Consumer Choice Options for Prescription Drugs

By Joseph R. Antos and Grace-Marie Turner

While there are significant differences among health systems in the United States and countries in the European Union, our nations also share similar problems. Among them are the rising costs of health care, aging populations that will demand more and more expensive medical care, and consumers who are demanding greater control over health choices. These issues will only become more acute over the next several decades. In all of our nations, the next generations are being threatened with huge tax burdens to pay for the obligations to today’s and tomorrow’s beneficiaries.

All of our nations are engaged in major debates over the best ways to address the challenges in our health care systems. It is important for all of us to learn what we can from one another in the search for solutions.

The United States seldom is held up as a model for European nations as its health care system has obvious flaws. Europeans often are appalled at a country that would tolerate having 44 million of its citizens without health insurance. But there is a strong safety net in the United States. Federal law stipulates that no one needing medical treatment can be turned away from a hospital emergency room without being treated and stabilized, and there are many free clinics, community health clinics, and other facilities that provide medical care, most often to those without health insurance.

The United States also leads in developing new innovations in medical treatment, including new pharmaceuticals. In addition, there are innovations in health care financing in the United States that offer new ideas, especially the movement toward consumer choice options in health care.

The Medicare debate

Currently, the United States is engaged in a great national debate over reform of its Medicare system, the federal government’s program that spent more than $250 billion last year to provide medical care to 40 million elderly and disabled people. This is one of several public programs in the U.S. that together accounted for 45% of the $1.5 trillion in total health care spending last year.
The U.S. Medicare program is faced with many of the challenges of European health systems. Like European systems, Medicare is run by a central government agency in Washington that sets thousands of prices for medical services, decides what services will be covered, and under what circumstances those services can be delivered. Medicare is criticized as inefficient, overly costly, and unresponsive to patients and providers alike.

Medicare is desperately in need of modernization so that it can adapt to changes and innovations in health care technologies and care. The program does not cover prescription drugs provided on an outpatient basis despite the striking improvements in drug therapies that are now available. Lack of prescription drug coverage is the direct consequence of a top-down system where decisions are made by politicians rather than by consumers.

Despite limits on covered services and government price setting, Medicare spending continues to spiral out of control. Without changes in Medicare’s financing structure, the program will be faced with bankruptcy when the population eligible for the program nearly doubles over the next several decades.

The U.S. Congress is debating how to modernize and improve the Medicare program. A market-based approach is being considered that gives seniors a choice of staying with traditional Medicare or picking from a wide range of competing private health plans.

The best way to add an outpatient prescription drug benefit to the program is an important part of that debate. Three-fourths of seniors have supplementary coverage to help them with outpatient prescription drugs costs, through either private or public programs, but one-fourth do not have any such insurance. Most of those without drug coverage have low or moderate incomes—too high to qualify for low-income medical assistance through Medicaid, but too low to afford commercially available private policies that include a prescription drug benefit.

Some members of Congress would prefer to add a prescription drug benefit to Medicare that operates much like the rest of the program: Washington would develop a list of covered drugs and establish federal price schedules. Bureaucrats would determine when and for whom new pharmaceuticals would be reimbursed. Contractors would administer the benefit by paying pharmacies for providing authorized drugs to eligible seniors and be reimbursed according to the federal price schedule.

We are very concerned that such a plan would seriously undermine future pharmaceutical research and limit patient access to superior treatment options. Government price controls would inevitably be tightened as the demand for pharmaceuticals increased, particularly in an era of rising budget deficits. Since Medicare accounts for some 40 percent of the U.S. pharmaceutical market, such fiscal tightening would discourage the research and development that could lead to new treatments and cures.
An alternative idea

We have developed an alternative plan that has gained a great deal of attention and interest in Washington and also among the states. Our plan would provide a prescription drug benefit to Medicare beneficiaries, but it would structure the benefit on a more competitive, consumer-friendly model that we believe would engender competition and innovation.

Our plan would be available to all Medicare beneficiaries while providing more generous subsidies to seniors with lower incomes. Seniors, rather than government, would make their own decisions about spending on prescription drugs.

Key Elements

We call our idea the Prescription Drug Security (PDS) plan:

- Seniors would select a private plan to administer their drug benefit. The plan would negotiate discounts and provide other administrative and information services.

- Seniors would receive a fixed amount of cash that they can use to purchase the medications of their choice. The subsidy would be provided through smart card technology that would automatically qualify the beneficiary for discounted prices at the pharmacy. Any amount of money that seniors did not spend in one year would be rolled over to the next to encourage wise spending and savings for the future. The drug plan, not government, would determine what FDA-approved drugs would be on the formulary and the prices of those drugs.

- The health plans would also ensure coverage for large medical expenses so seniors would pay little or nothing for drugs once their spending reached a certain threshold. To assure that high costs are shared fairly across private plans, the government would organize a national risk pool. The premiums charged to beneficiaries would include a modest amount necessary to pay the extraordinary costs of a small minority of very ill patients. This arrangement would offer the advantages of a shared risk pool without the threat of price controls and limits on beneficiary choice posed by fully federalized benefits.

The PDS approach gives consumers control over their own health care, and engages market forces to maintain a wide range of choices while keeping costs down. Unlike a traditional first-dollar insurance program that fosters inefficiency and leads to price controls, the PDS structure aligns incentives properly. Here are a few examples:

- Consumers who spend money from their smart card account would be much more interested than those for whom drugs are free or nearly so in getting the best price for the most effective drug.
Consumers would have the ability to switch drug plans, giving the plans an incentive to provide fair prices and a full range of pharmaceutical choices. Consumers could take their business to another plan if that plan offered better value—including more options and lower costs.

The drug plans would have an incentive to manage drug spending since they would be at risk for high drug costs.

Starting small

One lesson that those of us engaged in the health policy debate have learned is the great difficulty of trying to institute too much change at once. It is much more politically palatable, and reforms are much more likely to be succeed, if small changes are presented that can grow into larger changes over time as both citizens and the marketplace gain more comfort and experience with them.

As a result, our plan starts small. We would target the benefit so that low- and moderate-income seniors receive the largest subsidies, rather than giving the same subsidy to everyone regardless of need. Instead of changing the entire Medicare program, we would provide a new benefit that is structured in a different way, around competition and consumer choice.

There are many potential variations on this idea. But the core concept is one that is very much in harmony with changes in the rest of the economy: Engaging competition to keep costs down, providing an incentive for consumers to make their own determinations of what constitutes the best value for the money, and providing an important new government-funded benefit without the unnecessary encumbrances of government control. In addition to funding the benefit, the government would continue to have an important consumer protection role and the fiduciary responsibility to assure that taxpayers’ dollars are being spent to their best advantage.

Options

We are at the threshold of dramatic increases in the demands that aging societies will place on their health systems. All nations, including the United States, must find ways to fund health care without dampening the explosion of effective new medical technologies, including prescription drugs, which could become available over the next decades. Policies can be developed to give consumers more direct control over their health care, and more personal responsibility and greater ability to spend their health care resources wisely.

Consumer choice approaches can take many different forms. Governments could phase in new programs and allow varying degrees of consumer decision-making responsibility. One option would be to start small with a targeted benefit to meet the immediate prescription drug needs of specific high-risk populations; another could give all citizens the opportunity to manage spending for one part of their health benefits; and
a third could facilitate the creation of new savings accounts for citizens to help fund future health costs. For example:

- **A targeted cash benefit for high-risk populations:** Certain populations with greater health needs—possibly identified by their age, income, disability status, or specific disease (such as diabetes)—could be given a cash subsidy to enable them to access medicines that may not be on the government’s formulary lists. Smart card technology could be used to allow those eligible to access their Special Needs Account to purchase medicines. Such a new benefit would allow government to control the costs because the subsidy to the beneficiary’s account would be fixed rather than an unlimited entitlement to payment.

- **A targeted cash benefit for the general population:** A bolder approach would give all citizens greater control over a specific part of the overall health benefit package. For example, a portion of the national health budget devoted to prescription drugs could be allocated to each individual, giving citizens the freedom to purchase the medications of their choice, including new drugs that have not yet been approved for reimbursement through the national health insurance system. Citizens might use their prescription drug allocation to purchase private insurance for large drug expenses as well as helping to pay directly for routine medications. Potential actions by the U.S. Congress could lead to higher drug prices in Europe and increase pressure on health budgets, providing an additional incentive to explore alternatives such as this.

- **A tax-preferred savings account for health care:** Governments could leave their current health benefit structure in place but create the option for citizens to contribute to a new Future Health Needs Account on a tax-preferred basis. Citizens could use their tax-preferred savings to supplement the government health benefit—paying for additional drug costs, supplementing other current health spending, and saving for future health needs.

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