

Senate Democratic Policy Committee Hearing
An Oversight Hearing on Providing Relief to Seniors Who Have
Fallen into the Prescription Drug “Donut Hole”

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July 17, 2006

Thank you for giving me the opportunity to be here this afternoon.

My name is Pamela Bell, I am 43 years old, and I reside in Jacksonville, NC. I was employed as a Production Supervisor at a small factory for 8 years. I became disabled in August 2003 due to fibromyalgia, Hepatitis C, and lumbosacral neuritis, which has me wheelchair dependent.

I also have several other chronic illnesses and conditions for which I take numerous medications, a few being a heart condition and emphysema. I also suffer post traumatic stress disorder from childhood.

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

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

I take eleven medications for my illnesses. Six of those medications do not have a generic equivalent. The retail cost of my prescriptions for one month, not including my husband's prescriptions, and without drug coverage, totals \$1,729.50.

Before the Medicare Part D plan went into effect, I was able to get my brand name medications through various Patient Assistance programs directly through the pharmaceutical companies. This allowed me to purchase my remaining prescription medications with a drug discount card at a cost of about \$120 per month.

We chose an insurance plan through the Medicare Part D program that offered catastrophic coverage and covered all of our prescriptions. Brand name drugs have a co-pay of \$25 and generic a co-pay of \$10 without a deductible. We found out though, that the description of the gap coverage was somewhat confusing.

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

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

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

I contacted my insurance company and had them explain the “donut hole” in a way I could understand. They informed me that once I reached \$2,250 total drug cost, I would have to pay 100% of the cost of the drug if it was a brand name. But, if I would choose the generic equivalent they would cover 80% and I would continue to pay the \$10 co-pay. This stays in effect until I reach my \$3,600 total out-of-pocket cost at which time I would then pay only 5% of the drug cost for the rest of the year and be in the catastrophic coverage portion of my plan.

On May 25, I was forced to pay \$324 for my narcotic pain medication, which is a brand name drug without a generic equivalent. My lower back problem – lumbosacral neuritis – causes extreme weakness, and numbness, in my lower extremities and without this prescription, I am in severe pain and bedridden. Because of the cost of this one prescription, I was unable to purchase any of my other medications, or most of my husband's, for that month.

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

Out of the six brand name prescriptions I take, I was able to get two in a generic form, one of those being my pain medication. But it is not as effective as the brand name

I was taking, since an exact generic equivalent was not available. Four of the medications are not available in generic form – only their expensive brand name versions.

For three months I was unable to take my heart medication because I was unable to afford it. My doctor was upset that I had gone that long without taking it and found a generic version to try me on – the generic was not the exact equivalent but was an equivalent of a different brand name. The drug I am on now has to be taken more often and I still have some symptoms that were once controlled with the brand name drug.

There are four other prescriptions that I am still unable to take because of cost. Two being the prescriptions I mentioned earlier for migraines. The third is a medication I take for post traumatic stress disorder I hope will become available in generic form by the end of July. I have been without that medication for two months and I now suffer mood swings and depression again.

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

My husband is still within his \$2,250 limit but with the rising cost of prescription drugs he may reach his own “donut hole” soon. He is an insulin-dependent diabetic who is home bound because of severe diabetic neuropathy, and chronic back pain. He has been hospitalized frequently because of a weak immune system and recurring staph infections. At the rate we are heading I’m afraid we will be unable to reach the \$3,600 by the end of the year and then the plan renews and we start over again.

I have tried to apply for assistance but we make \$500 a year over the limit of to qualify. We do not qualify for state assistance because we are under age 65.

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