

## Appendix D

### Example of Gap Payment System

The following excerpt from *Balanced Choice: A Common Sense Cure for the U.S. Health Care Systems*<sup>1</sup> describes how the gap payment system would function as a national model for containing excessive pharmaceutical costs. On the state level, the gap payment system has less power because Colorado is only a small portion of the market. In the Colorado Balanced Choice proposal, Colorado would negotiate, perhaps in alliance with other states, to lower pharmaceutical prices, and then use the base and gap payment system in addition to negotiated prices.

#### Chapter 7

#### A Balanced Choice Pharmacy Plan

*Summary: The Balanced Choice Pharmacy Plan establishes functional market dynamics that lower prices, raise quality, and improve accessibility. Pharmaceuticals have not competed on the basis of price, which has resulted in continuous increases in the price of established medications. Balanced Choice restores functional market dynamics through three features. It makes a price comparison list available to providers and patients, assures that consumers have an expert provider available when they make decisions about medications, and encourages consumers to be cost conscious by requiring a gap payment. The Pharmacy Plan offers promise for greatly lowering the cost of medications without government price controls. In addition, the Pharmacy Plan can be implemented to repair the unpopular and flawed Medicare Part D program.*

The Balanced Choice Pharmacy Plan demonstrates how Balanced Choice creates a functional market and lowers the cost of medications. It is an example of how providers and consumers can conveniently use price information when making treatment decisions. In addition, the Pharmacy Plan is one aspect of Balanced Choice that can be implemented independently of the entire Balanced Choice package. This offers the possibility of a stepwise transition to Balanced Choice. By becoming a replacement for the unpopular Medicare Plan D, Balanced Choice can lower costs, make the plan consumer-friendly, and greatly improve coverage.

#### Pharmaceutical Market Dynamics

*The current pharmaceutical market is dysfunctional.*

In functional markets, when there are competitors, prices are supposed to decline. The opposite is happening with pharmaceuticals. The cost of medications that have been on the market for years, usually medications that have competitors, are rising as much as 360% of the rate of inflation.<sup>1</sup> If prices had been decreasing as a result of market competition, this would have offset some of the increases in medication costs for new products and increased medication use in the general population.

How is it that the market does not work to lower costs of medications that have competitors? The pharmaceutical market effectively prevents providers and consumers from being fully cost conscious in several ways. First, price information is extremely difficult to obtain. Providers and patients do not have price information available in the doctors' offices where the medications are chosen. Second, because most insurance companies charge a flat copayment for prescriptions, cost differences between medications do not matter to most patients. And third, cost increases are so gradual that they are not visible to providers or patients. For example, 50 of the most prescribed drugs for seniors had an average of an annual 4.9% price

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<sup>1</sup> Miller, I. J. (2006). *Balanced Choice: A Common Sense Cure for the U.S. Health Care Systems*. Bloomington, ID: Authorhouse.

increases in the five-year period ending in January 2003.<sup>ii</sup> As a result of the obscurity of price information, consumers and providers can only be aware of large price differences or the difference between generic and brand name medications.

The health insurance industry has made some ineffective attempts to simulate price competition. Many managed care companies created drug formularies—books that rate the cost of medications in a manner similar to the star systems used by movie reviewers and by creating barriers to obtaining medications thought to be too expensive. Unfortunately, formularies function more like annoying bureaucracy than a market force. Other managed care companies intercede when prescriptions are taken to the pharmacy and pharmacist benefit managers attempt to persuade providers to change the prescription to less expensive medications. The use of pharmacist benefit managers is time-consuming and highly abrasive to patients and providers. The current fad is to have three-tiered systems with a different copayment for each tier. The low copayment tier is for generic drugs; the middle copayment tier is for medications that are favored by the managed care company due to price, negotiated special deals, or rebates; and the high copayment tier is for drugs considered expensive. Tiers save money for managed care companies that may have negotiated a special deal or rebate from a pharmaceutical company for including a medication on the second tier, but these negotiations do not change the price of medication for the rest of Americans.

These attempts to simulate price competition do not discourage pharmaceutical companies from their practice of small, but frequent price increases. These small increases are not large enough to affect a medication's star rating in a formulary or move it from one tier to another. Even if an insurance company does restrain a pharmaceutical company from small increases by contractual arrangements, the pharmaceutical company still can raise prices for other customers.

Traditionally, pharmaceutical companies have argued that the price increases are essential to pay the costs of research and development. However, this is not where they allocate the majority of their revenues. The top seven pharmaceutical companies in the United States spend an average of 14% of their revenue on research and development but allocate 18% to profits and 32% to marketing, advertising, and administration.<sup>iii</sup>

*Balanced Choice corrects the market dysfunctions.*

Balanced Choice has three features that make the pharmaceutical market functional. First, Balanced Choice creates price lists by requiring that drug manufacturers publish the maximum price for their medications. The published price is used by Balanced Choice to create a cost-comparison chart for the typical dose at a typical pharmacy—the expected retail price list. Medications can be listed easily in groups with similar medications so that costs can be compared at a glance, just as is done with various brands of food in the supermarket. Even small increases or decreases in the price of a medication would show up on the list, and thus there would be normal functional market pressure to keep prices as low as possible. The list allows doctors and patients to make price comparisons, and it also shows patients the amount of the anticipated gap payment they will need to pay for each medication. As with suggested retail prices of many other products, consumers can often obtain additional savings depending on where they shop.

Second, Balanced Choice assures that consumers have an expert medical advisor available when making complex medical decisions. It has been argued that consumers are not knowledgeable enough to make health care decisions. While it is true that consumers usually need a knowledgeable advisor in order to make wise health care decisions, this is no different than numerous other areas where consumers use expert advisors. When making legal decisions, consumers consult attorneys, and when making tax decisions, consumers consult accountants. In health care, consumers use their physicians as their expert medical advisors.

In the Balanced Choice Pharmacy Plan, consumers are not left alone to compare the costs and benefits of various medications. Just as always, the doctor makes the decision about which medications can be

prescribed. The only difference is that price information is handy, and consumers can ask their doctors to consider price when choosing among similar medications.

Third, Balanced Choice maintains consumer cost consciousness by having patients make a *gap payment*. Balanced choice pays a base amount for each category of medicines, and patients pay the full *gap* between the base amount and the actual charge for a specific medication. The following example shows how gap payments work.

**Simplified Example of Balanced Choice Expected Retail Price List**  
 (This is a list of three medications in the same category)

Medication	Retail price	Balanced Choice pays pharmacy this base amount for medications in this category	Patient's gap payment
Medication A	\$45	\$40	\$5
Medication B	60	40	20
Medication C	65	40	25

In this example, Balanced Choice pays the same base payment of \$40 for all medications in the category regardless of the cost of the specific medication. Patients pay the gap between the base amount and the actual cost. If the doctor and patient select Medication A, which costs \$45/month, the patient pays a gap of \$5/month. If the doctor and patient select the higher priced Medication B or Medication C, the patient pays a gap of \$20/month or \$25/month respectively.

**Example of how Balanced Choice works in the doctor's office—a fictional dialog.**

Dr. Goodheart: Considering your history of heart problems and high blood pressure, I would like to start you on a beta-blocker.

Mrs. Beewell: Okay, but my finances are tight so I would like you to consider cost while choosing a medication.

Dr. Goodheart: Gladly, I know that cost matters. I have in my hand, here, this month's Balanced Choice expected retail price list. There are five beta-blockers, but only three that I would consider prescribing for you. Now on this chart, the lowest priced one would have a gap payment of \$30 per month, but more patients report side effects with that one. The next lowest priced one would have a gap payment of \$39 per month and fewer people report side effects.

Mrs. Beewell: Why don't I try the \$30-per-month one for a couple of weeks, and if I get side effects, I will try another?

Dr. Goodheart: Good idea. We have a plan. I will see you in two weeks to see how well the medication is working.

(As it turned out, Mrs. Beewell found a discount pharmacy that lowered her gap payment to \$21 per month and the less expensive medication proved to be just right for her. Overall, Mrs. Beewell found her annual gap payments were lower than her combined copayment and deductible costs on the health insurance she had before the Balanced Choice Pharmacy Plan.)

There is tremendous power that will come from the cost-conscious patients using the Balanced Choice expected retail price lists to select medication. Once providers are sensitized to price, they will probably consider price differences even with low-income patients who have the full cost of their medication paid by Balanced Choice. The market will change from the current situation, in which drug companies hardly ever face real price competition, to one where there are few places to hide from real price competition. The result should be a functional market in which there is a steady decline in the price of established medications.

It is true that one medication cannot always be replaced by another in the same category, and therefore no two drugs are equal competitors. Two medications in the same category may be equally effective for only some patients. This is no different than most other parts of the free market system. Competitors are usually not offering identical products, and they still compete on price.

Will price competition work for medications? Of course it will; it does in every other sector of a functional market. Other countries have tried versions of the Balanced Choice plan called “reference pricing.” Most notably, Germany has had reference pricing on some medications since 1989. In the time period from 1989–2001, the *price index for reference-priced medications decreased 30%* while the price index for medications not reference priced rose 25%.<sup>iv</sup> Although some other cost-control measures during this time period made it difficult to evaluate the precise effect of reference pricing, it shows that there is great potential for price competition to reverse the rising cost of medications in the United States. It would be a great accomplishment if, in the United States, the Balanced Choice Pharmacy Plan would take 30% or more out of the bloated prices that have developed in the years without price competition.

When price competition begins to work, it will restrain medication costs without requiring government cost controls that might stifle the invention of new drugs. After all, it is well established that price competition is a traditional component of functional market systems and is known to stimulate innovation and new products. Pharmaceutical companies, just as other industries that cope with price competition, will be able to make healthy profits.

The Balanced Choice plan also saves money because it eliminates most of the administrative costs that occur in both managed care entities and government bureaucracies. The Balanced Choice plan requires minimal administration to distribute price lists and to make the base payments directly to pharmacies.

There is another bonus that comes from the Balanced Choice plan. Critics have blamed expensive direct-to-consumer advertising for pushing up the cost of medications. The pharmaceutical industry defends itself by saying it is only educating consumers about the possibility of improving their health care. If the Balanced Choice plan is implemented, when Mrs. Beewell sees Dr. Goodheart and inquires about the medication she heard about on TV, he might say, “Yes, you have that condition, and because I know you care about cost, let’s see how much each of the different medications for that condition cost.” When advertising expenses push up the cost of the medication, the advertiser may lose the sale in the doctor’s office if its medication is not competitively priced.

The difficulties in implementing the Balanced Choice Pharmacy Plan should not be exaggerated. Other countries that have used this system have had a single payer system, and consequently, consumers were very reluctant to pay significant gap payments.<sup>v</sup> In the United States, on the other hand, consumers are accustomed to paying significant amounts for medications. Gap payments could be designed so that overall, they are no more costly than most consumers are already paying. Categories of medications are already established in the Physician’s Desk Reference and would only need slight alterations. Moreover, even though individual dosage will vary, the expected retail price list does not need to show an individual’s exact gap payment; it only needs to show comparative prices.

The Balanced Choice plan can be designed to pay any desired portion of the overall pharmacy costs—60%, 70% or more, as long as the gap payments are affordable for the vast majority of patients. Furthermore, an essential Balanced Choice concept is that no one should forego a necessary health care service due to lack of financial support. The design could increase the size of the base payment as medication costs rose toward the catastrophic level, and low-income patients would have their gap payment completely subsidized by Balanced Choice.

### Using Balanced Choice To Replace Medicare Part D

In order for Balanced Choice to establish a functional market for medications, it needs to have a large enough portion of the entire market to cause pharmaceuticals to compete on price. Establishing such a large portion is possible by converting the Medicare pharmacy benefit to a Balanced Choice Pharmacy Plan. Seniors account for 42% of the expenditures on medications in the United States<sup>vi</sup>. In addition to Medicare patients, if there were an expected retail price list available to physicians, the 45 million uninsured, as well as the uncounted millions who have insurance but no pharmacy benefits, would use this list when choosing medications and add their market power to Medicare patients. Once cost-conscious consumers sensitize providers to price, they often consider price differences even when the patient is not paying the bill. With this kind of market power, the cost of medications could be lowered.

The Medicare Part D program needs to be changed. It has been widely criticized for placing the interests of insurance and pharmaceutical companies above the interests of Medicare recipients. Instead of directly paying for medications, the Medicare Part D subsidizes insurance companies which compete to provide complicated prescriptions plans. Because Medicare subsidizes insurance companies without obtaining the lowest possible prices for medications, it is a program that is more expensive than necessary.<sup>vii</sup>

Choosing a Medicare Part D plan has been a mind-boggling task. There are an average of 15 of these plans in each state<sup>viii</sup> and as many as 67 different insurance plans in some places.<sup>ix</sup> Each plan has different premiums, deductibles, copayments, gaps in coverage, medications in their formularies, pharmacy networks, and areas of geographic coverage. As a result of the complexity, beneficiaries and their advisors have been overwhelmed by the near impossibility of determining which plans are best. Even after a plan is selected, when prescribed medications change, it changes which plan is advantageous. As a result of the complexity, many beneficiaries will not enroll, which leaves them uninsured for medications.

Medicare also has major gaps in coverage that result in its beneficiaries being underinsured. Some medications are unavailable on any plan, and many medications and pharmacies are unavailable on each individual plan. A financial gap results in high out-of-pocket expenses for many beneficiaries.<sup>x</sup> For example, patients whose medication costs \$5,100 per year will still pay \$4,020.<sup>xi</sup> It is no wonder that twice as many seniors view Medicare Part D unfavorably as view it favorably.<sup>xii</sup>

Until now, the major argument against reforms in the Medicare Plan D program is that alternative proposals have all focused on the government negotiating or setting the price of medications. Such price negotiations are so similar to price controls that these proposals have not been able to overcome economic and political concerns. Balanced Choice is an option that lowers the cost of medications, allows the market to determine price, and is administratively much less complex than subsidizing scores of confusing insurance plans.

### **Conclusion**

The Balanced Choice Pharmacy Plan establishes a functional market for medications. It allows consumers and providers choice of medication, lowers the cost of medications for everyone, and accomplishes all this without government controls over prices. Price competition has been proven to work in other parts of the free market system. It has the added possible benefit of being used to repair the Medicare Plan D program.

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- <sup>i</sup>. Families USA. (2004). Sticker shock: rising prescription drug prices for seniors. Washington DC: Author. Of 30 brand-name drugs most frequently used by the elderly, the cost of the 26 that have been on the market for over three years rose at 3.6 times the rate of inflation from 1/01–1/04. A review of these 26 in the Physician's Desk Reference, 2004, reveals that at least 22 have competitors.
- <sup>ii</sup>. Families USA. (2003). Out of bounds. Washington DC: Author.
- <sup>iii</sup>. Families USA. (2005). The choice: Health care for people or drug industry profits. Publication No. 05–104, Washington DC: Families USA.
- <sup>iv</sup>. Kanavos, P. and U. E. Reinhardt. (2003). Reference pricing for drugs: Is it compatible with U.S. health care? *Health Affairs*, 22(3), 16–30.
- <sup>v</sup>. Ibid.
- <sup>vi</sup>. McCloskey, A. (2000). Cost overdose: Growth in drug spending for the elderly, 1992–2010. Washington DC: Families USA.
- <sup>vii</sup>. Baker, D. (2006). The excess cost of the Medicare drug benefit, Washington, DC: Institute for America's Future Center for Economic and Policy Research.
- <sup>viii</sup>. Kravitz, R. L. & Change, S. (2005). Promise and perils for patients and physicians, *New England Journal of Medicine*, 353, 2735–2739.
- <sup>ix</sup>. Families USA. (2005). Pick a plan: The new CMS drug benefit game for seniors, Washington DC: Author.
- <sup>x</sup>. Families USA. (2005). Gearing up: States face the new Medicare law. The holes in Part D: Gaps in the new Medicare drug benefit (Part 1 of 2), Washington DC: Author.
- <sup>xi</sup>. Families USA. (2004). The Medicare road show. Washington DC: Author. Families USA explains that in the model program there is a \$35/mo. premium, \$250 deductible, insurance coverage of 75% for expenses between \$250 and \$2,250, and a \$2,850 gap in coverage for expenses between \$2,250 and \$5,100.
- <sup>xii</sup>. Kaiser Family Foundation. (2006). Selected findings on seniors' views of the Medicare prescription drug benefit. Publication #7463. Washington, DC: Author.