**Thinking About Health**

**By Wendell Potter, Rural Health News Service**

**Medicare and drug coverage: some good news, some bad**

One of the benefits of the Affordable Care Act to Medicare beneficiaries has been the gradual closing of a big and costly gap called the “doughnut hole” in the prescription drug (Medicare Part D) program. By the end of 2020—if the ACA is not repealed or altered substantially by Congress—the doughnut hole will be completely closed.

In 2010, people hit the doughnut hole coverage gap when the total amount they and their plan had paid for prescription drugs reached $2,800 in a coverage year. At that point, people had to pay the full cost of their prescription drugs until they had reached the out-of-pocket spending limit established by the law. In 2010 that limit was $4,550. After someone paid that much, their plan paid 95 percent of the cost of their drugs for the rest of the year.

The gap has been shrinking a little every year since the ACA (Obamacare) was enacted in 2010. This year, those enrolled in the Part D program personally paid 40 percent of the cost of brand-name drugs in the doughnut hole and 51 percent of the cost of generic drugs. Next year, the percentages will drop to 35 percent and 44 percent, respectively. In 2020 and beyond, Medicare Part D beneficiaries will pay 25 percent for both brand-names and generics.

While that’s good news, the amount of money Part D enrollees have to pay out of their own pockets before their coverage kicks in has been going up every year. In 2010, people with Part D paid 100 percent of their drug costs until they had spent $310. In 2018, they’ll have to pay until their costs reach $405.

Despite that, Part D beneficiaries next year will get more coverage after they meet their deductibles and before they reach the doughnut hole: at the point that the individual and his or her plan has spent $3,750.

Yes, it’s complicated, but that’s because of the way the Part D program, which went into effect in 2006, was established. The doughnut hole was ostensibly created to save the government money, but it quickly became the program’s most unpopular feature—along with the often-bewildering choice of plan options.

During the first year of the program, the standard Part D plan paid 75 percent of the prescription drug costs until the beneficiary’s drug costs reached $2,250. The beneficiary was then on the hook for all their drug costs until they had spent $5,100 for a total of $2,850 out of pocket. In 2018, that amount will drop to $1,250.

The not-so-good news is that the because the law that established the Part D program did not set a hard cap on total out-of-pocket spending—and does not allow Medicare to negotiate with drug companies for lower costs—an increasing number of Medicare beneficiaries are now facing higher out-of-pocket costs overall than in years past.

After Part D enrollees get past the doughnut hole, they automatically get what is called “catastrophic coverage.” Their plan will then pay at least 95 percent of the cost of their drugs. But for the growing number of people on high-cost medications, that remaining 5 percent can add up to a substantial sum.

A recent study by the Kaiser Family Foundation found that in 2015, 3.6 million Medicare Part D enrollees incurred that substantial sum. While most of them received low-income subsidies to help cover the costs, 1 million of them did not. Those enrollees spent on average more than $3,000 out of pocket on their prescriptions in 2015; one in 10 spent at least $5,200.

The reason for the spike in out-of-pocket spending: the eye-popping cost of drugs for conditions such as hepatitis C, multiple sclerosis, leukemia and HIV/AIDS.

While those high drug prices have hit beneficiaries the hardest, they have also been very costly to the federal government—meaning, of course, taxpayers. A January report by the U.S. Office of Inspector General found that federal payments for catastrophic coverage exceeded $33 billion in 2015—more than triple the amount paid in 2010.

The OIG warned that if policymakers did not address high drug prices, the Part D program could be at risk: “The dramatic growth in federal payments for catastrophic coverage and the underlying issue of high drug prices must be analyzed and addressed to secure the future of the Part D program,” the report concluded.

Among the OIG’s solutions: Allow Medicare to negotiate prices for certain drugs. That has been proposed numerous times since the Part D program was created and has had bipartisan support. It has never become law, however, because the pharmaceutical industry, one of the most influential in Washington, has been able to block it.