THE CENTURY FOUNDATION
Issue Brief

HELP, I'VE FALLEN INTO THE DOUGHNUT HOLE AND I CAN'T GET UP: THE PROBLEMS WITH MEDICARE PART D

BY BEVERLY GOLDBERG

INTRODUCTION

Ever since the enactment of Medicare Part D, which pays private insurers to offer senior citizens plans to help cover the costs of their prescription drugs, bitter complaints about the program have been the norm. Most of the complaints have focused on the "doughnut hole," the coverage gap that occurs when someone spends more than the year's covered amount—$2,510 in 2008—on his or her medications. When that cap is reached, because an individual is on multiple medications or extremely expensive ones or both, the costs of medications must be paid for out-of-pocket until the person spends up to a level that is significantly higher than the covered amount—an additional $3,216 in 2008. At that point, the plan again begins to cover needed drugs under a catastrophic coverage provision.

THE COMPLEXITIES INVOLVED IN CHOOSING A PLAN

Medicare recipients can choose whether or not to enroll in one of the numerous Part D plans offered by private companies in their area (nationwide there are 1,824 different plans available). These private companies receive payments from the federal government to provide coverage; when Part D began in 2005, the government paid them an "average of $94.08 per month for every person who enroll[ed] for drug coverage."[1] The plans vary from region to region and offer different costs and benefits from year to year. For low-income seniors who meet certain requirements, there are a limited number of what are known as "benchmark" plans that do not require a monthly premium.[2]

It is up to each purchaser to decide which plan offered in his or her community provides the most beneficial coverage given the medications he or she currently takes and then enroll in that plan. The process is so confusing that many senior citizens end up either not choosing a Medicare prescription drug plan or choosing one that does not provide them with the proper benefits. In congressional hearings aimed at exploring the complaints about the program, Vicki Gottlich, a senior policy attorney with the Center for Medicare Advocacy, testified that the large number of Medicare prescription drug plans "affect the ability of beneficiaries to understand the program, choose plans, pay premiums, benefit appropriately from the low-income subsidy, and utilize the exceptions and appeals process." She added that some analysts have "concluded that having to

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choose among many options creates a burden" for Medicare beneficiaries and "increases their difficulty in making an informed and meaningful decision."[3]

The most difficult aspect of the choice is the fact that "Part D plans can change their formularies (the drugs they cover) . . . [and] their pricing tiers (how they charge for different categories of drugs) . . . throughout the year, even though most beneficiaries are locked into their chosen plans until the next open enrollment period."[4] Moreover, even if enrollees develop new medical problems that require drugs not well-covered by the plan they have chosen, they still would not have the option of changing plans before the next enrollment period.

In 2008, the standard plan included an initial $275 deductible. After meeting the deductible, the beneficiaries paid 25 percent of the cost of covered Part D prescription drugs, up to $2,510. After that, they fell into the coverage gap. Clearly, the more drugs seniors take that their plans offer at a very good price, the longer it will take to reach the gap. The various health insurance providers also may offer versions of the standard benefit (so-called enhanced benefit plans) that eliminate the deductible phase completely and/or extend the initial coverage limit to shrink the size of the doughnut hole. Of course, the premiums for these enhanced plans are higher to offset the increased benefit, making them unaffordable for many seniors.

A Kaiser Family Foundation report released in August notes that "among Part D enrollees who filled one or more prescriptions but did not receive low-income subsidies in 2007, one quarter (26 percent) had spending high enough to reach the coverage gap," and half of those reached the gap by the end of August.[5] In other words, "about 3.4 million beneficiaries (14 percent of the total population of Part D enrollees) reached the coverage gap and faced the full cost of their prescriptions in 2007."[6]

Economic Hardship

Difficult as that gap has made life for seniors in past years, this year it may affect far more of them. According to an AARP survey conducted in late April 2008, before this fall's sharp drop in the market and further cuts in interest rates, those over sixty-five already were "feeling some direct impact from the worsening economic situation. Almost one-half (44%) have seen their 401(k)s or other investments decrease in value." As a result, the survey revealed that six in ten seniors were "finding it more difficult to pay for essential items (such as food, gas, medicines) and for utilities (47%)."[7]

The problem that emerged in late April also was a result of increases in the price of gas, which had reached highs in the $4.00 range, and sharp rises in food prices, just when cuts by the Fed had brought interest rates down to 2 percent, a real problem for those who rely on their savings to supplement their Social Security benefits and pensions. When you add the dramatic deterioration of the economy in the six months since that survey was completed, it should come as no surprise that many retirees are having even more difficulty finding ways to make ends meet.

Moreover, as Maggie Mahar reports in a new study of Medicare, in 2007 "about half of Medicare's beneficiaries lived on incomes of $20,000 or less. Eighteen percent were scraping along somewhere below the poverty line ($9,060 for those living alone, and $11,430 for married couples). Note that 'income' includes every dollar that comes into the home, including Social Security, dividends, capital gains, food stamps, and income from part-time jobs."[8]

How Seniors React to Falling into the Doughnut Hole

Some of the most common medications taken by those on Medicare (see Table 1) are aimed at controlling chronic diseases, such as diabetes or hypertension, which, if left untreated, can result in hospitalizations, life in a nursing home, and even death.

Table 1
Share of Part D Enrollees Who Reached the Coverage Gap and Catastrophic Coverage in 2007, by Drug Class
(Excludes Part D Enrollees Who Receive Low-Income Subsidies and Non-users)

Drugs	*% that Reached Gap but not Catastrophic Coverage*	*% that Reached Catastrophic Coverage*	*% of Part D Enrollees Who Use the Drug*
For Alzheimer's	49	15	4
Oral anti-diabetics	41	10	12
Proton pump inhibitors	40	11	18
Antidepressants	35	10	18
Angiotensin receptor blockers	35	7	17
Statins	33	6	40
Osteoporosis drugs	32	7	15
ACE inhibitors	30	5	28

Notes: Estimates based on analysis of retail pharmacy claims for 1.9 million Part D enrollees in 2007. Groups not mutually exclusive; enrollees may use drugs in more than one of the eight drug classes.

Source: Georgetown University/NORC/Kaiser Family Foundation analysis of IMS Health LRxdatabase, 2007.

Unfortunately, what happens when people cannot afford to pay for their drugs once they have fallen into the doughnut hole is that some 20 percent, according to the Kaiser report, stopped taking their medications altogether; reduced their dosage, for example, by taking medications on alternate days; or switched to different medications (see Table 2).[9]

Table 2
Changes in Drug Use by Part D Enrollees after Reaching the Coverage Gap in 2007

Drugs	*% that Stopped Taking Medication*	*% that Reduced Amount Taken*	*% that Switched Medication*
Average	15	1	5
Proton pump inhibitors	20	—	6
Antidepressants	15	1	6
Oral anti-diabetics	10	5	8
Osteoporosis drugs	18	1	3
ACE inhibitors	16	—	4
Statins	13	—	5
Angiotensin receptor blockers	14	—	3
For Alzheimer's	8	2	4

Notes: Estimates based on analysis of retail pharmacy claims for 1.9 million Part D enrollees in 2007. Groups not mutually exclusive; enrollees may use drugs in more than one of the eight drug classes.

Source: Georgetown University/NORC/Kaiser Family Foundation analysis of IMS Health LRxdatabase, 2007.

Clearly, forcing seniors to choose between food, shelter, heat, and medications, which seems to result in many forgoing needed drugs, may prove more costly in terms of what Medicare eventually spends on them than would making changes to the way Part D works in order to close the coverage gap.

COMPLICATING FACTORS

The problems involved in addressing the issue of the doughnut hole are magnified by the fact that the plans vary from state to state as do such things as the weather and the percentage of seniors. For states, this can result in an inability to provide enough resources to aid all those in need.

Many seniors reach the coverage gap and have to pay for medications out-of-pocket just as fall sets in and heating costs become a factor. That is important because, as the Kaiser report explains, the share of people who reach the coverage gap was particularly high (33 percent) in "Arkansas, and the seven-state Northern Plains region that includes Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota and Wyoming,"[10] and those seven Northern Plains states experience some of the coldest average winter temperatures in the United States.

For example, in Minnesota, "an estimated 25 percent of enrollees hit the doughnut hole" in September 2008. Yet in 2009 fewer plans available to Minnesotans will offer any coverage of the hole. Karin Patrick, health information manager at the Minnesota Senior Federation in St. Paul, reported in September, "We're getting a lot of heartbreaker stories—people who hit the doughnut hole and now are paying 25 percent or more of their income for drugs."[11]

This often results in seniors choosing between heat and medications, which can have deadly results because older people are more susceptible to hypothermia. The problem has been exacerbated by the administration's blocking of $2.5 million of additional funding for the Low Income Home Energy Assistance Program (LIHEAP) that is aimed at helping people, especially seniors, with heating costs.[12]

The number of seniors residing in a state also makes a difference because seniors often require many resources that are traditionally provided by state and local government. Thus, while some 12.4 percent of citizens in the United States are over sixty-five, of the eight states with the highest share of people who reach the coverage cap, six (North Dakota, Iowa, South Dakota, Arkansas, Montana, and Nebraska) have a higher percentage of citizens past age sixty-five than the national average, with North Dakota ranked fourth (14.8 percent); Iowa, fifth (14.7 percent); and South Dakota, sixth (14.3 percent).[13] Moreover, five of those six are in the cold Northern Plains.

OPTIONS FOR CHANGE

The doughnut hole poses a major threat to the lives and health of many seniors. The question is, what can be done about it? The possible solutions vary from those that provide some help to people who have already fallen into the hole to some that change the way the program works:

- When it comes to patients who have reached the coverage gap, physicians who become aware of the problem can help by, for example, switching those patients to generics whenever possible and prescribing pills in larger doses and instructing patients to split them in two when safe—a 20 mg pill costs far less than two 10 mg pills and a simple, inexpensive device for splitting pills is readily available. A more effective solution, according to a study by Consumers Union, is for doctors and patients to be aware of the value of "switching to low-cost, effective medicines before signing up for the insurance." Using these so-called Best Buy Drugs, they say, would allow seniors to save "between $2,300 and $5,300 a year under various Medicare Part D insurance plans."[14]

- One proposed change has proved extremely contentious: charging the Secretary of Health and Human services to negotiate with pharmaceutical companies for better prices on drugs marketed through the Medicare drug program. A recent report prepared for the House Committee on Oversight and Government Reform found, when comparing the differences in the cost of the exact same drugs when purchased through Medicaid (a federal-state program) and through Medicare Part D, that "Medicare Part D pays on average 30% more

for drugs than does Medicaid and . . . that this discrepancy in pricing produced a windfall worth over $3.7 billion for drug manufacturers in the first two years of the Medicare Part D program."[15] Despite such evidence, the effort to make this change has met with strong resistance from the pharmaceutical companies and the administration, and while there may be some problems with the approach, it warrants serious further exploration, especially since another recent study estimated that "relative to OECD countries the U.S. pays 70 percent higher prices for drugs."[16] If an examination of the system indicates the wisdom of such an action, a change in the composition of Congress and a new president may make it possible to repeal the provision in President Bush's Medicare Modernization Act that explicitly prohibited Medicare from using its size and clout to demand fairer prices from these companies, as every other developed country does.

- Yet another proposed change would allow people to purchase their drugs abroad since many of the most frequently prescribed drugs are available at far lower prices in other countries (some citizens living close to our borders with Canada and Mexico already cross the border to purchase the medications they need at much lower cost). The drug manufacturers argue against this solution on two grounds: first, they say that the safety of such drugs cannot be guaranteed because of possible counterfeiting or tampering; second, they claim that allowing such purchases would reduce their profits, making it impossible for them to pursue the costly research and development that have brought so many beneficial new drugs to market. In terms of this last argument, it is important to keep in mind that, according to Maggie Mahar, "the pharmaceutical industry spends approximately one-and-a-half times as much on marketing and sales as it spends on research and development."[17]

- The change that would go the furthest to help seniors would be for Medicare simply to take over Part D. While seniors would still have to pay a premium for coverage (just as they do for other parts of the program), it is likely to be less than what they now pay private insurers, for two reasons: first, unlike private insurers, Medicare would not have to spend on such things as advertising and marketing, high executive salaries, and generating profits for stockholders; second, Medicare would have far more negotiating clout with drug makers than individual companies, each of which represents a smaller group of purchasers. But perhaps just as important, such a change would lessen the difficulties seniors now have choosing a plan, and it would avoid the problem of their finding, months after choosing a plan, that changes in their health require medications that are not covered by the plan they chose.

LOOKING AHEAD

It is interesting to note that while the presidential candidates both agreed that something needs to be done to reduce the high costs of health care in general, and each expressed some support for reforming Part D specifically, according to Ariene Weintraub, neither addressed the issue of the doughnut hole in depth. She reported that "Senator Barack Obama backs the idea of letting government negotiate drug prices for Part D. . . . [while] Senator John McCain has said that higher-income beneficiaries should pay higher premiums for their Part D plans."[18] One problem with Senator McCain's plan is that it might encourage affluent beneficiaries, especially the ones who take the fewest medications, to drop Part D coverage (which is voluntary), while keeping Part A (which covers hospitalizations); the result may well be an increase Part D premiums or lowering of benefits

for those left in the pool of beneficiaries—the very seniors who are having major problems when they reach the coverage gap.

This issue is so important that the president elect, as well as the members of the new Congress, should be pushed to develop concrete proposals for helping seniors escape the doughnut hole well in advance of the inauguration. For once in office, the president will be so busy dealing with the extremely volatile global economy, what looks like a recession in this country, and the conflicts in Iraq and Afghanistan that addressing the problem of the coverage gap could fall by the wayside, becoming the subject of commissions and task forces rather than action.

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