FamiliesUSA
The Voice for Health Care Consumers

SPECIAL REPORT
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Coverage through the "Doughnut Hole" Grows Scarcer in 2007

Introduction

Unlike most forms of insurance, the Medicare Part D prescription drug program has a hole in its middle. This coverage gap, colloquially known as the "doughnut hole," is perhaps the most bizarre and troublesome aspect of the Part D drug program. After beneficiaries reach their initial limit of total drug expenses ($2,250 in 2006), they have no prescription drug coverage until their total drug expenses reach a catastrophic threshold for the year ($5,100 in 2006). While beneficiaries are in the doughnut hole, they must continue to pay their monthly premiums, although they do not receive any drug benefits. Only after they have spent thousands of dollars of their own money to get out of the hole ($2,850 in 2006), in addition to their monthly premiums, does their coverage resume.

The doughnut hole makes little sense from a medical perspective, as it financially penalizes sicker individuals who have more substantial drug needs. It has also generated considerable anxiety among seniors and people with disabilities in Medicare, who fear falling into the doughnut hole and being unable to afford their prescriptions.

The Administration has touted the many plan options available in Part D as providing good choices for beneficiaries seeking coverage through the doughnut hole. For example, in testimony to Congress earlier this year, Centers for Medicare and Medicaid Services (CMS) Administrator Mark McClellan stated that competition has led to a broad range of choices for seniors, including "coverage in the coverage gap." [1] More recently, with the introduction of the 2007 Part D plans, Secretary of Health and Human Services (HHS) Mike Leavitt stated that the prescription drug benefit "keeps getting better," and that, in 2007, "there will be more plans with coverage in the gap." [2]

For doughnut hole coverage to be *meaningful*, however, it needs to cover the drugs that seniors actually use. Table 1 lists the top 25 drugs most commonly prescribed to seniors.[3] Of these 25 drugs, 18 are not available in a generic form. As a result, drug plans that provide coverage through the doughnut hole for generic drugs only are virtually meaningless for seniors who need the most frequently prescribed medications. This report examines what is happening to stand-alone drug plans that provide *meaningful doughnut hole coverage*—that is, plans that provide doughnut hole coverage of both the generic and non-generic drugs that most seniors need.

Table 1

Top 25 Drugs Prescribed to Seniors, 2004

Drug Name	Strength	Dose Form	Therapeutic Category	Generic Available
Actonel	35 mg	tab	Osteoporosis Treatment	No
Aricept	10 mg	tab	Alzheimer's Treatment	No
Celebrex	200 mg	cap	Anti-Inflammatory/Analgesic	No
Combivent	14.7 gm	aerosol	Respiratory Agent	No
Digitek	0.125 mg	tab	Cardiac Glycoside	Yes
Evista	60 mg	tab	Osteoporosis Treatment	No
Fosamax	70 mg	tab	Osteoporosis Treatment	No
furosemide	40 mg	tab	Loop Diuretic	Yes
isosorbide mononitrate	30 mg	tab ER	Anti-Anginal Agent	Yes
Klor-Con M 20	20 meq	tab ER	Potassium Replacement	No
Lipitor	10 mg	tab	Lipid-Lowering Agent	No
Lipitor	20 mg	tab	Lipid-Lowering Agent	No
metoprolol tartrate	50 mg	tab	Beta Blocker	Yes
Nexium	40 mg	cap	Gastrointestinal Agent	No
Norvasc	5 mg	tab	Calcium Channel Blocker	No
Norvasc	10 mg	tab	Calcium Channel Blocker	No
Plavix	75 mg	tab	Antiplatelet Agent	No
Prevacid	30 mg	cap DR	Gastrointestinal Agent	No
Protonix	40 mg	tab	Gastrointestinal Agent	No
Toprol XL	50 mg	tab	Beta Blocker	No
Toprol XL	100 mg	tab	Beta Blocker	No
Xalatan	0.005%	sol	Glaucoma Treatment	No
Zocor*	20 mg	tab	Lipid-Lowering Agent	Yes
Zocor*	40 mg	tab	Lipid-Lowering Agent	Yes
Zoloft*	50 mg	tab	Antidepressant	Yes

Source: This list of drugs is based on the 25 drugs with the highest claims volume in Pennsylvania's Pharmaceutical Assistance Contract for the Elderly (PACE) program in 2004. Data on generic availability are from the Medicare Prescription Drug Plan Finder, available online at www.medicare.gov.

*Zocor and Zoloft became available as generics during 2006.

Key Findings

- In 2006, four states have no stand-alone drug plans that provide meaningful coverage to seniors in the doughnut hole. In 2007, that number will grow to 13 states (Table 2).
  - Several states with large numbers of Medicare beneficiaries, including Florida, Michigan, New York, and North Carolina, will have no stand-alone plans with meaningful doughnut hole coverage in 2007.
  - All of New England (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont) will have no stand-alone plans with meaningful coverage through the doughnut hole in 2007.
- In 2006, about 375,000 Medicare beneficiaries have no stand-alone drug plan in their state that offers meaningful coverage through the doughnut hole. In 2007, that number will grow to more than 6.6 million beneficiaries—17.8 times higher [4] (Table 2).
- In 2007, every state that has a stand-alone drug plan with meaningful coverage through the doughnut hole will see substantial increases in the monthly premiums for these plans. Premium increases will range from 22 percent to 185 percent. Nationally, the median increase in premiums will be 87.4 percent (Table 3).
  - Seven states in the Upper Midwest (Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, and Wyoming) will see the largest percent increase, with monthly premiums for these plans increasing by 185 percent. Overall, their premiums will shoot up from $38.70 in 2006 to $110.30 in 2007.
  - In New Jersey, premiums for plans with meaningful coverage through the doughnut hole will increase by 180 percent, from $48.50 in 2006 to $135.70 in 2007.
  - In Missouri, premiums for plans with meaningful coverage through the doughnut hole will rise by more than 111 percent, from $56.43 in 2006 to $119.50 in 2007.

Table 2

Medicare Beneficiaries with No Access to Stand-Alone Drug Plans that Offer Meaningful Coverage through the Doughnut Hole, by State, 2006 and 2007

2006		2007	
State	**Beneficiaries**	**State**	**Beneficiaries**
Alaska	27,000	Alaska	27,000
Hawaii	122,000	Connecticut	310,000
Maine	127,000	Florida	1,935,000
New Hampshire	99,000	Hawaii	122,000
Total	**375,000**	Maine	127,000
		Massachusetts	532,000
		Michigan	887,000
		New Hampshire	99,000
		New York	1,340,000
		North Carolina	727,000
		Rhode Island	102,000
		Vermont	52,000
		Wisconsin	408,000
		Total	**6,668,000**
Total Growth, 2006 to 2007			**6,293,000**

Sources: Estimated beneficiary data are from the Centers for Medicare and Medicaid Services (CMS), *State Enrollment in Prescription Drug Plans, November 15, 2005 to June 11, 2006* and from the Social Security Administration (SSA), *Status of Medicare Low-Income Subsidy Applications Received as of 7/14/06*. Plan information is from CMS, *Landscape of Medicare Prescription Drug Plans* source files, 2006 and 2007, available online at www.medicare.gov.

Notes: Figures include all Medicare beneficiaries reported by CMS as having prescription drug coverage in June 2006. Dual eligibles and those approved by SSA for the low-income subsidy are not included in these numbers, as they have coverage while in the doughnut hole.

Table 3

Lowest Monthly Premiums for Stand-Alone Drug Plans with Meaningful Coverage through the Doughnut Hole, by State, 2006 and 2007

State	Lowest Monthly Premium, 2006	Lowest Monthly Premium, 2007	Percent Increase, 2006 to 2007	State	Lowest Monthly Premium, 2006	Lowest Monthly Premium, 2007	Percent Increase, 2006 to 2007
Alabama	$67.16	$123.80	84.3%	Montana	$38.70	$110.30	185.0%
Alaska	No Plan	No Plan	– –	Nebraska	$38.70	$110.30	185.0%
Arizona	$53.54	$78.10	45.9%	Nevada	$49.59	$84.30	70.0%
Arkansas	$58.97	$93.20	58.0%	New Hampshire	No Plan	No Plan	– –
California	$50.91	$74.80	46.9%	New Jersey	$48.50	$135.70	179.8%
Colorado	$54.89	$73.00	33.0%	New Mexico	$59.77	$72.80	21.8%
Connecticut	$55.08	No Plan	– –	New York	$47.93	No Plan	– –
Delaware	$52.88	$103.20	95.2%	North Carolina	$65.03	No Plan	– –
District of Columbia	$52.88	$103.20	95.2%	North Dakota	$38.70	$110.30	185.0%
Florida	$61.70	No Plan	– –	Ohio	$63.91	$95.90	50.1%
Georgia	$73.17	$96.40	31.7%	Oklahoma	$57.85	$96.50	66.8%
Hawaii	No Plan	No Plan	– –	Oregon	$51.18	$75.00	46.5%
Idaho	$52.08	$73.50	41.1%	Pennsylvania	$58.46	$104.50	78.8%
Illinois	$61.51	$106.00	72.3%	Rhode Island	$55.08	No Plan	– –
Indiana	$66.89	$108.30	61.9%	South Carolina	$68.74	$104.20	51.6%
Iowa	$38.70	$110.30	185.0%	South Dakota	$38.70	$110.30	185.0%
Kansas	$54.20	$102.30	88.7%	Tennessee	$67.16	$123.80	84.3%
Kentucky	$66.89	$108.30	61.9%	Texas	$58.69	$96.50	64.4%
Louisiana	$69.92	$110.40	57.9%	Utah	$52.08	$73.50	41.1%
Maine	No Plan	No Plan	– –	Vermont	$55.08	No Plan	– –
Maryland	$52.88	$103.20	95.2%	Virginia	$58.18	$92.20	58.5%
Massachusetts	$55.08	No Plan	– –	Washington	$51.18	$75.00	46.5%
Michigan	$65.15	No Plan	– –	West Virginia	$58.46	$104.50	78.8%
Minnesota	$38.70	$110.30	185.0%	Wisconsin	$57.21	No Plan	– –
Mississippi	$62.12	$103.00	65.8%	Wyoming	$38.70	$110.30	185.0%
Missouri	$56.43	$119.50	111.8%				
Median U.S. Premium					**$55.08**	**$103.20**	
Percent Increase in Median U.S. Premium							**87.4%**

Source: Centers for Medicare and Medicaid Services (CMS), *Landscape of Medicare Prescription Drug Plans* source file, 2006 and 2007, available online at www.medicare.gov.

Discussion

As meaningful coverage through the doughnut hole becomes prohibitively costly—or nonexistent—beneficiaries will have to look for alternative sources of coverage. They are likely to turn to options such as generic-only coverage, coverage for generics and preferred brand-name drugs, or a Medicare Advantage managed care plan. As discussed below, all of these options have serious flaws. Moreover, in the coming years, the doughnut hole will grow, exposing more beneficiaries to greater financial risk.

- **Generic-Only Coverage Is Insufficient**

  Beneficiaries looking for coverage through the doughnut hole are often directed to plans that offer coverage only for generic drugs. Indeed, plans that cover only generic drugs through the doughnut hole are much more common than those with meaningful coverage. This is not surprising, as generics are generally cheaper than non-generics. And when they are medically appropriate, generics provide good value for consumers and insurers. But as Table 1 shows, the overwhelming majority of the drugs most commonly prescribed to seniors are not available in generic form. Generic-only plans therefore leave most seniors without meaningful coverage through the doughnut hole.

  The limitations of generic-only coverage are of particular concern for those whose health or life depends on the availability of a promising new drug, such as people with serious and complex medical conditions like cancer or severe arthritis. When new drugs enter the market, they are sold as brand-name drugs, not generics. For consumers who need these new drugs, Part D plans without meaningful coverage through the doughnut hole are woefully incomplete. These vulnerable beneficiaries need meaningful coverage through the doughnut hole, but such coverage is becoming either increasingly expensive or unavailable.

  A new type of hybrid Part D plan may be emerging in 2007 that claims to offer coverage through the doughnut hole for "generics and preferred brands." In theory, such plans might provide modest help to beneficiaries who take a limited number of brand-name drugs. Upon closer analysis, however, these plans appear to offer little added value. An examination of these plans from across the country could not find a single plan that offered coverage through the doughnut hole for *any* of the 18 top non-generic drugs prescribed to seniors.[5]

- **Medicare Advantage Plans Are Not a Reasonable Alternative**

  Proponents of Part D have suggested that beneficiaries seeking full coverage through the doughnut hole should switch from traditional Medicare to a Medicare Advantage managed care plan that provides such coverage. These plans exist, but only in less than half of the country.

And switching to a private Medicare Advantage plan, even if it offers better doughnut hole coverage, may require beneficiaries to make tradeoffs that could jeopardize their care. In general, Medicare Advantage plans impose limits on which doctors their members can see or which hospitals they can use. Beneficiaries are therefore at risk of losing access to their chosen health care providers. They may also face higher cost-sharing for some medical services than they would have under traditional Medicare. In short, moving to a Medicare Advantage plan forces beneficiaries to give up traditional Medicare and its open access to doctors of their choice in exchange for improved drug coverage.

Requiring such a tradeoff runs counter to one of the basic premises of the Medicare Modernization Act (MMA) that created the Part D program. As Congress debated the MMA in 2003, President Bush asserted that "all seniors should be able to choose the health care plan that best fits their needs without being forced into an HMO."[6] This is why stand-alone Part D drug plans were established—to supplement traditional Medicare, rather than to limit drug coverage to only Medicare Advantage managed care plans. For a large number of seniors, however, the promise of choice—the promise of being able to obtain meaningful drug coverage within traditional Medicare—will be broken in 2007.

Doughnut Hole Problems Will Worsen

Looking to the future, it is troubling that stand-alone drug plans with meaningful coverage through the doughnut hole will become increasingly expensive—or disappear entirely. The size of the doughnut hole is not fixed. Rather, it is tied to overall increases in the cost of Part D drugs. As drug prices increase, so does the size of the hole. Table 4 shows how the doughnut hole has grown from 2006 to 2007, as well as its projected size in 2013. In 2007 alone, the doughnut hole will grow from $2,850 to $3,051. It could reach more than $5,000 by 2013.[7]

Table 4

The Growing Doughnut Hole

Year	Initial Coverage Limit (Doughnut Hole Begins)	Catastrophic Threshold (Doughnut Hole Ends)	Overall Coverage Gap (Size of Doughnut Hole)
2006	$2,250	$5,100	$2,850
2007	$2,400	$5,451	$3,051
2013*	$4,000	$9,066	$5,066

Sources: 2006 and 2007 data are from the Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, Medicare Part D Benefit Parameters for Standard Benefit: Annual Adjustments for 2007 (Washington: CMS, May 22, 2006), available online at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/downloads/2007_Part_D_Parameter_Update.pdf. 2013 projection by the Congressional Budget Office, *A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit* (Washington: Congressional Budget Office, July 2004), p. 9.

*Projection.

As the doughnut hole grows in future years, seniors will need better coverage to protect themselves from its financial burdens. The current $2,850 gap, which is already a major worry for those with substantial drug needs, could well become a crushing financial burden for seniors very soon. But information on the 2007 plans indicates that stand-alone Part D plans are not going to be a source of meaningful, affordable coverage through the doughnut hole in the coming years.

Conclusion

The release of information on the 2007 stand-alone drug plans brings discouraging news to those seeking coverage through Part D's doughnut hole. Fewer plans are offering meaningful doughnut hole coverage, and those that do are charging substantially more. The major alternatives for seniors, such as limiting their doughnut hole coverage to generics, or generics and preferred brand-names, are inadequate. Joining a Medicare Advantage plan with good doughnut hole coverage, when one is available, requires substantial tradeoffs. Moreover, the problem of inadequate doughnut hole coverage will worsen in the future as the doughnut hole grows.

Fundamental changes are needed to the structure of the Medicare Part D benefit to eliminate the doughnut hole and provide the continuous, comprehensive drug coverage that all Medicare beneficiaries need and deserve.

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[1] Testimony of Mark McClellan before the House Committee on Energy and Commerce, Subcommittee on Health, March 1, 2006, p. 5.

[2] U.S. Department of Health and Human Services, *News Release: Medicare Releases Data on 2007 Drug Plan Options* (Washington: U.S. Department of Health and Human Services, September 29, 2006).

[3] Data are on the 25 most frequently prescribed drugs in 2004 in the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) program.

[4] Not all of these beneficiaries are currently covered by stand-alone prescription drug plans. Some have coverage through former employers, for example. If they need a stand-alone drug plan with meaningful doughnut hole coverage in 2007, however, they will not be able to obtain it. In these states, an additional 134,000 beneficiaries in 2006 and 2.3 million beneficiaries in 2007 will have coverage while in the doughnut hole because they are Medicaid-Medicare dual eligibles or have been approved for the low-income subsidy by the Social Security Administration.

[5] We used the Medicare Prescription Drug Plan Finder to assess the offerings of most plans listed as providing generic and preferred brand-name drug coverage through the doughnut hole. None of these plans provided any doughnut hole savings on the top non-generic drugs.

[6] Remarks of President George W. Bush, March 4, 2003, available online at http://www.whitehouse.gov/news/releases/2003/03/20030304-5.html.

[7] Congressional Budget Office, *A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit* (Washington: Congressional Budget Office, July 2004), p. 9.

Methodolgy

Identifying the Plans

The Centers for Medicare and Medicaid Services (CMS) provides basic information about all stand-alone drug plans and Medicare Advantage plans in its *Landscape of Plans*, which is available online at www.medicare.gov. We used the source file for the *Landscape of Plans* to identify every stand-alone drug plan in each state that provided coverage for all formulary drugs in the doughnut hole in 2006 and 2007. (The source file is preferable to the actual *Landscape of Plans* documents because it appears to have been updated more recently.) In states where more than one such plan was available, we reported the plan with the lowest monthly premium for that year.

We also used the *Landscape of Plans* source file to identify stand-alone drug plans that covered generic and preferred, brand-name drugs through the doughnut hole. We then used the Medicare Prescription Drug Plan Finder to determine if these plans provided doughnut hole coverage of the top 25 drugs used by seniors.

Finally, to assess the availability of Medicare Advantage plans with complete doughnut hole coverage, we used the *Landscape of Medicare Advantage Plans* and examined the availability of such plans in each state.

Counting the Beneficiaries

The number of affected beneficiaries in Table 2 is drawn directly from CMS's reported figures for the number of Medicare beneficiaries with prescription drug coverage as of June 2006. As noted in Endnote 4, not all of these beneficiaries are currently enrolled in stand-alone prescription drug plans. Some are in Medicare Advantage plans, and others have coverage through former employers. However, the availability of a stand-alone drug plan with meaningful doughnut hole coverage is relevant to all these beneficiaries, as they may choose, or be forced to, switch to traditional Medicare (for example, if their former employer cuts their coverage).

The enrollment figures subtract dual eligibles reported by CMS and individuals eligible for the low-income subsidy reported by the Social Security Administration (SSA), because both groups have coverage while in the doughnut hole. A small number of individuals in Medicare Savings Programs also have coverage through the doughnut hole, but state-specific data are not available for this population, which is roughly 1.1 million nationally. The estimates for 2007 also do not reflect the expected growth in Medicare due to people aging into the system. Therefore, the 2007 figures both slightly overestimate and underestimate the actual numbers of beneficiaries affected.

Drugs

The top 25 drugs cited are the most frequently prescribed drugs in the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) program for 2004. More information about this drug list is available in the Appendix to *Big Dollars, Little Sense: Rising Medicare Prescription Drug Prices* (Washington: Families USA, June 2006).

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