
The Medicare Part D Coverage Gap: Costs and Consequences in 2007

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A unique feature of the Medicare Part D drug benefit is the so-called “doughnut hole,” the gap in coverage in which Part D enrollees are required to pay the full cost of their drugs until they qualify for catastrophic coverage. In 2007, the first full year of enrollment in Part D plans for many beneficiaries, the coverage gap began when a beneficiary incurred \$2400 in total drug spending and ended after out-of-pocket spending reached \$3850, equivalent to \$5451 in total drug spending (Figure 1). Once through the gap, beneficiaries become eligible for catastrophic coverage where most of the costs of on-formulary drugs are covered. Between 2007 and 2017, the dollar value of the coverage gap is projected to double, exposing some beneficiaries to potentially high out-of-pocket costs and increasing the risk of cost-related noncompliance. In 2008, as in 2006 and 2007, the majority of stand-alone Medicare prescription drug plans (PDPs) and Medicare Advantage Prescription Drug (MAPD) plans have a coverage gap and most Part D enrollees are in plans with such a gap.¹

This report provides new information to address several important questions related to Medicare Part D enrollees’ experiences with the coverage gap in 2007. Because 2007 is the first year in which most beneficiaries were enrolled for 12 months, it represents the first time they faced the full impact of the gap. The study examines the share of enrollees that reached the coverage gap in 2007 and their characteristics, and the share of enrollees with spending high enough to receive catastrophic coverage. It assesses the

extent to which Part D enrollees stopped taking medications or switched to less expensive alternatives after they reached the coverage gap, focusing on Part D enrollees taking one or more drugs in eight drug classes to treat several relatively common chronic conditions: Alzheimer’s disease, high cholesterol, depression, diabetes, gastroesophageal reflux disease, heart failure, hypertension, and osteoporosis. It also examines changes in out-of-pocket and total spending associated with the coverage gap and cata-

strophic coverage. To address these questions, we analyzed nationwide patient-level retail pharmacy claims data for Part D enrollees from IMS Health, a leading pharmaceutical market research organization. IMS Health collects and links data at the person level for about 50% of all retail prescriptions filled in the United States, excluding prescriptions filled by mail order, institutional pharmacies, and through certain integrated health plans, such as Kaiser Permanente. Their Longitudinal Prescription (LRx) database includes person-level retail pharmacy claims for 4.5 million Part D enrollees who filled at least one prescription in 2007. We used cumulative total drug spending for each Part D enrollee to estimate whether they reached the coverage gap and catastrophic coverage. This analysis focuses on the experiences of Part D enrollees at risk of reaching the coverage gap, so it excludes individuals who receive low-income subsidies (LIS) for Part D coverage because they are not required to pay the full cost of their drugs even after their total spending is high enough to reach the coverage gap.

What Share of Part D Enrollees Reached the Coverage Gap in 2007?

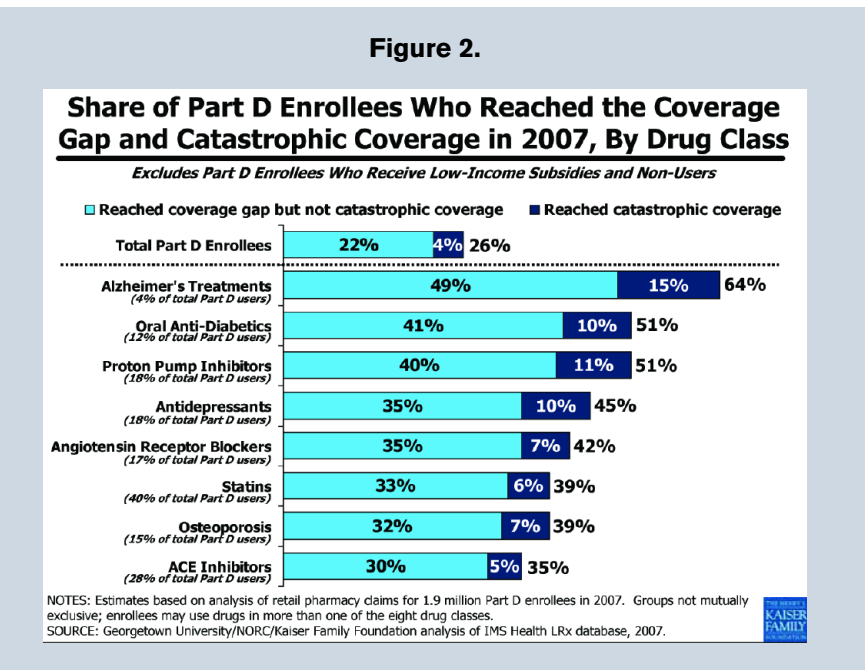
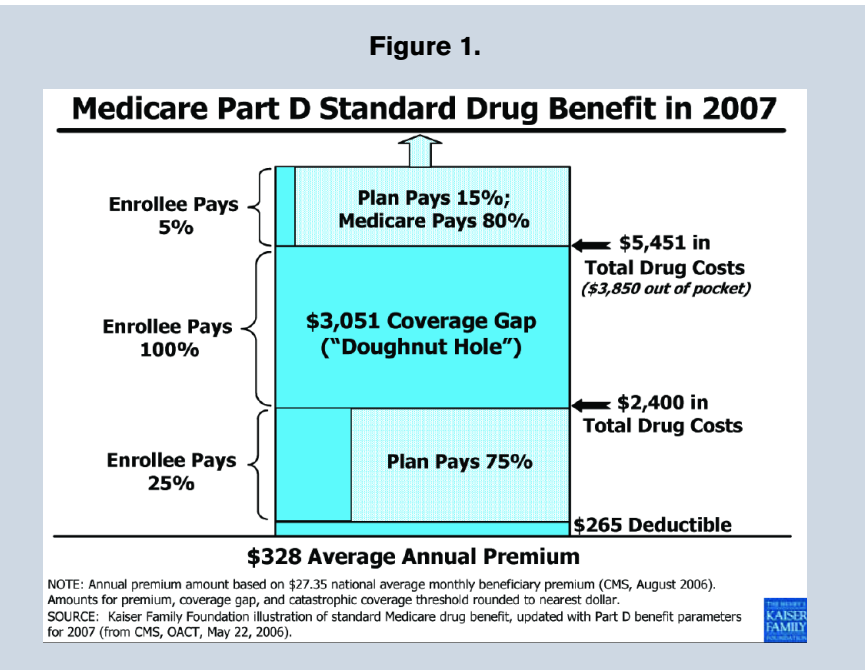
Among Part D enrollees who filled one or more prescriptions

but did not receive LIS in 2007, 26% had spending high enough to reach the coverage gap.* Fifteen percent of these Part D enrollees who reached the coverage gap ultimately had spending high enough to reach catastrophic coverage (Figure 2).

Applying this estimate to the entire population of Part D enrollees, the analysis suggests that about 3.4 million beneficiaries (14% of all Part D enrollees) reached the coverage gap and faced the full cost of their prescriptions in 2007.

The share of non-LIS Part D enrollees who reached the coverage gap in 2007 varied by age, Medicare drug plan region, and by the type of drugs they take.

- **Age.** The share of enrollees with spending high enough to reach the gap increased with age, from 25% of Part D enrollees aged 65 to 74 to 33% of those aged 85 and older. A smaller share of Medicare beneficiaries under age 65 with disabilities reached the gap compared to those aged 65 and older.
- **Medicare Drug Plan Region.** The share with spending high enough to reach the coverage gap ranged from fewer than 20% in three PDP regions covering four states (Arizona, Nevada, Vermont, and Maine) to 33% in eight states (Arkansas, and the seven-state Northern Plains region that includes Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, and Wyoming) and 36% in Hawaii.
- **Drug Class.** The share of enrollees with spending high



enough to reach the coverage gap varied across the eight drug classes, from 35% of enrollees taking angiotensin-converting enzyme (ACE) inhibitors for hypertension and heart failure to 64% of those taking drugs for Alzheimer's disease.

How Soon Did Part D Enrollees Reach the Coverage Gap?

Half of all Part D enrollees who had spending high enough to reach the coverage gap in 2007 did so by the end of August.

Only a small share of enrollees

* The share of Part D enrollees with spending in the coverage gap could be lower than this estimate because the IMS data exclude people who do not take medications and because of the relatively large share of Part D enrollees categorized as LIS recipients; the actual share in the coverage gap could also be higher because the IMS data does not include the universe of pharmacies and excludes all mail order expenditures under Part D plans.

who reached the coverage gap in July or later had spending high enough to reach catastrophic coverage before the end of the year; instead, most spent the rest of the year in the coverage gap.

On average, enrollees who reached the coverage gap remained in the gap for just over 4 months.

Change in Drug Use in the Coverage Gap

Averaged across Part D enrollees using drugs in one or more of eight drug classes, 20% of enrollees who reached the coverage gap in 2007 either stopped taking a medication in that drug class, reduced their medication use (eg, skipped doses), or switched to a different medication in that class when they reached the gap (Figure 3). Others may have changed their use of medications for other health conditions, but these are not measured in our analysis. Of those who reached the gap:

Half of all Part D enrollees who had spending high enough to reach the coverage gap in 2007 did so by the end of August.

- 15% stopped taking their medication
- 5% switched to an alternative drug in that class
- 1% reduced their medication use

Enrollees' response to the coverage gap varied by drug class. For example:

- Among Part D enrollees using medications for diabetes who reached the coverage gap in 2007, 10% stopped taking their dia-

betes medication and did not switch to an alternative, 8% switched their medication, and 5% reduced their medication use.

- Among Part D enrollees taking medication for osteoporosis who reached the coverage gap, 18% stopped taking their osteoporosis medication, 3% switched to an alternative medication, and 1% reduced their medication use.

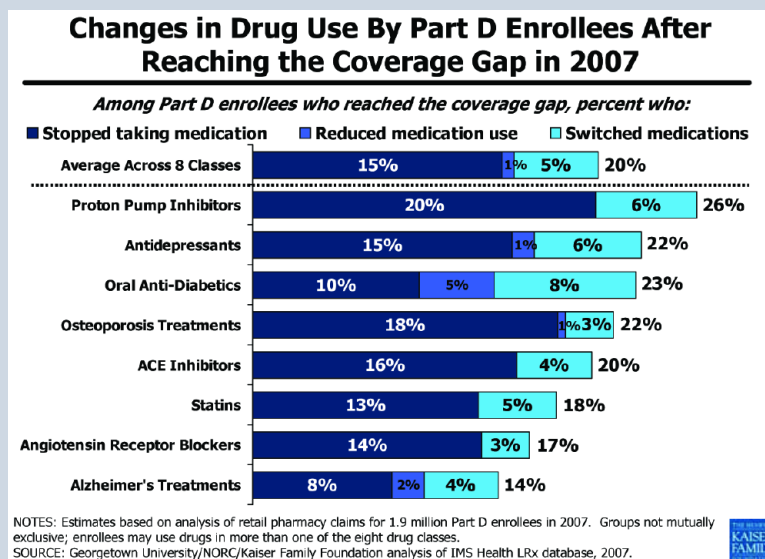
Effect on Out-of-Pocket and Total Spending

Among non-LIS Part D enrollees who reached the coverage gap in 2007, average monthly out-of-pocket spending on prescription drugs during the coverage gap was nearly twice as much as in the months prior to reaching the gap.[†] This reflects the design of the coverage gap, which requires enrollees to pay the full cost of their medications.

- For those with drug spending high enough to reach the coverage gap but not high enough to reach catastrophic coverage in 2007, monthly out-of-pocket spending nearly doubled from \$104 prior to the coverage gap to \$196 during the gap.
- For those with spending high enough to receive catastrophic coverage in 2007, monthly out-of-pocket spending increased from \$207 in the months prior to the coverage gap to \$408 per month during the gap, and then dropped down to \$285 per month during the catastrophic coverage period.

Average annual total spending for Part D enrollees who did not reach the coverage gap in 2007 was much

Figure 3.



[†] Because of the limitations in how we determine who reaches the gap, the actual difference in out-of-pocket spending may be even higher.

lower than for those who reached the gap. Generally, patterns of total spending over the course of 2007 are consistent with our finding that some stopped taking medication or switched medications when they reached the gap during the year.

Discussion

With the Medicare prescription drug benefit now in its third year of implementation, there continues to be considerable interest in understanding how well the benefit is working for the 25 million people on Medicare currently enrolled in Part D plans. This study focused on the “doughnut hole,” a unique feature of the Medicare drug benefit that leaves a gap in coverage, in order to estimate how many enrollees reached the coverage gap and catastrophic coverage in 2007, and to assess the extent to which the gap affected enrollees’ use of medications and out-of-pocket spending. Our findings suggest that a large share of Medicare Part D enrollees who take prescription drugs and are not receiving low-income subsidies can expect to have spending in the coverage gap, while only a small share of these enrollees pass through the gap and qualify for catastrophic coverage. Out-of-pocket spending increased substantially when enrollees reached the coverage gap in 2007, which could help to explain our finding that some enrollees who reached the gap made changes to their drug use regimen, including stopping their medications altogether.

From a health outcomes perspective, our finding that some enrollees stopped taking their medications or reduced medication use when they reached the coverage gap could be a

serious concern. Individuals with diabetes, for example, risk immediate and potentially serious health consequences if they stop taking their medications. For individuals with other chronic conditions, such as osteoporosis or high cholesterol, the health effects from stopping their medications might not be immediately apparent but it could increase their risk of negative outcomes over time. On the other hand, switching medications to save money might be a clinically acceptable response to the coverage gap.

Physicians can play an important role in helping beneficiaries who reach the coverage gap identify opportunities to switch to lower-cost alternatives, but in order to do so, physicians and patients need to talk with each other about drug costs. Ultimately, both stopping and switching medications could result in higher costs for other parts of the Medicare program if beneficiaries have health issues that are not being

controlled by medication, or if they simply require more physician visits to prescribe and monitor changes in medications. Careful attention is needed to ensure that gains to Medicare beneficiaries from the addition of the Part D drug benefit are not undermined by the coverage gap—especially for those enrollees who are highly dependent on medications to manage ongoing chronic conditions.

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Reference

1. Hoadley J, Thompson J, Hargrave E, Merrell K, Cubanski J, Neuman T. “Medicare Part D Data Spotlight: The Coverage Gap.” Publication 7707. Kaiser Family Foundation Web site. <http://www.kff.org/medicare/upload/7707.pdf>. Published November 2007. Accessed March 27, 2009.

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PROVIDER ACTION

Impact to You

As Medicare moves toward pay-for-performance, physicians will increasingly be held accountable for their patients’ outcomes. As a result of nonadherence with treatments, patients will fall short of achieving their ideal outcomes. This will translate into a lost opportunity not only for the patient, but for the physician as well.

What You Need to Know

The “doughnut hole” is the gap in coverage in which Part D enrollees are required to pay the full cost of their medications until they qualify for the catastrophic coverage. Half of all Part D enrollees who had spending high enough to reach the coverage gap in 2007 did so by the end of August. Of those who reached the gap, 15% stopped taking their medication (although there were significant differences between the eight treatments studied). For example, while over a quarter of beneficiaries were affected by the doughnut hole, that number jumps to 64% when examining those taking Alzheimer’s treatments.

What You Need to Do

Physicians can play an important role in helping beneficiaries who reach the coverage gap identify opportunities to switch to lower-cost alternatives, but in order to do so, physicians and patients need to talk with each other about drug costs.