Senate Democratic Policy Committee Hearing

"An Oversight Hearing on the Implementation of the Medicare Prescription Drug Benefit"

Monday, February 27, 2006
1:30 p.m. to 3:30 p.m.
192 Dirksen Senate Office Building

Transcript

SENATOR DORGAN: We're going to begin the hearing, I'm Sen. Dorgan, I'm joined by Sen. Bingaman. This is a hearing of the Democratic Policy Committee on the implementation of the new Medicare prescription drug benefit. I want to welcome the witnesses and those in the audience today.

I think all of us understand that the need for Rx drug coverage, particularly for senior citizens in this country; Senior citizens are around 12% of America's population, and yet they consume well over 1/3 of the Rx drugs that are used in this country. Many of them have no Rx drug coverage and for that reason the Congress has adopted a piece of legislation that provides Rx drug coverage, but in its implementation we're finding all kinds of challenges and difficulties and that's what this hearing is about.

When traveling in North Dakota last week I heard plenty of criticism about this new plan, concerns about the implementation by The Center For Medicare/Medicaid Services; people say its too complicated, they want to know why health plans are able to change their prices and their formularies seemingly on a whim, they want to know why pharmacists are prohibited from helping patients figure out how to enroll in a plan. Pharmacists have told me that some plans will not even return telephone calls when they want to join a plan's network; other pharmacists have said they've had to take out short term loans because of payment delays; so there are problems on the part of senior citizens, problems on the part of pharmacists. Nearly everyone thinks this benefit is too complicated. In North Dakota we have 105,000 eligible beneficiaries; we have 41 drug plans being offered by seventeen different companies. It is unbelievably complicated to deliver this type of program. Because of the confusion and because of the problems with implementation only 37% of seniors in North Dakota have drug coverage; the sign-up has been very slow with over 1/3 of the sign-up completed. Last week Secretary Leavitt said 'the marketplace will simplify the program.' I'm sorry that's ignoring the problem. The marketplace is a wonderful thing, I used to teach a little economics, I'm a big believer in the marketplace, but the marketplace is where Judge Judy earns 100 times more than the Chief Justice of The Supreme Court, or a third-baseman signs a contract for $250 million, equivalent of about 250,000 elementary school teachers. The marketplace is a wonderful thing but it is not always right, it needs a referee. In this case the marketplace is not going to solve this problem, we have to think through and the administration has to think through, how to make this plan work, how to make it work for senior citizens, how make

it work for the main street pharmacists, how to make it work for our government so it's not going to break the bank. That's the purpose of this hearing.

We have some great witnesses this morning and following Sen. Bingaman's opening statement I will describe the witnesses and we will have their testimony at that point. Sen. Bingaman thank you very much for being here today,

SENATOR BINGAMAN: Thank you Sen. Dorgan for having this having this forum here, I think it's very useful to have these experts to give their insights as to what we can do. I was in my state last week as you were, talking to seniors, had a couple of meetings one in Roswell and one in my hometown of Silver City, New Mexico; talking about this Rx drug plan and I came away with renewed conviction that we need to make some changes. Unfortunately we've got a difference of opinion between ourselves and the administration on that point; the issue came up as you recall—Sen. Grassley I believe offered a Senate resolution in opposition to legislative changes at this time, I think he got 42 votes—the majority believes we need to make legislative changes.

The list of possible legislative changes is long, let me just list a few of the things that have been urged. Sen. Rockefeller of course has a bill to provide immediate re-imbursement to the states, Medicare beneficiaries, and pharmacists, and I some of the governors may be talking to the President about this very issue today. There's a proposal to enact legislation to deal with the assets test which is a very major problem; I know that Dr. Rice in particular has focused on—I believe something like 60% of people applying for the low income subsidy are turned down because of the assets test.

Sen. Feinstein has legislation to allow private drug plans to correct part of the legislation that allows private drug plans to change their drug formularies after the beneficiaries sign-up for the plan. I've begun to hear complaints in my state about that provision in the law. Sen. Nelson has a bill that I co-sponsored to deal with this pending enrollment deadline of May 15, which is a very real problem which I can't find a lot of support for maintaining that kind of an enrollment deadline.

Let me mention one other thing, and that is an alternative which I have been working with Congressman. Patrick Kennedy on, and that is legislation that we are calling the "Medicare Extras Act" that would allow Medicare senior citizens and the disabled to bypass all the complexity and problems associated with the current Medicare prescription drug plan, that we have enacted into law. The legislation would allow Medicare beneficiaries to get all their Medicare benefits, including their prescription drugs, directly delivered directly by Medicare. That was something as you recall that many of us were urging at the time this debate started. We felt that would make a lot more sense than the private system and the complex system that we have since chosen to adopt. This Medicare Extras opinion is something which I feel would be preferable to many of my constituents to what we have in place today.

Again thanks for having the forum and for letting me participate.

SEN. DORGAN: Sen. Bingaman thank you very much. I think one of the first things we should do is pass legislation to extend the deadline to at least the end of the year. That makes a lot of sense as does Sen. Feinstein's bill; second there is a perversion in the legislation creating the drug benefit and that perversion is a provision that prohibits federal government from negotiating lower prices with the pharmaceutical industry. It is an unbelievable perversion of what ought to happen in public policy. We've had votes on that in the Senate and surprisingly those who believe we should not be negotiating lower rates prevailed. Even if this worked really well, and it is not, it's going to break the bank someday unless you put downward pressure on pricing, empowering the federal government to negotiation lower prices with the pharmaceutical industry.

Having said that, we have some excellent witnesses. Robert Hayes is President and General Counsel of the Medicare Rights Center. Thomas Rice is Vice-Chair of the Department of Health Services at the UCLA School of Public Health. Gerard Anderson is Director of the Center for Hospital Finance and Management at Johns Hopkins Bloomberg School of Public Health. Tim Westmoreland is the former director of Medicaid and a research professor at Georgetown University. David Olig is the owner of the Prescription Center Pharmacy and Southpointe Pharmacy in Fargo, North Dakota.

First Mr. Hayes, who I mentioned is President and General Counsel of the Medicare Rights Center. He lead the National and the New York Coalitions for the Homeless from 1979-1989; practiced law with firms in New York and Maine; a graduate of Georgetown University and the New York University School of Law; He was McArthur foundation fellow and has received honorary degrees from ten colleges and universities. Mr. Hayes you have a wonderful background, thank you very much for being here with us today, and you may proceed.

MR. HAYES: Thank you so much Sen. Dorgan, Sen. Bingaman for having us. We're very grateful for your concern over this public health emergency that has been caused by the inevitably bungled mismanagement of the new Rx drug program. We're grateful to bring to this committee and anyone in government who will listen to our day-to-day experiences in helping people with Medicare.

The Medicare Rights Center is a not-for-profit consumer service organization, with offices in New York, Washington, Chicago and Baltimore. We provide counseling and education services to tens of thousands of individuals and organizations, and we promote public policy rooted in the real needs of the people we serve. We are neither supported nor controlled by Senators, the pharmaceutical or insurance industries, and our sole and non-partisan mission is to serve people with Medicare.

Two months into the new drug benefit we questioned whether it is furthering Medicare's fundamental goal, that is providing health security of the American people, by an act of the Congress but also by the remarkably submissive regulation by the Administration; parking plans have broad leeway to decide which drugs they cover, what they will charge, and what impediments they will place between patients and needed

medicine. What does this mean for people with Medicare? Fear, anxiety, and uncertainly. Exactly the opposite of what Medicare has offered the American people for the last 40 years, the opposite of what the American taxpayer should be purchasing with their hundreds of billions of dollars committed to this program.

The fear and anxiety is not unwarranted, Senators. One quick example, of one our clients, Ms. S, a 76-year old widow. Until January used New York's Medicaid program to fill her prescriptions. Like over six million others with Medicare and Medicaid nationwide, Ms. S was switched from Medicaid to Medicare drug coverage on January 1, 2006. It worked for her it seemed on paper, because armed with both her Medicaid card and her new Medicare drug card, she went to her local pharmacy to get her blood pressure medicine—only to learn that her medication was not covered. She left the pharmacy empty handed, and a week later, she was taken by ambulance to the hospital. Her heart was beating so slowly, she could no longer stand up.

That's not the most dramatic example, but it is a routine example of the day to day life of certain people with Medicare, across New York State and the United States. The litany of start-up problems, which became routine in January, included: the poorest people with Medicare were wrongly charged unaffordable co-payments and deductibles simply because they were not entered into plan computer systems. Drug plans did not provide temporary fills for drugs not on their formularies even though they were promised to do so. Routinely neither the government nor the plans hotlines for consumers or pharmacists were functioning reasonably.

Responsibly, most states stepped in to provide stop-gap coverage through their Medicaid programs to people who receive both Medicare and Medicaid benefits – a step vehemently and irresponsibly fought by the Bush Administration throughout 2005 and the early days of 2006, while we're trying to ensure that there would be some safety measures for folks who would be lost to the system.

This temporary coverage has indeed saved lives, no question about it. But once these safety nets are pulled, we expect not just more bungling, but systemic deprivation of medicines caused by the designs of the drug plans. One design feature in particular will keep needed drugs from people with Medicare. These are the so called utilization management's practices. These practices are classic 'hide the ball' plays. Neither the plans nor the CMS websites explain how these plans work; curiously, that's okay with CMS. People need that information to decide if their drug regimens are compatible to plan restrictions.

The process to appeal the denial of drug coverage is not working. Patients and doctors alike routinely cannot get through to plans, even to obtain the forms and documentation necessary to conduct an appeal. Each plan has different forms, different documentation requirements; Some plans are out blatantly to undermine legitimate needs, for example, requiring doctors to submit articles from medical journals to back up their case for a particular drug for that patient. Right now physician groups, pharmacist

groups, and patient groups are developing model forms for the plans, but the use of this form will be voluntary – CMS, curiously, will not require plans to accept it.

Consuming the satisfaction that I would experience, not political, just human, is really a combination of the un-affordability of the benefit and the confusion. At the current pace of enrollment, there will be about thirteen million people with Medicare that will be without meaningful drug coverage come enrollment period termination date of May 15th. Low as the low enrollment figures are, Congress should quickly address the abysmal enrollment rates in the low-income subsidy, the "Extra Help." As Sen. Bingaman said the legislation to remove the asset test has been introduced, at this point the test not only punishes people who have scrimped to have at least some security, but also complicates the application process—preventing what could be an automatic enrollment program on the basis of information the government already has about low-income Americans.

Last word, people with Medicare do need and deserve an affordable, secure and intelligible drug benefit through Medicare and so does the American taxpayer. Thank you Senators.

DR. RICE: Thank you Sen. Dorgan and Bingaman. I am honored to have been asked to provide testimony on the Medicare prescription drug "asset test," and on barriers facing beneficiaries in choosing a Medicare drug plan.

Although the new Medicare prescription drug benefit provides much-needed coverage to seniors and disabled Americans, budget constraints forced Congress to adopt a fairly limited benefit. Even though beneficiary premiums are subsidized by general revenues, those purchasing drug coverage under Part D will face substantial costs, including monthly premiums, deductibles, and full financial responsibility of $2,850 during the doughnut-hole. Poor and near-poor persons cannot afford this burden. As a result, Congress has provided highly-subsidized coverage for beneficiaries who are dually eligible for Medicare and Medicaid and for others with incomes below 150% of the federal poverty level. Being eligible for this coverage makes an enormous difference. CMS estimates that on average, beneficiaries receiving the low-income subsidies would spend just $170 out-of-pocket in 2006 – compared to $1,122 on average for those not receiving it.

A big problem, however, is that eligibility hinges not just on having low income but on passing an asset test as well. Those whose assets are deemed too high do not receive the extra subsidies, and thus, face all of the costs of premiums, coinsurance, and the "doughnut hole." To get the best subsidies, assets cannot exceed $6,000 for individuals or $9,000 for couples. This includes amounts in checking and savings accounts, stocks, bonds, mutual funds, retirement accounts, and equity in real estate. The only things excluded are the value of first homes and cars.

Because these thresholds are so low, many otherwise qualified, low-income Americans are excluded from the subsidies. The federal government reports that out of 3.6 million applications processed for the low-income subsidies, only 1.1 million – or 31% – are eligible. Of those excluded, 57% exceeded the asset limit, which is what I'm speaking about, 32% the income limit, and 11% exceeded both limits.

In research funded by the Kaiser Family Foundation, and using data from the U.S. Census's, Katherine Desmond and I estimate that 17% of low-income individuals – 2.37 million people – are precluded from these vital low-income subsidies due to the asset test. We also found that, compared to the average beneficiary, those failing the asset test are more likely to be older, female, widowed, living alone, and without any insurance to supplement Medicare; and it is not just the wealthy who are affected. Half of those who fail the asset test exceed the limit by $35,000 or less – hardly a nest egg for the rest of one's life. Not surprisingly, almost half of their assets are from checking and savings accounts. Just 13% are from retirement accounts, 18% from stocks and mutual funds, 16% from real estate, and just 3% from ownership of a business.

So here's how we see the scenario. When a husband dies, income plummets, making the widow potentially eligible for these subsidies, but she has accumulated assets that exceed those allowed under the legislation. These older women are very vulnerable to financial catastrophe but, because they have some accumulated savings, are ineligible for the subsidies.

During their working years, Americans are encouraged to save for retirement and prepare for the possibility that they will face sizable long-term care expenses. Those to whom this message is most salient will have little or no income beyond what they receive from Social Security. By accumulating modest amounts of assets, either through bank accounts or retirement-savings vehicles, these same people have guaranteed that they will *not* qualify for the low-income subsidies – but the vast majority use prescription drugs every day. This burden tends to fall on the most vulnerable of seniors. Thus, modifying the asset test by increasing the threshold substantially or eliminating the asset test altogether, would help protect more than two million low-income Medicare beneficiaries.

Let me end by briefly mentioning a larger issue – the difficulty all Medicare beneficiaries have in choosing the right prescription drug plan. In Los Angeles County, where I live, there are a staggering 85 choices of drug plans available: 38 Medicare Advantage plan choices offered by 18 companies and 47 stand-alone prescription drug plans offered by another 18 companies. This is not just an urban phenomenon, Sen. Dorgan mentioned North Dakota, the numbers I have from Arkansas are very similar. Beneficiaries have 40 prescription drug plans offered by 15 companies.

In addition beneficiaries face difficult choices in such things as what, if any, supplemental insurance plan to choose for their non-drug expenses. In an article by Yaniv Hanoch and I have written, we illustrate the myriad of choices in a chart that I believe you have and is going to be posted right now. It just shows how amazingly complex the Medicare drug benefit actually is. I'd be happy to go over it. It appears hopelessly

complex, but the real benefit is more complicated than this because this doesn't show all the number of companies that people have to choose form. It is doubly-difficult for the poor, because they must do two things: sign-up for a drug plan and sign up for the low-income subsidies; they've had a lot of problems doing that. It's no wonder, that only about half of the 29 million beneficiaries predicted by the Department of Human Services to sign up for coverage, have actually done so.

I think Congress did seniors no favor by giving them such a complicated program with so many choices and decisions to make. It is no surprise that enrollment numbers are so low – few can figure the benefit out. Younger Americans face much less choice. Among employees offered health insurance from their employers, 37% have a single plan choice, 20% have two choices, 13% have three, and just 30% have four or more, we're giving people 40 or 80 choices if they're on Medicare.

An obvious way to simplify choice would be for government to act as a real broker, actively soliciting competitive bids and winnowing down the number of companies that ultimately can offer a product directly to beneficiaries – just like employers do for their employees. Your deliberations on these issues are of the greatest importance to the welfare of older and disabled Americans. Thank you.

DR. ANDERSON: Tom has given you the Harriet & Louise of Rx drug reform. 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 towards providing ongoing, chronic care. This transformation of the Medicare program is critical because two-thirds of Medicare spending is by beneficiaries with five or more chronic conditions. The next steps I believe Congress should consider are outlined in an article I wrote in the New England Journal of Medicine this summer. I have attached a copy to my testimony.

Today, I would like to talk about one aspect of the Medicare Modernization Act that is especially important for Medicare beneficiaries with chronic conditions – the so called "doughnut hole", or large gap in coverage in the current Medicare Part D benefit. As you know, Medicare covers 75% of the cost of prescription drug spending from $0 to $2,250, there is no real Part D coverage from $2,250 to $5,100, and then there is 95% coverage after that. According to data from Tricia Neuman of the Kaiser Family Foundation, nearly 95% of all prescription drug plans approved by Medicare have a "doughnut hole." The gap in coverage is especially onerous for the 23% of Medicare beneficiaries with five or more chronic conditions because they fill an average of 50 prescriptions during the year and nearly all of them will be affected by the "doughnut hole."

What my colleagues and I wondered was whether the "doughnut hole" 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 the journal *Health Affairs* which examined this issue. We calculated the amount that Medicare would pay for the 25 most commonly prescribed brand name and generic drugs in the United States. We then calculated the price that people in Canada, The United Kingdom, or France

would pay for the same market basket of 25 drugs. What we found was that even with the discounts the Medicare plans are receiving from the drug companies, Medicare beneficiaries will be paying 52 to 92% more that the people in Canada, the United Kingdom or France for the same drugs.

In July 2005, the Congressional Budget Office published a comparison of the rates different federal programs are paying for brand-name drugs. We compared the rates Medicare beneficiaries will pay for prescription drugs to the rates that the Veterans Administration and the Department of Defense pay for drugs. What the study shows is that the discounts the VA and DOD receive are similar to the discounts that people in Canada, the United Kingdom and France are receiving. One issue therefore is whether the Medicare program could negotiate as good a deal with the pharmaceutical companies as Canada, the United Kingdom, France, VA or the DOD. Economic theory would suggest that the Medicare program could negotiate an equally good or better deal if Medicare negotiated as a single entity instead of each individual health plan negotiating for a much smaller quantity of drugs.

We then developed a micro simulation model to see if the "doughnut hole" could be eliminated if the Medicare program paid the same rates as Canada, the United Kingdom, or France. A description of the model is included in our paper. What we found was that the "doughnut hole" could be completely eliminated if Medicare paid the same rates as Canada, the United Kingdom or France. Paying these lower rates for drugs the Medicare would spend the same amount as under current law while eliminating the "doughnut hole," so it wouldn't cost the Medicare program any more money. In addition, the Medicare beneficiaries and health plans would pay less and utilization of drugs would increase because drug prices were lower. We have subsequently ran the model using the CBO analysis of federal drug prices and found that the "doughnut hole" could also be eliminated if the Medicare program paid the same prices as the VA or DOD. We then analyzed the characteristics of Medicare beneficiaries who were most likely to benefit from the elimination of the "doughnut hole". These were primarily beneficiaries with multiple chronic conditions – beneficiaries with various combinations of diabetes, congestive heart failure, chronic obstructive pulmonary disease, Alzheimer's disease, depression and other chronic conditions.

I understand the choice the Congress faces is difficult. Maintaining the 'status quo' and paying higher drug prices might result in the drug companies spending more on research and development which could lead to the next big drug. Currently only 14% of drug company revenues are spent on research and development. Lowering the drug prices and eliminating the "doughnut hole" is likely to improve the health status of millions of Medicare beneficiaries because they will have better access to needed drugs.

One possibility is to have the federal government negotiate a maximum they will pay for a particular drug and allow the health plans to negotiate with the drug companies for an even lower price. I would be happy to answer any questions, and I apologize to the members of the committee that I have to leave at 2:45 to go to a conference call.

MR. WESTMORELAND: Senators thank you for holding this hearing and for inviting me here to participate. I am here today to discuss the Dual Eligibles—usually referred to simply as "the Duals." So far the treatment of Duals under Medicare Part D has been an acute problem, in some instances approaching an emergency. In the future the treatment of Duals will be a chronic problem. As one local health officer who has helped Duals through Part D recently testified to his State legislature: "Drug plans can change their formularies every month, pharmacies can move in and out of networks, and states must continually send lists of vulnerable low-income patients for enrollment. Medicare Part D as currently constructed guarantees a never-ending transition."

Who are the Dual Eligibles? Most simply put, Duals are those Americans who are eligible for both Medicare and Medicaid. There are about 6.4 million Duals. When compared to other Americans on Medicare, Duals are substantially—between two and three times—more likely to have chronic illnesses and disabilities, to have mental impairments or illnesses, and to have less than a high-school education, to be very old, and to live in nursing homes. This all means that these people are very likely to need prescription drug coverage and very unlikely to be able to sort through the complexities of Part D letters, forms, websites, and rules. And, when compared to other Americans on Medicare, Duals are substantially more likely to have incomes under $10,000 a year. This last point is particularly important for understanding the problems that Part D may pose, because these people are not only very vulnerable, but they also do not have the cash to do what others might do when they encounter an insurance problem: They cannot pay for their drugs and fix the problem later.

The Duals are, so far, the largest group enrolled in Part D. So when I talk about what's happening to the Duals, it's mainstream, not a backwater. What's happening to Duals is fundamental to Part D. When Part D began, Duals were to be automatically cut off from their Medicaid drug benefits and made automatically eligible for Part D. They were to be randomly assigned to a prescription drug plan in their State that was at or below the average premium, the so-called "auto-enrollment, they were to be allowed to choose a different plan than the one to which they were randomly assigned.

What has Part D actually done to the Duals? First, be aware that the problems that Part D has posed for the Duals and their families are not surprises. Medicaid directors were warning a year in advance that the transition for the Duals was a "trainwreck waiting to happen." One recently summed up that what has happened was "predictable and predicted."

Part D lost the Duals. Many Duals showed up at pharmacies that, using all the information available, could find no information about their enrollment or coverage. These problems were passed to pharmacists, state and local advocates, and families. They were, in effect, drafted to do the eligibility and enrollment work that the Federal government had not done.

Part D sent the Duals to inappropriate plans. Auto-enrollment was done without regard to the Duals' diagnosis or current drugs. Their drugs may not be on the approved list of what the plans will pay for or the plan's limits may require a new visit to the doctor

to get past the restrictions. Part D has sent the Duals to pharmacies that are inconvenient to the beneficiary. I think the most obvious of these is the auto-enrollment of Duals in Hawaii to plans that were not licensed to do business in the State of Hawaii. It's hard to imagine how such a beneficiary could easily find another, in-network drug store. But it's not just being on an island. For many other elderly and disabled people throughout the Nation, rural and urban, being randomly assigned to a new pharmacy poses barriers that may genuinely interfere with their access.

Part D has overcharged the Duals. There are widespread reports of Duals being charged deductibles and high co-payments that they were to have been protected from. Part D has made drugs unaffordable for some Duals. Some Duals have found the co-payments that they are legally charged according to the law to be unaffordable. Even low co-payments are out of reach for many Medicaid beneficiaries, and many Duals, especially people with disabilities, take many drugs. A three-dollar co-payment per drug multiplied by eight or ten drugs per month is just not possible for people with such low incomes.

What will Part D likely do for or to the Duals in the future? There will be ongoing problems. As I noted earlier, Part D is a program with a transition that never ends. Medicaid eligibility will change. People will qualify for Medicaid throughout the year. People don't uniformly become elderly, disabled, or poor on January 1. Plans will go out of business. There is widespread discussion of how the first year of Part D will produce a shake-out and consolidation of plans, with fewer and different plans being available next year. Any Dual enrolled in the disappearing plans will have to start over. Plans may raise their premiums above the State average, so that they are not longer eligible to take Duals. When this happens, the coverage of any Duals in the plan will be terminated, and these beneficiaries will need to be auto-assigned to another plan.

Plans are likely to make formularies more restrictive, and such changes in formularies will pose difficulties for Duals. The one time refill requirement has patched over these issues is only for 90 days. Duals can shift plans more frequently. This is good and will help protect Duals from all of these other problems. But there will be ongoing confusion among these vulnerable people and their families. What should the Congress do to make Part D better for the Duals? Provide a standard Medicare drug option available to all that can be a safe haven until they choose another plan. When Duals have to be auto-enrolled, auto-enroll them there until they choose to go elsewhere. This is not dissimilar to how Medicare works for hospital and physician services. Beneficiaries enroll in Medicare Part A and Part B, unless they themselves choose to join managed care in Part C.

Provide an ongoing transition payment through Medicaid to allow States to assure that a Dual who is newly enrolled in Part D is truly covered. Don't cut off Medicaid payment for a Dual until it's confirmed that Medicare will pay. Provide both the Federal agencies and State Medicaid programs with increased money and enforceable and enforced requirements to straighten out their data systems. Part D is not the only place where the inability to talk among Medicaid and Medicare and Social Security confuses the systems and mistreats beneficiaries. Audit the auto-enrollment plans for cost and

utilization. My guess is that they—like Medicaid managed care plans that have received auto-enrolled beneficiaries from States—are collecting premiums on a lot of people who don't even know they're enrolled and who are not getting any services.

In closing there absolutely must be a system for paying for prescription drugs for Medicare beneficiaries. Prescription drugs are a much-needed service for people on Medicare. Medicaid has very limited eligibility and does not help many of the people who need help. Conversely, Medicaid—and the States—have too long been shouldering a burden that should have been Medicare's. But there has to be a better way than this around-your-elbow-to-get-to-your-nose, Rube-Goldberg system of Part D. It serves neither the beneficiaries nor the taxpayers well, and it is endangering the health and wellbeing of some of the most vulnerable Americans.

MR. OLIG: Thank you Sen. Dorgan, Sen. Bingaman. I think it is reasonable to assume that the majority of the people in this room feel that a Medicare prescription drug plan is a necessary benefit for our senior citizens. I also think it is reasonable to assume that most of my colleagues in the pharmacy profession support providing a benefit.

However, I am concerned that the benefit that was enacted is too confusing and its implementation has been plagued with problems. I would like to outline some of the major problems and offer my advice about changes you should consider to improve the benefit.

First, I don't know how the federal government could have possibly made this benefit any more confusing. In North Dakota, there are 41 plans being offered, each with its own structure of co-payments, deductibles and coinsurance. To make matters worse, seniors are forced to try to match their current medication regimens with 41 different formularies. I am quite sure the majority of senior citizens neither understand the concept of a formulary nor why their specific medication may or may not be covered. Once a beneficiary does select a plan, there is no assurance that the terms of the plan will not change. Change is a very difficult thing for a senior citizen. The formulary system currently in place allows prescription drug plans to change the drugs that are covered with 60 days notice. There is nothing to stop a plan from engaging in "bait and switch" tactic to drive up enrollment.

The second problem—The one person who knows the patient's medication regimen, the pharmacist, is prohibited from helping patients enroll in the benefit. Pharmacists are also not compensated for the countless hours spent helping answer questions from individual patients. In contrast, prescription drug plans are allowed to hire agents and pay them to sign up seniors in their plan. This makes no sense. These agents have no incentive to provide honest and accurate information to seniors. Seniors often end up picking a plan that does not cover their medication or a plan that does not allow them to go to their local pharmacies. I believe we should allow and promote the services of the nation's pharmacists to facilitate the enrollment process and pay them accordingly for their services rendered.

The third problem I will discuss is the cost of the benefit to the government. It is unbelievable to me as a taxpayer that we would be spending this kind of money and not receiving the best prices in the nation. Why should Medicare be any different from the Department of Veteran's Affairs? I certainly do not understand this. I have brought a 39 page document that shows the manufacturers' price increases from December through February of this year. Those prices increases will continue unbridled without some form of a legislative mandate. You must find a way to control the cost of pharmaceutical products or this will be an unbelievably difficult runaway situation. One of the most obvious steps is allowing the government to negotiate for better prices.

I think it is important to point out how much I get paid for filling Medicare prescriptions. Of the 10 different plans my pharmacy currently provides for, the average reimbursement for a brand medication is between 5 and 11% gross margin. For example, for $100 worth of Lipitor – a medication many of us are on – I would have a gross margin of between $5 and $11, for that $100 of medication—with the average being between $5-7 per plan. Over the last two months, the price of that same 30 day supply of Lipitor was increased by $4.06 to 4.5%, basically my gross margin. I bring this up to point out that pharmacists are not the reason for high drug costs. If the current system is not changed, the slow and low reimbursement rates will be a financial disaster for community pharmacists. I have spoken with many of my colleagues nationwide and especially in rural areas that are in serous financial trouble because of this plan. Some pharmacists have been forced to take out short-term loans to cover their costs. Other pharmacists have tried to join a plan's network but can't even get their call returned; it takes many many weeks in some cases; we've heard horror stories about two and a half hours on hold, and then they tell you the computer system is down. This is not sustainable. I encourage you to talk to the local pharmacists in your community to get their opinions as we move forward.

One of the main problems is that the playing field between pharmacists and the prescription drug plans is not level. Small, community pharmacists have little to no leverage with the plans. The plans are able to set low reimbursement rates and give pharmacists take-it or leave-it offers. Pharmacists have to choose whether to lose money or turn away their Medicare patients. It's a choice of how you want to go broke: a low return on investment or losing the people you serve.

We should discard the concept of numerous formularies. This system is not in the best interest of the beneficiaries. The VA formulary system, while not perfect, might be a starting place to consider. The VA formulary could be modified to accommodate the needs of seniors. CMS is correct to require plans to cover all classes of medications. These formularies should also promote the use of generic substitution. In the short-term, plans should be prohibited from making changes to their formularies or prices during the year. Why would seniors want to enroll in a plan if that plan can suddenly change which drugs are covered or the price it charges?

Under the current system, the plans rely on rebates and discounts to make a considerable profit. Yet, the government is prevented from negotiating for better prices.

This makes no sense to me and should be changed. As I mentioned, pharmacists are already providing their services at a very competitive rate. We need to be fairly reimbursed for our services if we want our nation's community pharmacists to stay in business.

The playing field between pharmacists and the plans needs to be made level. Under the current system, plans hold all the power. They give pharmacists take-it-or-leave-it contracts. Pharmacists must decide whether to accept a low rate of reimbursement or turn away their Medicare customers. I encourage you to look for ways to give pharmacists more power in the marketplace.

In closing, I want to reiterate that I truly believe this nation needs a prescription drug plan for its senior citizens but one that is seamless, consistent, understandable and attainable. We as taxpayers should not be held hostage by the special interest groups that stand to benefit tremendously by the current plan design. I hope that you will consider meaningful changes to the current benefit. Thank you again for your time. I will be happy to answer any questions that you might have.

SENATOR DORGAN: Mr. Olig thank you very much. Sen. Bingaman?

SENATOR BINGAMAN: Thank you all very much for the excellent testimony. About two weeks ago we had a hearing in the Finance Committee with Secretary Leavitt. This Rx Drug bill was signed in December 2003, so it's been on the books for over two years, and for the first two years up until January 1, 2006, the administration's position was they opposed changes in the bill. Now it's fully implemented now, and their position is they still don't want changes in the law—These problems have occurred administratively and that they don't need Congress to do anything. I gather from some of the testimony I've heard here that you disagree with that; that you think some legislative changes are required. If you had your choice of one thing to fix legislatively, not administratively, what would you choose that would—what do think the highest priority ought to be for Congress in what should be fixed?

MR. HAYES: It would be to allow Medicare to have a Medicare drug benefit, that would enable Medicare to set a public interest oriented formulary to negotiate the lowest pricing. It would be quite easy to set up a program in an intelligible format. I think some folks would argue that the private system will never work; other people think we should give it time. It seems to me the Medicare advantage competing with Medicare would be applicable to a drug benefit…

SENATOR BINGAMAN: So this would be another option. This isn't a proposal to change the existing thing, but to enact additional option which would be a Medicare Rx drug option if they didn't want to go through the private system.

MR. HAYES: Allow the experiment for the private sector to continue to provide a safe harbor for people with Medicare.

SENATOR BINGAMAN: Okay. Professor Rice did you have a first priority legislative proposal?

DR. RICE: Well it depends on how broad one can be here. If we could have a Medicare Rx benefit that looked a lot like Part A and Part B of Medicare that would be my preference. I don't think that we're going to be in the massive redesign stage right now. If I had one choice it would be somewhat realistic; not allow every single player into the game—to substantially limit the number of drug companies allowed into the plan. Right now we have 40 or 80 choices, it's almost impossible to make choices by May 15th. Most people are paralyzed by these choices; they're not able to make it. If there were a handful of choices they could make, 4-6 choices I think they would be in a much stronger position.

SENATOR BINGAMAN: Mr. Anderson?

DR. ANDERSON: Medicare has been setting the prices for hospitals for over 20 years, setting the prices for physicians for over fifteen years, and setting the prices for all the other services of Medicare for ten or five years. I think Medicare, just like the VA and DOD, should set the prices or set the maximum that they are willing to pay.

MR. WESTMORELAND: First I'd like to associate myself with all those previous proposals. I would suggest that there be an ongoing transition payment through Medicaid so that states keep paying for a dual eligible until it's confirmed that Medicare will pay for the dual eligible instead.

SENATOR BINGAMAN: Mr. Olig?

MR. OLIG: I would re-iterate the point about regional providers, if you could centralize the program. This is a national endowment program that allows—you shouldn't have to choose between 50 or 60 different co-pay, co-insurance, formulary programs, there should be one. You could choose the deductibility, co-pay, co-insurance that you want and again purchasing is a huge issue.

SENATOR BINGAMAN: Let me just ask one other question. In the meetings I had in New Mexico last week, one issue which came up every time was, 'Why don't we have a uniform formulary?' Mr. Olig you suggested we take the VA formulary, maybe something had to be added to that. It seems to work okay, I don't know but it seems to work okay for the VA. Maybe the Congress doesn't have to do this, maybe the Secretary of Health and Human Services could do it. Just say, 'this is the formulary,' anyone who wants to participate after a certain date shall provide a certain set of medications. Is there anything wrong with that?

DR. ANDERSON: I think the problem is that you have new drugs coming into the market all the time. You'd probably want to defer that responsibility to the Secretary, or say it should be done the same way as the VA. Generally I think it's a great principle.

SENATOR BINGAMAN: There would have to be flexibility and responsibility at the Secretary level to update the formulary as new drugs became available.

DR. ANDERSON: Correct.

SENATOR BINGAMAN: Mr. Olig?

MR. OLIG: One of the things—We have a federal formulary and through Medicare as well, it's not a bad program; it's simply not dynamic enough. If you're going to do this, it would be on a larger scale and there would need to be more clinical intervention as to things that you could do and that you could not.

SENATOR BINGAMAN: Mr. Westmoreland?

MR. WESTMORELAND: I was simply going to point out that Medicaid's program has an open formulary, and in many ways it gets much better prices than the Medicare Part B seems to be getting.

SENATOR BINGAMAN: So shifting to an open formulary, requiring companies that want to participate have to—

MR. WESTMORELAND: That doesn't mean anybody can get anything. There are prior-authorization requirements in Medicaid as there are in almost all other kinds of Rx drug plans, but it is an open formulary.

MR. HAYES: One of the problems that folks who thought they were really smart and worked their way through plan selection, they found these formularies and cost-containment plans were based not on clinical needs, but on profit maximization, which after all is what the plans are obliged to do. They are fiduciaries to shareholders. What clients of ours are finding is that a drug can be unaffordable because of tiered costs and so fourth. So simply by having a clinically based formulary, you may not have skinned the cat sufficiently unless there is a degree of equity in what people pay drug by drug.

SENATOR BINAGMAN: Well thank you all very much, again, thank you for the excellent testimony.

SENATOR DORGAN: Senator Bingaman thank you very much. Mr. Olig let me ask you as a pharmacist, are you able, let's say I come into your pharmacy and say 'This is way too complicated. Can you help me figure out which plan I should enroll in? These are the medicines I am now taking.' What's your role in all that, what are you allowed to do and not do?

MR. OLIG: What we are allowed to do and what we've been doing is printing out a patient's medication profile and what medications they're on. I can't possibly have a list of 41 different formularies; you can go to the websites and try and get them. My pharmacists are highly paid professionals; they don't have the time neither do I. We do

and we have spent one on one time with the seniors to help them get enrolled. We can take it up to the point where we can say 'this looks like it makes the most amount of sense.' I can't fill out the blank for them. If I took them to the website and had them fill out the data, I can't hit 'enter'. That's actually the legal requirement.

SENATOR DORGAN: You're prohibited from doing that?

MR. OLIG: Legally prohibited, yes. We can do the clinical work and take a look at the different formularies and see how they match up, and find the one that makes the most amount of sense and at that point we have to stand back and let them make their own choices.

SENATOR DORGAN: Mr. Olig do you or others have any idea on how these companies are marketing their plans? Are they sending agents out to stand in front of the drug store? Tell me about the marketing plans.

MR. OLIG: The ones that I've actually seen—for instance Mutual of Omaha has an agent in a small community, in North Dakota and they actually said 'we'll help you sign up for your drug plan'. They're not looking at the 41 different plans because they don't have the clinical information; they don't have the patient's profile. So they pick plans that fits within their organization, and that's the one that they're signing up for. There was an example where a patient signed up for a plan where the only pharmacy in town didn't accept that particular plan. So we're going to have to try and find a way to re-do those as well.

SENATOR DORGAN: Dr. Rice you said in Los Angeles where you live there are 85 drug plans available?

DR. RICE: That's right. We have such heavy managed care in urban areas in California, the beneficiaries have a choice of 38 managed care plans and 47 stand alone drug plans. It's a daunting challenge.

SENATOR DORGAN: Well that's a labyrinth through which most seniors could never navigate. It appears from information we've gotten that CMS was counting on it's website to be a source of information and counseling about the drug plans. Does anyone here know how many senior citizens have computers and have access to CMS website?

MR. OLIG: If you will Senator, we've never turned anyone away. We've always helped them if we can. Have you ever tried to navigate CMS's website? It's a difficult task and to send some 84 year old widow—if you just go to CMS dot com or whatever it happens to be, it simply has not worked out in the past at all.

SENATOR DORGAN: Mr. Anderson go ahead.

DR. ANDERSON: I've had the opportunity to work with a number of parents of my friends who are trying to negotiate this set of activities. I'm pretty aware of

computers, and I can tell you I get confused on this. I'm sitting here testifying before you and I get confused on which choice they should make.

SENATOR DORGAN: Dr. Rice?

DR. RICE: Yes I have data conducted from a survey conducted by the Kaiser Family Foundation just a couple of weeks ago. 6% of Medicare beneficiaries have gone to Medicare.gov to do this themselves and 8% have had family or friends do it, so 14% have accessed the website.

SENATOR DORGAN: When the legislation providing for the Rx drug benefit was passed, included this prohibition on the negotiation between the government and the pharmaceutical industry—obviously since none of the five of you wrote that provision, I'm wondering if any of you can think of one justification for a provision like that. We've actually had votes on the composition of repealing that provision, and it has been unsuccessful so far in the United States Senate. Can anyone here think of any reason why that would be a justifiable provision to retain?

DR. ANDERSON: I don't think that it's a justifiable provision but I think the argument that has been given is that the pharmaceutical industry needs high drug prices in order to maintain their commitment to research and development. All I would point out is that they only spend 14% of the dollar they receive on research and development.

SENATOR DORGAN: And the pharmaceutical industry actually spends more on marketing and promotion than it does on research and development.

DR. ANDERSON: That is correct.

SENATOR DORGAN: Mr. Westmoreland you wanted to add something to that?

MR. WESTMORELAND: I was going to say something more cynically than that. If the goal is to enrich pharmaceutical companies and insurers at the expense of taxpayers and beneficiaries, then you should keep that provision.

SENATOR DORGAN: I'm going to ask Mr. Olig, but first Mr. Hayes. Mr. Olig is a retail pharmacist. He's on main street, he's the person to whom a patient comes to fill an Rx given by a doctor. He has described the increase in the price of Lipitor over the last three months, and so that's not negotiated by anybody, that's a piece of information that he got from a pharmaceutical manufacturer that said, 'all right, this is not a negotiation, this is the new price.' That is called the market system. I think from your testimony you've indicated that the lowest income seniors get hit the hardest with this plan, with the asset test and so fourth. Let me ask you to comment just for a moment if there is a market system which works in Rx drugs, especially from the standpoint of low income seniors.

MR. HAYES: There's probably a good reason why after my first course at Georgetown in Economics I went to Law School. You don't have to be a BS'er to think that folks who think the market system is working are far removed from reality. A case and point: You asked about the marketing system of the insurance companies in respect to their plans. The marketing that is going on is aimed at maximizing enrollment for the plans, and as Mr. Olig pointed out, often by independent agents who have every incentive to sign people up regardless of whether it's good for them or not; they're paid commissions. We have found even the so called largest most responsible health plan sponsors, United Healthcare for instance, will send out marketing material, dubbed educational material, that clearly misleads consumers. The marketing plans that have been sent out make our job in educating and counseling consumers more difficult. If a plan decides to try and get market share by having a low deductible, that will be the one aspect of the plan that they magnify and that sells. It doesn't mean it's a good plan or the most efficient or the most effective for anybody. Very often people who pay low premiums pay the highest out of pocket costs. Marketing always accentuates one thing to get attention, and that has been very confusing to folks who are trying to make an informed choice. When the information is so asymmetrical between the seller and the buyer, of course the marketing is going to work, and of course the people with the least amount of information, the consumers, are effectively shooting in the dark. So I see very little market theory that would work, as people are trying to decide what to buy into.

SENATOR DORGAN: Mr. Olig you're a main street business person, probably belong to the Chamber of Commerce don't you?

MR. OLIG: I don't sorry. I did actually; I just didn't have time to go to the meetings.

SENATOR DORGAN: Former Chamber of Commerce member. So your supplier sends you a note and says 'Here's your new price fella.' The price of which you're going to have to pass along to your customer. In most businesses if you were selling socks, or T-Shirts, or tractors or whatever, you would probably decide, we'll take a look at what someone else offers, and is there competition in price and so on. In this case there really isn't especially in brand name drugs. Is this a competitive situation or is this a market system which no longer works?

MR. OLIG: There is virtually no competition in the brand marketplace. If multiple drugs in a particular class, if the innovator comes out at 95 dollars or 100, the second comes out at 98 or 96. They don't have to compete, they don't have the same research and development, they know what the markets are, they have to go through the same trials and things but they don't have the same process. The answer is they are not competitive at all. Mr. Hayes is right, confusion leads to fear. Fear leads to doing the wrong thing or doing nothing.

SENATOR DORGAN: With so much of the sign up period, over a third now gone, and in so many states, particularly in my state, with so few having signed up I think it is a circumstance where people are paralyzed with fear about how to navigate this so

you end up doing nothing. Mr. Anderson, you have provided some fascinating information on pricing policies as to the sales of pharmaceuticals to Canada and France. Or the pricing through negotiating with the VA and the pharmaceutical industry. First question, do you think that the pharmaceutical industry sells Rx drugs to people who live in Canada and France at an economic loss, or do you believe that they are selling Rx drugs at a profit?

DR. ANDERSON: I believe that they are selling them at a profit.

SENATOR DORGAN: So they are selling identical Rx drugs, FDA approved, in most cases at a lower price than what they sell for in the US, but they are still making profits in those countries.

DR. ANDERSON: Yes I've been working in Eastern Europe in a variety of places and I can tell you that they are in fact earning a profit in places like Poland and Canada and a variety of other places.

SENATOR DORGAN: It's interesting that under the new repatriation provisions of tax law, this Congress gave a huge a generous nugget to companies who last year repatriate foreign income; and it said if you repatriate foreign income, you'll be able to pay an income tax rate of 5.25%. That's half the income tax rate of the lowest rate taxpayer that's taxed in this country. Very large companies have repatriated some $320 billion, a substantial part of that comes from the pharmaceutical industry, which suggests that even with lower prices for virtually every other country in which they sell the drugs, they've made very substantial profits. Mr. Anderson you've talked about this 'doughnut-hole' and that's a foreign language to most Americans. A doughnut-hole in public policy has become the jargon for describing that portion of Rx drug coverage that for which the patient pays 100% of the cost; that's between $2250 and $5100. So after you've received the benefit, for the next several thousand dollars, that's all out of pocket. That's a huge disadvantage in this coverage. We call this 'coverage' but there's zero coverage for that portion. You're saying that portion could be covered in its entirety with one of two strategies: Either just get the pricing that the VA has, or get the same pricing that the Rx drug companies are providing the Canadians and the French. Is that what you're saying?

DR. ANDERSON: Exactly, and not only will it not cost Medicare any more money, but it would cost the health plans that are selling the stuff less money so the people will be paying less money. It will utilize more Rx drugs because it will cost them less money to but the Rx drugs. So their health status will improve.

SENATOR DORGAN: Do you know what you are? Let me just give you the pharmaceutical industry full treatment because I've had it all. 'You're somebody that doesn't care about research, about curing rare diseases, you don't care that companies are investing all this money to find cures. You want to dry it all up and force prices down so these companies can't come up with the next miracle drug. Shame on you.' That's the pharmaceutical industry's line. So you tell me why you're right and they're wrong.

DR. ANDERSON: Well I think we should have some money for research and development but I don't think that United States Medicare beneficiaries should pay for almost half the research and development profits cost for the entire world. Unless the Medicare beneficiary was getting complete coverage at a reasonable price, then we could afford the luxury. I just don't think that we should be paying the world's bill.

SENATOR DORGAN: There's actually a shorter answer to the pharmaceutical industry. 'You're making some of the highest profits in the history of the world, and you ought not to be charging the highest prices in the world to American consumers, shame on you.' That's the short answer. Let me ask Mr. Westmoreland, the issue of dual eligibles. This was a real travesty at the start of this process. These are people in most cases on Medicaid that showed up to get the information about these plans to fill their prescriptions…Mr. Anderson thank you very much thank you for your contribution today.

DR. ANDERSON. Thank you (departs room).

SENATOR DORGAN: Mr. Westmoreland, the dual eligables that showed up only to discover that their records were lost and weren't able to get the Rx drugs that they needed, all of us were horrified at those results. Your testimony states that we're not through with this problem, we're just beginning. Can you expand on that?

MR. WESTMORELAND: We will see a huge problem at the beginning of this transition because everybody has to move into it at once. But we'll have a chronic problem with this throughout the running of Medicare Part D. People do not become uniformly elderly or disabled as of January 1st. That means we will always have these transfer systems, and the federal and state data systems do a very poor job of talking to each other; Medicaid systems have been notorious for years in being inadequate in their assessment of who's on Medicaid and who's not. It's going to keep going. We will have an ongoing transition.

SENATOR DORGAN: Dr. Rice and Mr. Hayes I don't remember which one of you said that there should be a safe-haven Rx plan, that is a Medicaid plan that you move into gradually picking one later. Never the less there should be a safe haven. That sounds intriguing.

MR. HAYES: I think that's a very intriguing idea, because it's so fundamental. In our sense, people have been very happy with Medicare as they know it, for it's reliability, it's affordability; sure there are out of pocket costs but they anticipate it and they can buy supplemental insurance if they can afford it. There's something disingenuous about saying, 'let there be a safe-haven, and let the folks who experiment with private plans compete.' After all, that's what markets do, they reward successful competitors. It's clear that not many of these insurance companies would be able to compete with a Medicare drug plan, one for the affordability differences that we could extract, and two because we could have a national program that is clinically based not a profit motivated formulary to cover drugs for people. I think it's in a sense challenging

the proponents of the competitors in the market, saying 'okay if you're so good, compete with Medicare, see what you can do.' Most people who speak to me about it from the industry side say 'we'll shut down and go out of business because we can't compete.'

SENATOR DORGAN: They can't compete because the cost of providing the service is are dramatically lower in Medicare. It's 3 or 4%, the administrative costs, versus 12 or 14% or higher in the insurance company.

MR. HAYES: I've been given the enormous subsidies and marketing costs at this point of the part D program—the numbers will be even more dramatic. I think the baseline finding by Medipac with regard to the private Medicare plans, they're costing about 108% of what Medicare itself pays for people who stay in Part A and Part B.

SENATOR DORGAN: Mr. Westmoreland.

MR. WESTMORELAND: I just want to point out we have a rough proxy for this already. I have a Medicare Part A and B, if you will, the default setting for most beneficiaries. They can choose to leave and go into Part C, managed care. It has been an experiment that has not produced overwhelming results; most people prefer to stay in A and B. They don't flock out to the private plans. I think a system like that in D would be an interesting project, if you give people the choice, will they prefer to go into these other multiplicity of plans.

SENATOR DORGAN: Let me make a couple of points. I think all of us share feeling that there's something wrong, something missing here, something needs to be fixed. It's not clear to Congress, but I think it won't take much more time to elapse where it will become evident to everybody, that this system is a system that's not working properly. The very first step—This is going to break the bank unless we find a way to negotiate lower prices just as Canada does, just as France, does just as the VA does; if we don't do that for this program it's going to break the bank. Number two we have to simplify this, if we don't simplify this it's not going to work. Fear will paralyze people and they won't sign up. I think a number of your suggestions today are excellent suggestions. I'm mindful of what Mark Twain once said. He was asked if he would engage in a debate, and he said 'yes as long as I could have the negative side.' They said 'you haven't even been told what the subject is', and he said 'it's okay the negative side will not require any preparation.' I'm very mindful of that notion; to criticize is very easy. But in this case it's very worthy. We're just in the implementation stage but it's painfully clear to everybody that there's some things missing here, and there's some complexity that is just completely unjustifiable. One final point, we normally do not do this, but a woman raised her hand, and we have some senior citizens who have joined us today. I'm going to ask that if you would like to stand up and give me your name I'll be happy to hear a comment from you.

(Inaudible Crosstalk)

MRS. JACKSON: I am Mrs. Margaret A. Jackson, I am originally from the eastern shore of Maryland, and I am here representing the National Committee to Protect Medicare and Social Security. These are my colleagues. Do you want to ask me any direct questions?

SENATOR DORGAN: Have you signed up for the Rx drug benefit?

MRS. JACKSON: Well I just want to say I do have access to a computer. Just as was stated I think there's a lot of flaws in this Rx D, I think it needs to be worked out. I did enjoy the persons here, and I was able to gain a lot of information. However I am around people as I go to get my prescriptions and they tell me 'I have to pay $65.' So I say go up to the membership on the 8th floor and you may be able to receive help. So this lady was very happy, and I want to say something else. Education is vital to seniors in this program. There are a lot of people that do not have access to a computer. I would say to this committee, employ more of us that you would consider grassroots people. I live in Adams Morgan in Washington DC. So sell a program that would train people where to go, what do to, and what to do next. I think it was Dr. Rice, and Mr. Hayes, you stated so eloquently that a lot of people cannot afford this Rx D. They're totally frustrated as what to do, where to go. I think it was said that that there was a lady who was not able to afford her Rx, and she was sent to the hospital. So I'm looking at these people, and I'm also looking at rural America, former educators, like me, and some of my colleagues. As you retire you are on a different income. If I didn't have A plus B plus C, and I only have two prescriptions. What is going to happen to people who have six, seven, or eight? I want to thank you Sen. Dorgan and the National Committee to Protect Medicare and Social Security.

SENATOR DORGAN: Margaret Jackson thank you very much. Every committee prays for a member like you. We appreciate very much your coming. The people whom we've had as witnesses have a broad education and interest in healthcare; they've offered us some great advice and as you've suggested that some of the best advice we can get will come from senior citizens who've been through this experience and who can tell us the frustration and what can be done to simplify it. I normally don't do this but you raised your hand…

MRS. JACKSON: I raised my hand because I had access to a computer.

SENATOR DORGAN: Well, I appreciate your being here Margaret. I think it's safe to say that in the coming couple of months this issue is going to reach a really important stage, because either the Congress is going to understand that this signup isn't working, its too complicated, we need some time, and we're going to extend the signup period till the end of the year at the minimum, That ought to be the first baby step the Congress takes. Extend the signup till the end of the year and give people the chance and time to understand this. In the meantime fix some of the things that are obviously wrong, and get rid of that insidious provision that says we're not allowed to negotiate lower prices for prescriptions; I'd love to find the author of that and see if we cant give that person a bit of publicity, but it's unbelievable that on behalf of the pharmaceutical

industry there's this little nugget that says 'the American consumer and the Federal government on behalf of the world should pay the highest prices in all the world for Rx drugs.' That's an unbelievable proposition, and one we reject. There are other things we can do and should do to fix this, but first we need some time and knowledge, and part of that knowledge is to hold hearings and forums; that's what this is. This hearing is a part of the Democratic Policy Committee; we do invite the Republican Policy Committee to join us and we furnish statement as well to our colleagues, but we very much appreciate the five of you including Mr. Anderson who had to leave and your contribution Margaret, will be very helpful as we proceed to evaluate the alternatives and address this issue in the coming weeks and months. This hearing is adjourned.