



The Origins of the Doughnut Hole: Excess Profits on Prescription Drugs

BY DEAN BAKER

The Medicare drug benefit was not designed in a way to minimize costs to the government and beneficiaries. Instead, Congress designed a plan that ensures high profits for the pharmaceutical and insurance industries. One result of this design is that the Medicare drug benefit includes an unusual \$2,850 gap in coverage, where beneficiaries are entirely responsible for their drug bills. The standard plan covers 75 percent of prescription drug costs until the beneficiary's drug expenditures reach \$2,250 for the year. The beneficiary is then fully liable for their drug expenses until they reach \$5,100.¹ At that point, the insurance kicks back in, covering 95 percent of additional drug costs.

This gap in coverage was put into the plan to save the government money. While the bill was intended to assist seniors with their drug expenses, Congress wanted to limit public spending on the program. The "doughnut hole" gap in coverage was the mechanism chosen. The excess profits of the prescription drug industry are the main factor that led to the need for the doughnut hole. This paper calculates the amount of excess profits of the 20 most commonly used drugs, and compares them to the size of the doughnut hole.

Of course, the doughnut hole was not the only way that Congress could have limited the cost of the program. Congress chose to administer the program through private insurers instead of allowing the public Medicare system to offer the drug benefit as a simple add-on. It is far more expensive to administer the program through private insurers because they incur marketing expenses. Private insurers also have highly paid top executives and must produce profits for their shareholders. According to the Congressional Budget Office, the decision to administer the plan through private insurers added almost \$5 billion to the annual cost of the program, an amount that is equal to 22 percent of the size of the doughnut hole gap in coverage.²

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¹ The size of this gap is projected to increase by approximately 8.5 percent annually since the cutoffs are indexed to average per person drug expenditures for people included in the Medicare drug benefit.

² This is discussed in Baker, D. 2006a. "The Savings From an Efficient Medicare Drug Benefit," Washington, D.C.: Center for Economic and Policy Research, [http://www.cepr.net/publications/efficient_medicare_2006_01.pdf].

TABLE 1**Excess Profits Created by the Medicare Drug Act (by Prescription Drug)**

Drug	Manufacturer	Annual Prescriptions (millions)	Prices (in dollars)			Excess Profits (millions of dollars)
			Veterans Administration	Part D (low)	Part D (high)	
Actonel	Proctor& Gamble	9.7	372	703	903	223.8
Aricept	Pfizer	4.3	1059	1553	1796	143.9
Celebrex	Pfizer	11.0	632	903	1107	216.4
Fosamax	Merck	17.9	265	728	903	543.9
furosemide	(generic)	34.8	9	13	89	60.9
Lipitor (10 mg)	Pfizer	31.6	520	749	927	530.1
Lipitor (20 mg)	Pfizer	31.6	782	1068	1302	669.8
metoprolol tartrate	(generic)	22.0	7	12	90	39.4
Nexium	AstraZeneca	22.9	848	850	1652	358.5
Norvasc (5 mg)	Pfizer	16.3	316	463	593	180.8
Norvasc (10 mg)	Pfizer	16.3	490	637	795	188.8
Plavix	Bristol-Myer's	18.8	989	1284	1529	412.4
Prevacid	AstraZeneca	22.2	657	862	1650	603.1
Protonix	Wyeth	16.4	214	1111	1529	990.4
Toprol XL (50 mg)	AstraZeneca	8.2	163	225	343	48.4
Toprol XL (100 mg)	AstraZeneca	8.2	250	336	491	65.7
Xalatan	Pfizer	6.9	280	556	701	130.2
Zocor (20 mg)	Merck	11.2	127	1275	1776	855.7
Zocor (40 mg)	Merck	11.2	191	1275	1711	800.4
Zoloft	Pfizer	27.0	542	787	1170	585.2
Total						\$7,647.9

Source: Families USA 2006 and author's calculations, see appendix.

Congress also prevented Medicare from directly negotiating price discounts with drug manufacturers, as is done by the Veterans Administration and the health care systems in most other wealthy countries. As a result, prescription drugs cost far more under the Medicare drug benefit plan than is necessary. In the case of many drugs, the prices paid by insurers participating in the plan are more than twice as high as the prices paid by the Veterans Administration.

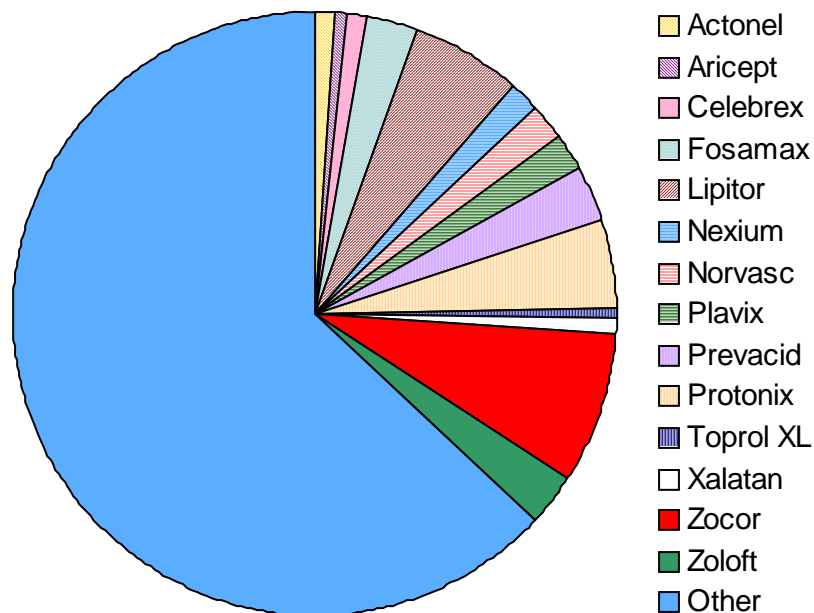
Since the industry is already making a profit at the price for which it sells drugs to the Veterans Administration, the higher price paid by the private insurers participating in the Medicare drug benefit is pure profit for the drug industry. The excess profits earned by the industry as a result of these higher prices can be thought of as the “doughnut” in the Medicare drug benefit. It is relatively simple to get an approximation of the size of these excess profits for the most widely used drugs.

Table 1 calculates the amount of excess profits earned on each of the twenty drugs most frequently used by seniors. (See the appendix for a full explanation of the construction of the table and sources.) The first column lists the drugs in alphabetical order. The second column shows the

manufacturer for each of the brand drugs. The third column shows the total number of prescriptions issued for each drug in 2005. The fourth column shows the lowest price at which the drug is available through the Veterans Administration. The fifth and sixth columns show, respectively, the lowest and highest prices listed for the same drugs from private insurers participating in the Medicare drug program. The last column shows the excess profits earned on each of the drugs. The calculation of excess profits is based on the difference between a weighted average of the prices available through insurers participating in the Medicare drug benefit and the price at which the drug can be obtained through the Veterans Administration.³

The table shows that for several of the drugs the excess profits are substantial. For example, the excess profits earned on Protonix, a heartburn medication, are calculated as just under \$1 billion. The combined excess profits earned on the two dosages for Zocor, a cholesterol lowering drug, are more than \$1.6 billion. The combined excess profits for the two dosages of Lipitor, another cholesterol lowering drug, come to \$1.2 billion.

FIGURE 1. Where the Doughnut Hole Goes



Source: Author's calculations, see appendix.

The excess profits on this small group of drugs is in fact fairly sizable relative to the doughnut hole gap in coverage under the prescription drug plan. Figure 1 shows the size of excess profits on these drugs relative to the size of the doughnut hole. The excess profit earned on Protonix alone is almost 5 percent of the size of the doughnut hole, the excess profits on Lipitor are close to 6 percent of the size of the doughnut hole.

In fact, there are thousands of different types of drugs, dosages, and delivery mechanisms, which in nearly all cases cost more than necessary under the Medicare drug plan, because Congress prohibited

³ The weights for the insurers' prices are 0.67 for the lowest price from a private insurer and 0.33 for the highest price. The assumption is that most drugs brought through the private plans are bought at prices that are close to the lowest available price in the system.

Medicare from directly negotiating drug prices with the pharmaceutical industry. If Medicare had been allowed to negotiate in the same way as the Veteran's Administration, the savings would have been more than enough to eliminate the doughnut hole gap in coverage. The calculations in this paper simply show the size of the excess profits on a small subset of this group. The excess profits for the industry as a whole, measured as the gap between the prices paid under Medicare Part D and the prices paid by the Veteran's Administration will be close to \$50 billion in the first full year of the program's operation. This is more than twice the size of the doughnut hole.⁴

⁴ This calculation can be found in Baker 2006a.

Appendix

The list of the twenty most frequently used drug by seniors, as well as the Veterans Administration and Medicare Part D prices, is taken from Families USA, 2006. “Big Dollars, Little Sense: Rising Medicare Prescription Drug Prices,” Washington, D.C.: Families USA. [<http://www.familiesusa.org/resources/publications/reports/big-dollars-little-sense.html>]

The number of prescriptions for each drug was based on the 2005 data from RxList – “Top 300 Drugs” [<http://www.rxlist.com/top200a.htm>]. In cases where different dosages of the same drug appear on the Families USA list, the calculations assume that prescriptions are evenly divided between the two dosages. The calculations assume that each prescription corresponds to one-month’s usage, so that the number of prescriptions was divided by 12 to get the number of full year users. The calculations also assume that 70 percent of the prescriptions for the top 20 drugs among seniors were used by seniors in the Medicare drug plan. The savings per user are calculated as the difference between a weighted average of highest and lowest Medicare drug benefit price ($0.67 * \text{the lowest price} + 0.33 * \text{the highest price}$) and the Veterans Administration price. The size of the doughnut hole for figure 1 is calculated as \$20.4 billion.⁵

⁵ See Baker, D. 2006b. “Waste in the Medicare Drug Benefit: Why the Doughnut Hole Is Unnecessary,” Washington, D.C.: Center for Economic and Policy Research [http://www.cepr.net/publications/medicare_waste_2006_07.pdf].