Senate Democratic Policy Committee Hearing

"An Oversight Hearing on Providing Relief to Seniors Who Have Fallen into the Prescription Drug 'Donut Hole'"

Monday, July 17, 2006
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Transcript

0:00

SEN. DORGAN: We'll call this hearing to order. This is a hearing of the Democratic Policy Committee. An oversight hearing on the issue of providing some help to senior citizens who have fallen into this prescription drug plan "donut hole," which is Washington language, and I will describe that in just a moment. When someone talks about a donut hole, most would say "well, what on earth is that?" That was a term that was used in the discussion about the prescription drug plan that was put together under the Medicare program that describes the period of time in which a senior citizen does not have coverage, and must pay 100% of their prescription drug costs. Under most plans, Medicare will pay for 75% of drug costs up to $2,250 after the initial $250 deductible. But then Medicare pays nothing until drug expenses exceed $5,100. During that gap in coverage, from $2,250 to $5,100, beneficiaries continue to pay their monthly premiums, but have no prescription drug coverage. That is what is referred to here in policy discussions as the "donut hole." There are probably better descriptions of it and more earthly descriptions used around the country, but sufficient to say, that's the way it's described here in Washington, DC.

1:30

I have a picture of a fellow from North Dakota, his name is Donald Bush; he lives in Fargo, North Dakota. He was a high school principle for 37 years. He enrolled in the Medicare prescription drug benefit plan last year to make sure his coverage would start on June 1, excuse me January 1 I should say, and in June, his pharmacist called to let him know that he no longer had prescription drug coverage, and was in something called the donut hole. Donald's not sure how he got in the donut hole, or how he'll be able to pay for his prescription drugs. Didn't know there was a donut hole that existed in this entire plan, but he pays for medications dealing with diabetes and other health issues that he must take, and he was not aware when he signed up that there was a gap in coverage. So now he's in the position, as are many other seniors or will be many other seniors, it's estimated one-third of those who have signed up will be in a position of actually paying a monthly premium, and not having any benefit during the period for which the premium exists. And we're going to discuss that today. There are so many consequences of that. We're going to discuss what those consequences are, and we're going to discuss how to fix it as well.

We have some witnesses who have come forward to tell their situation, and talk about the policy issues. I have two colleagues who have joined us, Senator Bingaman and Senator Salazar. We expect some others as well, but before I describe those who will be testifying at this hearing today, I want to yield to my colleague Senator Bingaman.

3:15

SEN. BINGAMAN: Thank you very much Mr. Chairman for having the hearing, and thanks to all the witnesses for being here. This is a very important issue for people in my state. Not only do we have a lot of people finding out they are in the donut hole or falling into the donut hole who did not expect that to happen at this stage, but for a great many seniors in my state, they find once they're in the donut hole if they then get assistance in obtaining their prescriptions, from the Indian Health Service or from the community health center or from the patient assistance program of a pharmacy, that essentially assures that they'll never get out of the donut hole. They'll just stay there. We've got legislation, Mr. Chairman, that you're co-sponsoring with me that we just introduced last week to try to correct that problem at least, and to provide that if you are getting assistance while you're in this donut hole, that that assistance will count toward getting you out of the donut hole. I think clearly that's the very least that we ought to try to do legislatively, and I hope we can prevail with that, but I'm anxious to hear the witnesses, and again I thank you for having the hearing. It's a very important issue.

SEN. DORGAN: Senator Bingaman, thank you very much. Finally, Senator Salazar from Colorado.

4:45

SEN. SALAZAR: Thank you very much Senator Dorgan and Senator Bingaman for being here and for holding this hearing for the DPC on a very very important issue that affects so many Americans. I think from the beginning of Medicare Part D, there were many of us that raised concerns about the program, what has been the cost over-runs that we've encountered which were totally off the projections that the Administration had given, and secondly the confusion that has been caused by Medicare Part D around the country. In my own state there are some 42 plans that are being offered. It's very hard for somebody who is a beneficiary of Medicare Part D to essentially navigate through that confusion. And the third issue, which I think is of huge importance to us and is what this hearing is all about, that donut hole, which we are in fact seeing, and in fact going to hear from the witnesses today about the donut hole. I want to again thank Senator Dorgan for his leadership in the Democratic Policy Committee and for holding this hearing on the donut hole issue, which in some places in my community it's been known as the death valley, because it leaves some 7 million seniors and the disabled to fend for themselves through the $2,850 gap in drug coverage year after year. In Colorado alone we have over 100,000 seniors and disabled people who rely on the drug benefit and will face the gap in coverage, and they will face these mounting drug costs year after year,

unless we correct it here in the Congress. Many will be unable to afford the prescription drugs at all, and will go without the prescription drugs they need to survive.

I want to especially thank Dave and Sharyn Madison of Loveland, Colorado Lakewood, Colorado for being here today. They have come here to share their horrifying experience from a personal point of view, of what has happened in their own personal circumstance. Dave is a worker, a proud retired bricklayer in my state. He and his wife enrolled in one of the forty-two drug plans offered in Colorado believing they were making the prudent choice that would allow them to obtain affordable prescription drugs, because that was what Medicare Part D was supposed to do. What Dave and Sharyn got instead was a donut hole, which causes them to pay exorbitant amount for drugs, and which threatens their financial well-being as well as their physical health. We owe Dave and Sharyn Madison and millions of seniors and disabled Americans like them more than a drug benefit that leaves them to fend for themselves. We owe them our best efforts to enact legislation that will allow them to purchase drugs at reasonable rates. Thankfully there is a solution, and it can be implemented. The solution is to allow the government to use its bargaining power to obtain drugs more cheaply for Medicare beneficiaries. For years the VA has done this successfully for our veterans and their families, and we know that our seniors deserve the same. With the savings from the lower drug prices, we can plug the so called "donut hole," and that is exactly the legislation that many of us are co-sponsoring, The Medicare Prescription Drug Reduction Act of 2006, spearheaded by Senator Bill Nelson and others, and The Medicare Prescription Drug Savings and Choice Act spearheaded by Senator Durbin, Senator Bingaman and others will allow us to deal with this Donut Hole that we currently are facing. Again, I want to thank Senator Dorgan for putting the focus on this issue that is affecting so many millions of Americans throughout our nation. Thank you very much.

8:23

SEN. DORGAN: Senator Salazar, thank you very much. There are a number of pieces of legislation that I and Senator Bingaman, Senator Salazar and others have introduced recently dealing with these issues. One of which would be to eliminate the requirement to pay premiums while you don't have coverage, and that would be paid for by reducing the slush fund that was made available to the HMOs in the underlying bill. Second was as a result of something Dr. Anderson talked about in the previous occasion when he appeared, and he indicated that if you eliminate the prohibition of negotiating lower prices with the pharmaceutical industry, you accomplish about enough savings in order to eliminate the donut hole. It is almost unbelievable to me that this issue stands: that there is a prohibition against the Federal government from negotiating lower prices with the pharmaceutical industry. If you ever think of what is a sweetheart deal in government, that's it; prohibiting us from having fairer prices, lower prices, and better prices from the pharmaceutical industry, and we'll hear about that today. But that is almost unbelievable that we've tried and tried and tried to dump that provision so that we can negotiate lower prices, and we have been blocked by the majority party. People just shake their head and say, "What on earth could they be thinking about?"

9:45

At any rate, we have a number of witnesses. We'll get into the discussion about all of this. David Madison, as my colleague Senator Salazar has said, is a resident of Lakewood, Colorado; was a union bricklayer for some 40 years I understand. In April of this year was diagnosed with pancreatic cancer. In July of this year he fell into what is called the prescription drug donut hole, which means he is paying premiums for prescription drug coverage under Medicare, but has no coverage for prescription drug costs under Medicare. His treatment requires expensive medication, perhaps for the rest of his life, and Mr. Madison all of us of course pray for your recovery and know that as you meet this challenge, you have people all over the country that care about you. And your willingness to come here to talk about what you are facing as someone who needs to take prescription drugs at this point, it's a very admirable thing and a very courageous thing, and we appreciate you being here today. Mr. Madison, you may proceed.

10:50

MR. MADISON: Thank you, Chairman Dorgan for inviting us to testify at this hearing. My wife Sharyn and I feel that in order to give a complete account of our relationship with Medicare part D, and the 'donut hole' under discussion here, that we should first make it clear how we came to be enrolled in a drug program which we first believed to be in our best interest.

We read the brochures mailed to us from Medicare, which grabbed our interest immediately. We followed up by speaking with a representative from Rocky Mountain Health Care, my health insurer, who used simpler language to suggest that we enroll in Medicare part D, as it would drop the co-payments on our medications. We have always trusted our health insurer, and saw no reason to be skeptical of their advice. We believed that an additional slight premium to reduce co-pays sounded like an excellent idea.

SEN. DORGAN: Mr. Madison would you pull the microphone just a bit closer to you? Thank you very much.

MR. MADISON: We did not understand, even vaguely, the risks and pitfalls involved in our signing up, as the program was brand-new. We signed up, enthusiastically believing it was in our best interest. Then I got cancer. After five months of repeated doctor visits, extensive testing, second and third opinions, and lost sleep, we finally received the diagnosis: inoperable pancreatic cancer, which had started to spread into my liver.

12:40

More rounds of doctor visits were necessary to decide which treatment plan would maximize my chances of going into remission, and extend my life with my family as long as possible.

We were told by a prominent cancer surgeon that my cancer was inoperable. However, he then told us of an experimental treatment plan available to us at one of the best facilities in the country, the University of Colorado's Anschutz Cancer Pavilion. The doctor recommended to us, Dr. Madeline Kane, who has had excellent results with this new treatment program in the last six months with two other men battling pancreatic cancer. After our visit with Dr. Kane, we both felt extremely confident that the new approach was the one for me. The regimen would include a combination of intravenous chemotherapy three times a month, and a new daily pill form of chemotherapy called Tarceva. We had no idea what was in store, but we went forward with faith.

Little could we have guessed that the pill form of chemo would be so dramatically expensive. My pension and social security after 47 years as a union bricklayer affords us a total annual income of only $34,000. We soon realized that the Tarceva prescription alone would cost us 18 to 20 percent of our entire household income, due to the gap in coverage, or 'donut hole,' in our new drug program. We feel that there is something very wrong with the way Medicare part D is written, because we have worked hard all of our lives and feel as though we are being dropped out of the picture. The cost of Tarceva alone caused anxiety, but when paired with the cost of the intravenous chemo, CAT-scans, repeated co-pays for doctor visits, and the costs of attending to my wife's health, we realized how truly catastrophic this situation is for us.

14:58

If this treatment was for a less aggressive form of cancer, we may have been less frightened, but the doctor told us to expect that I will need this grueling regimen for the rest of my life. The expenditures of my Tarceva prescription will be calculated annually, so I will face this coverage gap year after year. We decided to appeal to the manufacturer of Tarceva, Genentech, for any sort of financial assistance to help us afford this drug. We learned that financial assistance has dried up, and have since received no help whatsoever.

We have always had really good credit, but now it is already becoming questionable. We are going into debt, and fear the prospect of selling our car or cars, taking out a third mortgage, credit cards at their limit, and possibly even bankruptcy.

I used to feel pride that I could afford to take my wife to dinner or a movie. Now we can only put all of our money into my treatment and hope it saves my life.

We are here in front of this assembly because we believe it is the responsibility of those with the power to create and change this nation's laws to plug the 'donut hole' for those of us who cannot afford such absurdly expensive drugs. We realize there are millions of seniors in the same scary situation as us, and find it gratifying to be a part of changing the current law. We are pleading with you to change the Medicare part D drug program for all of us who feel like we are being left behind. Thank you very much for listening.

16:45

SEN. DORGAN: Well David Madison you're a very special person for being willing to publicly talk about these issues and to speak up for other; God bless you for being here we appreciate very much your testimony.

MR. MADISON: Thank you Senator.

SEN. DORGAN: We will have some questions following testimony from others. We also today will hear from Pamela Bell. Pamela Bell is a resident of Jacksonville, North Carolina, is disabled, and receives prescription drug coverage through Medicare, and is also what is in what's called the prescription drug donut hole; that is she is paying for a monthly premium for drug coverage and receiving no benefits. Prior to leaving her job due to illness she was a production manager with a small silver reclamation company. Pamela Bell thank you for joining us today, you may proceed.

MS. BELL: Thank you for giving me the opportunity to be here this afternoon. My name is Pamela Bell, I am 43 years old, and I reside in Jacksonville, North Carolina. I was employed as a Production Supervisor at a small factory for 8 years. I became disabled in August 2003 due to Fibromyalgia, Hepatitis C, and Lumbosacral Neuritis, which has me in a wheelchair.

18:00

I also have several other chronic illnesses and conditions for which I take numerous medications for a few being a heart condition and Emphysema. I also suffer from Post Traumatic Stress Disorder from childhood.

When I became disabled in August 2003 and was no longer able to work, I lost my employee insurance and was unable to afford COBRA coverage. In order for us to survive, and still afford our prescriptions, I had to withdraw my 401K retirement fund before I started receiving my disability payments in February of 2004.

My husband became disabled in 1999 and is receiving disability payments for several medical conditions. After receiving our disability payments our combined monthly income after paying Medicare premiums and living expenses is less than $300.00 a month. We were also receiving some financial help from our son who is in the Marine Corps and was serving in Iraq at the time.

19:10

I take eleven medications for my illnesses. Six of those medications do not have a generic equivalent. The retail costs of my prescriptions for one month, not including my husband's, and without prescription coverage, totaled $1,729 a month.

Before the Medicare Part D plan went into effect, I was able to get my brand name medications through various Patient Assistance programs directly through the Pharmaceutical companies. This allowed me to purchase my remaining prescription medications with a drug discount card at a cost of about $120.00 a month. We chose an insurance plan through the Medicare Part D program that offered catastrophic coverage and covered all of our prescriptions. Brand name drugs have a co-pay of $25.00 and generic a co-pay of $10.00 without a deductible. We found out though, that the description of the gap coverage was somewhat confusing.

20:20

In February of 2006 I qualified for Medicare, and Medicare Part D, after the 24 month waiting period that's required before people who are on disability are allowed to use Medicare. When filling our prescriptions for the first time using this drug coverage, the communication between the pharmacy and the insurance company was utter confusion. Our insurance company was unaware of our coverage and we had to wait two days before the pharmacist could get our insurance information straightened out. We also realized that the retail price of our prescription drugs had almost doubled since the beginning of the year.

By the end of April I had reached my $2,250 coverage limit and was now in the "donut hole" without even being aware that I was reaching that point. I had gone to the pharmacy to pick up two prescriptions and was hit with a bill of $463. One of those prescriptions was a brand name costing $453. It was a medication to control recurring migraine headaches.

21: 33

Unfortunately I was unable to purchase it and now I suffer from recurring migraines because of the cost. I also have another prescription to stop migraines when they occur, and at a cost of $250, I am unable to afford that prescription either.

I contacted my insurance company and had them explain the donut hole in a way I could understand. They informed me that once I reached $2,250 total drug cost, I would have to pay 100% of the cost of my drugs if it were a brand name. But, if I would choose the generic equivalent they would cover 80% and I would continue to pay the $10 co-pay. This stays in effect until I reach my $3600 total out-of-pocket cost at which time I would then pay only 5% of the drug cost for the rest of the year and be in the catastrophic coverage portion of my plan.

22:34

On May 25, I was forced to pay $324 for my narcotic pain medication, which is a brand name drug without a generic prescription. My lower back problems, Lumbosacral Neuritis causes extreme weakness and numbness in my lower extremities and without this prescription, I am in severe pain and bedridden. Because of the cost of this one

prescription I purchase, I was unable to purchase any of my other medications for me or my husband for that month.

Because I am now covered on a Medicare Prescription drug plan, I no longer qualify for Patient Assistance programs through the pharmaceutical companies. I can not use a discount card because the cost of the drug is still too high. A few of my medications I am able to get samples of from my doctors, but only when they have them on hand.

23:36

Out of the six brand name prescriptions I take, I was able to get two in a generic form, one of those being my pain medication. But it is not as effective as the brand name I was taking since the exact generic equivalent was not available. Four of the medications are not available in generic form, only their expensive brand name versions.

For three months I was unable to take my heart medication because I was unable to afford it. My doctor was upset that I had gone that long without taking it and found a generic version for me to try. The generic was not an exact equivalent, but it was an equivalent of another brand name.

The drug I am on now has to be taken more often and I still have some symptoms that were once controlled with the brand name drug. There are four other prescriptions that I am still unable to take because of cost. Two being the prescriptions I mentioned earlier for migraines; the third is a medication I take for Post Traumatic Stress Disorder I hope will become available in generic form at the end of July. I have been without that medications for two months and I now suffer mood swings and depression again.

25:06

The inhaler I use for my Emphysema was provided by a pharmaceutical company a year ago. I received six inhalers which I use only when necessary and not as prescribed. They are now past the expiration date but I still use them because I can not afford to buy more. The medication has no generic equivalent.

My husband is still within his $2,250 limit but with the rising cost of prescription drugs he may reach his own “Donut Hole” soon. He is an insulin-dependent diabetic, who is home bound because of severe Diabetic Neuropathy, and chronic back pain. He has been hospitalized frequently because of a weak immune system and recurring staff infections. At the rate we are heading I’m afraid we will be unable to reach the $3600 by the end of the year and then the plan renews and we start over again.

26:09

I have tried applying for assistance but we make $500 a year over the limit of to qualify. We do not qualify for State assistance because we are under age 65. In order for

us to qualify for Medicaid we must spend $8,000 out of pocket in medical bills every six months. The premiums for Medicare Supplement Plans in North Carolina are too high for us to afford, and most plans are not available in the county which we reside. When my husband reaches his "Donut Hole" I am afraid we will be back to choosing whether to pay bills, buy food, or purchase medications. The Medicare Part D Plan was suppose to keep us from having to make those choices. Thank you.

27:02

SEN. DORGAN: Well Pamela Bell, thank you very much. You've come to Washington in a wheelchair, asking for fairness and asking for policies that help people and your story is a very compelling one and my guess is you're not alone. Many others who do not have a voice and are not able to be here have experienced exactly what you are experiencing today and we appreciate your being here to testify.

Finally we will hear from Melvin Kinnison. Melvin Kinnison is a resident of Huntington Beach, California; a retired sheriff's deputy, and a Part D of the Medicare Bill—the prescription drug part—is in the so called donut hole. He's taking multiple medications for several conditions including: diabetes, congestive heart failure, and prostate cancer. Mr. Kinnison, and let me thank you again for coming here from California to be a part of this and to tell us your story. You may proceed.

28:01

MR. KINNISON: Well thank you for inviting me, and I thank the Committee for having us here. I have worked most of my life; I served in the Marine Corps, and worked as a Los Angeles Deputy Sheriff, until they retired me due to an accident.

I live on a small retirement income and Social Security. My two sons, one is 21 and one is 15, live with me, so I must try and budget my funds to cover the cost of my bills. I'm separated from my wife, but she helps all she can.

I read the brochures sent to me by Medicare, and many other companies regarding the prescription Part D program. I received a call from my health organization who invited me and others to a luncheon to explain Part D in more simpler terms.

I have had a good working relationship with my HMO. At the luncheon they explained that Medicare Part D would be helpful in my co-pays for my medications. They further stated that they would see to it that I would be put in the best program that fit me financially—with that, I signed with them. They also said that this would ensure that I would keep my doctor that I have had for years. I didn't want to change my doctor, he knew all about me and I didn't want to change.

29:15

I have diabetes, and I am not an insulin dependent diabetic. I suffer from neuropathy, which is getting worse. I have congestive heart failure, and I have a history of strokes and found out that I now have prostate cancer, which has started to grow. So once it starts to grow my doctors have told me that when the cancer starts to grow I will need to have some sort of radiation and possible chemotherapy, or I may have to take drugs which he told me are tremendously expensive.

I don't know how much of an increase there actually is. I haven't sat down and really figured it out, but I know I hit the donut hole when I went to pick up two $10 prescriptions that cost me $20 before and they were $228; they were both for 30 days. So now I know I must pay the next $2,250 out of my pocket, plus the deductible of $250 every year. I don't know how exactly I am going to come up with the money but I will with help from my family.

After a talk with my doctor, he did take me off three medications; I take a total of eighteen medications, and six medications I go to GNC which are generic, herbal kind of medicine which helps me with the neuropathy. So he took me off of three and said I could stay off of them for a while but I must have blood tests to find out if I'll have to go back on them and if I have to go back on them it will be an added cost to my bill, and they are expensive.

30:49

I'm here like the others to appeal to those in power to change or create a policy that would help seniors like us with the "donut hole," who basically are going in the hole more and more just to try and cover our medications. There are so many seniors in this situation and in much worse situations than I am at the present time and they really need your help desperately. I hope this committee can help them, I know it's not going to be an overnight thing, it's going to take a while to get it fixed but I hope you guys will fix it.

I want to thank you all very much for having me.

31:30

SEN. DORGAN: Mr. Kinnison, thank you very much as well, for being with us and telling us your story. We'd like to ask some questions, obviously we'll wait, but we now have three additional witnesses who come from the policy side with organizations that have been involved in the policy debate on this issue. Let me turn to Ron Pollack. Ron is with Families USA, the founding Executive Director of Families USA, which is a national organization for healthcare consumers. Its mission is to achieve high quality affordable health coverage in the United States. In 1997 Mr. Pollack was appointed as the sole consumer organization represented on the President's advisory board on consumer protection quality in the health industry. In that position Mr. Pollack helped create the Patients Bill of Rights which has passed in many state legislatures and is something that I have debated many times before on the floor of the United States Senate in support of, although it has not passed the Congress. But Mr. Pollack has linked the

experience in all these issues and we appreciate your being here. Why don't you proceed.

32:45

MR. POLLACK: Thank you Chairman Dorgan, Senator Bingaman, Senator Salazar for inviting us here today. Let me just start with an unpaid non-partisan political advertisement. There's a video that we at Families USA had prepared, it's narrated by Walter Cronkite, it's a fourteen minute video which you are invited to use at you see fit. It vividly draws the connection between the donut hole and the prohibition that prevents Medicare from bargaining for better prices. I think your constituents will find it very educational.

Mr. Chairman you mentioned at the beginning that people continue to pay a premium at the same time they're in the donut hole. I analogize it to somebody going to a gas station and filling their car with gas but no gas is going into their car but the dollar signs keep going up. That's essentially the way the donut hole operates. I'm going to focus on the connection between the very high drug prices in the Medicare program and what could be done about that and filling the donut hole. So I want to make several points.

34:07

First, the Administration defends this prohibition on Medicare bargaining for cheaper prices and they say "competition among these Part D plans will bring prices down." Well we took a look at what happened to the prices since the program began. Ms. Bell in her testimony talked about her experiences which she had in one of her medications in how the prices went up. What you'll find is that since the program began its enrollment in mid-November, actually the prices have gone up. We looked at the top 20 drugs for seniors, and I'll give you an example. 100% of the Part D plans raised their prices for Zocor, which is a cholesterol lowering drug, from mid-November to mid-April. Almost 99% of the plans increased the prices for Fosamax which is used for osteoporosis. More than 97% of the plans increased their prices for Lipitor, also a cholesterol lowering drug. Over 96% of the plans increased their prices for Actonel, Toporol, and Zalatin, drugs used for osteoporosis, high blood pressure, and glaucoma respectively.

More than 94% of the plans increased the prices for Celebrex, Nexium, and Norvasc, drugs used for anti-inflammation treatment, gastrointestinal problems, and heart problems. Over 92% of the plans increased the prices for Aricept, and Plavix, used for Alzheimer's and for strokes respectively.

36:00

So if you take a look at the Top 20 drugs prescribed for seniors what you'll see is, rather then the Administration's claim that prices are coming down through this so called

market competition, quite the contrary has occurred, the prices are going up and they are going up substantially.

Now where do these prices stand with respect to a comparison to VA prices, prices secured by the Department of Veteran's Affairs (VA)? It's an interesting question because the Department of Veteran's Affairs has precisely the kind of bargaining situation that enables the VA to get cheaper prices. For every one of the top 20 drugs prescribed for seniors, the prices secured through negotiation by the VA are lower than the prices of any of the plans. So, you can literally take the lowest price of the lowest plan for each one of these drugs and the VA gets a cheaper price, and the median price difference between the very lowest price secured by these Part D plans compared to the VA is an astounding 46%. It's extraordinary, that's an incredible waste of taxpayer's money, and the money of seniors and people with disabilities who are in the program. Let me give you a few examples: Zocor, the lowest annual, I'm giving the total years price, the lowest annual VA price is $127.44, the lowest Part D plan price for that same drug is $1,275.36 a difference of 901%. For Protonix, which is a gastro-intestinal agent, the VA price is $214.45; the lowest Part D Plan price for that same drug was $1110.96, a difference of 418%. For Fosamax, the VA price, $265.32, the lowest Part D Plan price for that drug is $727.92, a 174% difference. One last drug, Zalatan, the VA price $279.84, the lowest Part D Plan $555.96, a 99% difference. The key point, I think, out of all this is that there can be significant savings achieved if we actually had the government do what every purchaser who purchases in bulk does, and that is bargain for cheaper prices, and those enormous savings could be plowed into eliminating or at least ameliorating the donut hole.

I want to make one last point, and that is, in the current legislation these Part D plans supposedly bargain for cheaper prices, some of them use pharmaceutical benefit managers, and when they bargain for cheaper prices, say they try to get a discount, or they get a rebate, what the law tells us is that the plans have got to give the beneficiaries some portion of the savings. It doesn't define what that portion is. Is it 1%? Is it 99%? It's only some portion, and to make matters worse, what they actually have negotiated and whatever rebates they do get is not made public. It's not made public, it's not even provided to the committees of jurisdiction in the Senate and the House, and so as a result there may be some rebates in this program and some discounts, but they're not being passed on to the beneficiaries of the program or the taxpayers. That should be changed.

40:00

SEN. DORGAN: Mr. Pollack, thank you very much, we appreciate your being here and your testimony. Next, Dr. Gerard Anderson. Dr. Anderson has joined us once previously, a year or so ago. Professor of Health Policy and Management and International Health at Johns Hopkins University in Bloomberg School of Public Health, he's also a Professor of Medicine at Johns Hopkins University School of Medicine, serves as the national program director for Partnership for Solutions, Better Lives for People with Chronic Conditions, which is a program sponsored by the Robert Wood

Johnson Foundation. He has written books, served in government, and has a lot to say. Dr. Anderson we appreciate you being with us today.

40:47

DR. ANDERSON: Thank you very much Senator Dorgan and members of the Committee. Several months ago I had the opportunity to testify on Part D, and like Senator Dorgan says I discussed the donut hole. This time I hope to get it right so you won't have to invite me back again, we can get it clear this time. I think Mr. Madison, Ms. Bell, and Mr. Kinnison really set the stage for this very effectively.

Today what I'd like to do is emphasize two points. First of all as you said in your opening statement, the donut hole can be eliminated completely if the Medicare program pays the same prices as the VA, Department of Defense, or Canada pay, and it could be done at no additional cost to the Medicare program and at lower cost to Medicare beneficiaries. Second, private insurers have demonstrated that they are less successful at demonstrating and obtaining discounts from hospitals than the Medicare program over a 20 year period. There's no reason to believe that these same private insurers will be any more successful in negotiating with drug companies.

With the passage of the Medicare Modernization Act, Congress began the long overdue transformation of the Medicare program from one oriented around providing acute episodic care, to one oriented around providing ongoing chronic care. This transformation of the Medicare program is absolutely critical because two-thirds of Medicare spending is by Medicare beneficiaries with five or more chronic conditions. I have outlined the next steps that I think the Medicare program should take in a *New England Journal* article that I wrote last summer. But today what I'd like to do is focus just on the donut hole.

The gap is particularly important for the 10 million Medicare beneficiaries with five or more chronic conditions, because they fill an average of fifty different prescriptions during the year, and nearly all of them will be impacted by this donut hole. Today you heard from Mr. Madison, Mrs. Bell, and Mr. Kinnison and I think their stories were exceedingly powerful. Many of the beneficiaries would love to have come but they're even sicker than these three individuals. What I did two years ago was wonder whether or not the donut hole, as it was being developed, could be filled if the Medicare program paid the same prices for pharmaceuticals as people in Canada, the United Kingdom, or France. We published an article in *Health Affairs* which examined this issue, and a full copy of this article is in my testimony. What we did was we calculated the amount that Medicare would pay for a market basket of the 25 most commonly prescribed brand-name and generic drugs in the United States. Then we calculated the price for people in Canada, the United Kingdom, and France would pay for the same 25 drugs. What we found was even with the discounts Medicare plans for receiving from the drug companies, Medicare beneficiaries would be paying 52-92% more than what Canada, the United Kingdom, and French citizens were paying.

In July of 2005 the Congressional Budget Office published a comparison of the rates that different federal programs were paying for brand name drugs. What the study showed is that the VA and the DOD received the same discounts that people in Canada, the United Kingdom, and France are receiving. The CBO report also showed that Medicare beneficiaries were paying much higher rates than the VA or DOD was paying. So we used this data to update the *Health Affairs* article. One issue is whether or not the Medicare program can negotiate as good a deal with pharmaceutical companies as Canada, the United Kingdom, France, the VA, or DOD are doing. Many people, including those at the CBO, believe that the private sector would be able to negotiate a better deal. However, the evidence that Medicare can obtain better rates in the private sector is really lacking.

In 1982 I helped design the Medicare prospective payment system for hospitals, and watching this program become operational I've been surprised by many things. Right now my greatest surprise is that the private sector has continually paid higher rates for hospital services than the Medicare program. The most recent MEDPAC report shows that private insurers are paying between 14 and 30 percent more than Medicare is paying for similar hospital services. As an economist I would expect that large insurers who operate in a competitive marketplace would be able to negotiate effectively with hospitals, and much more than they actually have. These are the same private insurers that have argued they would be able to negotiate better rates than Medicare with the pharmaceutical companies and CBO has adopted this argument in developing its cost estimates. If the private insurers have been unable to negotiate better rates for hospitals for the past twenty years, than why would anyone think that they, the same institutions, would be able to negotiate better rates with pharmaceutical companies.

In our *Health Affairs* paper we developed a micro-simulation model to see if the donut hole could be eliminated if the Medicare program paid the same rates as Canada, the UK, and France. We subsequently ran the model using the CBO analysis of federal drug prices, and we found that the drug donut hole could be completely eliminated if the Medicare program was to pay the same rates as the VA or DOD. The Medicare program would not have to pay anymore than under current law, and beneficiaries would pay substantially less. I sent this information to Senator Bill Nelson of Florida and he used this information in S. 2354, to propose that the Medicare program should be able to negotiate effectively with pharmaceutical companies.

46:50

We then analyzed the characteristics of Medicare beneficiaries who are most likely to benefit from the elimination of the donut hole and these are people you've heard here today. These are people with multiple chronic conditions, beneficiaries with various combinations of diabetes, congestive heart failure, COPD, Alzheimer's, depressions and other chronic conditions. I understand the Congress is facing a difficult issue. Maintaining the status quo and paying these higher drug prices, which you heard from the witness today, could result in the drug companies spending more on research and development, and this could lead to the next big drug. However, pharmaceutical

companies are right now only spending 14% of their revenues on research and development. On the other hand, lowering drug prices, eliminating the donut hole is likely to immediately improve the health status of millions of Medicare beneficiaries because they're going to have much better access to needed drugs.

For me it's unclear why the Medicare beneficiaries should have to pay much higher rates for the same drugs as seniors in Canada, the UK, France, or seniors participating in the VA or DOD, which is especially a concerns issue here today with gaps in coverage that effects both their health status and their pocketbook. One possibility is to have the federal government negotiate a maximum they will pay for a particular drug and then allow the health plans to negotiate with the drug companies for even a lower price, if they can do it. This would allow the marketplace to operate, but seriously protect the Medicare beneficiary. Thank you very much.

48:35

SEN. DORGAN: Dr. Anderson, thank you very much for being with us. And finally we will hear from Robert Hayes, who is the president and general council of the Medicare Rights Center, the largest independent source of healthcare information and assistance in the U.S. for people with Medicare. Before joining the Medicare Rights Center, Mr. Hayes led the national and New York coalitions for the Homeless, 1979 to 1989, and practiced with law firms in New York and Maine. A graduate of Georgetown University and New York University School of Law, he's a MacArthur Foundation Fellow, and has received many honorary degrees. Mr. Hayes you have a very distinguished background, we appreciate you being with us, you may proceed.

MR. HAYES: Thank you very much Senator Dorgan, Senator Bingaman, we do very much appreciate the opportunity to share our experiences assisting people with Medicare who are now finding themselves in the prescription drug coverage gap, the infamous donut hole. I do especially want to thank you Senators and your staffs, and of course the witnesses who have joined us this afternoon because for once there is a dose of reality to what this is doing, this donut hole, to real people. I do wish that we could legislate that the balance of your colleagues would have to come and face these stories as you are today or, at least spend a day working in our office with the clients who call our hotline. Because regrettably we're here to report that the toll from this coverage gap is taking on the most vulnerable men and women with Medicare is devastating. The calls to our consumer hotlines, the abrupt end of prescription drug coverage is just what doctors across the country anticipated, a grave threat to the health and financial security of the frailest and sickest Americans.

This bizarrely structured drug benefit breaks the mold by ignoring what has made Medicare great, and what has allowed older and disabled Americans security and peace of mind. Remember this drug program is not Medicare; it is a cottage industry of for profit insurers selling incomprehensible benefit packages to people with Medicare. At the Medicare Rights Center we rarely have confronted a situation, where like now, we can do so little to assist people. Rarely have we, experts in assisting people with

Medicare, had so few options, so few answers for people in the Part D donut hole who call with their question, "I need to fill these prescriptions, my coverage has stopped. What can I do?" It is disheartening, it is heartbreaking. It is why groups like the Medicare Rights Center have brought in trauma counselors to assist our staff overcome the despair of having no answers to dire human needs.

Those of us, most of us in this room probably, who have agonized over the political and policy implications of the donut hole often forget that virtually no one who signed up for a Part D drug plan had any idea about this coverage gap, and for nearly all of our callers falling into the donut hole comes as a shock out of the blue. It's no surprise, the drug plans have kept quiet, very quiet, about the donut hole. Insurers hawking their goods to people with Medicare spent millions of dollars, millions of tax dollars advertising and marketing. "We have no deductibles" scream some plans, "we have low premiums" say others, "we have smiling pharmacists, convenient drug stores" they all say. "We are the trusted AARP," says one group of plans. But I challenge you to find one ad, print, internet, radio, or television that candidly tells people with Medicare about the donut hole. Markets do not always work fairly or honestly; Hummers don't advertise about their mileage, Mini Coopers don't advertise their safety, and what we've learned this year is that profiteering drug plans do not disclose gaps in drug coverage.

There's no question, some Americans are securing benefits from this drug program, but the irony, given the money we're putting into this program is that in too many cases our clients, once they hit the donut hole, are far worse off than they were twelve months ago. Many people have been forced to stop taking medication abruptly when they hit the donut hole. At times, especially with certain medical and psychiatric conditions, they would have been far better off never starting a course of treatment at all. Others are also worse off; some have been shifted from retiree drug coverage to Part D, no prior prescription drug plan ever tossed enrollers into a coverage gap. Some states, Florida for one, ended their assistance programs on the promise that Part D would take care of their citizens.

Then there is the continuing scandal of the performance of the drug industry in this country. It should be an industry of heroes; it is instead making itself into a band of villains. The drug companies, as Mr. Pollack pointed out, are making billions of dollars in profits from this congressionally bestowed bonanza, and unbelievably, at the same time, are cutting their charitable assistance programs, and all the while blaming the federal government for these cut-backs. The Part D loan and subsidy program in theory should help, but remember there's a finely tuned experiment in bureaucratic disentitlement. Nearly three out of four people eligible to sign up for that assistance are not getting it.

54:01

The Part D Low-Income Subsidy program, in theory, should help. But remember, there is a finely tuned experiment in bureaucratic disentitlement, nearly three out of four people eligible to sign up for that assistance are not getting it.

We should enroll people in the extra help program automatically when their financial data demonstrates probable eligibility. Arduous applications were not required when President Bush sent tax refunds out to people a few summers ago. Onerous eligibility review is not being required as the Administration begins next year to charge higher income Americans larger Medicare Part B premiums. Our government, based on existing federal financial records, knows nearly everyone who is eligible for the extra help program. We should get it to them rather than creating a labyrinth of eligibility hurdles.

As I think we all realize the only true solution is to eradicate the donut hole as we would eradicate any other public health menace.

Professor Anderson and others have taught us that Medicare could close the donut hole if only it were not barred from using market power to drive drug prices to levels competitive with other developed nations. If the Veterans Administration can do it, why not Medicare? The question is rhetorical and the answer obvious. It is a question of values. Values governed by the moral compass of our national leaders. Thank you.

55:30

SEN. DORGAN: Mr. Hayes, thank you very much. I appreciate all six of you for taking your time to come here to this hearing room and spend time with us. I am going to withhold my questions until the end. I am going to invite my colleagues Senator Bingaman to inquire, and then my colleague Senator Salazar. After which I will ask a series of questions. But it is interesting, disappointing, in many ways it angers me to hear the result of policies that could so easily be changed to benefit people. But to understand that the construction of these policies in many ways has been to benefit those who least need the benefits. And it is almost unbelievable to me that we have a provision, as I said at the start of this, a provision in law that actually prevents the negotiation of lower drug prices by the federal government. I think most people would hear that and say who on earth could possibly have supported that. We have tried on multiple occasions to change it to eliminate that perversity and have been unsuccessful because the pharmaceutical industry wanted that provision and they got it. And there are plenty of friends around here that prevent us from taking it out and benefiting people. At any rate let me call on my colleague Senator Bingaman and then Senator Salazar after which I will ask some questions. Senator Bingaman?

56:57

SEN. BINGAMAN: Well thank you all again very much for being here. Mr. Hayes, let me first of all say I agree with you that the real solution is to eradicate the donut hole. But I fear that may be a difficult thing to get accomplished given the current congress and the current administration. So I guess what I would like to focus on are some of the perverse things that we might be able to get people to focus on. A woman of my home state of New Mexico called our office this morning and was complaining

bitterly about the fact that she now is becoming responsible for her medication because she has fallen into the donut hole. And she pointed out that she is since signing up for this Medicare Part D, she has determined that she needs some drugs that are not on her formulary and everything she pays out for those drugs do not count towards the donut hole. She is not just limited to the size of the donut hole, as far as what she has to spend before she gets Medicare coverage again. She's got a great deal more that she is going to be liable for.

One other thing that occurred to me in listening to Ms. Bell's comments there. You indicated that you are not eligible for the Patient's Assistance Program now that you have signed up for the Medicare Part D Program. Is that correct?

58:43

MS. BELL: That is correct.

SEN. BINGAMAN: You were eligible for it before. But now that you have signed up for Part D, you are not?

MS. BELL: Yes, the pharmaceutical companies have this program based on your income for prescription drugs that they make. They would have assistance, but once you get on the insurance program, whether it is a private insurance or Medicare part D program, you are supposed to use that Medicare Part D Program and they do not consider that gap. Once you qualify for insurance you are cut off from the Patient's Assistance program

SEN. BINGAMAN: We had a meeting several months, with some of us on the finance committee, with some of the corporate leaders and some of these pharmaceutical companies about how this thing was being implemented. And one of the messages I heard from them was, since our providing of drugs under these patient assistance programs does not count towards peoples' obligations to pay out of pocket expenses, you know, we basically, if we keep our prescription assistance programs going, we're essentially taking these people along for good. They are on the Part D program, but they are never going to reach catastrophic coverage because they're in fact no credit given for all of the free assistance that the pharmaceutical companies are required, previously providing. I do not know if these are problems that Mr. Hayes, maybe, you have encountered these in some of your deliberations. But there are problems that have come to my attention, that I think deserve attention here in the congress as well.

1:00:40

MR. HAYES: Without question, Senator, I am not sure if we have deliberated on it but we are trying to work people through what is an incredibly complex calculus of decision making. So for instance, if you are in the donut hole, and if you can sign up, and most of the plans are maxed out now and most of the charitable programs are maxed out. But if you can get into one it's almost always for a single drug. So you might be able to

get that one medication and yet any client, as Professor Anderson points out, has many other medication needs. So that will keep them from catastrophic level, exact same problem with our formulary, exact same problem with folks who changed plans they were foul ups by computer systems and it did not communicate how much they were spending out of pocket. So out of network expenses don't count. And there is always the problem, you can tell people in the donut hole that you can often find less expensive drugs on the internet or over in Canada, but that won't count either. So do you spend the money trying to get to catastrophic? Can you spend the money? It's very complex. And it would help to count everything towards what the government calls true out of pocket expenses.

SEN. BINGAMAN: Dr. Anderson, have you experienced any of these complications, people trying to get both? I guess it's not that complicated getting in the donut hole; it's just complicated getting back out. Any thoughts you got on that I would be interested in.

DR. ANDERSON: I have a couple of thoughts. First of all, the whole issue of free assistance. Some of it is by the drug companies. A lot of it is by community organizations and others who are strapped for money. And we are essentially asking those organizations to subsidize the drug companies. We're asking them to subsidize the people who filled out these contracts and got contracts. And I think, given that they have so little money now, asking them to pay a lot of money to subsidize the drug companies and just subsidize the Medicare is wrong.

1:02:40

You asked about short term fixes besides just allowing negotiations. I think three things strike me. And I think you have heard all three of them today. One is changing health status. If you develop cancer after you make your decision in terms of which health plan you would chose. And that is wrong, because all of a sudden you have a huge health care bill that you never anticipated, and so you got that. Second of all, these health plans can change their drug prices any time they want to change them. You can't change them, you can't change your health plans, but they can change their prices. So you thought you had the best deal. The next day they change the prices, and you don't have the best deal. And the third thing is that they can change their drugs in the formulary. So you signed onto a health plan because they had a particular drug on the formulary and now it is no longer on the formulary. So everything is set up to benefit the drug companies and the health planners.

SEN. BINGAMAN: Ron, did you have any comment on this?

MR. POLLACK: I agreed with what both Bob and Gerry said with one caveat. There are new rules with respect to changes in the formularies and how that impacts a patient. If a patient signed up with a specific formulary and the plan changes the formulary a patient is supposed to be allowed to receive the drugs for the remainder of the year. But still the prices can change as Gerry indicated. That can be a big deal. I do

just want to make one point. And that is, I do support these pharmaceutical assistance programs, but they're not the be all and end all as you know Senator. It is essentially some combination of charity, promotion of a drug, and PR.

1:04:37

And a lot of people that need these pharmaceutical assistance programs are not getting them. It is not the easiest thing to get into. But clearly we got to find some ways and when people are ingenious about getting drugs in some other means that must count for them ultimately climbing out of the donut hole.

SEN. BINGAMAN: Thank you very much. Thank you all again for being here.

SEN. DORGAN: Mr. Kinnison, had you wanted to comment? It looked to me like you wanted to make a comment on something that was said.

MR. KINNISON: I really do not know how much my drugs cost. But I have figured up the retail price of ones I have taken. It has come up to $2,700, almost $2,800. I was paying between $70-80 before, and when I signed up through my HMO, they said they'd automatically shift me into this Medicare D Program. Once I found out about the donut hole, I said well shift me out of it. And they said, "No you cannot get out of it because you lose all. We would cancel you too." You cannot get out of it once you are in it.

And as for VA, I don't know that much about VA. I am a veteran, but I served back in the 50s. And I don't know if I am qualified because I am a non- war vet. I was in between everything, thank goodness. I would serve now if I could, but I was in between everything so I do not know if I am qualified through vet. I do not know about these assistance programs, if I qualify, because I did not research it properly, I guess. I was taking the word of my HMO who said that we will get you into this program because this is the best one for you financially. But when all of these drugs that I take just shot up tremendously, and I am going to have to go off of them. So I cannot get out of it. One other question I have here. The VA - they are just too confusing for me to handle so that is why I went with my HMO to help me out on this. I cannot understand 40 or 50 programs. I do not know how they figured out the money for the donut hole. I don't know what adds up. Is it once you reach the retail price, once you reach the retail price of the drug is that when the donut hole kicks in? Or is it another price? I am not sure of that. I would like to know what counts and when do you reach the donut hole? And what do they set their pricing on?

1:06:52

SEN. DORGAN: We will address that in just a moment. Senator Bingaman thank you for being here, I know you have another obligation. But I appreciate your participation. Let me call on Senator Salazar and Mr. Pollack and we can talk a little about what gets you to that donut hole in just a minute.

SEN. SALAZAR: Thank you very much Senator Dorgan. Let me just have two questions with a little bit of commentary. My first is to Mr. Madison and Mrs. Bell and Mr. Kinnison. And first let me say to you David and Sharyn and to Mrs. Bell and Mr. Kinnison, thank you for coming here today because I know the sacrifice you made to come here, but you being here gives voice to a lot of other people who could not be here. When I think about 100,000 people in our little state of Colorado who could not be here today. Your presence here is giving them a voice. And when all three of you combine the number of people being affected by this donut hole, you are giving voice to millions and millions of people all across America. So I give you my own personal thanks.

My question to each of you is, I think you asked for it already in part Mr. Kinnison, but to each of you is this: when you signed up for your Medicare Part D plan, were you made aware of the existence of the donut hole?

MR. KINNISON: No, I was not.

SEN. SALAZAR: You were not Mr. Kinnison? Mrs. Bell?

MRS. BELL: I kind of knew about it, but it was not really explained.

SEN. SALAZAR: Mr. Madison?

MR. MADISON: I was completely unaware of it.

1:08:30

SEN. SALAZAR: Completely unaware of it, and so when you found out about it, when you got, for example, to the level when you were going up the cliff into the donut hole, what were you feeling? Mr. Madison, Mrs. Bell, Mr. Kinnison, when you got to that point?

MR. MADISON: Well, it didn't take long to get there because my first month's prescription for Perceva for the month of June was out of pocket, $1,307. And I found out for July it was going to run $2,500 just for one month's supply of Perceva. So I was shocked and felt that it would be catastrophic for our financial situation.

SEN. SALAZAR: How did you find out about it then? When you got to the donut hole? Did you get your prescription re-ordered? And all of a sudden you had this big bill that you had to pay? Is this how you ended up finding out about it?

Mr. MADISON: Correct.

SEN. SALAZAR: So it wasn't that Medicare telling you that you were going to hit the donut hole. You ordered your prescription that you needed to stay alive. And they said this is what the cost is going to be because you are now at the donut hole.

1:09:44

MR. MADISON: That's correct

SEN. SALAZAR: And is that similar kind of experience that you went through Mrs. Bell and Mr. Kinnison?

MS. BELL: I was pretty much, when I found out I hit the gap, I guess, both a feeling of rage and worry. I figured, had the part D plan once in two or three years I could actually take everything that I'm prescribed and maybe I could go back to work part time with that ticket to work, but once I hit that gap and found out I couldn't afford to take most of my medications my dream kind of went down the tubes because I can't function without my medications.

SEN. SALAZAR: So it took you by surprise as well, Mr. Kinnison.

MR. KINNISION: Yes it was the same thing; I don't want anything for free. I put into my country, and I expect just a little help. You know, I don't somebody to give me something, I expect to pay my share, but when I went to get two drugs that cost me $20 and they told me the bill was $250 for a 30 day supply instead of $20 I had to leave them there until I could go back and check my finances and see if I had enough money to cover the drugs. Then all the rest of the drugs prices went up. They told me in 2007 they're going to go up even higher. So you're going to be hit harder. It's going to be difficult for me and it's going to be much difficult for a lot more people to reach that out of their own pockets.

1:11:07

SEN. SALAZAR: How many of us have, we all have constituents, and many of us have family members who find themselves in the same situation where you end up seeing family members getting those huge bills for prescription drugs that they never anticipated and were never able to budget for so they find themselves in this surprise and which ends up creating this kind of acute challenges that you face and millions of Americans face.

My question to you Mr. Pollack, and Anderson, and Hayes, has to do with the cost of the prescription drugs to the part D program. I very much agree with Senator Dorgan, it's an outrage when you have our United States of America, our government, essentially putting on a prohibition of what Medicare can do in terms of how it purchases its drugs. And when you think about the Veterans Administrations and how the VA can go out and negotiate for the prices of drugs we see the huge difference in terms of what happens when you're allowed to negotiate.

1:12:10

I can't think of an example in the private sector where you're making a huge buy where you don't have the right to go out and to negotiate and try to bring the prices down. My mother, who is on, I think 11 prescription drugs at the age of 84 suffering from congestive heart failure and other problems I think takes 11 or 12 prescription medicines every single day, some of which are on this list. Dr. Ron Pollack, I was looking at your costs for Zocor, which is one of the prescription drugs that she takes, and had the lowest VA price at $127 approximately and the lowest Part D plan price was $1,275. That's a huge amount of money, the differential there is a $1000 for the same prescription. I'll ask each of you to just in a sentence or paragraph, try to quantify for this committee, try to quantify for the nation, what you think the savings would be if we were to allow Medicare to go out and actually to negotiate for the price of prescription drugs in the same way that the VA is able to do so today, starting with you, Mr. Pollack.

MR. POLLACK: Now Mr. Salazar, as I indicated, the median price difference for the top 20 drugs prescribed for seniors between the VA price and the lowest price secured by any Part D plan is an astounding 46 percent. So obviously I didn't do a quick back of the envelope calculation, but 46 percent is extraordinary, and you can certainly plug the donut hole. There's another important thing to keep in mind here.

SEN. SALAZAR: Let me ask you this, so we take 46 percent and say the costs of the prescription program are somewhere close to $900 billion, so if they were allowed to go and negotiate and use that same calculation of 46 percent, its very conceivable, in fact very real that we could shave off a couple hundred million dollars just off the cost of prescriptions drug program under Medicare

1:14:22

MR. POLLACK: Certainly, certainly, I want to make one other point here, and that is that the size of the donut hole, and indeed even premiums and deductibles will be changed every year. This year we're talking about a donut hole that has a gap of $2850, between $2250 and $5100. CBO projects that the gap, the donut hole in the year 2013, only seven years from now, is not going to be $2850, but is going to be $5066, because what happens is what seniors have to pay in premiums, deductibles, and in the donut hole increase as the cost of the program increases. So as prices go up, so will the out of pocket requirements that the beneficiaries have to pay, and in indeed what the taxpayer is going to have to pay.

SEN. SALAZAR: We will have a donut hole that will increase by two times

MR. POLLACK: It will be almost double in seven years.

SEN. SALAZAR: Dr. Anderson

DR. ANDERSON: What the pharmaceutical industry saw was how well Medicare negotiates with hospitals, negotiates with physicians, negotiates with everybody else and says, "We don't want that", and so essentially says we want to be

able to negotiate with the private sector because we know looking at history for twenty years we can get a better deal, and that's essentially what they've got. To answer your empirical question, we estimated, and you get different numbers depending on what the asked cost estimates you have, but probably, it's about a 40 percent reduction over what Medicare is paying now, so here's your 900 million dollar number, that's almost a 300-400 billion dollar savings.

SEN. SALAZAR: 300-400 billion dollar savings?

DR. ANDERSON: Correct

SEN. SALAZAR: Wow. Mr. Hayes

MR. HAYES: Senator, I would never fight numbers with an economist, but I would say that what those numbers mean, or to reflect in our mind, the pain of our own mothers who can't get a medicine that they need, and we were to reflect thousands and thousands and thousands of older mothers around the country who are going to be in that donut hole because of that ordeal that Professor Anderson described. Thank you very much.

Thank you again Senator Dorgan for holding this very important hearing.

SEN. DORGAN: Senator Salazar, thank you very much. Let me ask either the three policy witnesses. How many Americans will be apart of this gap in coverage called the donut hole in this year? For some reason, I think of the term 7 million roughly, does anybody know how many will find themselves in this gap of coverage?

1:17:07

DR. ANDERSON: Based upon what happened last year, its somewhere between 7 & 10 million people, but you know, people might respond differently, so it's hard to do projections like that right now, but based upon the data that we have, what they went into last year, it would be somewhere between 7 & 10.

SEN. DORGAN: So Mr. Madison, Ms. Bell and Mr. Kinnison are three people who come to this hearing room, but they represent millions perhaps, 7-10 million Americans who will find themselves in the same position. Some of those Americans will be able to recover, they'll have their own financial resources perhaps, not be facing exactly the situation that you three are facing, but it's probably safe to say that many of them will face exactly the same situation that you face for this reason. About 12 percent of the American people are 65 years of age or older, and they use slightly more than 1/3 of all the prescription drugs in our country. So, a relatively small part of our population, that is those are retired, those who are reaching Medicare and social security age, they consume just slightly over 1/3 of the prescription drugs in this country, therefore this question of pricing and coverage especially with people that reached their declining income years, the pricing and coverage of prescription drugs is very important. It can

often mean the difference between whether they can buy groceries, how much money they have to meet other living needs, paying rent, electricity, air conditioning, and so on. So, Mr. Madison, you talk about this situation, you find yourself in a really tough health care challenge; you've got to fight cancer. At the same time you have to fight this issue, how on earth do you deal with the situation where you're paying premiums now for a prescription drug plan that pays you no benefits? And you talked a little about your financial situation. What will happen as you project out? Mr. Kinnison talked about his doctor taking him off of three medicines. I'll ask him about that in a minute, but I assume it's not because he didn't need them. I assume it is because his doctor felt that maybe marginally he could get by without them in the short term in order to save himself some money. You are in a situation where you can't be taken off medicine, I assume. You've got to fight this cancer, and you've got to fight it with the medicines that you need to take and you need to take now, so how do you deal with financially, you and your wife.

1:19:44

MR. MADISON: It leaves us, our future, very, very uncertain at this point because the first two months, June and July, were catastrophic enough. I can't even begin to think about how we're going to come up with the money for August prescription. Well, I shouldn't say August, because we won't have reached that point where the insurance will pay 95 percent. But, beginning January 1 again, we will be faced with the same situation all over again. By that time, costs may have risen even more than they are right now. So, we are facing a situation where without some assistance from programs we've applied to, we're going to be faced with selling cars, selling our home, I really don't know where the money's going to come from. If I were a younger man now, and not retired, I could go out possibly and earn the money. But, I am retired, and I can't lay brick anymore. So, I'm just faced with a totally uncertain future right now.

SEN. DORGAN: Ms. Bell, you indicated that as you fight though these issues it affects your credit rating, which affects a lot of other aspects of your daily life, is that correct?

MS. BELL: Yeah, and I've noticed a couple of problem where a lot of assistance agencies or companies, they will look at your gross income, and don't take into effect you pay premiums and Medicare, and you've got bills. They don't look at what you have left after this, and I don't know how many millions of people who were relying on Medicaid. As soon as the Medicare Part D program went into effect, Medicaid stopped paying for prescription drugs for people who had Medicare. There's even people who are at worse financial status than the three of us who probably can't take any of their medications because they no longer have Medicaid covering their prescription because they've got the Medicare Part D plan. So how many out there are dying from illnesses because they can't take their medications

SEN. DORGAN: How many medications do you take?

MS. BELL: Eleven, and four of them I cannot afford.

SEN. DORGAN: And so what are you doing with respect to those?

MS. BELL: I'm not taking them, I can't take them, and I don't foresee taking them by the end of the year because I'm not going to make that $3600, there's just no way I can afford it.

SEN. DORGAN: Mr. Kinnison, I think it would be safe to say that most doctors would not want a patient to stop taking medicine that they need to take, and yet your doctor said at least three of these medicines, why don't you stop taking them for a while; we'll measure you very carefully and see what impact it has. Do you think your doctor's decision about that was solely as a result of your inability to afford them?

MR. KINNISON: Yes

SEN. DORGAN: Did he tell you that?

1:23:11

MR. KINNISON: I went to him, I made an appointment with him to go and discuss my medicines and the cost, and if I could get off of any of them. And he took me off of these three because they were kind of like a duplicate, and he would take blood tests and he would test me further down the line, but he said eventually you'll have to get back on them. Because there are congestive heart failure medicines, and there are water pills and I have to take them so that I don't have congestive heart failure. So, I eventually have to go back on them. But right now he took me off of them to give me a break. But I will have to go back on them. I just asked Ron about the Medicare, did you have to sign up for it. I wasn't sure if you had to sign up for it or not. I was told you had to sign up for it. If you don't sign up for it, then you're going to get hit with a big penalty. Because I was going to say, well take me off of it. Because there was a thing with my HMO which was giving me great service at a good discount price, but I now I can't do that, so I'm stuck either way now.

SEN. DORGAN: Well the purpose of a prescription drug plan and Medicare is to be helpful to senior citizens, not to hurt them.

MR. KINNISON: That's what I was told.

SEN. DORGAN: And yet the paradox here, in a very sad way, is that in many cases people are getting hurt, and you're describing circumstances where you're not on medicines that you should be because you don't have the money. Ms. Bell is talking about not being able to afford medicines that she should be taking

MS. BELL: I have to fight for durable medical equipment as it is. Why should I have to fight to get prescriptions?

SEN. DORGAN: And Mr. Madison has just been diagnosed within the last, when was your diagnosis Mr. Madison?

MR. MADISON: I was diagnosed in May

SEN. DORGAN: So, I mean this is a relatively new battle and new challenge that you're facing.

MR. MADISON: That's right. I've undergone two rounds of intravenous chemotherapy and taking the Tarcevis since about the middle of June.

SEN. DORGAN: Mr. Hayes, let me ask you, you said in your testimony that, first of all, let's talk about this man named Furfaro that is in your testimony. It's a fellow that has had a heart transplant. So, when someone goes through a heart transplant procedure, that's a very sophisticated medicine, very expensive. And at that point you need to be on drugs to prevent rejection, you're probably on drugs the rest of your life, I assume, is that correct? Or in most cases close to that.

1:25:41

MR. HAYES: I believe so, yes

SEN. DORGAN: And so you describe the situation with Mr. Furfaro and say that he's had a heart transplant and now he's trying to figure out how he can afford the drugs, he can't afford the drugs, and what does he do next?

MR. HAYES: His story is sadly typical I suspect, although I guess he does point to one fairly inhumane solution. This gentleman needs a couple of immunosuppressant medications on an ongoing basis to protect the transplant. When he hit a donut hole, he's suddenly facing $1000 a month in costs that he could not afford. He was shocked to find himself in this position. And not take the medication, tried to sign up for charitable programs, and was told that it was really, at this point, no sense in even getting on the waiting list because it was so full. So he wound up in the hospital and he got his immunosuppressant drugs in the hospital covered by Medicare part A as well as the hospitalization and he's alive today because of that. But that's obviously horrible medicine, horrible economics, and pretty inhumane.

SEN. DORGAN: That is absolutely an idiotic result isn't it? The highest cost health care is in an acute care bed in a hospital, bar none. That's the highest cost health care we can deliver. So because a fellow that gets a heart transplant can't afford the medicine he needs, he gets into an acute care bed and gets the immunosuppressant that he needs in an acute care bed. You know, you talk about perversity, that's the kind of thing

that is just unbelievable. To me, that is exactly the wrong thing that we ought to be trying to incent here with legislation.

MR. HAYES: Senator that's exactly what many of the sponsors of this legislation said on the floor of the Senate that would be avoided.

SEN. DORGAN: I think probably all three of you describe that there was virtually no one in advertising their plans that we're talking about the fact that if you sign up by the way, you'll pay premiums right on through, but you'll have a portion of the time when you'll get no benefit but will still be paying premiums. And in your testimony Mr. Hayes you also talked about the *Parade* magazine. *Parade* magazine is a Sunday supplement to the Sunday paper in many parts of America. And what was put in Parade magazine and by whom?

1:28:12

MR. HAYES: This was not a sin of drug plans. This was an educational supplement. I don't know the cost, but the centers for Medicare and Medicaid services put into *Parade* magazine two Sundays last fall to educate people with Medicare about this new drug benefit coming down the road and somehow in the multi-page supplement even the administration neglected to mention the donut hole or the gap in coverage in describing the legislation's standard plan.

SEN. DORGAN: So the government itself, CMS or HHS that puts out this information just conveniently forgets to point out to senior citizens there would be a gap in cove rage for which they're still paying premiums.

MR. HAYES: When you buy stock, you're protected against deceptive solicitations. People with Medicare should have at least that much protection.

SEN. DORGAN: You know, it's interesting. I assume almost no one will volunteer to say, "I'm the one that decided we should provide information about this plan and just conveniently forget about the lack of coverage or the gap." I introduced legislation along with Senator Lautenberg and some others to require that plans would disclose any gap in coverage; disclose any gap in coverage, and that legislation was blocked here in the United States Senate. And if I go over to the floor of the Senate this afternoon and ask the question "would someone raise their hand here in the United States Senate to take credit for the provision in law that says we believe that the federal government should be prohibited from negotiating lower prices with the pharmaceutical industry, can someone raise their hand and tell me they're the ones responsible for it? They came up with this goofy idea." I guarantee you there will be no hands raised in the United States Senate. And yet, we've had votes on this to try to dump it. In search of fairness, trying to dump this provision so that we can negotiate lower prices, and unbelievably, we can't get it done, it gets blocked. Mr. Anderson, you have done the research and it caught my eye the first time we talked that eliminating this gap in coverage that is so detrimental to Mr. Madison, Ms. Bell, and Mr. Kinnison, who now

find themselves in the situation where they can't figure out how they get prescription drugs, can't afford prescription drugs they need to take for their health, that eliminating this is actually very simple. This is not some complicated construct that requires a piece of legislation with 20 different parts. This can be eliminated quickly and effectively, right?

1:30:50

DR. ANDERSON: Sure you could just say we're going to pay the VA rates as an interim and that's an already established rate. It's very simple to do this.

SEN. DORGAN: And the VA rates are rates that are negotiated between the VA because the VA can negotiate. There's nothing that prohibits them from negotiating. It's just that the current law the federal government cannot negotiate with respect to Part D and Medicare for lower prices, right?

DR. ANDERSON: It singled out the Medicare beneficiary for prescription drug coverage only.

SEN. DORGAN: Why did you think that happened?

DR. ANERSON: Because I think the pharmaceutical industry was astute and recognized that they could get better deals from Wellpoint, United Healthcare, and all the other health plans than they could from the Medicare program.

SEN. DORGAN: How much money does that save the pharmaceutical industry?

DR. ANDERSON: I would say that it's a 300 billion dollar benefit per year over ten years.

SEN. DORGAN: $300 billion over ten years? $30 billion a year roughly?

DR. ANDERSON: Correct

SEN. DORGAN: Those are big stakes, right?

DR. ANDERSON: Those are big numbers.

SEN. DORGAN: Mr. Pollack, you agree with that?

1:31:55

MR. POLLACK: Since the difference, the medium price difference for the top drugs is 46 percent it's very much in the ballpark, so yes. And by the way, in terms of people being surprised by the donut hole, remember that when people are 65 or older, they probably had health insurance previously. The donut hole doesn't exist in nature;

they've never experienced anything like this. So for them to have an expectation that there is a donut hole is so contrary to all of their experiences. So unless you positively, affirmatively, repeatedly tell people that this is what you're going to face in Medicare Part D, nobody has a reasonable expectation that this point exists. Name one insurance policy that's not Part D that functions like that. Simply doesn't

SEN. DORGAN: Mr. Madison, Ms. Bell, and Mr. Kinnison, I wanted to give you an opportunity to say on this last occasion, what do you want from Congress? What would you advise Congress to do at this point?

MR. MADISON: Well, the best thing that I can think of is the last part of my testimony was that if the lawmakers can figure out a way to change this law and implement something that will plug the donut hole, I'd certainly feel that it's going to be beneficial to millions of seniors. I don't know the process by which this can be done, not that familiar with legislation, but I'm hoping and praying that the legislation that you and your other senators are going to place before the Senate will be successful and it will be placed into law. That's my fervent hope.

SEN. DORGAN: Ms. Bell?

1:34:10

MS. BELL: About the same. If the law can be passed, or the government or Medicare can control the price of prescription drugs from the pharmaceutical company, and like the VA so we can eliminate this donut hole, or even allow, not really allow, but like I had said in my speech where there are private insurance companies where you can pay a little extra. I think one person, a friend of mine, she pays $31 over her ADA that's withdrawn from Medicare to a plus plan; she doesn't have to worry about a gap because her drugs are covered. But in my case, the county I live in, the plus plan's not available, and I was under the assumption that the President had passed the law and Congress passed the law where a plus plan was supposed to be available to everyone on Medicare in the United States. But I can't access that because it's not available in my county. And maybe try to fix for the people who are on Medicaid, some kind of provision that when they get into the gap, that Medicaid might kick in and help them a little so they can get their prescription drugs to keep them from getting so ill that our population is dropping off because people can't take their prescription drugs. Or even the pharmaceutical companies, some kind of provision when they get into the gap or the donut hole allowing assistance so we can get drugs from them.

SEN. DORGAN: Mr. Kinnison, you are probably a tough guy. You were deputy sheriff for many years, right?

MR. KINNISON: Yes

SEN. DORGAN: That's a profession that requires you to be tough from time to time.

MR. KINNISON: Yes, I've worked in some very bad areas, yeah. I thought in my youth that I was invulnerable, but you don't plan ahead for this kind of thing.

SEN. DORGAN: Hence you purse a career that requires you to be tough and at the end of your career then you face another adversary, you face this healthcare challenge from a series of different directions. What is the access to prescription drugs to you? Is your life at stake? Describe to me what this means to you.

1:37:03

MR. KINNISON: Well I don't believe my life is at stake. I think I will get sicker if I can't afford the medicines that I now take. If I have to get off of them, I think I would decline. And now with cancer that's starting to grow that I'm going to have to look at that down the road. But I think everything's been said, I just think that you and the Committee will have to do something to change law. I know it's not going to be an overnight thing, you can't do that. But if everybody works ahead and we get a lot of people that are really fed up. Like I didn't know about the donut hole, nobody ever explained the donut hole to me. Even when I went to the lunch with my HMO, they tried to get me to sign up with them because they said they had the best programs available. I wasn't told about an extra premium that she talked about that you get paid a little extra and maybe get by the donut hole. I was told that there is no such premium in my state, California. I don't know if that's true or not, that's what I was told. So I accepted things the way they were, that I'm going to have to do this. But then when I hit the donut hole, it was a tremendous shock. I have a backup family that's really good, but they won't last forever. So I don't know what I'm going to do down the line

SEN. DORGAN: I assume you're dealing with diabetes, congestive heart failure, and prostate cancer. I assume without medicine, without prescription drugs, your health would deteriorate rather quickly.

MR. KINNISON: Oh the diabetes would go crazy, yeah. I jumped from $20 a bottle diabetes. I ordered 3 bottles the other day and it was $133 just to maintain my diabetes shots that I have to have. That's the worst thing right now, I have a bad heart and its getting worse, I have congestive heart failure, I've had strokes, that's why I walk with a cane. I have a very bad balance problem and a memory problem due to the strokes. So it's not going to get any better. Hopefully I can maintain it at a level pace with the drugs, but it's not going to get any better if I stop taking the drugs. If I can't afford the drugs then I'm steadily going to down the hill.

1:39:02

SEN. DORGAN: The point is that this isn't something that's optional for you. In order to retain your health, you have to be able to access these prescription drugs.

MR. KINNISON: I have to stay on these drugs, yeah. The ones I'm off of right now are minimal drugs. I have to go back on them sooner or later because I'll lack potassium, then I get real sick, and other things. They'll keep me off of those for a while but then I'll have to go back on them.

SEN. DORGAN: I think all of us understand it is the case that there are prescription drugs available now that weren't available 40 and 50 years ago that you can take that will keep you out of an acute bed case bed in the hospital, that will provide some maintenance for your health. But it is true that miracle drugs offer no miracles to those that can't afford to take them. There are no miracles available for those who cannot afford access to those prescription drugs. And that's why we have these policy questions in this country about health care more generally and about this issue dealing with prescription drugs and Medicare. And finally let me just ask for a final comment from Mr. Hayes, Mr. Anderson and Mr. Pollack. I appreciate very much the work all of you do in these policy areas because there's a great deal of confusion about health care and a great deal of confusion especially about this prescription drug benefit. It's interesting to note how much information went out in the private sector through competition for various plans. In my state of North Dakota I believe we had seventeen providers offering 42 different plans to senior citizens. It's unbelievably complicated. But most of the information that went out failed to note that there by the way would be a gap in coverage to people in most cases whose income wouldn't accommodate that gap and allow them to continue to receive medicines through their own purchases. So Mr. Pollack and Mr. Anderson and Mr. Hayes, you have I think described what you think Congress ought to do. But let me ask you if you can sharpen that point. What exactly would you do if you were willing to eat enough chicken dinners to be elected to the United State Senate? Assume that you're willing to do all of that and run for election and you're sitting here in the dais and you're a policymaker in the US Congress, the Senate or the House, and here's your plan to fix this and fix it now, not just in the sweet by and by, but between now and the end of this session of the Congress. What would you do Mr. Pollack?

1:41:22

MR. POLLACK: Senator I knew I wasn't as tough and Mr. Kinnison, but I don't think I'm as tough as you running for the Senate. But here are the things that I would do, and I would start with what I think is most important that we all agree on. Mainly let's get the VA prices into Medicare. You made a point earlier about how seniors consume about 1/3 of all prescriptions. Seniors account for 13 percent of the population. They count for about 1/3 of all prescriptions. They actually account for 43 cents of every dollar on prescription drugs because not only do seniors have a disproportionate number of prescriptions, their prescriptions tend to be more expensive. So the first thing I would do, I would have us move towards VA prices. None of us are naive enough to believe that that is going to happen in this Congress with this President. I think that there are several other things that are worth considering here, no particular order. First, we need to get a greater transparency in pricing and we've got to make sure that the prices that are negotiated by the pharmaceutical benefit managers are made public and I think that if they are made public, hopefully some of the discounts and rebates actually will now

actually go to the beneficiaries of the program and the taxpayers. Secondly, the people of course who do not fall into the donut hole are people that qualify for low income coverage. And as Bob Hayes alluded to in his statement, there's a whole lot more that we can do for those with a low income. I would have us eliminate this so-called assets test as a standard for low income people qualifying for these special subsidies. I would think that would add a number of people who therefore the donut hole. And lastly, perhaps some of the ways that people deal with their drug needs in the donut hole, whether it's through pharmaceutical assistance programs, or I think increasingly we're going to see people when they hit the donut hole try to purchase drugs from Canada. Those kinds of costs or contributions made on behalf of the beneficiaries, they should count to enable people to get out of the donut hole

SEN. DORGAN: Thank you Mr. Pollack, Mr. Anderson

MR. ANDERSON: I agree that paying the VA rates is clearly the way to go. I think we've got ideas here that hospitals pay essentially the Medicare rates and physicians get paid Medicare rates, why not prescription drugs? And I think sooner or later the hospital and physicians are going to be wondering why pharmaceuticals got such a sweetheart deal and they might start being concerned about this. I am concerned if we change relative prices over time. You've chosen the best deal based upon the prices that you have, and then somebody changes the price on you, you ought to be able to re-calculate whether or not that's the best health plan for you. And like Mr. Madison all of a sudden you develop a totally new illness, you should be able to get a new health plan that meets your needs when you develop a new illness.

SEN. DORGAN: I think a couple of you have said something today that I haven't thought much about. We have required them now, with the change in the rule to not drop a particular formula during the year. But they are not required to keep a fair price on that formula and that's another way of resisting. If you want to drop a drug and can't just jack the price way up. We need to look into that, that's a good point. Mr. Hayes.

1:45:20

MR. HAYES: I could only echo Ron and Jerry but would like to take note of the 800 pound gorilla which is standing outside the doorway here which is probably why we're having these kinds of problems. So my fantastic legislative achievement would be to look for a constitutional amendment. I guess we'd need to get a lot of duct tape and take the duct tape and put it over the mouths and wallets of every drug and insurance lobbyist in this town. Keep it there, really good duct tape, so it lasts ten years. And I think that way maybe the majority of Congress could probably do what they really would like to do and serve the public interest and really address some of the reforms that we've been talking about these last couple of hours.

SEN. DORGAN: Alright that actually has a lot of constitutional issues attached to it. This duct tape solution of yours really runs a foul of the first amendment.

MR. HAYES: For fear that I would be disbarred from several states, that's why I said it would have to be a constitutional amendment, I suspect.

1:46:29

SEN. DORGAN: Let me thank all of you for being here. There are other things you could have done on a Monday. Some of you have chosen to travel some distance and others are spending your lives in policy areas that are very important. This is but one issue. There are many issues in health care that are very, very important and my hope is that we could make some progress on this. All of you have contributed to that dialogue today. Thank you very much for being here. This hearing is adjourned.