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Medicare Beneficiaries Confused and Angry Over Gap in Drug Coverage

By [ROBERT PEAR](#)

WASHINGTON, July 29 — Tens of thousands of Medicare beneficiaries who signed up for prescription drug coverage are paying monthly premiums, but Medicare is not paying any of their drug costs because they have reached a gap in their coverage.

The gap, the notorious “doughnut hole,” is upsetting many beneficiaries, and it has become a potent symbol as politicians debate the merits of the new program.

Federal officials and outside experts say that 3 million to 3.5 million people may fall into the gap this year, about half the number predicted. While lawmakers and lobbyists were well aware of the problem, it is attracting fresh attention because many beneficiaries are just now discovering it.

The original estimates assumed that people would sign up for drug coverage in January, but many waited until April or May. They will file fewer claims than expected and are therefore less likely to reach the gap in coverage this year.

Poor people eligible for Medicare and Medicaid have no gap in the benefit. In addition, many retirees found that employer-sponsored health plans provided better drug benefits than Medicare, so they stayed in those plans, which rarely have a gap in coverage.

Beneficiaries often learn about the doughnut hole when they try to refill prescriptions. They may be asked to pay \$75 to \$125 or more for a drug they had been receiving for a co-payment of \$20 to \$30.

Marcella Crown, 80, of Des Plaines, Ill., near Chicago, takes Lipitor for high cholesterol, Diovan for high blood pressure, Synthroid for thyroid disease, Fosamax for osteoporosis, Nexium for heartburn and several other drugs.

Mrs. Crown signed up in November for a drug plan offered by Blue Cross and Blue Shield of Illinois. Her coverage began in January, and she reached the coverage gap in April.

Her husband, David F. Crown, a retired mechanical engineer, said: “Blue Cross is saying that even though she will get no benefit, she must still pay the premiums. That’s outrageous. We have never had insurance policies that gave us no benefit yet required us to pay premiums.”

Melvin A. Kinnison, 65, of Huntington Beach, Calif., a retired deputy sheriff with diabetes and prostate cancer, said: “The drug benefit was fine for a while, until the doughnut hole came around. It was a total surprise. Nobody ever explained it to me.”

Mr. Kinnison said he reached the coverage gap in June. The cost for a month’s supply of Cymbalta, which he takes for diabetic nerve pain, jumped to \$104, from \$20.

Former Senator Dave Durenberger, a Minnesota Republican who runs a national health policy forum, said, “The doughnut hole could have negative repercussions for [Republicans](#) in the November midterm elections.”

[Democrats](#) hope that is the case. The coverage gap is “a goofy idea,” said Senator Byron L. Dorgan, Democrat of North Dakota.

Administration officials play down such concerns.

Dr. [Mark B. McClellan](#), administrator of the Centers for Medicare and Medicaid Services, said beneficiaries had already saved about \$1,500 by the time they reached the coverage gap. Beneficiaries concerned about the gap, Dr. McClellan said, can often reduce their costs by switching to generic drugs and by taking advantage of assistance programs offered by many states and by drug manufacturers. Next year, he said, they can switch to plans that offer some coverage in the gap.

While beneficiaries are generally responsible for all drug costs in the gap, they do have access to discounts negotiated by their plans.

Many beneficiaries, like Mr. and Mrs. Crown, had heard about the coverage gap but did not fully understand how it worked.

Under the standard drug benefit defined by Congress in the 2003 Medicare law, the beneficiary pays a \$250 deductible and then 25 percent of drug costs from \$251 to \$2,250. When total yearly drug costs, paid by the beneficiary and the plan, reach \$2,250, the coverage stops, and the beneficiary pays 100 percent of the cost of each prescription, until the person's out-of-pocket costs reach \$3,600. At that point, insurance resumes, and the beneficiary pays about 5 percent of the cost of each drug. The tabulation of costs begins anew each year.

Wen A. Daniels of California Health Advocates, an insurance counseling organization, said she had clients who reached the gap in January or February because they were taking high-cost drugs like Avastin, Gleevec and Iressa for different types of cancer; Pegasys for hepatitis; Betaseron for multiple sclerosis; and Tracleer for a life-threatening lung condition.

UnitedHealth, the largest sponsor of Medicare drug plans, with 4.5 million members, said that 45,000 of them had reached the point where the coverage gap begins.

Jacqueline B. Kosecoff, chief executive of Ovations Pharmacy Solutions, a unit of UnitedHealth, said that 13,000 beneficiaries now had to pay the full cost of their medicines. The other 32,000 receive low-income subsidies that reduce or eliminate their co-payments, Dr. Kosecoff said.

Mrs. Crown fell into the coverage gap much sooner than she had expected. She thought she would not have to pay the full price for drugs until she had spent \$2,250 of her own money. In fact, the gap begins when total spending, by the beneficiary and the plan together, totals \$2,250.

"I did not understand the rules," Mrs. Crown said. "When I heard about the doughnut hole, I thought it referred only to the amount that I paid for my prescriptions."

Other beneficiaries have underestimated the size of the coverage gap. They incorrectly believed that it would run from \$2,250 to \$3,600, the figures emphasized in brochures published by the government and insurance companies.

In fact, the coverage gap is twice as large as those numbers would suggest. The \$2,250 is a measure of total drug spending. The \$3,600 is a measure of out-of-pocket costs; it corresponds to about \$5,100 in total drug spending. Under the standard benefit, a consumer is personally responsible for \$2,850 of drug spending in the coverage gap — the amount from \$2,250 to \$5,100.

Most people with Medicare drug coverage, about 90 percent, are in plans that differ from the federal prototype. One insurance plan may have a \$20 co-payment for a particular drug, while others charge \$30 or \$50. People taking the same drugs in different plans will reach the gap at different times and will pay different prices once they are in the gap.

Some plans partly fill the gap by covering low-cost generic drugs. A small number of plans also cover brand-name drugs, but beneficiaries usually must pay higher premiums.

Lawmakers do not defend the coverage gap as sound health policy. Rather, they say, it was a way to limit the cost of the new program while providing some benefits to almost everyone, comprehensive coverage to low-income people and generous catastrophic coverage to people with high drug costs.