commit to one card because it offers discounts on the drugs that he/she needs, and then will find that the company offering the card drops the drugs the individual needs from their list of covered drugs. Some have raised the prospects of large-scale "bait and switch" operations. Any consumer who loses discounts on the drug that they need is likely to be justifiably upset about this program. It is essential that CMS monitor the price changes and the drug lists carefully and take appropriate steps. If price changes are large and frequent, or if the drug list drops drugs frequently, then CMS should consider revoking the approval for a card (while protecting existing enrollees). In addition, this is the type of practice that should disqualify a company from serving as a prescription drug plan when the Medicare drug benefit begins in 2006.

5. The CMS should aggressively ***expand*** the role of generics in the marketplace, and police against discount drug cards that steer beneficiaries toward brand name drugs.

We have questions about whether the discount drug card program will adequately encourage the use of generics instead of high-priced brand name drugs. CMS has established 209 drug categories. Generics must be offered in 55 percent of these categories (which, according to CMS, represents 95 percent of the drugs for which generics are available).[6] This means that there will be only brand-name drugs available in

94 categories. We are concerned that the large number of drug categories may unnecessarily limit the inclusion of generic drugs. The Academy of Managed Care Pharmacy argues that fewer categories would have allowed larger discounts; similarly, fewer categories may have allowed for greater reliance on generics.[7]

We are concerned about the potential for drug manufacturers to manipulate the discounts that they offer in these categories to ensure a place on the sponsors' formularies, possibly through large discounts on these brand name drugs. The end result could be patients locked into brand-name drug therapy. We urge the CMS to carefully monitor whether the program in fact steers enrollees to brand name drugs when generics (possibly in other related categories) would be appropriate. We note that manufacturers have supported the CMS approach, while pharmacy benefit managers (PBMs) and pharmacies have opposed it,. We would hope that the Medicare website would automatically include comparative pricing information (possibly at reputable websites) for generic drugs *whenever* they are available, even if they are not available through the discount drug card offered.

6. The CMS should compare the discounts available from all discount drug cards with a standard drug-pricing basis such as the federal supply schedule to help consumers compare cards.

One troubling reality of the new discount drug care program is the failure of Congress and CMS to establish base reference prices against which the discounts are measured. Families USA has pointed out that "there are also no rules that prevent base prices from increasing substantially quickly."[8] Between January 2002 and January 2003, prices for the top 50 drugs increased at a rate of almost three-and-one-half times the rate of inflation, according to Families USA.[9] Not only should CMS establish a base price for comparison purposes, but it would be helpful if CMS also provided information about how the discount card prices compare with other prices. Beneficiaries who are a short bus trip away from Canada may well be interested in Canadian prices. People who are not eligible for federal programs (such as Medicaid and veterans' benefits) would not be able to benefit from the same low prices for prescription drugs in these programs. Still, they would be interested to know how their prices compare with the prices available to federal purchasers (i.e., the federal supply schedule), and to the VA to cover veterans' drugs (though of course veterans pay modest cost-sharing for this deeply discounted price). These programs can demonstrate to the public the benefits of negotiating for deep discounts and using bulk purchasing power saving money for consumers and taxpayers.

7. The CMS and Congress should pay particular attention to the use of formularies (drug lists) by the discount drug card companies.

Formularies are basically lists of prescription drugs, in this case, for which the discount drug card company will negotiate a discount on behalf of enrollees. (Formularies in the eventual Medicare prescription drug benefit have more far-reaching impact since they determine whether the drug is covered by the enrollee's insurance coverage, and whether any out-of-pocket costs count toward reaching the catastrophic benefit.) One of Consumers Union's concerns about the ultimate implementation of the Medicare Modernization Act of 2003 in the year 2006 is the model that relies on participation by hundreds of insurance companies and health plans in providing the benefit, and their use, in turn, of possibly hundreds of formularies that determine which drugs are covered for enrollees. The intent of the legislation is that these formularies be evidence-based. It is unclear to us, given that that all formularies are meant to be constructed based on objective scientific evidence, why there should be scores or hundreds of alternative formularies. In 2006, this will mean that a Medicare beneficiary on one street could have in effect different drug coverage than a beneficiary on the next street. More formularies do not necessarily result in more choice for beneficiaries, who remain at the mercy of decisions of the prescription plans to enter the market in their region. It is unclear what the benefits for consumers are of scores of different formularies/drug lists by each discount drug card. Whether formularies, as determined by the companies offering discount drug cards, serve the best interests of consumers should be monitored carefully throughout this program.

8. The CMS and Congress should apply additional lessons from the discount drug program (e.g., the reliance on evidence-based, scientific findings; changing coverage, changing prices; harm due to consumer lock-in) to refine and improve the Medicare prescription drug benefit that begins in 2006.

Throughout this program that will last approximately one-and-one-half years, there will be issues that may have implications for the drug benefit that begins in 2006. We urge Congress – and CMS – to carefully consider the implications of this program for the future drug benefit. In addition to the use of formularies, Congress should consider whether additional limits should be placed on changes in formularies; prices charged; implications of consumers being locked-in to the plan they choose; the adequacy of choices available in different regions; the affordability of the coverage, and many other elements. This learning period will also be important for the discount drug card companies, many of which are participating with the intent of gaining experience (and market share) that will benefit them when the 2006 benefit begins.

9. The government should aggressively reach out to all those eligible for the $600 subsidy to assure that all who are eligible receive the subsidy, when that's the best deal for them.

Low- and moderate-income Medicare beneficiaries need all the help that they can get to make prescription drugs affordable. It is important that CMS take aggressive steps to be sure that these seniors and disabled enroll in the program that is best for them, while minimizing costs to the taxpayer. (As noted above, shifting costs from pharmaceutical company programs to the taxpayers, without extra relief for beneficiaries, is not a good idea). We would hope that the government would minimize the enrollment hoops demanded of beneficiaries, as these restrict access to the programs. For example, we urge Congress to encourage CMS to automatically enroll all current Medicare Savings Program beneficiaries (QMB, SLMB, and QI-1 individuals) in the transitional assistance and special transitional assistance programs without requiring a separate enrollment process.

10. In light of the fact that high prescription drug prices are denying millions of Americans access to needed prescription drugs, Congress should take steps to lower prescription drug prices for all, including those not eligible for Medicare.

In enacting the Medicare Modernization Act of 2003, Congress rejected other pricing models that have successfully saved money for consumers and taxpayers. A 1998 CBO study found that federal facilities paid 58 percent of the average invoice price paid by retail pharmacies for 100 brand-name drugs in 1994, compared with 91 percent for hospitals and 82 percent for HMOs.[10] In other words, federal facility prices were 29 percent lower than HMO prices, a substantial savings. More recently, through the use of an evidence-based formulary and volume discounts, the Department of Veterans Affairs is able to achieve discounts well below the federal supply schedule prices, which are already among the lowest prices in the market.[11]

Another high priority for prompt Congressional attention (and the topic of an FDA task force) is the issue of legalization of reimportation of prescription drugs from other countries. Consumers Union believes that in light of the urgent need for relief from high prices and the reality of reimporation that is underway, Congress has a responsibility to help ensure the quality and safety of these medications in order to protect those consumers who are reimporting drugs. The lower prices from reimported drugs make the difference between many consumers being able to get needed medications and going without. The use of licensed brokers, with strict quality controls, as currently done successfully within Europe, is one model that should be carefully considered. Congress and the Food and Drug Administration should move forward expeditiously to make safe and fairly priced drugs available to U.S. consumers.

At the same time, it is important that the Congress recognize its responsibility in using market forces where possible to provide better value to taxpayers and consumers for prescription drug values. Oregon has done pioneering work that studies the scientific evidence about clinical effectiveness as a basis for the selection of drugs in its Medicaid

program. The Medicare Modernization Act of 2003 includes a provision in section 1013 that calls for further synthesis of medical evidence about the comparative clinical effectiveness of alternative prescription drugs by the Agency for Healthcare Research and Quality. This important provision should be funded promptly and implemented soon to provide consumers and government programs with the scientific basis, and analysis, to make sound decisions based on evidence, reducing the impact of decisions that are based on an incomplete picture that is often presented in direct-to-consumer advertising.

Conclusion

The challenge of assuring that Medicare beneficiaries (and all Americans) have access to affordable prescription drugs is daunting. The discount drug card program that will soon go into effect may offer beneficiaries modest relief (especially for those eligible for the $600 subsidy). However, the program is fraught with potential problems: beneficiaries will be confused and bad actors will try to take advantage of their confusion. The Congress and the Administration should guard against marketplace manipulation, encourage the use of generics, provide a standard basis for evaluating the discounts offered, monitor the use of formularies, and aggressively pursue other steps to help all Americans have access to affordable, safe medicines.

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[1]Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide consumers with information, education and counsel about goods, services, health, and personal finance. Consumers Union's income is solely derived from the sale of *Consumer Reports*, its other publications and from noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, *Consumer Reports,* with approximately 4.5 million paid circulation, regularly carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions that affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

[2] *Phony Medicare drug cards*, Consumer Reports, May 2004.

[3] http://www.cms.hhs.gov/medicarereform/issueoftheday/01082004iotd.pdf

[4] Oregon Health Resources Commission. The review notes that "patients with recent history of bleeding ulcers should avoid using aspirin, NSAIDS **or** COX-2 inhibitors, and that "compared to other NSAIDS, Vioxx and Celebrex may be *less* likely to cause bleeding ulcers in seniors." *See:* http://www.oregonrx.org/OrgrxPDF/One%20Page%20Summaries/OHPR%20factsheet%20NSAIDs1.pdf

[5] http://www.aarp.org/or/rx/Articles/a2003-10-02-or-rx-arthritustable.html

[6] p. 69853, Federal Register notice, Medicare Program; Medicare Prescription Drug Discount Card, 42 CFR Part 403, CMS-4063-IFC. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

[7] "Drug Makers Split with PBMs, Insurers Over Coverage of Drug Card, " InsideHealthPolicy.com, February 4, 2004.

[8] The New Medicare Prescription Drug Discount Card: A Very Flawed Program, at wwwfamiliesusa.org

[9] Dee Mahan, *Out of Bounds: Rising Prescription Drug Prices for Seniors*, Families USA, 2003.

[10] p. 25, *How Increased Competition From Generic Drugs has Affected Prices and Returns in the Pharmaceutical Industry,* Congressional Budget Office, July 1998. *See also:* P. 155-156, and footnote 17, Huskamp, et.al., "The Impact of a National Prescription Drug Formulary on Prices, Market Share, and Spending: Lessons for Medicare?" *Health Affairs*, Vol. 22, No. 3., May/June 2003.

[11] Description and Analysis of the VA National Formulary, Institute of Medicine, 2000.