Waste in the Medicare Drug Benefit: Why the Doughnut Hole is Unnecessary

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About the Author

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Executive Summary

This paper examines some of the costs associated with the design of the Medicare drug benefit using the "doughnut hole" gap in coverage as a yardstick with which to assess these costs. It notes that:

- The Congressional Budget Office's projection of the higher administrative costs that result from having the plan administered through private insurers, instead of the existing Medicare system, is almost one-fourth as large as the doughnut hole. This implies that if the benefit had been administered through the existing Medicare system, then the doughnut hole could be considerably smaller at no additional cost to the government.

- If Medicare had been allowed to bargain directly with the pharmaceutical industry, and could obtain prices as low as the Australian government does, the savings would be more than twice the size of the doughnut hole. This would allow for elimination of the doughnut hole, in addition to substantial savings for the federal and state governments.

- A survey by the Medicare Payment Advisory Council found that the typical beneficiary spent more than 8 hours deciding among the competing plans being offered under the program. The implicit cost of this time is equal to approximately 40 percent of the size of the doughnut hole.

- A survey by a consulting firm found that primary care physicians claimed that they were spending an hour and half daily counseling patients on the benefit. While this figure is far too high to be plausible, it does indicate that doctors perceive the benefit as imposing a substantial burden on their time. The time required of doctors, pharmacists and other health care providers because of the unnecessary complexity of the plan is likely to be substantial and should be included in any comprehensive assessment of the benefit in its current design.

It is clear that the specific design of the 2003 bill added substantially to the benefit's cost and complexity. It will be important to assess these costs through time in order to find ways in which the bill can be redesigned to be more efficient.

Introduction

This summer and fall, millions of senior citizens and disabled Americans enrolled in Medicare Part D drug plans will discover first hand the "doughnut hole," the unusual $2,850 gap in coverage that was placed into the plan to save the government money. This doughnut hole is peculiar because it goes directly against the general design of insurance. Usually insurance policies are designed to protect holders against large losses. Policies typically have deductibles and/or co-pays with the assumption that most people can afford modest costs. After a certain level of costs, typically the share born by the insurer increases – this is the bad event against which the policy holder is insuring themselves.

FIGURE 1. Per Person Drug Expenditures Under Medicare Drug Plan
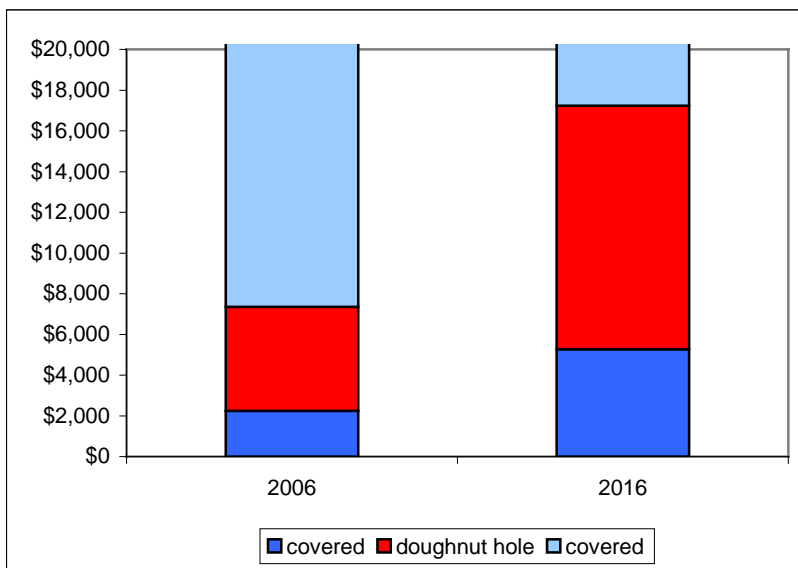
Source: Author's calculations: see text

The Medicare drug benefit effectively takes the opposite approach. There is an initial deductible, and the basic formula provides for a 25 percent co-payment, but the benefits continue only until the beneficiary incurs $2,250 in drug expenses for the year. At that point the beneficiary is directly liable for the next $2,850 in annual expenditures, with no assistance provided through the benefit. Only if expenses exceed $5,100 for the year will the insurance again provide benefits, at that point paying 95 percent of expenses in excess of $5,100.

The size of this doughnut hole will grow in the future, since the basic benefit schedule is indexed to average per person drug spending, which is projected to grow at a rate of more than 8 percent annually. This means that the spending cutoff that places people in the doughnut hole will be 8 percent higher next year (approximately $2,430), but the point at which coverage kicks back in will also be 8 percent higher (approximately $5,508). This would leave a gap, where seniors could potentially spend $3,078 on prescription drugs, without receiving any assistance from their Part D insurance. (It is worth noting that beneficiaries are still required to pay the monthly insurance premium even during the period where they are in the doughnut hole.) Current projections show the

size of the doughnut hole expanding to more than $6,100 in 2016 (see Figure 1). While the Part D benefit will still pay on average the same percentage of beneficiaries' drugs, with drug prices projected to rise rapidly relative to income growth, the gap in coverage will be far larger relative to projected income in the future than it is today.[1]

This peculiar design was adopted in order to limit the cost of the Medicare drug benefit. Of course, there were other ways in which costs could have been contained. For example, the Congressional Budget Office estimated that the decision to have the program administered through private insurers rather than the existing Medicare program added nearly $5 billion a year to the program's expenses. In addition, the provision to prohibit Medicare from bargaining directly with the drug companies for lower prices, as is done by the Veterans Administration and other governments, may have added more than $40 billion to the annual cost of the program in its first years.[2] This paper compares the size of the savings from the doughnut hole with various sources of waste that resulted from the design of the Medicare drug benefit.

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[1] See Baker, D. 2003. "Still a Pain: The Cost of Prescription Drugs to Seniors With the Medicare Drug Benefit." Washington, DC: Center for Economic and Policy Research [http://www.cepr.net/publications/medicare_drug_benefit.pdf].
[2] See Baker, D. 2006. "The Savings From an Efficient Medicare Drug Plan," Washington, DC: Center for Economic and Policy Research [http://www.cepr.net/publications/efficient_medicare_2006_01.pdf]. The additional cost that results from the prohibition on bargaining is projected to rise to more than $100 billion annually by 2012.

The Size of the Doughnut Hole

While the doughnut hole will grow through time as drug costs rise, the savings to the government from the doughnut hole are limited. Table 1 shows the percentage of beneficiaries projected to reach various spending levels for prescription drugs in 2006.

TABLE 1

Projected 2006 Spending on Prescription Drugs by Medicare Beneficiaries

Spending levels	Percent of Beneficiaries
$0 -$1,080	35.0%
$1,080 - $2,160	17.0%
$2,160 - $3,240	13.7%
$3,240 - $4,320	9.2%
$4,320 - $5,400	7.2%
$5,400 - $6,480	4.9%
$6,480 - $7,560	3.1%
$7,560 - $8,640	2.4%
$8,640 - $9,720	1.4%
$9,720 -$10,800	1.2%
Over $10,800	4.3%

Source: Congressional Budget Office.

Based on this projected distribution of spending, it is possible to calculate the amount of drug spending that will fall into the doughnut hole. Table 2 shows the amount of expenditures for each spending bracket that will fall into the doughnut hole. The calculations assume that average spending in each bracket is the mid-point on the bracket.

The calculations in Table 2 show the size of the doughnut hole based on 2006 levels of drug expenditures would be approximately $20.5 billion, if all beneficiaries were enrolled in the program from January 1. Since many beneficiaries did not enroll in Part D until April or May, the number of people and the amount of expenditures that fall into the doughnut hole in 2006 will be substantially less than is indicated by the calculations in Table 2.

However, these calculations still provide a useful point of reference. In 2007, when the vast majority of beneficiaries will be enrolled in the program for the whole year, the calculations in Table 2 should give a reasonable approximation of the amount of expenditures that will fall into the doughnut hole, with the qualification that average per person drug expenditures are projected to be approximately 8.0 percent higher than in 2006. Given the program's formulas, the size of the doughnut hole will rise through time at the same rate as the increase in the cost of drugs per beneficiary, or 8 percent annually, as projected by the Congressional Budget Office.

TABLE 2

**Projected 2006 Doughnut Hole Expenditures by Medicare Beneficiaries**

Total Spending Levels	Per Person Doughnut Hole Expenditures	Number of Beneficiaries (millions)	Total Doughnut Hole Expenditures (billions)
$0 -$1,080	$0	11.2	$0
$1,080 - $2,160	$0	5.3	$0
$2,160 - $3,240	$308	4.3	$1.30
$3,240 - $4,320	$1,118	2.9	$3.30
$4,320 - $5,400	$1,928	2.3	$4.40
$5,400 - $6,480	$2,138	1.5	$3.30
$6,480 - $7,560	$2,138	1	$2.10
$7,560 - $8,640	$2,138	0.8	$1.60
$8,640 - $9,720	$2,138	0.4	$0.90
$9,720 -$10,800	$2,138	0.4	$0.80
Over $10,800	$2,138	1.4	$2.90
Total			**$20.5**

Source: Congressional Budget Office and author's calculations.

Unnecessary Costs of the Drug Benefit

There are several sources of unnecessary costs associated with the specific design of the Medicare Modernization Act of 2003. Two sources of higher costs have received considerable attention: the additional administrative costs incurred as a result of providing the benefit through private insurers rather than the existing Medicare system, and the higher cost of drugs due to the prohibition against Medicare bargaining directly with drug companies for lower prices. The law imposes other costs that are more difficult to document, but may nonetheless be substantial. One of the most obvious of these is the cost imposed on beneficiaries, in the form of time spent analyzing various policy options as a result of the excessive complexity of the system. This cost is also imposed on health care providers and pharmacists as they assist beneficiaries in navigating the system. This section will assess the size of these costs in comparison to the size of the doughnut hole.

FIGURE 2.   The Relative Size of the Doughnut Hole and Sources of Waste in the MMA
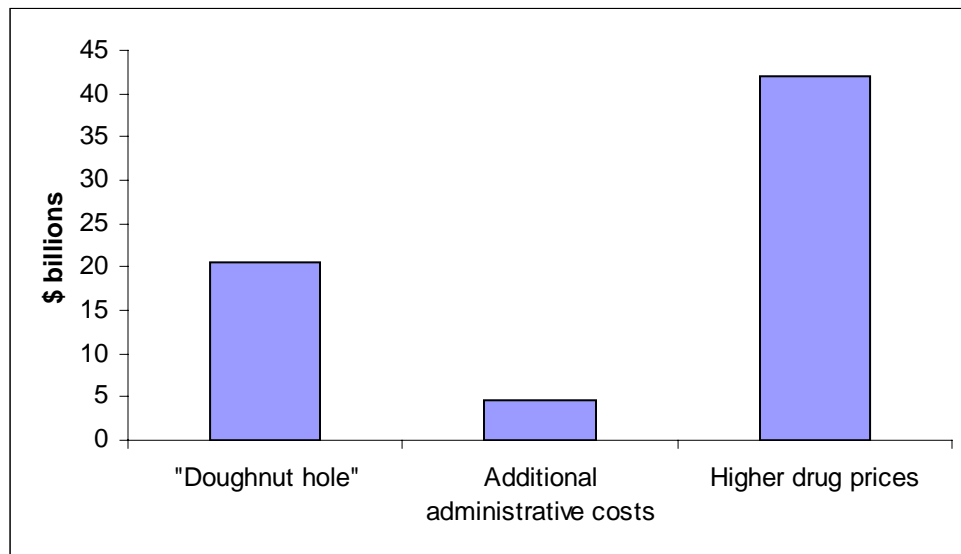
Source: Congressional Budget Office and author's calculations

It is relatively simple to obtain estimates of the additional costs associated with the decision to offer the benefit through private insurers instead of the existing Medicare system. The Congressional Budget Office projected that additional administrative costs due to the marketing expenses and profits of the private insurers would be approximately $4.6 billion in the first year for which the program was in operation.[3] It is also possible to calculate the potential savings to the beneficiaries and the government if Medicare had been allowed to use its bargaining power to negotiate drug prices on behalf of beneficiaries. If Medicare had been able to negotiate the same price reductions as

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[3] This projection appears in CBO, 2004. "A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit." Washington, DC: Congressional Budget Office, p 17 [http://www.cbo.gov/showdoc.cfm?index=5668&sequence=0].

the Australian government, it would have reduced projected drug expenditures by approximately $42 billion in 2006.[4]

Figure 2 shows the size of the doughnut hole in 2006, relative to the additional administrative costs attributable to the decision to provide the benefit through private insurers, as well as the potential savings from having Medicare act as a bulk buyer of drugs. As can be seen, the additional administrative expenses that result from using private insurers are equal to almost one-fourth of the size of the doughnut hole. This means that if the program had taken advantage of Medicare efficient administrative structure, the doughnut hole would be considerably smaller. The last bar shows that the potential savings from having Medicare negotiate directly with drug industry are more than twice the size of the doughnut hole. In other words, if Congress had allowed Medicare to negotiate directly with the drug industry, it would have been possible eliminate the doughnut hole altogether, and still have savings left over to reduce the costs to the federal and state governments.

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[4] The derivation of this calculation is explained in Baker, 2006.

Other Costs of Administrative Complexity

It is more difficult to quantify the costs to beneficiaries and providers of the additional complexity resulting from the decision to provide the drug benefit through private insurers, but it is possible to calculate the general order of magnitude of these costs. In the case of the cost incurred by beneficiaries as a result of the time required to select among competing plans, a survey by the Medicare Payment Advisory Commission found that more than half of the people who had signed up for a plan (the survey was conducted in February and March of 2006) had spent more than 8 hours examining their options.[5]

Assigning the economy-wide average hourly compensation for workers as the value of this time to beneficiaries implies that the cost of this selection averaged $240 for the beneficiaries who went through this process.[6] This cost is substantial relative to the size of the doughnut hole.

FIGURE 3.   The Per Person Cost of the Doughnut Hole and Time Spent Choosing Plans
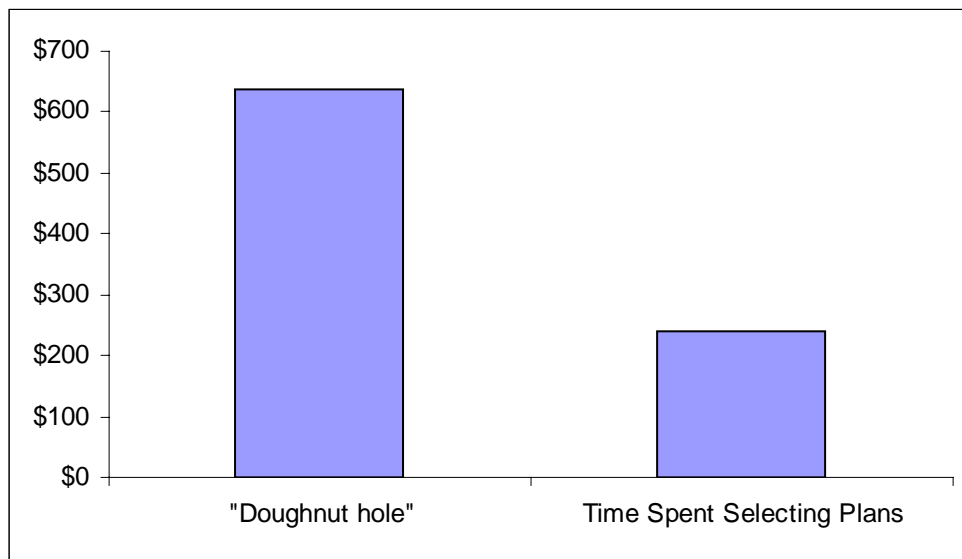
Source: Congressional Budget Office, Medicare Payment Advisory Commission, and author's calculations

Figure 3 shows the average size of the doughnut hole ($640 per beneficiary) compared to the cost of the time spent choosing plans. It is understandable that many seniors would have viewed this expenditure of time as a substantial and unnecessary burden. In principle, this will be a one-time expenditure of time, since most seniors will probably opt to remain with the plan they have chosen. However, it is possible that changes in their prescription drug usage or changes in the plan coverage

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[5] See Medicare Payment Advisory Council, 2006. "How Beneficiaries Learned About the Drug Benefit and Made Plan Choices," Table 8-4, [http://www.medpac.gov/publications/congressional_reports/Jun06_Ch08.pdf].

[6] This calculation assumes an average hourly compensation of $30. This is derived from the $26.60 average hourly compensation for all workers shown in Mishel, Bernstein and Allegretto, 2005, Table 2-2, adjusted upward by 12.6 percent for the inflation in the years from 2002-2006.

may make their current plans less desirable. It may also be the case that some insurers may opt to leave the market, as happened with the Medicare Plus Choice program. In such circumstances, beneficiaries will be forced to go through the process of selecting a plan again.

The fourth source of costs incurred by the decision to have the drug benefit administered through private insurers is the additional time spent by doctors and other health care providers in helping beneficiaries navigate the system. No reliable data exists yet to measure how much time the benefit is actually requiring from providers, but there is some anecdotal evidence suggesting that the cost is substantial. For example, a survey by the J. Scott Group found that the average primary care physician was spending 1.5 hours a day communicating with patients about the Part D benefit.[7] While this figure is far too large to be plausible, it does indicate that physicians perceive the benefit as being a substantial imposition on their time. Even if the burden were just 1.5 hours per week, it would still impose costs in terms of physicians' time of more than $1 billion a year.[8]

Of course, even the simplest benefit would require some amount of time from doctors, as they would still be required to consider cost as a factor in choosing medicines. But, this time would be far less if there were just a single set of prices and rules. Also, if Medicare had bargained drug prices down closer to their production costs, price differences would usually not be large. This would allow doctors to make their prescription decisions based primarily on their assessment of the best drug for their patients.

In addition to the demands on doctors' time, the complexity of the plan is also placing a large burden on pharmacists. They have had learn the rules for the various plans that are part of the Medicare program. Pharmacists have also had to deal with the slip-ups with the system, which have often left people without proper coverage. In these cases, pharmacists have frequently opted to still provide drugs to customers in the hope of getting payment later, rather than sending Medicare beneficiaries home without necessary medication. Such situations have both involved large amounts of time, and also exposed pharmacies to financial risk.

A full assessment of the cost of the Medicare Modernization Act would have to include these costs and other costs that have been imposed on providers due to its complexity. While providers may initially absorb many of these costs, over the long-term, they will be passed on to consumers. If doctors find that they have less time to treat patients because of the complexity of the paper work associated with the Medicare drug plan, they will end up charging higher fees for their time with patients. Similarly, if the complexity of the plan forces doctors offices, hospitals, and pharmacies to hire more office staff, then this cost will also be passed on in higher prices. It is too early to know whether the problems encountered thus far are simply a result of the initial confusion associated with the introduction of the benefit, or whether they are intrinsic to the structure of the new plan. In either case, these costs are likely to be large relative to the cost of the program and must be considered in a full assessment of its impact.

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[7] These results are reported on PharmaLive.com, June 8, 2006
[http://www.pharmalive.com/News/index.cfm?articleid=348220]. In addition, the survey found that their staff was fielding an additional 5 calls per day.
[8] If hourly compensation averages $80, this implies a time burden of $6,000 per year, per physician.

Conclusion

The peculiar features of the Medicare Modernization Act have imposed large costs on seniors, people with disabilities, the government, and health care providers. Specifically, the rule that prohibits Medicare from establishing its own plan, and negotiating price discounts directly with the pharmaceutical industry, has added hundreds of billions of dollars to the cost of the program over its first decade.

In addition, the decision to only provide the benefit through private insurers substantially increased both the cost and complexity of the program. The direct administrative costs are readily measured, with the Congressional Budget Office projecting the size to be almost one fourth as large as the "doughnut hole" in coverage. Other costs from the complexity are less well measured, but are also likely to be large. These include the costs to individuals in the form of the time spent selecting from the various plans available and the time that doctors, pharmacists, and other providers must spend familiarizing themselves with plan rules, and counseling beneficiaries. At this point, it is too early to have reliable estimates of these costs, but the evidence that it is available indicates that these costs could be substantial.

The design of the Medicare Modernization Act was highly controversial when it was approved by Congress in 2003. As more evidence becomes available concerning its cost and complexity, Congress would be wise to reform the benefit to reduce waste and improve coverage.