



STATEMENT OF

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BEFORE THE

**United States House of Representatives**  
**Committee on Oversight and Government Reform**

CONCERNING

**“The Medicare Drug Benefit:  
Are Private Insurers Getting Good Discounts for the Taxpayer?”**

July 24, 2008

Chairman Waxman, Ranking Member Davis, distinguished members of the Committee, thank you for the opportunity to testify today on behalf of Medicare beneficiaries concerning prescription drug pricing under Medicare Part D. I am Judith Stein, Executive Director and Founder of the Center for Medicare Advocacy, a national, non-profit, non-partisan organization that works to ensure fair access to Medicare and quality health care.

Since 2006, the Center has assisted tens of thousands of Medicare beneficiaries and their helpers in Connecticut and across the country to understand and utilize Part D. We hear repeatedly from them about problems that arise from the complexity of the program and about its ever-increasing costs to them. There are myriad plans, each with varying benefit structures, formularies, and out-of-pocket costs, making meaningful comparisons impossible. Beneficiaries have insufficient information to understand formularies, co-insurance, co-payments, and coverage gaps; they lack sufficient information to make sound choices. Indeed the Center has hired an experienced advocate who dedicates all of her time just to handling Part D problems for people in Connecticut.

We thank Chairman Waxman for his leadership in investigating prescription drug costs under Part D and in his continued oversight of the Part D program as a whole. We also thank committee member Congressman Murphy, from the Center's home state of Connecticut, for his efforts to ensure that Medicare beneficiaries in Connecticut and across the country have access to affordable prescription drugs.

Over the past several years, the Center has written extensively about the negative effect on our clients of the increased reliance on private insurance plans to provide Medicare coverage and benefits. Private plans lack the stability and uniformity of the Medicare program as originally designed. This often results in decreased access to care and increased costs to the older people and people with disabilities who are enrolled in these private plans. Unfortunately for our clients, the

only way to get Medicare coverage for outpatient prescription drugs is through private insurance plans. Our clients must decide each year which plan to choose from among dozens of plans, with varied cost-sharing and coverage rules. If beneficiaries seek assistance—and if it is available—they must divulge private information about their health and medications. This is information many beneficiaries do not even want to share with their family let alone with an unknown helper, a 1-800-MEDICARE representative, or a plan operator. Experience now shows that, as a consequence, the vast majority of beneficiaries do not change plans from year to year even though staying with the same plan is often not in their best interest. And, as the Committee knows, there is no option to obtain drug coverage through the Medicare program itself.

Thus, our clients are subject to the whims of the companies that decide to offer drug benefits through the Medicare program. They cannot petition their Members of Congress, as they can when changes to coverage under Parts A and B of the Medicare program are proposed, to say that they disagree with their drug plan's latest change to tiered benefit structure, to formulary choices, to premiums, and to coverage of drugs in the so-called doughnut hole. Instead, they must either bear the increased costs and/or reduced access to prescriptions, or go through one or another onerous process—either to seek an exception to their plan's structure for the drug in question or wait and choose a new drug plan for the following year—with no guarantee that their new drug plan will not change its benefit package in the future.

As this Committee found in its report of October 2007, *Private Medicare Drug Plans: High Expenses and Low Rebates Increase the Costs of Medicare Drug Coverage*, "...use of private insurers to deliver Medicare drug coverage is driving up costs and producing only limited savings on drug prices." According to on-going studies by AARP, any savings in drug costs achieved by Part D

were achieved through a reduction in the cost of generic drugs.<sup>1</sup> However, the prices for 169 brand name drugs have gone up 50.4% between 2001, when AARP first began studying drug prices, and 2007. The general inflation rate for that time period was 19%.<sup>2</sup>

High costs of brand name drugs can be particularly difficult for people who depend on the highest cost drugs, often referred to as “specialty drugs.” The Centers for Medicare & Medicaid Services (CMS) allows drug plans to place drugs that cost more than \$600 in a specialty tier. Even if the plans have flat co-payments for drugs in other tiers, they generally charge a percentage, or co-insurance, for specialty drugs. Thus, the more a drug costs, the larger the out-of-pocket cost for the plan enrollee. About twice as many of the national prescription drug plans (PDPs) (now 41 of 47) include a specialty tier in their benefit structure in 2008 as did in 2006. Twenty-one of these plans charge a co-insurance of 33% for specialty tier drugs, up from four plans in 2006.<sup>3</sup>

Higher drug costs mean that beneficiaries reach the coverage gap, or doughnut hole, sooner. Once in the doughnut hole, when they are paying the full cost of their drugs, they are paying more than they should. And, increased costs can have a significant impact on beneficiaries with chronic conditions for which there are no generic equivalents. Coverage of brand-name drugs in the doughnut hole is virtually non-existent. No national stand-alone PDP offers gap coverage for brand name drugs in 2008. Humana offered such coverage in 2006 and Sierra Rx offered such coverage in

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<sup>1</sup> AARP, *Rx Watchdog Report Trends in Manufacturer Prices of Generic Prescription Drugs Used by Medicare Beneficiaries 2003 to 2007* (May 2008), [http://assets.aarp.org/rgcenter/health/2008\\_08\\_generic\\_q407.pdf](http://assets.aarp.org/rgcenter/health/2008_08_generic_q407.pdf).

<sup>2</sup> AARP, *Rx Watchdog Report Trends in Manufacturer Prices of Brand Name Prescription Drugs Used by Medicare Beneficiaries 2000 to 2007* (March 2008), [http://assets.aarp.org/rgcenter/health/2008\\_05\\_watchdog\\_q407.pdf](http://assets.aarp.org/rgcenter/health/2008_05_watchdog_q407.pdf).

<sup>3</sup> Hoadley, J., et al., “Medicare Prescription Drug Plans in 2008 and key Changes since 2006: Summary of Findings.” Kaiser Family Foundation (April 2008), [www.kff.org/medicare/upload/7762.pdf](http://www.kff.org/medicare/upload/7762.pdf). The number of national PDPs charging 33 percent co-insurance for specialty tier drugs has increased more than five-fold since 2006, from 4 to 21 national PDPs in 2008. Cost-sharing for drugs placed on a specialty tier is generally limited to 25 percent coinsurance, although CMS allows plans to have higher cost-sharing for drugs on the specialty tier if offset by a lower deductible.

2007, but each eliminated that option after offering it for one year. Additionally, plans are providing less extensive gap coverage of generic drugs in 2008 than they did in previous years.<sup>4</sup>

The Center hears frequently from beneficiaries and their families who find themselves without any way to pay for needed medications. A woman in California recently e-mailed us:

I am particularly troubled because I am actually a social worker in California, and I am having a horrible time trying to find a way to pay for medication for my father's chronic illnesses! He is diabetic (Type II), is receiving ongoing chemotherapy for bladder cancer, and has recently been diagnosed with cardiac arrhythmia and now has a blood clot. He and my mother are both retired (ages 68 and 70) with a meager income of about \$1900 per month. As you know, this is NOT ENOUGH to survive, especially in California. My father is currently in the "doughnut hole" in Medicare and has NO WAY to pay for his medication for the rest of the year. I have had no help from local agencies. They have even told us to go to Mexico for medications.

A client from Connecticut contacted the Center for help on the advice of her physician. This 52-year-old woman has sickle-cell anemia. Her PDP refused coverage for a \$6,000-per-month medication which she had been taking, as ordered by two of her physicians. The plan did not cover the dose needed by our client and refused coverage despite the fact that her doctor wrote that she would have excruciating pain if she did not continue on the medication as prescribed. The Center had to appeal this case to the Independent Review Entity—outside the plan—in order to get coverage. What would have happened to our client if she did not have a dedicated doctor who brought the case to our attention? What do other beneficiaries without such physicians and advocates do?

A beneficiary from Tennessee wrote:

I am diabetic and mentally [sic] ill. I went into the doughnut hole quickly. I need drug coverage desperately [sic]!!! I am not taking all the drugs I need because I can't afford them. I am having to beg my Drs. to give me samples of what I just have to have. This is degrading as some of us still have a little pride left. Where is the help we need? I worked and paid my dues and look where I am. Can't someone help us?

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<sup>4</sup> *Id.*

Beneficiaries who want to try to find the best prices for their medication are stymied by the system. CMS tells beneficiaries to go to the Medicare plan finder to find the best drug plan for them, but the plan finder does not include information about the actual cost to the drug plan of their drugs. Nor does it provide information about manufacturer rebates negotiated with the plan. Beneficiaries can find information about the projected cost of the drugs, but even that information may not be accurate. As one beneficiary explained in an e-mail to the Center:

Assume one uses the Medicare Prescription Drug Finder and comes up with two or three plans that seem right for them. Since information [in] this tool are only estimates it makes sense to check with the companies. But trying to get through to a company can involve a long wait. (I waited over 40 minutes today to speak to a Humana representative.) When I asked the representative to review my Drug Finder results her figures were not even close to those quoted in the Drug Finder...I'm assuming [the] Medicare Drug Finder will be generally accurate, but I really don't have a way to check their estimates with the company if I can't get through to them or if the information they give me differs significantly from the Plan Finders results. I also tried to use Humana's website to get Rx prices. But the site was not operational. So where does that leave one in trying to review their 2008 options?

Beneficiary advocates also found that the information on the Medicare plan finder about prescription drug prices did not always comport with the information they received from the plans themselves. CMS was very responsive to complaints about this concern filed by the Center, the State Health Insurance Assistance Programs (SHIPs), and the advocates with whom we work, especially when we could provide specific information about discrepancies between the plan finder and the information provided by the plans. However, CMS did remind one national organization with which we partner that discrepancies between the plan finder and the plans over pricing are harder to resolve because plans can change prices on a weekly basis. How are beneficiaries supposed to choose when the cost of the drugs presented to them in December are not the cost they will pay in July when they reach the doughnut hole?

The burden of unnecessarily high drug costs is borne not only by Medicare beneficiaries, but also by the Medicare program itself. Many of the Center’s clients who are dually eligible for Medicare and Medicaid automatically qualify for the low-income subsidy (LIS), often referred to as “extra help.” We also represent clients who receive LIS because they are eligible for one of the Medicare Savings Programs, or because they applied for LIS through the Social Security Administration. Receipt of the LIS immunizes our clients and individuals like them from the effect of overpriced prescriptions. Eligible beneficiaries pay no deductible, pay low, flat rates for their prescriptions, and have no gap in coverage. Because Medicare subsidizes these beneficiaries by paying the difference between what they pay and what other, non-LIS eligible enrollees in the same plan would pay, Medicare pays more when Part D plans do not get the best prices or do not pass along the full savings to their enrollees.

And, when Medicare has to expend more than it should to cover the cost of drugs, all Medicare beneficiaries, as well as all taxpayers in general, lose out. We do not have to remind this Committee of the budgetary shortfalls facing the Medicare trust fund, shortfalls grievously exacerbated by payments to private insurance plans. But, we would like to point out that when funds go to pay private drug plans more than necessary, there is less money for other Medicare items and services. While we are pleased and thankful that Congress included beneficiary improvements in the law passed last week, those improvements—including improved access to preventive benefits and mental health services—were less generous than improvements included in legislation passed by the House of Representatives last summer, partly because of the lack of resources to pay for them.

States also end up paying more to make sure that their citizens can access affordable drugs when private drug plans do not negotiate the best prices or do not pass on savings from rebates by

reducing drug costs. The State of Connecticut, where the Center is headquartered, is one of about two dozen states that offers a State Pharmaceutical Assistance Program (SPAP).

Our Connecticut program, called ConnPACE, helps eligible Connecticut residents pay for certain prescription drugs, insulin, insulin syringes, and needles. To qualify, the individual must have resided in Connecticut for at least 183 days and must be at least 65 years old, or at least 18 years old and disabled. The annual income levels for an individual and for a married couple are higher than the income eligibility levels for LIS; there are no asset restrictions. There is an annual ConnPACE fee of \$30.00. All enrollees must pay a maximum of \$16.25 toward the cost of approved drugs each time a prescription is filled. For those with Part D coverage, the state of Connecticut pays the actual cost of prescribed drugs above ConnPACE's \$16.25 co-payment.

Needless to say, when Part D prescription drug prices are inflated, Connecticut must expend more to meet its obligations under the ConnPACE program. This unnecessary expense comes at a time when states are experiencing their own economic downturns, with more residents becoming eligible for needs-based programs as their own incomes decline. Expenditures under the ConnPACE program must be authorized every year. The ever-increasing costs of prescription drugs, exacerbated by Part D, puts ConnPACE at risk.

Further, in order to continue to provide the same prescription drug coverage for Connecticut's dually eligible residents as that provided for non-dually eligible Medicaid participants, Connecticut "wraps around Part D" to cover the co-payments and other payment gaps in Part D that are covered by Connecticut Medicaid. Here too, as drug prices increase, so do costs to the state. It would be very unfortunate if, as a result of these higher expenses, Connecticut or other states that provide some assistance with Part D costs decide to eliminate or reduce the assistance they provide.



Congress can take steps to reduce the cost of the Part D program to beneficiaries, to Medicare, and to the states while also making the benefit more responsive to the needs of Medicare's older and disabled beneficiaries:

1. Include a prescription drug benefit in the traditional Medicare program and authorize the Secretary of Health and Human Services to negotiate the cost of prescription drugs.
2. Require drug plans to pass along the full extent of the rebates they receive, including to beneficiaries while they are in the coverage gap.
3. Increase transparency by requiring drug plans to make available information about their pricing and rebates.
4. Increase oversight of the Medicare web page, including the plan finder and drug pricing tools, to monitor for quality control.
5. Require CMS to provide greater oversight of Part D plan websites and customer service representatives in regard to pricing information.

When PDPs fail to negotiate the best price for their formulary drugs, or fail to pass along to their enrollees the manufacturer rebates they receive, Medicare beneficiaries and taxpayers are not getting what Congress promised—access to *low-cost* prescription drugs. As a beneficiary from Oregon wrote to the Center during the annual enrollment period in November 2007:

So did the “market place” work for us as Secretary Leavitt exclaimed in 2005. [sic] Did “choice” work for us. [sic] No. The premiums are higher. The donut hole coverage is gone. The brand name drug prices are higher. The company making the main drug my wife takes charges \$430 retail for a months [sic] supply, up from \$383 in early 2006. That company, Bristol-Myers Squibb had a 34% increase in that drug's revenue in the third quarter of 2007. This due to higher demand and higher net prices. (It's on their own website in their investor section).

Medicare beneficiaries, and taxpayers, are paying more than they should for the drugs people with Medicare need. The Part D program is simply too expensive, too unresponsive, and too resource-intensive. It is not the best way to provide this much needed drug coverage.

Thank you for the opportunity to testify today.