US: Millions of Medicare beneficiaries to be left without drug coverage

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Many older Americans reliant on Medicare prescription drug coverage are now being confronted with the so-called "doughnut-hole" written into Part D, the drug benefit plan legislated in 2003. Some 3 million beneficiaries are expected see an end to federal payments for their medicines as they reach an annual spending cap, and will then be forced to choose between paying thousands of dollars for their prescriptions and going without.

Part D, which went into effect this year, is a partial government subsidization of drug costs, managed through private insurers. Under the plan, Medicare beneficiaries are required to pay premiums and deductibles to private insurance companies along with a co-payment on prescriptions. Typically, enrollees pay a quarter of the actual annual cost of the drugs, up to $2,250; for those whose drug costs exceed $5,100, the co-pay drops to 5 percent. But beneficiaries whose drug expenses range from $2,250 to $5,100 fall into the coverage gap and must then pay the full price themselves. Only after paying $3,600 in prescription costs can beneficiaries in the doughnut hole again qualify for federal coverage.

This poses both a financial disaster and major health crisis for those caught in the gap, as most live on fixed incomes. A quarter of the 24 million who were enrolled in Part D as of January 1 were "dual eligible," meaning that they qualified for both Medicare and the income-contingent Medicaid program. Of these 6.2 million beneficiaries, more than 4.3 million earn less than $10,000 a year. In most cases, these enrollees had their prescription costs covered through state-administered Medicaid programs before the Department of Health and Human Services automatically shunted their cases into managed care plans. Now some are left with no coverage at all.

For individuals living on modest, fixed incomes, thousands of dollars in extra, out-of-pocket expenses are unmanageable. Many who exceed the $2,250 threshold will remain in the doughnut hole for the remainder of the year and will have little choice but to cut out needed prescriptions, sacrifice other basic necessities, or take on debt.

A June 2006 study published in the *New England Journal of Medicine* found that a similar cap at $1,000 on the accounts of Medicare +Choice enrollees in 2003 had a drastic and direct effect on their health. Those who passed the cap reduced their intake of medications by either skipping doses or foregoing refills altogether, and were more likely to have made trips to hospital emergency rooms rather than regular clinic visits. Significantly, the annual mortality rate for those who reached the threshold was 22 percent higher than other Medicare beneficiaries.

When the shift to Part D went into effect, the Kaiser Family Foundation estimated that as many as 7 million Medicare beneficiaries would reach the gap this year. On the defensive, Bush administration officials denied the figure and insisted that affected beneficiaries were eligible to purchase supplemental coverage to cover the gap. The confederation of Part D participating insurance companies, America's Health Insurance Plans (AHIP), released the 3 million figure last week with an air of satisfaction. Far from representing a failure of privatized, for-profit management, AHIP CEO Karen Ignagni said the estimate was proof the plan was a success. "Health insurance plans have exceeded expectations by ensuring that millions of beneficiaries receive prescription drugs at lower out-of-pocket costs than previously predicted," she said in a September 21 press release.

In contrast, a study released the same day by Wolters Kluwer Health, an information services provider of the pharmaceutical industry, projected that through the end of 2006, approximately 6 million Part D enrollees—35 percent of all Part D enrollees—will have entered the coverage gap. According to their data, 4 million will already be without coverage by the end of September. A report also issued September 21 by Democrats on the House Ways and Means Committee suggested that the number is still likely to be around 7 million this year.

House Democrats have also suggested that only 12 percent of Medicare beneficiaries had purchased supplemental

insurance for continued coverage in the Part D gap, meaning that contrary to public statements by administration and managed-care spokespersons, most enrollees in the gap were without a safety net.

Regardless of the specific figure this fall, the proportion of Part D enrollees falling into the hole is almost certain to grow in the coming years as medical costs continue to soar. That "only" 3 million are likely to be denied coverage is seen by the program's overseers as good news is an indictment of the for-profit health system. It is a consequence of the Medicare bill itself, which was crafted by the Bush administration to the specifications of pharmaceutical and insurance industry lobbyists and passed through Congress only with the active support of leading Democrats.

Not only did the bill not attempt to reform the profiteering of the drug, health care, and insurance corporations, it contained prohibitions against price negotiating to attain bulk purchase discounts and against buying considerably cheaper drugs from Canada. Instead, cost-saving measures were imposed directly on the enrollees themselves through co-pays and a punitive coverage gap.

Medicare Rights Center president Robert Hayes told the *Washington Post*, "Virtually everyone who calls to say they've been denied coverage, they're shocked . . . Trying to explain that this is the way the program was created by Congress angers folks who think it makes no sense."

The paper interviewed a number of retired and disabled Part D enrollees, including a 65-year old retired school cafeteria aide whose co-pay jumped from $58 to $1,294 to cover a three-month supply of five medications. "It's not my fault I take this medicine," she said. "I pay a little bit at a time. What am I going to do? I need it . . . Sometimes, just to think about it, I cry." She stopped taking one drug as part of breast cancer treatment and charged the cost of her prescriptions for diabetes, osteoporosis and high cholesterol to her credit card. She told the *Post* that she was hoping to manage her glaucoma by obtaining free samples of eye drops.

A 67-year-old retired county administrator recounted similar difficulties in paying $387 each month for eight medications to manage cancer, seizures, and a heart condition. According to the Post, she was in an economic bind after her physician advised she take an additional drug, which in itself cost $239 a month. "I'm not destitute," she told the paper, "but I can't pay that and buy gasoline and food and pay the mortgage.... I'm scrambling around trying to find help." Undoubtedly, such predicaments are endemic to the coverage gap.

Part D, pushed as a streamlining and cost-saving measure necessary to avert a long-term funding crisis, was yet another step toward the substitution of "free market" competition for government-funded social programs, tailored for and by the multibillion-dollar pharmaceutical and insurance industries. The plan was promoted as a way to increase efficiency through privatizing the bureaucratic oversight of subsidized care and having the elderly "shoulder" more of the cost of their care.

By requiring premiums and co-pays through private health maintenance organizations, the logic went, Medicare beneficiaries would be encouraged to cut back on their medical needs and "take personal responsibility" for their health. The frailest and sickest have in effect been told to fend for themselves. Meanwhile, pharmaceutical companies have steeply and arbitrarily jacked up the price of drugs, exacerbating the very crisis by which the Medicare overhaul was justified in the first place.

The enormous increase in medical costs, far outpacing the rate of inflation over the past decade, dovetails with the dismantling of the US public health system in the pursuit of personal enrichment by a handful of ultra-rich.

Spending on prescription medications in the US is nearly $200 billion each year; total medical outlays are 10 times that each year—this in a country where more than 46 million people are uninsured and private insurers refuse to cover 20 percent of applicants because of preexisting conditions. Moreover, a new study from the Commonwealth Fund found that of the privately insured population paying $1,000 or more in deductibles, more than 40 percent were not covered for basic medical needs. Without government coverage, millions of Americans are simply at the mercy of the free market, a notoriously unmerciful guardian.

The solution to the growing health crisis in the US entails recognizing medical care as a right rather than a privilege or commodity. In order to realize this moral and social imperative, billion-dollar drug, insurance and medical care companies must be transformed from privately owned, for-profit enterprises into utilities run by and for the public.