

**Summary of  
Testimony of Ronald F. Pollack, Executive Director, Families USA  
Before the House Energy and Commerce Health Subcommittee  
On Medicare Discount Cards**

Discount cards are much ado about very little: Only about one in six Medicare beneficiaries is likely to participate, and for 5/6ths, it is of no consequence. Extraordinary inflation in brand prescription drugs continues unabated and will rapidly erode any value of discount cards and of the post-2006 Medicare benefit. Families USA will soon be releasing an update of its 2003 report, which showed that the prescriptions most-used by seniors increased at 3.4 times the general rate of inflation.

Discount cards are a weak substitute for what should have been done: Congress should have enabled Medicare to bargain for lower prices, similar to the VA, or as the Canadian government does. Data is attached comparing the price of the most-used prescriptions in Medicare discount cards in six of the Subcommittee's Congressional Districts with the price available in Canada or through the VA. Data is also provided showing that because the new law does so little to moderate drug prices, the Part D benefit 'doughnut hole' grows from \$2850 in 2006 to \$5066 by 2013, and a larger and larger percentage of seniors' income is consumed in prescription drug expenses.

The \$600 transitional assistance is important and useful, and we should do more to ensure maximum enrollment. This summer the Committee should consider and approve emergency legislation to presumptively enroll Medicare Savings Program enrollees in the transitional assistance program: it is the only way to quickly and efficiently reach these people.

Consumers should expect drug discount card benefits to erode because of continuing inflation. Consumers should beware of the inherent conflict of interest in many of the card sponsors, where the companies can make more money advocating expensive drugs over generic drugs. Consumers should wait on selecting a card until the accuracy and quality of the pricing data improves.

The new law is much too complex. Many seniors will be unable to navigate the system or make the best choice and many will despair of trying. Families USA made test calls last week to the 1-800-Medicare line. The 36 percent level of disconnects we experienced is unacceptable. Wait times are too long. When we got through, we found the staff to be friendly and competent, with an 86% accuracy rate on typical questions.

The chaos of the last several weeks should be a lesson to be avoided in the fall of 2005 when the real program begins. But there is a major decline in CMS's administrative budget three months before the permanent program begins. Congress must begin now to ensure the resources for the agency in the fall of 2005. More resources should be given to the State Health Insurance Assistance Programs (SHIPs), which provide efficient, low-cost, volunteer-centered help at the local level in settings seniors are most comfortable with.

Testimony  
of  
Ronald F. Pollack  
Executive Director  
Families USA

Before the  
Subcommittee on Health  
Committee on Energy and Commerce  
U.S. House of Representatives  
May 20, 2004

### Medicare Prescription Drug Discount Card

Mr. Chairman, Members of the Committee:

Thank you very much for this opportunity to testify on the Medicare prescription drug discount card program.

#### **Discount cards: Much Ado About Very Little**

The new drug discount card that goes into effect on June 1, 2004 is much ado about very little. This new card program, which the Department of Health and Human Services projects will enroll only 7.4 million Medicare beneficiaries – merely one out of every six people (18 percent) in the program – will be of no consequence for the vast majority of seniors. Those seniors will continue to face the brunt of ever-increasing prices that have risen at multiples of inflation for every year over the past decade.

Perhaps most important, this drug discount program is an extremely weak substitute for what should have been in the recent legislation – namely, enabling Medicare to bargain for lower prices with the drug companies, similar to what the

Veterans' Administration does for veterans. This alternative would have helped all seniors, not simply the one out of six that receive discount cards. Moreover, for the one out of six seniors who enroll in the discount card program, it would have provided considerably larger savings.

Before I describe in greater detail why this discount card program is much ado about very little, I do want to make clear that we support the transitional assistance program that provides \$600 per year for those under 135 percent of the federal poverty level. This benefit will be particularly useful, especially when it can be combined with state and pharmaceutical assistance programs, and we all must do all we can to help enroll eligible beneficiaries in this program.

Having said that, we feel that beneficiaries should be warned to approach the program with low expectations, so that they are not disappointed.

--We do not know how much discount card prices may increase in coming months, but as Families USA's research work has repeatedly shown, brand name drug prices consistently inflate at approximately three or more times the underlying rate of inflation. Last year, we found that the cost of the 50 drugs most used by seniors increased at 3.4 times the rate of inflation in 2002. We will be releasing a new report on the rate of inflation of the most popular brand name drugs used by seniors soon. Thus a discount card may provide some much-needed relief, but the relief erodes—rapidly—as drug prices keep rising much faster than inflation.

--Many of the companies involved in these discount cards have an inherent conflict of interest: they are likely to make more money by encouraging the use of

more expensive prescriptions and keeping a portion of the larger absolute dollar discounts and rebates they receive from manufacturers of those more expensive drugs. The just-announced Federal Court Order settlement with Merck-Medco is an example of the kind of anti-consumer practice “bait and switch” that needs to be guarded against if consumers are to obtain true savings.

--The information available on the Medicare website may not be accurate and should be double-checked. At least one major news report notes major discrepancies between what’s reported on the Internet and what local drugstores are actually willing to do (see Washington Post story cited below).

### **A missed opportunity**

In looking at the discount card prices, one is continually reminded of the missed opportunity: If the United States had the type of cost containment that other nations had, or if the purchasing power of the Department of Veterans Affairs had been used, huge savings could have been obtained, not only in discount cards, but for Medicare and Medicaid. These savings would have allowed Congress to provide a comprehensive benefit that would truly excite Medicare beneficiaries and that would have helped the states deal with their Medicaid budget crises.

In attachment #1, we have listed the high and low Medicare-endorsed discount card prices of the 8 most common prescription drugs used by Medicare beneficiaries. We then listed the VA price and the Canadian Ontario government prices for those same drugs in late April. We have picked six comparison zip codes corresponding to the three most senior Majority and Minority Members of this Subcommittee.

The data make it clear that the drug discount cards are a pale benefit compared to Medicare bargaining or re-importation of drugs from Canada. It shows savings are possible. And it shows those savings pale compared to the prices available when a government uses truly effective purchasing power.

**Need to do more to control drug prices for sake of Medicare and taxpayers**

The failure of the new law to obtain any meaningful drug cost containment is a disaster for beneficiaries, Medicare, and taxpayers. Using the CBO’s own data, because of drug inflation, the amount beneficiaries will pay will change as follows:

Benefit	2006, when program starts	2013, at end of CBO budget window
Estimated premium	\$420	\$696
Deductible	\$250	\$445
Initial coverage limit where beneficiary pays 25% between deductible and start of ‘donut’	\$2,250	\$4,000
Donut	\$2,850	\$5,066
Catastrophic threshold starts when your out-of-pocket expense equals	\$3600	\$6,400

Families USA believes that a ‘donut’ of \$5,066 is ridiculous. Beneficiary disappointment at a \$2,850 gap in coverage will turn to anger at the thought of a yearly \$5,066 gap.

If these inflation changes coincided with changes in income, it would not be as much of a problem. But drug inflation far exceeds seniors’ income gains. Again using CBO numbers and Census estimates, the following is what a typical senior at median income and average drug use will experience between 2006 and 2013:

	2006 (est.)	2013 (est)
Average drug expense	\$3,167	\$5,425
What you would pay with those drug expenses (+ premium)	\$2,087	\$3,455

Income	\$23,708	\$28,181
<b>Percent of your income spent on drugs and premiums</b>	8.8%	12.3%

Because of the failure to obtain true cost containment, despite the expenditure of \$400 or \$534 billion over ten years, beneficiaries will still see more and more of their income consumed in drug expenses.

The recent 2004 Medicare Trustees' report makes the point even more starkly: the addition of the prescription drug benefit means that the combined premium/copay/deductible burden of Medicare Part B in 2010 rises from 16.6% of Social Security<sup>1</sup> income before the addition of Part D to 36% of income after Part D is added. Obviously the new drug benefit saves beneficiaries significant amounts, but the Trustees' report example shows how burdensome the gaps in the new program will be to those who live only on Social Security.

The failure to obtain cost containment is a major reason, of course, that the next Congress is likely to see the new law's 45% trigger reached<sup>2</sup>, and that your Subcommittee will be faced with making major changes in the program just two years from now. Many of those changes could hurt beneficiaries.

**The new law is too complex: that's what we are hearing from all over the Nation from beneficiaries**

The new law, including the new discount card program, is much too complicated. That's what we are hearing from seniors all over the nation. If there were a single negotiated price, like the VA obtains, that would be simple, understandable, and popular.

---

<sup>1</sup>Note, this is Social Security income only. The previous paragraph referred to median total income, thus the different percentages.

<sup>2</sup> MMA, Sections 801-804

We would like to include for the Record a piece from the Washington Post of May 18, 2004 entitled, “Pick a Card! #?#!” by Lisa Barrett Mann, a younger person who describes spending nine hours trying to help her 82-year-old mother get the best card. It is an excellent description, with perhaps one error: the writer says that “changes aren’t allowed until open season at the end of the year.” Actually, according to CMS, changes can occur at any time, both in price and the specific drug covered. Ms. Mann’s article makes a good recommendation at the end:

“We’ll wait a few weeks. There’s no deadline for enrolling and, as far as I can tell, the savings aren’t going to be so great (if there are any at all) that deferring the decision could cost Mom much....So I’ll give Mom’s pharmacy time to sort out which programs it participates in and then get a list from Medicare.

“In the meantime, maybe Medicare will clear up some of the Web site glitches. Maybe the discount card programs will work out their customer service and database issues and update some of those 1997 prices. Maybe the PBMs will let the pharmacies know which programs they are working with. Maybe Medicare will spring for a few more phone operators [note: they did!] and cut back on the TV commercials....

“I figure that, in a few months, helping Mom pick a discount card will be easy. It should take about an hour.”

Waiting until the data becomes more available and accurate is good advice, but for millions of seniors without help, it will still take much more than an hour. Most seniors are not internet comfortable. And most of all, we need to remember that about 20 percent of Medicare beneficiaries, about 9 million people, have some form of cognitive or mental illness. For these people, it is not a joy to shop among 40+ different plans—it is a nightmare—a task so daunting many will not even try.

**The \$600 benefit is important for low income individuals, but many won’t get it because of confusion: Beneficiaries in Medicare Savings Program should be presumptively enrolled.**

Not only is the program confusing, when you add it to existing state programs of assistance, it becomes even more baffling. In an event in Illinois, a member of Families USA staff started to recommend the \$600 card to lower-income seniors, but was corrected by local experts, who noted that such people should be advised to join the much better Illinois program. We note recent press reports that the Speaker of the House of Representatives, in an Illinois town meeting event attended by the Medicare Administrator, made the same “join Medicare discount” recommendation without mentioning the better Illinois program, but unfortunately was not corrected. I cite this just to indicate how terribly complicated the new program is, especially when it interfaces with local programs.

Historically, it has been very difficult to reach out to lower-income individuals and enroll them in key means-tested programs of assistance. Despite nearly 15 years of work enrolling Medicare beneficiaries in the Medicare Savings Programs (MSP),<sup>3</sup> only about half the eligibles have enrolled. Add the complexity of the new, temporary 19-month discount card program, and Families USA is very concerned that CMS will be unable to achieve its goal of enrolling 4.7 million out of a total of 7.2 million eligible low-income beneficiaries.

We hope we are wrong, and that the full 4.7 million and more are enrolled—but Congress should demand to know what the enrollment figures are early in June. If the enrollment levels are below CMS’s predictions, it is not too late to act. Individuals who are enrolled in the MSP programs could be presumptively enrolled in the discount card

---

<sup>3</sup> QMB, SLMB, and QI-1, which pay Part B premiums and, in the case of QMB, deductibles and copays.

program.<sup>4</sup> Senators Bingaman and Lincoln have just introduced legislation (S. 2413) that would provide for such a presumptive enrollment program, and we urge you to consider such legislation. It is certainly the type of legislation that could be passed on the suspension calendar—and probably the consent calendar. Enrolling these individuals would free up a tremendous amount of time and energy for outreach to other eligible individuals.

### **The 1-800-Medicare number: call 911**

The 1-800-Medicare number was overwhelmed in its first two weeks. It is certain to get better, but the initial experience has been a real turn-off—or one could say, disconnect. The Washington Post reporter cited above tried to get through seven times on one day and never did. Families USA decided to try a few calls last week to judge the accuracy of responses to some fairly simple test questions. We had better luck. On 70 calls, we were “only” disconnected 36 percent of the time, sometimes on purpose and with the warning ‘call back later,’ and other times abruptly and without warning. On another 9 percent of calls, we were told to punch various numbers on the phone, and found that after a circuitous route, we were eventually re-directed to call 1-800-MEDICARE! There was no way to get to a human. When we did get through—the longest we were on hold was 17 minutes—I am pleased to report that the answers were 86 percent accurate, and the staff courteous, helpful, and willing to ‘walk the second mile.’

---

<sup>4</sup> The \$600 benefit is not available to those in TRICARE, FEHBP, or who have other health insurance with any outpatient prescription drug coverage (except a M+C plan or a Medigap policy), but those under 135% of poverty are very, very unlikely to be eligible for or enrolled in such programs, and this provision should be presumed met.

There are clearly mechanical problems with the 1-800 number and some of its routing codes. They need to be fixed, ASAP. Unannounced disconnects are infuriating, and must be stopped.

Most importantly, CMS needs to learn from this experience and be better prepared for the fall of 2005, when the entire Medicare population will be trying to make sense of the new choices. Call volume is likely to be much higher than it is this May. The choices will, frankly, be much more important for people to understand. We need to do a better job. Disconnects at the 36 percent level are not acceptable.

Congress needs to make sure that CMS has the resources to meet this future, larger tsunami of calls. The new law provided an extra \$1 billion for CMS in FY 2004 and 2005 for administrative start-up costs. This is money available outside the regular appropriations process. But that extra money runs out on September 30, 2005, 46 days before the new Part D enrollment period begins and three months before the new law starts. The following chart shows the very difficult budget situation facing CMS. The chart shows total administrative spending. As you can see, there is an increase of funding pre-FY 2006 largely due to the extra \$1 billion, but then there is a dramatic reduction of half a billion dollars in FY 2006—before the new law starts! This is a train wreck coming! It will make this May’s telephone and counseling situation seem efficient.

**CMS ADMINISTRATIVE BUDGET ONLY, DRAWN FROM 2004  
TRUSTEES REPORT  
(numbers in billions of dollars)**

Fiscal Year	HI	SMI	Rx D	Total
2002	2.5	1.8	N/A	4.3
2003	2.5	2.4	N/A	4.9
2004	2.8	3.0	0.3	6.1
2005	2.8	3.1	0.8	6.7
<b>2006</b>	<b>2.8</b>	<b>2.7</b>	<b>0.7</b>	<b>6.2</b>

2007	2.8	2.8	0.8	6.4
2008	2.8	2.9	0.8	6.5
2009	2.9	3.0	0.8	6.7
2010	2.9	3.1	0.9	6.9

*Source: From 2004 Medicare Trustees' Report, prepared by Families USA*

To avoid another rocky 1-800-Medicare start-up to the permanent program, Congress needs to ask tough questions about the resources available to CMS and prevent the huge fall-off in resources on October 1, 2005.

### **More Resources Needed for State Health Insurance Assistance Programs (SHIPs)**

We also urge Congress to provide more money for the State Health Insurance Assistance Programs (SHIPs), the largely volunteer-run, state-based counseling services offered in each of the states. These programs provide one-on-one counseling to seniors and specialize in small meetings in local neighborhoods to help Medicare beneficiaries navigate the insurance system. Polling of seniors shows that they like the type of one-on-one, face-to-face assistance provided by SHIPs. The Internet and 1-800 numbers are not as useful. Providing more money for SHIP computers, training and recruitment would be one of the most effective ways to ensure a smoother launch of the permanent Medicare drug program.

Prices on 8 drugs commonly used by seniors, 30 day supply

Zip Code: **33618 Tampa, Florida**

Drug	Quantity	VA	Canada	CMS -endorsed retail discount card low price	CMS-endorsed retail discount card high price
Liptor	10 mg	\$ 41	\$35	<b>\$65</b>	<b>\$72</b>
Plavix	75 mg	\$100	\$53	<b>\$113</b>	<b>\$123</b>
Fosamax	70 mg, 4 tabs/month	\$ 43	\$28	<b>\$57 ~ \$64*</b>	\$71
Norvasc	5 mg	\$ 25	\$28	\$42	\$48
Celebrex	200 mg	\$ 63	\$28	<b>\$77 ~ \$84</b>	<b>\$88 ~ \$178<sup>5</sup></b>
Zocor	20 mg	\$ 69	\$49	<b>\$101 ~ \$105</b>	\$129
Prevacid	30 mg	\$ 71	\$44	<b>\$111 ~ \$114</b>	<b>\$131</b>
Protonix	40 mg	\$ 27	\$42	<b>\$86 ~ \$89</b>	<b>\$104</b>
Price for all 8, in one card (i.e., the CMS column does not add cumulatively)		\$439	\$307	<b>\$657 ~ \$691</b>	<b>\$765</b>

\*\*Where a range of prices are listed, it means that the price available using that low (or high) cost discount card varies by the amount of that range among different pharmacies within the zip code. So one can pick a 'low' card, but one will still need to be careful which drugstore one uses.

Prices on 8 drugs commonly used by seniors, 30 day supply

Zip Code **75087, Rockwall, Texas**

Drug	Quantity	VA	Canada	CMS -endorsed retail discount card low price	CMS-endorsed retail discount card high price
Liptor	10 mg	\$ 41	\$35	\$ 65	\$ 72
Plavix	75 mg	\$100	\$53	\$106	\$124
Fosamax	70 mg, 4 tabs/month	\$ 43	\$28	\$ 61	\$ 71

<sup>5</sup> These \$178 high numbers, listed for two cards, may be an error. It is hard to imagine that much difference between drugstores that have an agreement with the same card company.

Norvasc	5 mg	\$ 25	\$28	\$ 43	\$ 48
Celebrex	200 mg	\$ 63	\$28	\$ 78	\$ 88
Zocor	20 mg	\$ 69	\$49	\$101	\$129
Prevacid	30 mg	\$ 71	\$44	\$112	\$131
Protonix	40 mg	\$ 27	\$42	\$ 87	\$104
Price for all 8, in one card (i.e., the CMS column does not add cumulatively)		\$439	\$307	\$671	\$765

Prices on 8 drugs commonly used by seniors, 30 day supply

Zip Code **49007, Kalamazoo, Michigan**

Drug	Quantity	VA	Canada	CMS -endorsed retail discount card low price	CMS-endorsed retail discount card high price
Liptor	10 mg	\$ 41	\$35	\$ 65	\$ 65
Plavix	75 mg	\$100	\$53	\$113-\$114*	\$128
Fosamax	70 mg, 4 tabs/month	\$ 43	\$28	\$57-\$64	\$ 74
Norvasc	5 mg	\$ 25	\$28	\$43-\$44	\$ 49
Celebrex	200 mg	\$ 63	\$28	\$77-\$84	\$89
Zocor	20 mg	\$ 69	\$49	\$101-\$105	\$134
Prevacid	30 mg	\$ 71	\$44	\$111-\$114	\$136
Protonix	40 mg	\$ 27	\$42	\$86-\$89	\$108
Price for all 8, in one card (i.e., the CMS column does not add cumulatively)		\$439	\$307	\$657-\$691	\$792

\*Where a range of prices are listed, it means that the price available using that low (or high) cost discount card varies by the amount of that range among different pharmacies within the zip code. So one can pick a 'low' card, but one will still need to be careful which drugstore one uses.

Prices on 8 drugs commonly used by seniors, 30 day supply

Zip Code **44052, Lorain, Ohio**

Drug	Quantity	VA	Canada	CMS -endorsed retail discount card low price	CMS-endorsed retail discount card high price
Liptor	10 mg	\$ 41	\$35	\$ 65	\$ 72
Plavix	75 mg	\$100	\$53	\$113	\$123
Fosamax	70 mg, 4 tabs/month	\$ 43	\$28	\$ 57-\$64*	\$ 71
Norvasc	5 mg	\$ 25	\$28	\$ 43	\$ 48
Celebrex	200 mg	\$ 63	\$28	\$ 77-\$84	\$ 93
Zocor	20 mg	\$ 69	\$49	\$101-\$105	\$129
Prevacid	30 mg	\$ 71	\$44	\$111-\$114	\$145
Protonix	40 mg	\$ 27	\$42	\$ 86-\$89	\$104
Price for all 8, in one card (i.e., the CMS column does not add cumulatively)		\$439	\$307	\$657-\$691	\$765

\*Where a range of prices are listed, it means that the price available using that low (or high) cost discount card varies by the amount of that range among different pharmacies within the zip code. So one can pick a 'low' card, but one will still need to be careful which drugstore one uses.

Prices on 8 drugs commonly used by seniors, 30 day supply

Zip Code: **90048 Los Angeles, California**

Drug	Quantity	VA	Canada	CMS -endorsed retail discount card low price	CMS-endorsed retail discount card high price
Liptor	10 mg	\$ 41	\$35	\$65	\$72
Plavix	75 mg	\$100	\$53	\$106	\$123

Fosamax	70 mg, 4 tabs/month	\$ 43	\$28	\$61	\$71
Norvasc	5 mg	\$ 25	\$28	\$43	\$48
Celebrex	200 mg	\$ 63	\$28	\$78	\$88
Zocor	20 mg	\$ 69	\$49	\$101	\$129
Prevacid	30 mg	\$ 71	\$44	\$112	\$131
Protonix	40 mg	\$ 27	\$42	\$86	\$104.33
Price for all 8, in one card (i.e., the CMS column does not add cumulatively)		\$439	\$307	\$667 ~ \$679*	\$765

\*Where a range of prices are listed, it means that the price available using that low (or high) cost discount card varies by the amount of that range among different pharmacies within the zip code. So one can pick a 'low' card, but one will still need to be careful which drugstore one uses.

### Prices on 8 drugs commonly used by seniors, 30 day supply

#### Zip Code 11241 Brooklyn, New York

Drug	Quantity	VA	Canada	CMS -endorsed retail discount card low price	CMS-endorsed retail discount card high price
Liptor	10 mg	\$ 41	\$35	\$ 65	\$ 74
Plavix	75 mg	\$100	\$53	\$113	\$127
Fosamax	70 mg, 4 tabs/month	\$ 43	\$28	\$ 63	\$ 74
Norvasc	5 mg	\$ 25	\$28	\$43	\$ 49
Celebrex	200 mg	\$ 63	\$28	\$78	\$89
Zocor	20 mg	\$ 69	\$49	\$102	\$134
Prevacid	30 mg	\$ 71	\$44	\$112	\$136
Protonix	40 mg	\$ 27	\$42	\$ 87	\$108
Price for all 8, in one card (i.e., the CMS column does not add cumulatively)		\$439	\$307	\$671-\$674	\$790

\*Where a range of prices are listed, it means that the price available using that low (or high) cost discount card varies by the amount of that range among different pharmacies within the zip code. So one can pick a 'low' card, but one will still need to be careful which drugstore one uses.