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The Use of Exclusive Drug Discount Cards in Medicare Advantage Plans

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ABSTRACT

The Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 created a temporary prescription drug discount card for most Medicare beneficiaries and a transitional assistance subsidy program to aid low-income beneficiaries in paying for pharmaceuticals until 2006, when the voluntary Medicare Part D prescription drug benefit goes into effect. While attention has been focused mostly on cards for Medicare beneficiaries in the traditional Medicare program who have no other source of coverage for pharmaceuticals, the program also authorizes exclusive cards that are offered by Medicare Advantage (MA) plans. These cards integrate with broader MA benefits, typically supplementing an existing prescription drug benefit. Enrollment in exclusive MA cards accounts for over half of those enrolled in the discount card program. This issue brief profiles the arrangements under which these exclusive cards are offered, the firms that offer them, areas in which they are offered, the way in which discount cards integrate with the existing drug benefit offered by many of the MA plans, and the potential lessons from this experience for the Part D benefit.

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INTRODUCTION

The Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 authorized the creation of a prescription drug benefit (Medicare Part D), beginning in 2006, through which beneficiaries will be able to voluntarily purchase drug coverage either from a free-standing prescription drug plan (PDP) or from a private health plan that integrates medical and drug benefits together. This second type of plan is termed a "Medicare Advantage" prescription drug plan (MA-PD). The category includes local managed care plans that already are available to Medicare beneficiaries and regional preferred provider plans that will become available in 2006.

To provide Medicare beneficiaries with assistance in meeting the high out-of-pocket costs for prescription drugs in the interim, the MMA created a temporary prescription drug discount card and transitional assistance program (Henry J. Kaiser Family Foundation, 2004). All Medicare beneficiaries (except those dually eligible for pharmacy benefits through state Medicaid programs) are eligible to enroll in the discount drug card program on a voluntary basis. The program runs from June 2004 through the end of 2005. Under the program, beneficiaries pay up to $30 per year to receive one of the Medicare-approved drug discount cards that are offered. The cards offer discounts for selected drugs when prescriptions are filled at an affiliated pharmacy or mail order supplier. Those with incomes below 135 percent of poverty who have no other drug coverage can receive up to $600 per year in "transitional assistance" to offset the remaining costs of prescriptions, and Medicare pays the enrollment fee for their cards.

Beneficiaries in the traditional Medicare program may obtain such coverage through 28 general card sponsors offering a total of 39 national and 33 regional general cards. In addition, there are specialized cards that are approved for those in unique circumstances, such as nursing home residents. Beneficiaries in Medicare Advantage, Medicare's program of private plans, most of which are now HMOs, also may enroll in drug cards, called exclusive drug cards, sponsored by their health plan. If an MA managed care organization chooses to offer an exclusive drug card, by law its MA enrollees only can enroll in that card.[1] The restriction was put in place to make it easier to coordinate any discounts available through the card with pharmacy benefits that MA plans might already provide.

The Centers for Medicare and Medicaid Services (CMS) originally estimated that 7.4 million of Medicare's 41 million beneficiaries (18 percent) would enroll in the card program by December 2005 (CMS press release, July 30, 2004). Since only 11 percent of Medicare's beneficiaries are in the Medicare Advantage program, this estimate assumed significant enrollment by beneficiaries in the traditional Medicare program. However, enrollment has been substantially below expectations, with only about 4 million enrolled in the card program by July 2004. Further, a disproportionate share of the enrollment—57 percent (or 2.3 million beneficiaries)—comes from those in Medicare Advantage plans, who were automatically enrolled in an exclusive card program.[2] The fact that these

[1] MA enrollees may enroll in a general card program if their MA plan does not offer an exclusive card.

[2] The Department of Health and Human Service's decision to auto-enroll low-income Medicare beneficiaries in randomly selected discount cards as of October 2004 likely will increase participation among Medicare beneficiaries in the traditional Medicare program (U.S. Department of Health and Human Services, press release, Sept. 22, 2004). However, this change will continue to mean that the great majority of enrollees in discount cards are there because their circumstances were such that they were automatically enrolled.

cards constitute so large a share of the discount cards' enrollment, together with the fact that the MMA envisions a potentially expanded role for MA in Medicare starting in 2006, has generated interest in better understanding how exclusive cards work, why they are offered, and what they provide.

This brief discusses the role of Medicare Advantage plans in the Medicare-approved drug discount card program. It first summarizes the requirements set forth in the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and by CMS, and how it applies to cards offered by Medicare Advantage plans that participate in the drug card program. It then reviews what share of Medicare Advantage plans have such cards and selected features of the way those cards operate. It next discusses some of the reasons why plans decided to offer or not offer the card. Finally, it considers what can be learned this experience about the future of the Medicare Advantage program and the private drug plans to be made available in 2006.

Methodology: This issue brief is based on analysis of publicly available data from the Centers for Medicare & Medicaid Services (CMS), including the Geographic Service Area files and the Medicare Compare database. Enrollment and participation numbers are based on June 2004 data. In addition, MPR interviewed a representative of CMS involved in oversight of the solicitation process to clarify the requirements in place and the processes used for approval of prescription drug cards offered by Medicare Advantage plans. We also reviewed reports of the card that appeared in trade publications and interviewed selected staff from a few major national firms with differing responses to the prescription drug card. The analysis reported here builds on knowledge gained about how private plans operate; this knowledge was developed in monitoring MA's predecessor, the Medicare+Choice program, since its inception (see Gold et al. 2004).

REQUIREMENTS FOR EXCLUSIVE CARDS AND THE APPLICATION PROCESS

The limited time between enactment of the temporary Medicare-approved drug discount card in December 2003 and its mandated effective date of June 2004 meant that the time frame for soliciting card sponsors and approving applications was very short. CMS issued its call for applications on December 16, 2003, with approved cards named on March 25, 2004 (CMS press release). Plans had less than one month to inform CMS of their intent to apply to become drug sponsors and approximately six weeks to put a full application package together. In our interviews, firms said that the speed with which they had to act, the high costs of implementing what would be a temporary program, and the fact that some already had made their negotiated discounts available to members were factors that discouraged their participation in the discount card program. But a desire to make the transitional assistance benefit available to their members in a form that integrated with their existing MA coverage encouraged participation, as discussed below. In addition, CMS worked closely with MA plans to address their concerns and make it as easy as possible for them to participate.

While exclusive drug cards are structured in the same way as general cards, the MMA gave CMS the authority to waive the general drug card sponsor requirements that duplicated or interfered with MA plans' standard systems for providing care under the MA program. While the requirements provide important beneficiary protections, they address areas that often already are regulated through

general MA or HMO licensure requirements. For example, many MA plans already offered a pharmacy benefit with approved formularies and procedures, so developing new ones, particularly for a limited program intended to last only about 18 months, would not be worth the effort. Further, because MA's existing policies already are subject to regulation, the additional gains in beneficiary protection through these requirements could be limited.

CMS dealt with the trade-offs associated with these issues by identifying six requirements they would automatically waive upon plan request, and allowed plans to propose and justify other waivers they believed necessary. Once these additional requests were handled, CMS shared the list of approved waivers with MA plans, allowing them to apply for such waivers if desired. Figure 1 lists the 10 additional waivers. Requests for waivers differed across plans depending on their operational circumstances. Information on how many plans requested and received each type of waiver is not available.

Exclusive cards differ from general cards in several obvious ways. First, because they are available only to plan members, exclusive cards are not listed on the Medicare website (www.medicare.gov) made available to the general public to support the selection of drug cards, which means that any arrangements in place for discounts likewise are not publicly reported. Second, because exclusive cards are offered as part of a broader package of coverage, sponsors of exclusive cards that offer access to their existing formulary do not have to meet the requirements general card sponsors face to cover at least one drug in at least 55 percent of a defined list of therapeutic categories. Third, exclusive card sponsors that have existing pharmacy networks can be exempted from drug card requirements used to assess the adequacy of geographic accessibility by the affiliated pharmacies. Fourth, enrolling in an MA card may not necessarily result in a beneficiary gaining a separate new card, as plans can petition to use their existing enrollment cards to verify eligibility.

The integration of transitional assistance for those enrolled in MA also differs. Beneficiaries enrolled in exclusive cards apply for transitional assistance in the same way other beneficiaries do—they submit an application to the health plan, which then submits it to CMS. CMS reviews the application and notifies the plan if the assistance is approved. The amounts of transitional assistance qualified beneficiaries receive is the same whether they are in general or exclusive cards; however, exclusive card sponsors have greater flexibility to wrap these funds around existing prescription drug benefits.[3] The funds may be used to offset a portion of the copays or coinsurance that is included in the MA plan's covered drug benefit. CMS requires that transitional assistance enrollees (in exclusive and general card programs) with incomes below 100 percent of the federal poverty line pay a minimum 5 percent coinsurance, and that those between 100 and 135 percent of the federal poverty line pay a minimum 10 percent coinsurance on all prescriptions they order through the discount card. Exclusive card sponsors also can apply these funds toward the cost of drugs either beyond the plan's benefit cap or that the plan's drug benefit does not cover (for instance, brand name drugs not covered by a plan that only covers generics).

[3] The MMA prohibits private plans (except MA plans) from offering transitional assistance to their enrollees if the plan already offers drug coverage. Cost plans are not considered MA plans; therefore, they are subject to this rule.

FIGURE 1

WAIVERS AND MODIFICATIONS FOR EXCLUSIVE CARD SPONSORS GRATNED BY CMS

Original List of Waivers and Modifications in the Solicitation for Applications for Medicare Managed Care Organizations:

Formulary. CMS will waive the requirement that card sponsors offer at least one drug in each therapeutic category and/or offer generic drugs in at least 55 percent of therapeutic categories if the sponsor offers drug card enrollees access to its existing formulary.

Manufacturer Rebates. CMS will waive the requirement that card sponsors obtain manufacturer rebates, discounts, or other price concessions.

Reporting. CMS will waive the requirements that card sponsors report customer service and grievance data to CMS. CMS will allow card sponsors to delete references to savings from manufacturers in reporting data.

Price Comparisons. CMS will waive the requirement that card sponsors display their negotiated prices on a price comparison web site.

Years of Experience. CMS will waive the requirement that card sponsors have at least three years of private sector experience in the U.S. in pharmacy benefit management.

Notice of Eligibility. CMS will allow card sponsors to notify beneficiaries of their drug card eligibility within seven days of the card sponsors' receipt of such information from CMS, compared to within five days for general card sponsors.

Waivers and Modifications Added after the Solicitation Was Published:

Distribution of Enrollment Materials. CMS will modify the timeframe for distribution of materials to new enrollees, allowing card sponsors to provide materials between 14 and 30 days after notification of eligibility from CMS, compared to within five days for general card sponsors.

Provider Directory. CMS will waive the requirement that card sponsors provide drug card enrollees with a directory of contracted network pharmacies.

Enrollment Dates. CMS will modify the requirement that card sponsors make enrollments in its drug card effective on the first day of the month immediately following the card sponsor's receipt of a complete enrollment application, allowing card sponsors to make enrollments effective according to the same schedule as that which governs enrollment in the card sponsor's Medicare managed care plan.

Member Identification Cards. CMS will waive the requirement that cards sponsors issue drug card enrollees an identification card in addition to a Medicare managed care plan identification card.

Member Handbook. CMS will modify the requirement that card sponsors provide each drug card enrollee with a member handbook, allowing card sponsors to provide this information as an addendum to their Medicare managed care plan member handbook.

Notice of Intent Deadline. CMS will waive the requirement that applicants submit a timely notice of intent to apply to become a card sponsor.

Distribution of Privacy Notice. CMS will allow card sponsors to comply with the requirement that the sponsor provide new enrollees with a Notice of Privacy Practices using an existing Notice for the sponsor's Medicare managed care plan, provided the existing Notice meets the requirements of the Privacy Rule in the MMA.

Group Enrollment. CMS affirms that if card sponsors choose to auto-enroll members, they must allow enrollees to opt out of the approved card upon request. The card sponsor must hold beneficiaries that opt out harmless for any enrollment fees. In addition, card sponsors must inform enrollees about the proper procedures for declining group enrollment.

Mandatory Use of Transitional Assistance (TA). CMS will waive the requirement that drug card enrollees be permitted to spend their TA at their discretion. Card sponsors may require their drug card enrollees who receive TA to apply such assistance to any copayments that are the enrollee's obligation under the sponsor's drug plan and to any covered drugs purchased using the card sponsor's drug card.

Eligibility/Enrollment Systems. CMS will waive the requirement that card sponsors demonstrate the capability to exchange data concerning beneficiary eligibility for enrollment in the card sponsors' drug card(s) and for TA.

Source: "Waivers and Modifications Granted by CMS Fact Sheet" from CMS.

Note: These waivers were granted on MA plan request; information on how many plans requested and received each type of waiver is not available.

AVAILABILITY OF DISCOUNT CARDS TO PLAN ENROLLEES

Forty-two MA plans offer an exclusive drug card to their enrollees, but they enroll 68 percent of all MA enrollees, meaning that exclusive cards are available to 3.2 million of the 4.7 million MA enrollees across the U.S. (see Table 1). All but four of the MA plans offering an exclusive card charge no additional enrollment fee with the card. Only a few plans charge an enrollment fee, but those that do typically set it at the maximum allowed ($30). Because the large Kaiser Permanente health plan in California is one of these plans, a higher share of enrollees is in fee-bearing cards than one would otherwise expect.

Under the MMA, all plans, regardless of whether they charged an enrollment fee, could automatically enroll plan members if they gave their members an opportunity to opt out of the program. The fact that most MA plans waived such a fee presumably reflects their perception that auto-enrollment was easier to implement if there was no associated charge for the card. That is, plans could avoid having to explain to individuals why they were charged for a card they did not necessarily elect to receive. Because plans could offset the enrollment fee with savings in delivering Medicare benefits (relative to the capitation rates), and because the amount of money involved was relatively small, MA plans presumably found the zero-fee card option an attractive one.

While data are not available on actual enrollment in the cards by plan, CMS reports that 2.3 million MA enrollees were automatically enrolled in exclusive cards as of May 31, 2004. Presumably, those automatically enrolled in MA cards included most of those in health plans offering a card without an enrollment fee (which we estimate to be a total of 2.4 million beneficiaries) and a smaller number of those from cards that charge a fee. CMS has released no data on the number of MA plan members who have enrolled in transitional assistance.

In addition to offering exclusive cards, MA plan sponsors also have the same option as other entities to sponsor a general card that is available to all beneficiaries. Fifty of the 181 MA plans offer or are affiliated with firms that offer a general card on a regional or national basis. Two-fifths of those offering a general card do so in addition to offering an exclusive card. Approximately 235,500 MA enrollees are in MA plans that have developed general cards in place of an exclusive card. These beneficiaries have the option to choose the general card their health plan is offering or any other general card that is available in their area.

Most (79 percent) of the 38 states that have one or more MA contracts have one that offers an exclusive drug card (see Appendix Table 1). The states with the highest MA enrollment (California, Florida, Pennsylvania, New York, and Arizona) are also the states with the most MA enrollees with access to exclusive cards through their health plans. The only other noticeable geographic feature is the low rate of card offerings in New Jersey. There are seven MA contracts in New Jersey, but only one offers an exclusive card to its members. As a result, just 0.1 percent (113 out of 84,000) of the MA enrollees in the state are in a plan offering a drug card. This may be partly explained by the fact that New Jersey has a disproportionate share of PPO demonstration plans (which are less likely to offer drug cards than other types of plans). However, the majority of the coordinated care plans (CCPs) do not offer exclusive cards either, suggesting that there are other state/market characteristics in play.

TABLE 1

AVAILABILITY OF DISCOUNT DRUG CARDS, UNITED STATES

	Number of MA Contracts	Percent of MA Contracts	Number of MA Enrollees	Percent of MA Enrollees
Total	181	100%	4,668,762	100%
Status of Drug Card				
No Exclusive Drug Card	105	58%	1,505,556	32%
Plan doesn't offer any card	75	41%	1,271,005	27%
Plan offers national card	24	13%	122,586	3%
Plan offers regional card	6	3%	111,965	2%
Exclusive Drug Card	76	42%	3,163,206	68%
Plan only offers exclusive card	56	31%	2,778,408	60%
Plan offers national card also	11	6%	217,910	4%
Plan offers regional card also	9	5%	166,888	4%
Exclusive Drug Card	76	42%	3,163,206	68%
No premium	72	40%	2,368,485	51%
With premium	4	2%	794,721	17%

Source: MPR analysis of CMS data.

Note: Data includes coordinated care plans and preferred provider organization demonstrations. Enrollment is as of June 2004.

MA CARD FEATURES IN RELATION TO MA BENEFITS FOR PRESCRIPTION DRUGS

MA plans with more extensive drug benefits are more likely to offer an exclusive card than other MA plans. Seventy percent of MA enrollees in plans that provide coverage for generic and brand name drugs have access to an exclusive drug card through their MA plan. By contrast, only 46 percent of enrollees in plans with no drug coverage, and 53 percent of enrollees with generic-only drug coverage, have access to an exclusive drug card (see Table 2). In plans that already offer a drug benefit, an exclusive card has the added advantage of allowing better coordination of MA benefits with discounts. Such advantages apply less readily when the plan's benefit covers only generics, because drug cards are required to cover brand as well as generic drugs.

A variety of factors undoubtedly contributed to plans' decisions to offer cards, including the perceived benefits to enrollees, the short and long-term advantages to the plan, and the administrative costs of jumpstarting a time-limited program. These costs probably were lower for MA plans that already offered an MA pharmacy benefit and were more familiar with the issues that could arise in providing such a benefit to Medicare beneficiaries. However, all plans are likely to have existing infrastructure to support discount cards even if they do not offer a drug benefit in their MA plan. MA plans are typically just one product line within a commercial managed care plan's range of products. Since pharmacy benefits are an inherent part of most commercial packages, the majority of health plans likely had the pharmacy networks, formularies and other features needed to offer a card.

TABLE 2

AVAILABILITY OF EXCLUSIVE DISCOUNT CARDS, BY EXISTING DRUG COVERAGE

	Number of MA Enrollees by Existing Drug Coverage				Percent of Enrollees by Existing Drug Coverage			
	All Plans	No Drug Benefit	Generic Only	Brand and Generic	All Plans	No Drug Benefit	Generic Only	Brand and Generic
Coordinated Care Plans								
Total	3,590,768	1,222,979	420,980	1,946,809	100	100	100	100
Exclusive card available from plan	2,172,329	571,972	223,166	1,377,191	60	47	53	71
No exclusive card available from plan	1,418,439	651,007	197,814	569,618	40	53	47	29
PPO Demonstration Plans								
Total	98,042	57,118	19,803	21,121	100	100	100	100
Exclusive drug card available from plan	11,787	4,430	3,071	4,286	12	8	16	20
No exclusive card available from plan	86,255	52,688	16,732	16,835	82	92	85	80

Source: MPR analysis of CMS data.

Note: Data includes coordinated care plans and preferred provider organization demonstration plans. Enrollment is as of June 2004. Information is not available on the number of individuals who have a card available and have enrolled; therefore this table provides data only on the availability of discount cards.

VARIATION IN EXCLUSIVE DRUG DISCOUNT CARD OFFERINGS BY MA PLAN TYPE

Coordinated care plans (CCPs), which account for most of the MA contracts in the market, are more likely to offer exclusive drug cards to their members than other types of plans (see Table 3).[4] The majority of CCPs are health maintenance organizations that manage care for their members; therefore, it may not be surprising that these plans offer exclusive cards in greater numbers than other, more loosely organized types of plans. CCPs also account for the lion's share of enrollment.

Table 3 shows that just 13 percent of cost plans offer their members an exclusive drug card. It is likely that this is due to the fact that the MMA excluded cost plans from offering the transitional assistance benefit to low-income enrollees if their plan already covered prescription drugs. The MMA only allowed MA health plans to offer transitional assistance to enrollees in plans with drug coverage, but because cost plans are not defined as an MA plan, they did not receive this allowance. Given that cost plans likely were unable to offer the transitional assistance in many cases, many of these health plans may have decided that the discount cards provided no substantive benefit to their members and therefore chose not to offer an exclusive card.

[4] We are including cost plans in this discussion even though the MMA does not define them as MA plans because these are still private plans that can participate as exclusive card sponsors in the Medicare-Approved Discount Drug Card and Transitional Assistance program.

TABLE 3

AVAILABILITY OF EXCLUSIVE DISCOUNT CARDS BY PLAN TYPE

	Number of Contracts	Number of Contracts Offering Prescription Drug Discount Card	Percent of Contracts Offering Prescription Drug Discount Card	Number of MA Enrollees	Number of Enrollees in Plan Offering Drug Card	Percent of MA Enrollees in Plan Offering a Drug Card
Total	218	82	38%	5,025,361	3,257,552	65%
Coordinated Care Plans	146	68	47%	4,570,720	3,151,419	69%
PPO Demonstration	35	8	23%	98,042	11,787	12%
Private Fee-For-Service	5	2	40%	32,080	11,140	35%
Cost Plans	32	4	13%	324,519	83,206	26%

Source: MPR analysis of CMS data.

Note: Enrollment and contract counts based on June 2004 data.

It is less clear why the PPO demonstration plans and the private fee-for-service plans were less likely than the traditional coordinated care plans to offer a discount drug card. The issue of being able to establish a pharmacy network probably was a problem for private fee-for-service plans that do not use networks for other types of providers. PPO demonstration plans typically have a higher premium associated with their benefit packages, and it has been suggested that these plans are more appealing to higher-income Medicare beneficiaries than the traditional coordinated care products. If that is the case, then these plans may have concluded that not enough of their enrollees would be eligible for the transitional assistance benefit to make the discount card a viable project. Additionally, if PPO demonstration contracts or private fee-for-service plans offer prescription drug coverage, it usually consists of generic coverage only (Gold, Achman, and Verdier, June 2003). Given that fact, the differences in offering a drug card by plan type are probably intertwined with the differences in drug coverage levels.

FIRM EXPERIENCE WITH OPERATION OF THE DRUG DISCOUNT CARDS

Managed care organizations that offered exclusive MA cards typically sent out mailings to their enrollees to inform them about the availability of drug cards. Despite these mailings, firms reported beneficiary confusion about how the discount card and transitional assistance programs work. For example, some enrollees, particularly those who already had access to negotiated discounts, were disappointed that they still had to pay something when they went to the pharmacy. Some MA enrollees tried to enroll in other firms' cards, even though they are precluded from doing so if their MA plan offered one. Plans say that enrollees have been confused about whether to fill out the transitional assistance form because they were unclear about either the eligibility requirements or about which of the forms their MA plans sent out applied to them. For instance, one plan that chose not to auto-enroll said that some MA enrollees who were not eligible for transitional assistance filled out the form applying for transitional assistance, while some who were eligible for the assistance sent in enrollment fees they were not required to pay.

Plans often base their arrangements for exclusive cards on the existing arrangements MA plans have in place for pharmacy benefits. These arrangements vary by plan, but typically involve some division of responsibility between what the plan handles and those functions for which the plan makes use of an outside contractor, typically a pharmacy benefits manager (PBM) (Draper, Gold, and Cook 2003). In some cases, plans modified these arrangements to deal with discount cards. For example, while a plan might have an established structure for providing drugs, it might need additional administrative support to handle enrollment if it was not automatic, or questions about transitional assistance. The cards also created new data requirements for card sponsors, such as tracking the administration of the transitional assistance benefit. When new arrangements are employed with existing partners or new partners are brought on board, health plans have to learn how to share data with new partners as well as with CMS.

In general, the firms we interviewed were pleased with the way in which CMS has handled the Medicare-approved drug card program. Health plans understood that CMS was given a large task with very short deadlines to meet. However, there have been a few glitches with card administration, including some problems with technology and waits for federal processing (*News and Strategies for Managed Medicare and Medicaid*, 2004b). For example, in one case, a plan's in-house pharmacies were listed on Medicare Compare as available to those selecting a particular general card. Plans said that CMS worked to correct such errors when they were pointed out. There also has been some friction over marketing materials, with the CMS contractor handling approvals requiring what plans viewed as overly extensive disclaimers on promotional materials and enrollment forms. For example, one interviewee noted, "For four lines of text in our marketing materials we need ten lines of disclaimers." The back-and-forth between CMS and card sponsors created delays in approval of marketing materials. While there were challenges, MA managed care organizations were in a better position to partner in the discount card program with CMS than other organizations in the general card program that had never worked with CMS before. MA organizations had worked with CMS in the past and understood their requirements and systems.

FIRM STRATEGIES

Most national firms that participate in the MA program offer exclusive cards to all or most of their members (see Table 4). Among the largest national firms, the only exceptions are two large national insurers whose enrollments in MA are low at this point: Cigna and Aetna. In Aetna's case, the firm decided to offer a general card rather than an exclusive card because they viewed the former as having more long run potential for pay off, given the associated costs and their currently small MA enrollment (Interview with Aetna staff, Sept. 2, 2004). Some smaller firms have chosen to stick with existing pharmacy benefit programs instead of offering a drug card because they feel these programs provide their members with an adequate level of prescription drug coverage and discounts (*Managed Care Week*, 2004).

Firm decisions to offer exclusive and/or general cards appear to be strategic with regard to the MA program. Firms are offering exclusive drug cards to retain current MA enrollees. As one staff person we interviewed noted, beneficiaries expect their plan to offer a card and so the plan is faced with a "perception issue." However, given the resources necessary to set up the program, health plans also decided to target their investment to some extent. For instance, Kaiser

TABLE 4

PARTICIPATION OF NATIONAL MCOS IN THE DRUG DISCOUNT CARD PROGRAM

National Managed Care Firms and Affiliations	Number of MA Contracts	Number of MA Contracts Offering Exclusive Drug Discount Cards	Number of MA Enrollees	Percent of Firm's Enrollees Offered[a] Drug Discount Card	Participation as a General Card Sponsor
Total	181	76	4,668,762	68%	NA
BCBS Affiliated Plans	20	9	824,244	62%	Offers 3 regional cards
Kaiser	5	1	763,836	82.%	None
PacifiCare	11	9	684,651	99%	None
Humana	6	6	319,489	100%	None
United HealthCare	27	11	244,330	89%	Offers 2 national cards
Health Net	6	6	167,947	100%	None
Aetna	8	0	96,166	0%	Offers national card
Cigna	1	0	36,398	0%	None
All Other MA Plans	97	34	1,531,701	42%	Offers 10 regional cards

Source: MPR analysis of CMS data.

Note: Based on enrollment and contract counts as of June 2004. Data include only coordinated care plans and PPO demonstration plans.

[a]Weighted by plan enrollment.

chose to offer the drug card only in its California contract, which accounts for most of the company's MA enrollment. Kaiser has a more established pharmacy network in California than in other areas of the country in which it operates. Additionally, most of the enrollees who would benefit from the transitional assistance were also located in California. Consequently, Kaiser decided to focus its efforts and resources in California rather than offering the card in all of its MA plans.

Other MA firms have decided to use the opportunity to offer general cards in addition to exclusive cards as a means to establish relationships with new segments of Medicare beneficiaries before the arrival of the full drug benefit, with the hope that those relationships can continue in 2006 and beyond. Both Aetna and United Healthcare offer general drug discount cards nationally, and a number of Blue Cross-Blue Shield and less affiliated local plans are offering regional cards. Firms are also participating in both the general and exclusive drug discount card program to give themselves an advantage for Medicare Part D. Firms want to let Medicare beneficiaries know that they are part of the pharmacy benefit market. In addition, they are keen to partner with CMS, both to show support for the MMA legislation and to smooth the way for participation in Medicare Part D. While firms hoped to gain a strategic advantage for Part D, some have found that participation in the drug discount card program has not been helpful, because the programs will ultimately be so different and require different infrastructure.

CONCLUSIONS

The majority of MA firms are participating in the Medicare-approved drug discount card program. Together, these firms account for more than half of drug card sponsors and more than half of drug card enrollment. The decision to offer a drug card, particularly an exclusive card, appears to be related to certain plan characteristics such as plan type, size and the presence or absence of other prescription drug benefits.

The main motivation for plans to offer such cards appears to be that their enrollees expect it and that the plans want to show support for the changes that will be forthcoming under the MMA. Plans also have tried to use the drug card experience to position themselves for 2006, though some say the changes in 2006 will be sufficiently different from the current situation with drug discount cards that their offering of such cards will provide little relevant experience for the future.

CMS appears to have worked closely with plans to help them to participate in the drug card program. Nonetheless, the tight time frame for implementation and the new administrative procedures created challenges for both CMS and plans to address. In addition, the complexity of the offerings created some confusion among enrollees. Presumably, all of these challenges will be tougher in 2006 when both new regional plan offerings and a new drug benefit become operational, and the stakes become higher for beneficiaries who are financially penalized for delaying enrollment in the drug benefit.

The experience with MA drug discount cards also may foreshadow elements of the future. The experience with discount cards suggests that getting large enrollments on a voluntary basis is likely to be particularly difficult when enrollees have to "opt in" rather than "opt out." Enrollment in any plan is likely to be heavily dependent upon whether beneficiaries believe that they are "getting something for their money." Under the drug discount card, enrollees who already had some drug benefits and who were not eligible for transitional assistance were said by some plans to be disappointed that the cards offered them little beyond the discounts already available to them, even though the card costs them nothing or very little. While the discount card is a limited program, experience with the card suggests that getting beneficiaries to enroll in the optional Medicare Part D drug benefit may be challenging.

APPENDIX 1

AVAILABILITY OF DISCOUNT CARDS BY GEOGRAPHIC AREA, BY STATE MA PENETRATION (HIGHEST TO LOWEST)

State	Number of MA Contracts	Number of MA Contracts with a Drug Card	Percent of MA Contracts with Exclusive Drug Card	Number of MA Contracts with $0 Enrollment Fee	Percent of MA Contracts with $0 Enrollment Fee	MA Penetration	Number of MA Enrollees in a Plan Offering a Drug Card	Percent of MA Enrollees in Plan Offering a Drug Card
RI	3	1	33.3%	1	33.3%	32.4%	15,086	26.3%
CA	12	8	66.7%	7	58.3%	29.1%	1,175,202	94.3%
AZ	9	4	44.4%	4	44.4%	25.9%	142,311	70.8%
PA	16	7	43.8%	7	43.8%	22.9%	366,329	73.7%
OR	6	2	33.3%	2	33.3%	22.8%	26,683	21.7%
CO	3	2	66.7%	2	66.7%	21.0%	51,912	47.6%
FL	20	12	60.0%	11	55.0%	17.6%	462,800	86.3%
NY	20	6	30.0%	5	25.0%	15.7%	152,750	34.1%
MA	4	1	25.0%	1	25.0%	15.5%	34,118	22.0%
WA	5	2	40.0%	2	40.0%	14.7%	46,818	39.0%
NM	2	1	50.0%	1	50.0%	13.0%	23,352	60.7%
NV	4	2	50.0%	2	50.0%	11.8%	25,979	83.2%
MO	9	2	22.2%	2	22.2%	11.4%	58,994	55.9%
HI	1	0	0.0%	0	0.0%	11.1%	0	0.0%
OH	14	6	42.9%	6	42.9%	10.7%	133,943	70.2%
LA	3	2	66.7%	2	66.7%	9.9%	32,574	50.5%
PR	1	1	100.0%	0	0.0%	8.9%	53,870	100.0%
IN	1	0	0.0%	0	0.0%	7.2%	0	0.0%
OK	3	2	66.7%	2	66.7%	7.2%	37,829	97.0%
TN	5	0	0.0%	0	0.0%	7.0%	0	0.0%
NJ	7	1	14.3%	1	14.3%	6.7%	113	0.1%
AL	5	1	20.0%	1	20.0%	6.4%	24,621	48.9%
ID	1	0	0.0%	0	0.0%	5.8%	0	0.0%
MN	2	2	100.0%	2	100.0%	5.6%	39,822	100.0%
CT	4	3	75.0%	1	25.0%	5.3%	26,849	95.2%
TX	5	2	40.0%	2	40.0%	5.3%	96,265	72.7%
NC	3	2	66.7%	2	66.7%	4.1%	50,060	95.6%
NE	2	2	100.0%	2	100.0%	2.9%	7,721	100.0%
WI	3	1	33.3%	1	33.3%	2.7%	6,856	30.3%
KS	3	1	33.3%	1	33.3%	2.4%	7,422	74.4%
KY	2	2	100.0%	2	100.0%	1.5%	10,304	100.0%
GA	1	0	0.0%	0	0.0%	1.4%	0	0.0%
MI	3	0	0.0%	0	0.0%	1.3%	0	0.0%
WV	2	1	50.0%	1	50.0%	1.1%	2,681	65.2%
MD	2	1	50.0%	1	50.0%	1.0%	3,342	48.9%
NH	1	0	0.0%	0	0.0%	0.6%	0	0.0%
IA	2	2	100.0%	2	100.0%	0.4%	1,942	100.0%
VA	1	0	0.0%	0	0.0%	0.4%	0	0.0%
IL	9	2	22.2%	2	22.2%	0.0%	44,658	68.0%

Source: MPR analysis of CMS files.

Note: Includes coordinated care plans and PPO Demonstrations. Enrollment is as of June 2004. Only states with one or more MA plan are included in this table.

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