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House of Representatives

"GOING TO HAVE TO SELL MY HOUSE . . . OR DIE": DISASTROUS CONSEQUENCES OF MEDICARE PART D

HON. BOB FILNER

OF CALIFORNIA
IN THE HOUSE OF
REPRESENTATIVES

Mr. FILNER. Mr. Speaker, Medicare Part D continues to bring problems for our Nation's seniors. As more and more reach the "doughnut hole," seniors are confronted with dramatic, no-win choices. I offer my colleagues a recent article in the San Diego Union-Tribune—"Going to Have to Sell My House . . . or Die." It's past time to start over with the prescription drug benefit! [From the San Diego Union-Tribune, July 16, 2006]

GOING TO HAVE TO SELL MY HOUSE ... OR DIE

(By Keith Darcé)

Frank Harrison says he's facing a choice between his health and his house.

When the Spring Valley retiree hit a coverage cap in his federal prescription drug plan in early June, his monthly medicine costs skyrocketed from about $250 to about $1,800, largely because of two expensive immune suppression drugs that he has taken since a kidney transplant six years ago.

The 62-year-old former computer company operations manager, whose main income comes from Social Security disability benefits, stopped taking one of the drugs, which cost about $575 a month, so that he could keep paying his $750 mortgage payment.

"What it boils down to pretty soon is that I'm going to have to sell my house. It's either that or die," he said.

Harrison is among the 3.4 million seniors and disabled Americans who have begun to fall into a gap in Medicare Part D coverage. They must pay the full price for drugs after they've spent $2,250 in co-payments and until their out-of-pocket costs reach $5,100 for the year.

Those in the so-called "doughnut hole" are likely to cut back on medicines to save money even if doing so jeopardizes their health, according to some research.

"Some are being caught totally unaware," said Jennifer Duncan, who manages the San Diego

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Health Insurance Counseling and Advocacy Program.

HICAP, which assists Medicare beneficiaries, has fielded calls in recent weeks from about 20 Part D enrollees who've either hit the coverage gap or are nearing it. Medicare is the government's health insurance program for those 65 and older and the disabled.

The gap is the latest headache to confront those who thought that signing up for a Part D plan would lower their costs for expensive medications. Early glitches blocked some from getting prescriptions because their names didn't appear in the computer systems of the private companies selected to operate the plans. Others tried to buy drugs only to learn at the pharmacy counter that the medicines weren't covered by their plans.

Still, several surveys have indicated that most participants are satisfied with the Part D program and have saved money during its first six months.

Congress created the Part D gap when lawmakers created the drug insurance program in 2003. The measure was added to reduce the program's overall cost. Lawmakers reasoned that only a tiny portion of Part D participants would reach the gap and most would be without coverage only for a short period.

Many of the 22.7 million people in the program will avoid the coverage gap, according to a recent report by accounting and consulting firm PriceWaterhouseCoopers. They have private supplemental insurance, are enrolled in a higher-priced Part D plan that doesn't cap benefits, have incomes low enough to qualify for exemptions or simply won't purchase enough drugs to reach the cap before calculations start over on Jan. 1.

Those falling into the gap are largely middle-class seniors who aren't poor enough to qualify for MediCal—the federal health insurance for the poor known as Medicaid outside California—or they are wealthy enough to afford higher-priced Part D plans that have no coverage caps.

People who fall into the doughnut hole don't pay the full retail price for drugs, said Peter Ashkenaz, spokesman for the Centers for Medicare and Medicaid Services in Washington, D.C. They pay the discounted price paid by their Part D plan operator—about 20 percent below retail prices, he said. "I think people tend to forget that piece of it."

But halfway through the first year of the prescription drug program, the San Diego HICAP is fielding calls from frightened seniors whose benefits are about to run out, Duncan said.

" 'Doughnut hole' is a lousy term. It's more like an abyss," she said. "It's a soft, funny way for saying you may not be able to pay your rent or eat this month because you're going to have to pay for all of your medicines."

One recent call was from a paraplegic who takes high doses of the pain-killer morphine that cost $1,500 a month. Another caller takes $10,000 worth of medicine each month to prevent his body from rejecting a transplanted lung.

Even beneficiaries facing less dire circumstances could have trouble dealing with the gap.

An overwhelming majority of Medicare recipients suffer from chronic diseases, such as hypertension and diabetes, said Kenneth Thorpe, chairman of the Health Policy and Management Department at Emory University in Atlanta.

More often than not, they also are being treated and medicated for multiple conditions, he said. "These are very expensive patients."

When their drug coverage runs out, even temporarily, they are likely to stop taking some or all of their medications, Thorpe said.

That's what Kaiser Permanente researcher John Hsu found when he studied about 200,000 Medicare beneficiaries in 2003 who participated

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in a more limited government prescription drug program that predated Part D. The results, published in the June 1 edition of The New England Journal of Medicine, found that people whose drug benefits were capped at $1,000 a year had higher rates of emergency room visits, hospitalization and death than those with unlimited coverage.

Hsu attributed the increases to people ending drug treatments once the insurance cap was reached. The cost for additional medical care offset the lower drug cost savings created by the cap, he reported.

When Harrison's coverage ended in early June, the maker of one of his immune suppression drugs put him on a program that delivered the medication for free. But he wasn't offered the same deal from the maker of the other medication, and his $1,300 monthly income is too high for him to qualify for the doughnut hole exemption available through Medi-Cal. He's hoping his doctors will provide an answer—perhaps an alternative drug available at a discount or for free from a manufacturer—when he goes in for a check-up in a few weeks.

Wendel Ott, 74, of San Diego, doesn't expect to hit the cap until September, but already he's considering cutting back on his eight medications.

"It's going to cost me a tremendous amount of money for the last part of the year," said Ott, who takes medicines for high blood pressure, an enlarged prostate and chronic bronchitis. "Let's face it, I'm not wealthy."

While many people were aware they might face a gap in coverage when they signed up for a Part D plan, it's clear some haven't prepared for it, said Michael Negrete, vice president of clinical programs for the California Pharmacists Association.

"Most people haven't saved money to deal with the doughnut hole," he said.

Once in the gap, people create a new problem for themselves if they try to save money by purchasing cheaper drugs outside their Part D program, Negrete said.

"When they get drugs outside of Part D, that doesn't go to the credit they need to get out of the (gap)," he said. "If they are getting their medicines from Canada or from a discount drug service, they will never get out of the doughnut hole."