S. HRG. 107–146

THE HIGH COST OF PRESCRIPTION DRUGS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED SEVENTH CONGRESS

FIRST SESSION

JEFFERSON CITY, MO

AUGUST 27, 2001

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CONTENTS

	Page
Opening Statement of Senator Jean Carnahan	1
PANEL I	
Norma Muhleman, Florissant, MO	3
Edna Sowells, Poplar Bluff, MO	7
L.C. Lakes, St. Louis, MO	14
PANEL II	
Robert Schmalfeld, AARP Volunteer Congressional District Coordinator, St. Louis, MO	28
Ken Bougeno, First Vice President, Missouri Council of Senior Citizens	37
Anne Steele, Advocacy Chair, Older Women's League, St. Louis, MO	40
PANEL III	
Dr. Lanis Hicks, University of Missouri School of Medicine	52
Dr. Stephen Zweig, Department of Family and Community Medicine	64
APPENDIX	
Written Testimony submitted by Mrs. Ruengert	75

JEFFERSON CITY FIELD HEARING THE HIGH COST OF PRESCRIPTION DRUGS

MONDAY, AUGUST 27, 2001

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Jefferson City, MO

The committee met, pursuant to notice, at 10 a.m., in the Capitol Building, Second floor, House Hearing Room 7, Jefferson City, MO, Hon. Jean Carnahan, presiding.

Present: Senator Carnahan.

OPENING STATEMENT OF SENATOR JEAN CARNAHAN

Senator CARNAHAN. Good morning. I call the hearing to order. I want to welcome each of the panelists that is going to be here today and thank you for participating on what is a very important subject.

I would also like to thank each member of the audience for being here today. As many of you know, I am a member of the Special Committee on Aging in the Senate, and our job is to help the Federal Government meet the needs of seniors. We gather information for the Senate, we highlight important issues, and we make recommendations to our colleagues.

Today we are here in Jefferson City to spotlight the high cost of prescription drugs. There has been a lot of discussion in Washington on the topic, but I wanted to come here and hear from you directly here in Missouri.

As you know, Jefferson City was my home for nearly 8 years. Not only the Missouri capital, it is part of America's heartland. So I want to come here to mid-Missouri to hear your thoughts on drug prices and how it affects your everyday lives.

During today's hearing, we will be receiving testimony from a variety of people from across the State. I am pleased to announce that Senator John Breaux of Louisiana, the Chairman of the Special Committee on Aging, and Senator Larry Craig of Idaho, the Ranking Member, have sent staff members to be with us here today as well, and together we will see that your message is taken back to Washington and conveyed to the Senate Committee on Aging.

Your message could actually not be more timely because next week, when we go back to Washington, back into session, this will be a high-priority item, the cost of prescription drugs.

Why is this such an important issue? It is important because Medicare, the Federal program that provides health insurance for some 40 million elderly and disabled Americans, does not include

a prescription drug benefit. While it may not have been a necessary component of Medicare when the program was first created back in 1965, it is certainly unacceptable not to have it today. [Applause.]

Prescription drugs save lives, and they improve the quality of life for millions of Americans. But when medication is unaffordable, we fail our sick and elderly. And when those in need have to choose between buying food or paying for a prescription drug, we are failing our seniors. And when older adults have to rely on family members to pay their drug bills, we fail both seniors and their families.

I hear these concerns everywhere I go, and I receive countless letters and e-mails from people all over Missouri on this subject. And it troubles me when I think about the tough decisions that our seniors, living on fixed incomes, have to make every day—choices between medicine and food, between medicine and rent, and medicine and heat. Sad and difficult decisions are being made every day in homes all across Missouri.

I want to create a prescription drug benefit as part of Medicare and have supported setting aside funds in the Federal budget for this purpose. We are still working out the difficult details, but we have agreed on a number of principles that a drug benefit should meet. And I want to share some of those with you that I believe in very strongly.

First, a benefit should be universal. Everyone that is enrolled in Medicare should be eligible to receive the benefit. [Applause.]

Second, the benefit should be voluntary. Seniors should have a choice as to whether they want to participate or not.

Third, the benefit should be affordable.

Fourth, the benefit should be stable. We want to create a benefit that provides coverage for a long time, not one that is constantly changing.

Fifth, the benefit should be available. It should not matter if you live in an urban or suburban or rural setting. You should be able to get prescription drug coverage wherever you live.

Finally, the benefit should be part of Medicare. We don't need to create a whole new system. Medicare is a program that works, and it is one that our seniors trust. We in the Senate need to understand what seniors need, the extent of the problem, and what the consequences are if we fail to act.

We are privileged today to have three panels of speakers here to address some of these questions.

The first panel is made up of Missouri seniors who will be speaking about their experiences in struggling to meet the increasing cost of drugs.

The second panel is comprised of representatives of organizations that advocate on behalf of Missouri's seniors, and they will be sharing with us their recommendations on how to craft a Medicare prescription drug benefit.

The third panel will provide a look at the scope of the problem. They will also examine the impact of drug prices on the health of seniors and on health care in general.

I look forward to hearing the testimony and to learning from their experiences, and I hope our audience will gain a greater understanding of this complex and costly health problem as well.

Now I would like to introduce the first panel of speakers, but before I do so, I probably should introduce someone else, who is in the audience who will not be participating, and that is a woman by the name of Doe Ruengert. She is here from Jefferson City, and she has submitted written testimony for the record on her care for her 91-year-old aunt, Dorothy Creighton. Mrs. Ruengert is a nurse, and she has cared for her aunt for a number of years in her home because her aunt was unable to live alone because of the cost of her prescription drugs. Mrs. Creighton pays upward to $800 a month just for prescription drug costs alone. So I appreciate her being here, and I will be referring to her testimony again later on.

Our first witness is Norma Muhleman from Florissant. If the three of you, as I call your names, if you would take your seats up here? She wrote to me back in March. Nice to have the chance to meet you today. You wrote to me about your husband and about your costs for your bills. Norma and her husband have lived in Florissant for 40 years. They were in business together for the past 13 years before he retired. She is the mother of a son and daughter and has three grandchildren. So we appreciate your being here today.

The second gentleman is Mr. L.C. Lakes from St. Louis City. Mr. Lakes is a retired welder. He is a member of the Friendly Temple Baptist Church. He is on the committee there that builds housing for senior citizens. And he also volunteers in the Caring Communities Program and works in the 22nd Ward to help provide a safe neighborhood there. So we welcome you as well.

Then our final witness on this panel comes from Poplar Bluff, Mrs. Edna Sowells. Is she here today? OK. Welcome. She is the former head cook at the Lucy Lee Hospital and has been very active in her church and community.

So I will begin by turning our floor over to our first witness, Mrs. Muhleman. Welcome.

STATEMENT OF NORMA MUHLEMAN, FLORISSANT, MO

Ms. MUHLEMAN. Thank you. Good morning, Senator Carnahan, and everyone else. I appreciate very much the opportunity to speak to you about my concerns about a prescription drug plan.

My husband and I are Medicare enrollees as well as we have Medigap plans to supplement Parts A and B of Medicare. But none of these plans pay for prescription drugs, dental, nor eyeglasses.

My husband has been on oxygen 24 hours per day for a few years because of his emphysema, heart problems, and other things that entail his having to use very expensive prescriptions. We do not have prescription insurance on any of our plans, and in checking the Medigap policies that would allow us coverage, if they accepted us with our medical problems, they have a cap or a limit on prescriptions that would only pay for a proverbial drop in the bucket on our cost of prescriptions, especially after paying the higher rate for prescription coverage. It would not help us at all.

We have investigated everything we have ever heard about, and there does not seem to be any plan that we could get paying for it ourselves that would help.

Two years ago, our prescriptions and out-of-pocket expenses were around $5,500. Last year, it was approximately $8,000 out of our

own pockets. As you can see, it increases constantly with the cost of drugs, et cetera.

We have thought for a long time that Congress should provide something to help people like us, of which there are many around us with the same problems, such as insurance where we could pay the premiums but enable us to have a copayment, like the large companies in the country provide for their employees.

We are very satisfied with Medicare as it is and hope it is not changed, other than to add a prescription drug plan that will pay for our prescriptions, with us paying a premium and a small copayment on our part.

Medicare has been tested many times with us, as my husband has been in the hospital many times, and we are thankful for its good coverage, along with our Medigap supplemental plans we have, but the drug costs are killing us.

We have worked hard and live economically. My husband worked as long as his health permitted and was 72 years old before he had to give up his work. Even then, while he was still working, he was on oxygen at night after working hours. We are hoping for something that allows us to pay premiums, as we do Parts A and B on Medicare, for our prescriptions. We are not asking for something free, but feel we older middle-class citizens deserve this opportunity.

Thank you.

[The prepared statement of Norma Muhleman follows:

WRITTEN TESTIMONY OF

NORMA MUHLEMAN
FLORISSANT, MISSOURI

SUBMITTED BEFORE SENTATOR JEAN CARNAHAN'S SPECIAL COMMITTEE ON AGING FIELD HEARING "RISING DRUG COSTS: FINDING A PRESCRIPTION FOR MISSOURI'S SENIORS"

AUGUST 27, 2001

Good morning, Senator Carnahan. I appreciate very much the opportunity to speak to you about my concerns about a prescription drug plan. My husband and I, are Medicare enrollees, as well as have Medigap plans to supplement parts A & B of Medicare, but none of these plans pay for prescription drugs, dental, nor eyeglasses. My husband has been on oxygen, 24 hours per day, for a few years, because of his emphysema, heart problems and other things that entail his having to use very expensive prescriptions. We do not have any prescription insurance on any of our plans and in checking the Medigap policies that would allow us coverage, if they accepted us with our medical problems, they have a "cap" or limit on prescriptions that would only pay for a proverbial "drop in the bucket" on our cost of prescriptions, especially after paying the higher rate for prescription coverage. It would not help us at all. We have investigated everything we have heard about and there does not seem to be any plan that we could get, paying for it ourselves, that would help. Two years ago, our prescriptions and out of pocket expenses were around $5500. Last year, it was approximately $8,000, out of our own pockets. As you can see, it increases constantly with the cost of drugs, etc. We have thought for a long time that Congress should provide something to help people like us, of which there are many around us, with the same problems, such as insurance where we could pay the premiums, but enable us to have a co-payment like the large companies in the country provide for their employees. We are very satisfied with Medicare, as it is, and hope it is not changed, other than to add a prescription drug plan that will pay for our prescriptions, with us paying a premium, and a small copayment on our part. Medicare has been tested many times with us, as my husband has been in the hospital many times, and we are thankful for its good coverage, along with our Medigap supplemental plans we have, but the drug costs are "killing us". We have worked hard and live economically. My husband worked as long as his health permitted and was 72 years old before he had to give up his work. Even then, while he was still working, he was on oxygen at night after working hours. We are hoping for something that allows us to pay premiums as we do Parts A & B on Medicare for our prescriptions. We are not asking for something free, but feel we older middle class citizens deserve this opportunity. Thank you .

Senator CARNAHAN. Thank you, Mrs. Muhleman. I appreciate your sharing that story with me. I had the opportunity to care for my father for 7½ years, and he had emphysema and diabetes and asthma. And so I can understand some of your concerns and some of the things that you have been going through.

Let's see. Mrs. Sowells, if you would?

Ms. SOWELLS. Do I push this button here?

Senator CARNAHAN. I believe that is correct, yes.

STATEMENT OF EDNA SOWELLS, POPLAR BLUFF, MO

Ms. SOWELLS. Good morning. My name is Edna Sowells. I am from Poplar Bluff, MO. Thank you, Senator Carnahan, for giving me the opportunity to testify this morning to millions of people like me for some sort of prescription drug relief.

For a number of years, I was a head cook at Lucy Lee Hospital in Poplar Bluff, MO. I have also been very active in my community, church, and helping neighbors in time of need, and babysitting and cooking food. I have been happily married for 44 years and have three wonderful, precious children.

Several years ago, I was diagnosed with diabetes I, I was able to control that by taking a pill and monitoring my diet. About 14 years ago, I lost a massive amount of blood that led to a radical surgery because I had only two pints of blood left in me. After this surgery, I tried to go back to work but found it impossible; therefore, I went on Social Security disability for stiffness on my right torso and my left foot and leg by a hysterectomy and surgery to remove a cyst. Since this surgery, my diabetes has now progressed and forced me to take two shots a day, two pills a day.

When I became disabled, not only the source of my income, a Social Security disability check, I also received medical help with my doctors' and hospital bills. However, I have no help to pay for my monthly prescription drugs. I pay at least $200 or more for my prescription drugs alone. For example, this month of August, I paid $206 at just one drugstore for my hives, my blood pressure, my diabetes, my nerves, my cholesterol, my acid reflux, and this in addition to the payments I have to make for my equipment. For example, last month, at a different drugstore I spent $120 for test strips, $13 for needles and syringes, because I got them on sale. I have to buy new equipment at least every other month and a half. However, sometimes money is so tight that I re-use the needle and syringes and alcohol swabs after thoroughly cleansing and contacting my doctor for samples or even resort to cutting pills in half in order to save a few dollars a month.

Because of this high prescription drug cost, I have to sacrifice several things that I would love to do, I would love to have the opportunity to do. I am unable to go out to dinner with my husband to a nice place and can no longer donate any money to my church or buy my kids and grandchildren gifts. These are all things that I used to do and enjoy before I became sick. I never dreamed that this would happen to me or that it would be difficult to survive once I stopped working.

Senator Carnahan, I was an orphan from the age of 10, and I learned at a young age how to be thrifty and efficient. I taught myself how to cook and sew in order to survive. However, things are

really tight, and I am unable to make ends meet. I would really benefit from some sort of prescription drug relief. Please work hard to address my and every other senior's needs for the prescription drug benefit.

Thank you very much for the opportunity to speak today, and I appreciate your kindness and concern.

[The prepared statement of Edna Sowells follows:]

WRITTEN TESTIMONY OF

EDNA SOWELLS
POPLAR BLUFF, MISSOURI

SUBMITTED BEFORE SENTATOR JEAN CARNAHAN'S SPECIAL COMMITTEE ON AGING FIELD HEARING "RISING DRUG COSTS: FINDING A PRESCRIPTION FOR MISSOURI'S SENIORS"

AUGUST 27, 2001

TESTIMONY OF EDNA SOWELLS
SENATE SPECIAL COMMITTEE ON AGING
FIELD HEARING
AUGUST 27, 2001
JEFFERSON CITY, MISSOURI

GOOD MORNING. MY NAME IS EDNA SOWELLS FROM POPLAR BLUFF, MO. THANK YOU, SENATOR CARNAHAN, FOR GIVING ME THE OPPORTUNITY TO TESTIFY THIS MORNING TO THE NEED OF MILLIONS OF PEOPLE LIKE ME FOR SOME SORT OF PRESCRIPTION DRUG RELIEF.

FOR A NUMBER OF YEARS, I WAS THE HEAD COOK AT LUCY LEE HOSPITAL IN POPULAR BLUFF, MO. I HAVE ALSO BEEN VERY ACTIVE IN MY COMMUNITY AND CHURCH, HELPING MY NEIGHBORS IN TIMES OF NEED BY BABYSITTING AND COOKING FOOD. I HAVE BEEN HAPPILY MARRIED FOR 44 YEARS AND HAVE 3 WONDERFUL AND PRECIOUS CHILDREN.

SEVERAL YEARS AGO, I WAS DIAGNOSED WITH DIABETES I AND WAS ABLE TO CONTROL THAT BY TAKING A PILL AND MONITORING MY DIET. ABOUT 14 YEARS AGO, I LOST MASSIVE

AMOUNTS OF BLOOD THAT LED TO RADICAL SURGERY BECAUSE I ONLY HAD 2 PINTS OF BLOOD LEFT IN ME. AFTER THIS SURGERY, I TRIED TO GO BACK TO WORK, BUT FOUND IT WAS IMPOSSIBLE. THEREFORE, I WENT ON SOCIAL SECURITY DISABILITY FOR STIFFNESS ON MY RIGHT TORSO AND LEFT FOOT AND LEG CAUSED BY THE HYSTERECTOMY AND SURGERY TO REMOVE CYSTS. SINCE THIS SURGERY, MY DIABETES HAS NOW PROGRESSED AND FORCES ME TO TAKE TWO SHOTS AND TWO PILLS PER DAY.

WHEN I BECAME DISABLED, MY ONLY SOURCE OF INCOME WAS A SOCIAL SECURITY DISABILITY CHECK. I ALSO RECEIVE MEDICARE TO HELP WITH MY DOCTOR AND HOSPITAL BILLS. HOWEVER, I HAVE NO HELP TO PAY FOR MY MONTHLY PRESCRIPTION DRUG COSTS.

I PAY AT LEAST OVER $200 PER MONTH FOR MY PRESCRIPTION DRUGS ALONE. FOR EXAMPLE, FOR THE MONTH OF AUGUST, I PAID $206 AT JUST ONE DRUG STORE FOR DRUGS TO HELP MY HIVES, BLOOD PRESSURE, DIABETES, NERVES, CHOLESTEROL,

AND ACID REFLUX. THIS IS IN ADDITION TO THE PAYMENTS I HAVE TO MAKE FOR MY EQUIPMENT. FOR EXAMPLE, LAST MONTH AT A DIFFERENT DRUG STORE, I SPENT $120 FOR TEST STRIPS, AND $13 ON NEEDLE AND SYRINGES, BECAUSE I GOT THEM ON SALE. I HAVE TO BUY NEW EQUIPMENT AT LEAST ONCE EVERY MONTH AND A HALF. HOWEVER, SOMETIMES MONEY IS SO TIGHT THAT I REUSE THE NEEDLE AND SYRINGES AND ALCOHOL SWABS AFTER A THOROUGH CLEANING AND CONTACT MY DOCTOR FOR SAMPLES OR EVEN RESORT TO CUTTING THE PILLS IN HALF IN ORDER TO SAVE A FEW DOLLARS PER MONTH.

BECAUSE OF THESE HIGH PRESCRIPTION DRUG COSTS, I HAVE TO SACRIFICE SEVERAL THINGS THAT I WOULD LOVE TO HAVE THE OPPORTUNITY TO DO. I AM UNABLE TO GO OUT TO DINNER WITH MY HUSBAND, AND CAN NO LONGER DONATE ANY MONEY TO MY CHURCH OR BUY MY KIDS AND GRANDKIDS GIFTS. THESE ARE ALL THINGS THAT I USED TO ENJOY BEFORE I BECAME SICK. I NEVER DREAMED THAT THIS

WOULD HAPPEN TO ME OR THAT IT WOULD BE THIS DIFFICULT TO SURVIVE ONCE I STOPPED WORKING.

SENATOR CARNAHAN, I WAS AN ORPHAN FROM THE AGE OF 10 AND LEARNED AT A YOUNG AGE HOW TO BE THRIFTY AND EFFICIENT. I TAUGHT MYSELF HOW TO COOK AND SEW IN ORDER TO SURVIVE. HOWEVER, THINGS ARE REALLY TIGHT AND I AM UNABLE TO MAKE ENDS MEET. I WOULD REALLY BENEFIT FROM SOME SORT OF PRESCRIPTION DRUG RELIEF. PLEASE WORK HARD TO ADDRESS MINE AND EVERY OTHER SENIORS' NEEDS FOR A PRESCRIPTION DRUG BENEFIT.

THANK YOU VERY MUCH FOR THE OPPORTUNITY TO SPEAK TODAY. I APPRECIATE YOUR KINDNESS AND CONCERN.

Senator CARNAHAN. Thank you, Mrs. Sowells. I think your testimony—sometimes we focus just on seniors, and we don't always focus on those who have disabilities as well, because that cuts back on the amount they are able to earn, and it also increases what they have to have as far as equipment and prescription drugs. So I appreciate your telling us about that.

Mr. Lakes.

STATEMENT OF L.C. LAKES, ST. LOUIS, MO

Mr. LAKES. Yes, good morning, Senator Carnahan.

Senator CARNAHAN. Could you get closer to the microphone? Thank you.

Mr. LAKES. For the record, my name is L.C. Lakes, a resident of the city of St. Louis, MO, in the 22nd Ward. I was born on November 20, 1932. I am currently retired. In my life, I have worked in several jobs, most notable working as a welder for 27 years. I am currently Captain of Block Unit 294, and an active member of several neighborhood initiatives aimed at improving the quality of life for the residents of our community. I am a member of Friendly Temple Baptist Church in St. Louis. I work on our church committee to build houses for the senior citizens.

I was also involved in the successful effort to locate a police substation in our neighborhood to help us fight the problems of drug abuse and crime in the 22nd Ward. I actually worked with the police officers, the aldermen, and other public officials in the effort to demolish the nuisance properties that are used to sell drugs. I have also volunteered with the Caring Community Program under the direction of Mr. Khatib Waheed in St. Louis to provide fun and safe activities for our youth.

I sincerely thank the committee for the opportunity to appear before them to discuss the critical issues of prescription drug coverage for senior citizens. It is an issue that either affects now or it will affect everyone in our Nation. Everyone in the United States is going to get old sooner or later. If you have a little luck, you will get to be an old man like me. But you are going to have to have a little luck.

My wife and I are now both retired and living on a fixed income. My wife receives a pension from St. John's Hospital where she worked for 28 years. She received Social Security benefits after she retired from St. John's. My wife was part of the HMO that the hospital provided for employees. While she was covered, she had to pay $200 every month to stay in the HMO. I also received coverage on her plan for a monthly fee.

Since my wife required so many different kinds of medicine, she was put out of the HMO. Since then she has been forced to seek a private insurance plan due to the high cost of our prescription drugs, especially for her heart condition. She spends several hundred dollars monthly for this medication. I was also put out of the plan because my wife lost her coverage. I pay the AARP $110 every month for supplemental hospital coverage.

Since Medicare only pays 80 percent of the cost of any hospital stay, the AARP pays the other 20 percent. Again, this only covers a hospital stay, not the cost of medicine. If it were not for this coverage, my wife and I would have nothing. For us in a time of bad

health, my wife and I both require several prescription drugs each month to maintain our health. I am on four prescriptions. My wife has been placed on nine by her doctor. I must spend $33 a month for—some of these medicines here I am unable to pronounce the name of them, but we got some things here—but I will go on to the others. To treat my high blood pressure and my borderline diabetes requires two medicines, Glucotrol and Glucophage, I think it is. They cost $35 for 30 pills. My doctor also prescribes Baycol for my high cholesterol, which has since been taken off the market. My wife's situation is even more serious. She must take nine different kinds of medicine, her gout prescription.

Senator, here are some more of the medicines here. I am not a doctor, so I can't pronounce a lot of these. But, anyway, the cost of this medicine is $10 for 20 tablets. The prescription for the heart condition costs $100 for 30 tablets. Due to their high cost, we can only afford to buy 15 at a time, half those what the doctor prescribes. Her high blood pressure medication costs $80 for 60 pills. Since she has to take two every day, she also needs a second blood pressure medicine which costs $30 a month. The complications from her blood pressure also forced her to take a $30-a-month prescription to remove water and fluid from around her heart and a $35 prescription for another one of them, Senator.

Her doctor also prescribes 60 potassium tablets at $49 a month. She also needs 120 tablets a month for Cuminid, a blood thinner, I believe that is. But she can only afford 30 at a time. Her Glucophage prescription for diabetes costs $45 for 60 tablets and $40 for her prescription of Glyburide, or whatever that is.

We must pay for all of this medicine I just read to you on a fixed retirement income of $886 a month for me, $730 a month for my wife. After requiring Medicare deduction of $50 each, together we have to survive on about $1,600 a month, and for that we must pay our electric bill, gas bill, water, sewer, food, and other expenses. If it wasn't for my wife's history at St. John's and our friendship with the doctors and nurses, we wouldn't be able to get the free samples that we need from them, which keeps the medicine costs where they are now.

Even now we have to cut back on the medicine that my wife needs because we just don't have the money. I urge you, Senator Carnahan, to do what you can to help us older Americans with a prescription drug benefit. You can do a great deal to make our lives easier. No one should have to choose between the medicine they need to live and food to eat, we senior citizens need your help.

Again, thank you for the opportunity to come before you. Thank you for hearing my concerns and those of other seniors in my community. Thank you.

[The prepared statement of L.C. Lakes follows:]

Testimony of

L.C. Lakes

Citizen, City of St. Louis

Before the

Senate Special Committee on Aging

United States Senate

Monday, August 27, 2001

Jefferson City, MO

Good morning, Senator Carnahan.

For the record, my name is L.C. Lakes, a resident of the City of St. Louis, Missouri, in the 22nd Ward. I was born on November 20, 1932 and am currently retired. In my life, I have worked in several jobs, most notably working as a welder for 27 years. I am currently Captain of Block Unit #294, and an active member of several neighborhood initiatives aimed at improving the quality of life for the residents of our community. I am a member of Friendly Temple Baptist Church in St. Louis, and work on our church committee to build housing for senior citizens. I was also involved in the successful effort to locate a police substation in our neighborhood to help us fight the dual problems of drug abuse and crime. In the 22nd Ward I actively work with our police officers, alderman, and other public officials in efforts to demolish nuisance properties used to sell drugs. I have also volunteered with the Caring Communities Program, under the direction of Mr. Khatib Waheed in St. Louis, to provide fun and safe activities for our youth.

I sincerely thank the Committee for the opportunity to appear before you to discuss the critical issue of prescription drug coverage for senior citizens. It is an issue that either affects now or will affect everyone in our nation. Everyone in the United States is going to get old sooner or later. If you have a little luck, you'll get to be an old man like me. But, you're going to have to have a little luck.

My wife and I are now both retired and living on fixed incomes. My wife receives a pension from St. John's Hospital, where she worked for 28 years. I receive Social Security benefits. After she retired from St. John's, my wife was part of the HMO that the hospital provides for employees. While she was covered, she had to pay $200 every month to stay in the HMO. I also received coverage under her plan for a monthly fee.

Since my wife required so many different kinds of medicine, she was put out of her HMO. Since then, she has been forced to seek a private insurance plan due to the high cost of her prescription medicine, especially for her heart condition. She spends several hundred dollars monthly for this medication. I was also put out of the plan because my wife lost her coverage. I pay the AARP $110 every month for supplemental hospital

coverage since Medicare only pays 80% of the cost of any hospital stay. The AARP pays the other 20%. Again, this only covers a hospital stay, not the cost of medicine. If it were not for this coverage, my wife and I would have nothing for us in times of bad health.

My wife and I both require several prescription drugs each month to maintain our health. I am under 4 prescriptions, and my wife has been placed on 9 by her doctor. I must spend $33 per month for both Micardis and Norvasc to treat my high blood pressure. My borderline diabetes requires 2 medicines, Glucotrol & Glucophage, that costs $35 for 30 pills. My doctor also prescribed Baycol for my high cholesterol, which has since been taken off the market.

My wife's situation is even more serious. She must take 9 different kinds of medicine. Her gout prescriptions (Allopurinol & Colchicine) cost her $10 for 20 tablets. The prescription for her heart condition costs $100 for 30 tablets. Due to their high cost, we can only afford to buy 15 at a time, half of what her doctor prescribes. Her high blood pressure medication costs $80 for 60 pills, since she has to take 2 every day. She also needs a

second blood pressure medicine, which costs $30 a month. The complications from her blood pressure also force her to take a $30 a month prescription for Laxic to remove water and fluid from around her heart, and a $35 prescription for Zaroxolyn. Her doctor also prescribed 60 potassium tablets at $49 a month. She also needs 120 tablets a month of Cuminid, but can only afford 30 at a time. Her Glucophage prescription for diabetes costs $45 for 60 tablets and $40 for a half prescription of Glyburide.

We must pay for all of the medicine I just read to you on fixed retirement incomes of $886.00 a month for me, and $730.00 for my wife, after our required Medicare deductibles of $50 each. Together, we have to survive on about $1600 a month. And from that, we must pay our electric bill, gas, water, sewer, food, and any other needs that come up. Were it not for my wife's history at St. John1s and our friendship with the doctors and nurses, we wouldn1t be able to get the free samples that we get from them which keeps the medicine costs where they are now. Even now, we have to cut back on the medicine that my wife needs because we just don't have the money.

I urge you, Senator Carnahan, to do what you can to help us older

Americans with prescription drug benefits. You can do a great deal to make our lives easier. No one should have to choose between the medicine they need to live and food to eat. We senior citizens need your help.

Again, thank you for the opportunity to come before you and thank you for hearing my concerns and those of other seniors in my community. Thank you.

Senator CARNAHAN. Thank you, Mr. Lakes. I notice you indicated that it takes a little bit of luck to age successfully.

Mr. LAKES. Yes, ma'am.

Senator CARNAHAN. But we want to try to eliminate the necessity for luck and put a little more certainty into aging, and having a prescription drug benefit would certainly help to do that.

Mr. LAKES. Thank you, ma'am.

Senator CARNAHAN. I would like to go to the questioning now of our panelists here for a minute. I can tell that you are making some budget decisions as you look to your costs, and that perhaps there are some sacrifices you are having to make. I can tell that you are already trying to—I believe, Mr. Lakes, you mentioned that you use samples sometimes that your——

Mr. LAKES. The doctors sometimes have. And if I may, Senator, sometimes when the medicine gets to selling, they don't have samples. They stop giving them out once they get going. And then the doctor don't have them. But it is mighty nice when the doctor gives them whenever he can.

Senator CARNAHAN. Then I believe it was, Mrs. Sowells, you indicated that sometimes you also use samples and that you halve the pill sometimes in order to make it go farther. But I am just wondering. You are making some adjustments in your medicines. What adjustments are you making in your budget? What is it you are not able to do as a result of this? What kind of sacrifices of priorities are you having?

Ms. SOWELLS. Well, I can no longer be no help to my family. I can't do anything for my church activities. I can't do anything for my grandchildren. And when it comes right—I don't do very much for my husband, and when it comes right down to me, you just might say we do without to stretch and make it. And I was telling Jason and Rich that we was with, two very nice men—appreciate their help—you have to learn to live within your income. If you keep going out of your income, you are going to really be in deep trouble. And I know I do a lot of things that I shouldn't do that the doctor don't want me to do, but you have to do in order to make it. They want you to use a needle and syringe one time. I can't do that. I can't make it. Most of the time they run $20 a month. And I re-use the needle and syringes after I thoroughly clean them. And on my medicines, sometimes when it gets so tight, I figure a half a dose is better than no dose. So I will put it in half in order to stretch it out.

Senator CARNAHAN. Would any of the others like to comment? Mrs. Muhleman——

Mr. LAKES. I would like to say that—and me and my wife——

Senator CARNAHAN. Could you speak a little closer to the microphone?

Mr. LAKES. Yes. Me and my wife's situation comes that sometimes we have to go to some of the city programs like energy and things like that to get some of our bills paid, like lights and gas. At this time of month we go and try to get help from the energy people to help us out there, and sometimes we were able to do that. And right now it is kind of hard since we got a new President to get that done. You know, they don't have no money half the time, they say, and if they ain't got it, they can't give it.

When wintertime come, we go to the gas—go back to the problem of gas, and me and my wife have that problem, you know. As she said, do the best we can. That is all we can do. But it is a long way from where we should be. I worked hard all—it ain't like, again, we are asking for something for nothing. I worked for some 30 years and just think it is no more than fair to try to give us some help.

Senator CARNAHAN. Mrs. Muhleman.

Ms. MUHLEMAN. It takes a lot of ingenuity, as Mr. Lakes says, with increasing gas prices, gasoline for the cars and also for heating, and for air conditioning. And it really keeps you busy, you know, juggling the budget. And sometimes it does have to come out of savings whether you really want to or not, because my husband's medicines are very expensive. They are, I guess, some of the most expensive that a person has to have for his condition. And I have health problems, too.

Senator CARNAHAN. Have any of you tried to get insurance to cover your drug prescriptions? I think you mentioned, Mrs. Sowells, that you had attempted to do this.

Ms. SOWELLS. I wasn't able to do this until—my husband does it for me. I cannot do it. He bought me a supplement insurance for the 100 percent deductible and 20 percent copayment. But it does nothing for drugs. And that runs him over $1,000, $1,200 a year for this insurance, which right at this present I am still paying on hospital bills that I had 3 and 4 years back that I am still paying on monthly besides everything else.

But I was not able to get insurance until then. Everybody would turn me down, or it would either be so high, we could not afford it. There was no way that we could get it and pay for it.

Ms. MUHLEMAN. Also, they will not take a lot of people that have pre-existing conditions.

Ms. SOWELLS. That is right. That is right.

Ms. MUHLEMAN. We have tried many times.

Senator CARNAHAN. So you have tried, but you didn't find anything that was attractive.

Ms. MUHLEMAN. Nothing. And the cap is usually $500, and that is nothing—for us, at least.

Senator CARNAHAN. Mr. Lakes, did you——

Mr. LAKES. Yes, ma'am. I did want to say just what she just made the statement, that my wife, being an HMO, she jumped from one to the other on account of $500 is the limit there. And a couple of months at the most, she's out of that $500 due to her condition and heart trouble. Some of the medicines cost about $3 a pill. It is something she got to have, you know, and——

Senator CARNAHAN. One of the issues that we are going over in Washington is whether or not a prescription drug benefit should be a part of Medicare or whether it should be covered by private insurers. Do you have any opinions on that? I see you shaking your head over here, Ms. Sowells.

Ms. SOWELLS. I would rather have Medicare than insurance, like I was talking about the insurance that my husband got, it was through his cousin that found this company to insure me, or I probably wouldn't be insured today. And as I said when we first started, it was about $1,000 for a little over a year, but now then it has

gone up to $1,250 a year to insure me for the $100 deductible and the 20 percent copayment. But, at that, it still does not cover none of the prescription drugs or anything that I have to have, like my expensive machines. And I guess Rich got a little—looked at me a little funny, but I kept saying, "Do you lock your van? Do you keep this locked? Do you keep that locked?" Because I have got all my medical supplies with me that I had to bring, and like I told him, I have things that I cannot replace. They are too expensive. My machine monitor and my—well, all my pills. There for a while I was carrying them in my purse, and I was tearing up my purse. And so I had to buy an extra bag in order to put all my medication in that bag, you know, to move it around. And I told them it is like going somewhere, it is just like moving, picking everything up and going.

But, no, I would rather to have it on Medicare than any insurance company.

Senator CARNAHAN. You just feel a little more confident being under Medicare.

Ms. SOWELLS. Yes, I do, because I feel like they wouldn't turn you down as quick as what an insurance company might turn you down on something that you would really need that they think, well, you really don't need that. Even if the doctor says you need it, they might think you don't need it.

Senator CARNAHAN. How do you feel?

Ms. MUHLEMAN. I think it should be with Medicare and us pay a premium like we do Parts A and B. I am very much for that.

Ms. SOWELLS. Yes.

Mr. LAKES. So I am. She speaks for me, too.

Senator CARNAHAN. OK. Very good. Well, as we mentioned earlier, we want to try to make this to be a voluntary benefit. But in order for it to work, we are going to have to have some features in it that are attractive to people. If we have to place limits on what we offer, what would you be willing to accept in terms of copay, deductibles, premiums, and so forth? What do you feel like you could afford to accept?

Ms. SOWELLS. Anything would beat what we are doing right now.

Senator CARNAHAN. OK. But, I mean, how much do you feel would be an acceptable amount that you could afford, say, a month?

Ms. SOWELLS. Well, if it would cover most of the drugs, even if we would have to pay a small amount, if it was something like Medicare, if we would have to pay a premium like Medicare in order to get the drug prescriptions, it would pay us to do that. It would be well worth it of what we are already paying. And then if we had to pay a little bit on each prescription, that wouldn't be——

Senator CARNAHAN. So you don't object to a copay? You would be willing for a copay?

Ms. SOWELLS. If it is necessary, yes.

Senator CARNAHAN. And some sort of deductible feature as well?

Ms. SOWELLS. Such as?

Senator CARNAHAN. Oh, like a $250 deductible before——

Ms. SOWELLS. In other words, you would have to be out the $250 before it would kick in?

Senator CARNAHAN. Right.

Ms. SOWELLS. Yes, ma'am. Yes, ma'am.

Senator CARNAHAN. Mrs. Muhleman, that is sort of——

Ms. MUHLEMAN. That would be good.

Senator CARNAHAN. You would be willing to pay a deductible?

Ms. MUHLEMAN. A copayment and a deductible would be OK.

Mr. LAKES. Well, I don't agree with the $200 deductible. You know, I just don't agree.

Senator CARNAHAN. You think that is too high?

Mr. LAKES. Yes, ma'am, I do. I think it is much too high. See, if you go with the HMOs, if they would stand still instead of the 30 months, they have maybe 5 months and 6 months, take a whole year in there, I would have thought it would be good. But if you are using a lot of medicine with an HMO, $500 is only a little bit, even though you pay $10 for that copayment, it is fine, but it don't last. So if you got to pay $200 or $300, or whatever, that is too much. I don't agree with that. I don't mind paying something, but——

Senator CARNAHAN. And this question might cause you to range out a little bit and think in terms of some of the friends that you know who have similar problems. Do you think that what you are going through is typical of the senior community?

Mr. LAKES. Yes.

Ms. SOWELLS. Absolutely.

Senator CARNAHAN. Mrs. Muhleman.

Ms. MUHLEMAN. Yes. In the breathing centers and places where my doctor has to go, and the hospitals, we find that this is very common.

Senator CARNAHAN. In what way?

Ms. MUHLEMAN. Well, the high prescriptions, the expense, all the—it is wonderful to have all these medicines, but they are very expensive. Just terrible. And they keep going up all the time. So it is a very common thing. Everyone talks about it.

Senator CARNAHAN. Among friends, OK.

Ms. SOWELLS. When one drug fluctuates $10 or $15 a month, it just nearly chokes you.

Senator CARNAHAN. So this happens commonly, that the drug would fluctuate and raise that much in a month's time?

Ms. SOWELLS. Well, that is what my pharmacists tell me. At one time I had one pill that jumped up $12, and I called him, I said, Oh, I can't handle this. And he said, "Well we don't want to do it, but," he said, "it's getting to that. So we have to do it." And I said, "Well, just don't fill it." Because it was already 30-some dollars, and then when they add $12 more to it, that is 40-something. And when you have got four or five that runs you 30 and 40 or close to $50 a month—and that is not—like I said, that is not all that you get. That is just part of what you get. You just can't do it.

Senator CARNAHAN. What about your friends? Do you have friends who are having similar situations?

Ms. SOWELLS. Yes. And another thing that I talked to Jason about and Rich about, I talked to my pastor and some of my senior citizens at my church about this, and they said, "Well, it sounds like to me that if they would do this, people that are not taking medicine or as sick as you are would be paying for your drugs."

And I said, "No, that is not what they told me." I said they reassured me that they had money put back for this and that it wouldn't be like that, it would be like Medicare. You either get Medicare or not have Medicare. And I said that is what they told me. And I said I believe that is the way it is.

It would be hard to, like he said, cough up the $200, $250, but it wouldn't be anything—it wouldn't be worse than what we are doing now. We could more apt to do that than keep doing this every month and every month and every month to where you—the quality of life is not enjoyable. You just dread—every day you dread what you have to do to live with your medicine. I don't know if anybody takes shots, but it is not enjoyable. And it was one of the hardest things I ever had to learn to cope with.

Senator CARNAHAN. Mr. Lakes.

Mr. LAKES. Yes, ma'am. Senator, I would like also just to—sometime your medicine that you may be taking—I will just name blood pressure medicine, for instance. It may stop working, and then the doctor prescribes another medicine. Sometime there may be two. In my case it was two prescriptions instead of that one I had before. You know, I was taking—Pezotag was one, and now I am taking two more that is supposedly going to do the same thing, but I take two medicines, two prescriptions, which costs two pieces of money, in the neighborhood of $35 or so for 30 pills. So that is a concern to me. Medicine doesn't always work, and when it stops working, they go to another one.

Senator CARNAHAN. I have one final question, and if you would each address this question. Did you have any idea that your retirement, what we often think of as our golden years, would be like this?

Ms. SOWELLS. No, not at all. Not at all. I tell my children sometimes life is not worth living, and they would say, "Mother, don't talk like that. Don't talk like that. We are not ready to give you up." And I said, "Well, when you can't live a quality of life, you know"—and sometimes it is depressing. It is heart-breaking. It is aggravating. It is frustrating. And I was talking about this one drug that I told the druggist not to refill. I was already paying—it was a nerve pill. My nerves was really bad, and the doctor said I was right at a nervous breakdown when I quit work. And he had me on four Xanax pills a day. And I was paying $60 a month, and it got so bad, I went into him, and I said, "Do not refill that prescription anymore." And he said, "Just a minute." And he went to the phone, and he called the pharmaceutical, that makes the medicine, and he was telling them about me, and I know they had asked him, "Well, does she really need it?" He said, "Yes, or I wouldn't be calling." Here this medicine was already 60-some dollars a month, and they said, "Let her have it at cost." They started charging me $20 for the medicine. That is what it took them to make my medicine, was $20, which I had been paying 60—over 60-some dollars a month for this one pill.

Senator CARNAHAN. Mr. Lakes.

Mr. LAKES. Senator, what I didn't anticipate when I was younger, that I was going to have these problems when I got older, you know, arthritis and all these other things.

Senator CARNAHAN. You were going to enjoy your retirement.

Mr. LAKES. Yes. But, unfortunately, I got old—I am glad I am living, though. [Laughter.]

But it just come up, you know, one thing after another. I thank God that I haven't got worse health, but we do need help, and we are—I watch you a lot on the radio and what have you—on the television, I should say, and I will say this: You will get my vote all the time. I will be working hard for you. [Laughter.]

Senator CARNAHAN. Mrs. Muhleman.

Ms. MUHLEMAN. My husband has a lot of infections that he takes a lot of antibiotics constantly, and, of course, they are very expensive. And he has one medicine that goes in his nebulizer, or breathing machine, that a month's supply costs over $200. And that is just for his breathing machine. So these medicines are extremely expensive.

Senator CARNAHAN [continuing.] told are very heart-rending. They make us all the more determined to do something and to help, and I appreciate your being here very much.

We will take a 5-minute break at this time.

Mr. LAKES. Thank you for having us, Senator.

Ms. SOWELLS. Thank you.

Ms. MUHLEMAN. Thank you. [Recess.]

Senator CARNAHAN. Could I have your attention? We will get started with our second panel. Our second panel will feature advocates for seniors in Missouri who have been working to relieve the burden of high prescription drug costs.

Robert Schmalfeld is an AARP volunteer congressional district coordinator from St. Louis. Mr. Schmalfeld is a retired lieutenant from the Navy and a former administrator at Oklahoma State University and more recently at University of Missouri in St. Louis. We welcome you today, Mr. Schmalfeld.

Mr. SCHMALFELD. Thank you.

Senator CARNAHAN. Ken Bougeno is the first vice president of the Missouri Council of Senior Citizens. Mr. Bougeno is a retired Chrysler employee and has been very active in his local UAW chapter.

And, finally, Ann Steele, welcome. She is the advocacy chair of the Older Women's League. Mrs. Steele is a retired educator. She taught in the Rittenour School District for 28 years, retiring in 1987, and she has been involved with the Older Women's League for over 10 years.

We are very privileged to have you all here today, and your written testimony will be included in the written record in its entirety. But if you would please limit your prepared remarks to 5 minutes today, that would be very helpful.

So we will get started with Mr. Schmalfeld.

STATEMENT OF ROBERT SCHMALFELD, AARP VOLUNTEER CONGRESSIONAL DISTRICT COORDINATOR, ST. LOUIS, MO

Mr. SCHMALFELD. Thank you, Senator. I am Robert Schmalfeld, an AARP volunteer, currently serving as congressional district coordinator from the city of St. Louis. I appreciate the opportunity to appear here today to discuss the need for Medicare prescription drug coverage.

In the 36 years since the Medicare program began, prescription drugs have become essential to the treatment and prevention of disease. The lack of prescription drug coverage in Medicare has become one of the programs biggest gaps, leading beneficiaries vulnerable to substantial costs. Further exacerbating the problem is the fact that other sources of drug coverage for older Americans are inadequate and undependable.

For instance, the number of employers offering retiree health coverage has seriously declined. In the 1980's, an estimated 60 to 70 percent of large employers offered retiree health benefits. By 1993, that had dropped to 40 percent, and in 2000, it was only 24 percent for future retirees. Medigap plans provide prescription drug coverage in only three of the standard ten plans, and these plans are expensive and place limits on the benefit.

Medicare+Choice plans are dropping out of Medicare, increasing premiums, or reducing benefits. As a result of inadequate and costly coverage, one-third of Medicare beneficiaries do not have prescription drug coverage, and this figure obscures the fact that only 53 percent of beneficiaries have prescription drug coverage for the entire year.

Prescription drug coverage in Medicare would improve quality of care, reduce unnecessary hospitalization, and offer the potential to reduce the risk of drug interactions. That is why AARP is committed to creating a Medicare prescription drug benefit. In particular, AARP believes that Medicare's benefit package must be modernized to keep up with advances in medicine.

A Medicare prescription drug benefit must be available to all Medicare beneficiaries. The benefit needs to be affordable to assure a healthy risk pool. This means that healthy and low-cost beneficiaries must choose to enroll in the benefit in addition to those who already have high drug costs.

Prescription drugs should be part of Medicare's defined benefit package set in law. It is critical that beneficiaries understand what is included in their benefit and that they have dependable and stable prescription drug coverage. The benefit should provide protection against catastrophic expenses. The benefit must include additional subsidies for low-income beneficiaries to protect them from unaffordable costs and assure that they have access to the benefit. The benefit must be financed in a fiscally responsible manner that is both adequate and stable. The benefit should be voluntary so that beneficiaries are able to keep the coverage that they currently have, if they choose to do so.

A new prescription drug benefit should also be part of a strong and more effective Medicare program. Senator Carnahan, we commend you for holding this hearing today to draw attention to the need for Medicare prescription drug coverage. AARP stands ready

to work with you and your colleagues to enact a meaningful benefit.

Thank you.

[The prepared statement of Mr. Schmalfeld follows:]

Statement of Robert Schmalfeld

on

The Need for a Medicare Prescription Drug Benefit

Jefferson City, Missouri

August 27, 2001

Thank you Senator. I am Robert Schmalfeld, an AARP Volunteer Congressional District Coordinator from St. Louis. I appreciate the opportunity to discuss the need for Medicare prescription drug coverage.

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- A Medicare prescription drug benefit must be ***available*** to ***all*** Medicare beneficiaries.

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- A new prescription drug benefit should also ***be part of a strong and more effective Medicare program.***

Senator Carnahan, we commend you for holding this hearing today to draw attention to the need for Medicare prescription drug coverage. AARP stands ready to work with you and your colleagues to enact a meaningful benefit.

Senator CARNAHAN. Thank you very much.

I might ask you some questions right now before we move on to our other panelists. I certainly appreciate the fact that AARP has been such a strong advocate for a prescription drug benefit, and we appreciate all that they are doing in that area.

You did mention a trend in your testimony. You said that employers and Medicare HMOs and other insurers are cutting back. Is this going to put—when they do this, do you think this is going to put a greater burden on Medicare beneficiaries? And do you think that this trend will continue? And as a result, will it cause Congress to have to heighten their interest in this topic and their need to do something?

Mr. SCHMALFELD. I believe that the need to have a prescription drug coverage in Medicare will increase as the number of employers continues to go down in terms of covering retiree benefits. There will be more and more people without the prescription benefit, and there will be an even greater need across the board for Medicare benefit—excuse me, a prescription drug benefit in Medicare.

If you think about it, the last 10 years there has been a 50-percent decline in the rate of coverage for those persons who used to be able to rely on having a prescription benefit in retirement.

I am not sure whether I have completely responded to your question. I hope so.

Senator CARNAHAN. Thank you.

Let's go on and hear from Mr. Bougeno, and then we will follow up with some questions as well.

STATEMENT OF KEN BOUGENO, FIRST VICE PRESIDENT, MISSOURI COUNCIL OF SENIOR CITIZENS

Mr. BOUGENO. Thank you, Senator Carnahan. My name is Ken Bougeno. I am the first vice president of the Missouri Council of Senior Citizens. I am here on behalf of them today. We also are an affiliate of the Alliance of Retired Americans.

As a retiree of UAW Local 136, I feel very lucky that at the present time we have a copay prescription program and I do not have to make the choice between getting my expensive prescription filled or eating. With each negotiation, we are losing a little piece of our benefits, and the day could come when the corporation will take away that benefit altogether.

There are 13 million senior citizens and disabled people who do not have prescription drug coverage. Older Americans depend on prescription drugs, and for many, drugs represent the difference between life and death. Seniors spend 42 cents of every dollar that is spent on prescription drugs, and they are the ones who can afford it the least.

As an officer of the Missouri Council of Senior Citizens, I can say that we support the commitment of the Alliance for Retired Americans in lobbying for Congress to enact a universal, comprehensive, and affordable prescription drug benefit under Medicare.

Seniors need an affordable copay prescription program that will protect them from increasingly expensive drugs, and employers should be provided with incentives to keep the prescription copay and even expand on it in their own corporations.

We have got to put some kind of control as well on pharmaceutical prices. They have just skyrocketed on us. [Applause.]

Senator, I want to thank you for the opportunity to come here today, and on behalf of the Missouri Council of Senior Citizens, we will support you in all your efforts, and anything we can do to help you, please call.

[The prepared statement of Mr. Bougeno follows:]

Ken Bougeno
1st Vice President
Missouri Council of Senior Citizens
Chairman, UAW Local 136 Retiree Chapter
980 Horan Drive
Fenton, MO 63026

As a retiree of UAW Local 136 I feel very lucky that at the present time we have a co-pay prescription program and I do not have to make the choice between getting my expensive prescription filled or eating. With each negotiation we are losing a little piece here and there and the day could come when the corporation will succeed in taking it away from us. There are 13 million senior citizens and disabled people who do not have prescription drug coverage. Older Americans depend on prescription drugs and for many, drugs represent the difference between life and death. Seniors spend 42 cents of every dollar that is spent on prescription drugs and they are the ones who can afford it the least.

As an officer of the Missouri Council of Senior Citizens I can say that we support the commitment of the Alliance for Retired Americans in lobbying for Congress to enact a universal, comprehensive and affordable prescription drug benefit under Medicare. A **universal coverage for all those who qualify for Medicare benefits.** Seniors need an affordable co-pay Prescription program that will protect them from increasingly expensive drugs. Employers should be provided with incentives to keep the prescription co-pay and even expand on it.

WE HAVE GOT TO PUT SOME SORT OF CONTROL ON PHARMACEUTICAL PRICES.

Thank you

Senator CARNAHAN. Thank you very much.
Ms. Steele.

STATEMENT OF ANNE STEELE, ADVOCACY CHAIR, OLDER WOMEN'S LEAGUE, ST. LOUIS, MO

Ms. STEELE. My name is Anne Steele. I am the advocacy chairperson for the Older Women's League, the Gateway Chapter, which is in St. Louis, and I have entitled my presentation to you today "Prescription for Change." I want to begin my remarks by telling you about a friend of mine whose name is Olivia, and I hope she will be able to join us a little later on.

Olivia has been with us for 21 years and has worked ceaselessly to develop a grass-roots organization to focus solely on issues unique to women as they age. She strives to improve the status and quality of life for midlife and older women. But when prospective members ask me how old you have to be to get into this organization, I reply, "39 or over, or ever hope to be." And we even take men.

We work together to bring about these following goals, our organizational priorities: health care, and we have had a lot of explanation of that; economic security; and quality of life. Those are the three issues that we support legislation, we work on those, so on and so forth.

Now, I want to talk about why are so many older women poor. By far, more retired women are much less able to support themselves, to support themselves with any degree of quality of life than men. Why is that?

When I was a kid growing up, there were three professions I could go into, and that was a secretary, a nurse, or a teacher. And I ended up being the teacher. But women's professions have changed a little bit, but since these were women's professions, the pay was low.

Women now are free to become trained in almost any field that they have the interest, aptitude, and opportunity. But just think, when the former man, Mr. Lakes, he said, "You have to have a little luck." And that is what opportunity is, too.

So I believe that you have to have that combination. It just doesn't come out and lay itself at your feet because you have aptitude or interest. It is that opportunity that really makes a difference in what you and I do with our lives, whether you are 80 or whether you are 8.

In June 1963, the historic Equal Pay Act was signed into law after a protracted 18-year battle. Thirty-eight years later—that is now—women have gained 13 cents in the pay gap. Instead of 59 cents for every dollar earned by men in 1963, we now earn 72 cents on the dollar. OWL has long called for the full enforcement of wage and age discrimination laws, as well as a speedy closure to the widening gap separating men's and women's wages.

Since Social Security monthly benefits are based on a worker's wage history, women who earn less become retirees who have less to live on. Older women depend most heavily on Social Security as a financial foundation. The poverty rate for women 65 and older is almost twice that of men, 12 percent vs. 7 percent. The average older women lives on $15,615 a year, vs. an average of $29,171 for

her male counterparts. And women live an average of 6 years longer to stretch this money for some quality of life.

For the women of color, the pay gap is magnified. African American women earn 65 cents and Latinas only 52 cents for every dollar earned by a white male. This cycle of low wages continues into retirement where African American and Hispanic older women have almost 3 times the rate of poverty as white women.

Savings are very hard to manage when you don't make enough money to keep body and soul together, so the third leg of that retirement stool is often denied women because of their lack of income all through their lives.

I want to refer a little bit to the ERA because we are trying to get that passed in the State of Missouri, and we are not succeeding.

It started back the days when our Constitution was written, this discrimination of women. When Abigail wrote to John and said, "Remember the ladies," he wrote back and said, "Depend upon it. We know better than to repeal our masculine system. I'd rather give this up. I hope General Washington and all our brave heroes will fight against it," meaning putting women in the Constitution. And so it was.

[The prepared statement of Ms. Steele follows:]

PRESCRIPTION FOR CHANGE

Why Women Need a Medicare Drug Benefit

presented by

OWL The Voice of Midlife And Older Women
Gateway Chapter
Anne B. Steele, Advocacy Chairperson

Introduction:

I want to begin my remarks by telling all of you about a friend of mine whose name is Olivia. She will be joining us shortly. Olivia has been with us now for 21 years and has worked ceaselessly to develop a grassroots organization to focus solely on issues unique to women as they age. She strives to improve the status and quality of life for midlife and older women. When prospective members ask how old one needs to be to join this organization, my reply is "39 or over or ever hope to be!" We work together as advocates to bring about the following organizational priorities:

1. Health Care: Owl is committed to the universal availability of the highest quality, affordable health care from birth to death.

2. Economic Security: Owl works to ensure that all women have the tools with which to build their own economic security today and in the future.

3. Quality of Life: Owl works to ensure that all people have the right to remain in control of decisions affecting their quality of life throughout their lives.

I WHY ARE SO MANY OLDER WOMEN POOR?

1. Pay Equity

- When I was growing up, there were three opportunities for women to work outside the home in a profession for a pay check: secretary, nurse, and teacher. Since these were "women's professions," the pay was low. That has changed somewhat. Now women are free to become trained in almost any field in which they have the interest, aptitude and opportunity. But the pay is still low-er than men get for the same work.
- In June of 1963, the historic Equal Pay Act was signed into law after a protracted 18-year battle. Thirty-eight years later, women have gained 13 cents in the pay gap: instead of 59 cents for every dollar earned by men, women now earn 72 cents on the dollar. OWL has long called for the full enforcement of wage and age discrimination laws, as well as a speedy closure to the wage gap separating women's and men's wages.

2. Access to Pensions

- A majority of women still work in retail, service, or clerical jobs. Almost two-thirds of minimum wage jobs are held by women. The lower the wage, the greater the chance the job

doesn't offer pension protection or other retirement plans **(20 percent vs. 47 percent of those over 65)** and when they do, their benefits are lower **($2,682 vs. $5,731).**

- The reason for this is clear: 8 in 10 defined benefit pension plans are based on wages. Since Social Security monthly benefits are also based on a worker's wage history, **women who earn less become retirees who have less to live on.** Older women depend most heavily on Social Security as a financial foundation.
- The poverty rate for women over 65 is almost twice that of men **(12 percent vs. 7 percent).** The average older woman lives on $15,615 a year, versus an average of $29,171 for her male counterpart. And yet women live an average of six years longer than men, so they must make their already-reduced income last longer. For women of color, the pay gap is magnified. African American women earn 65 cents, and Latinas only 52 cents, for every dollar earned by a white male. This cycle of low wages continues into retirement, where African American and Hispanic older women have almost three times the rate of ` poverty as white women

3. Savings

- Women cannot save their way to parity. While I believe that most make an effort to save some amount, especially during their middle years, there is no possible way to save enough from their incomes to guarantee having the sum available that men can save.

II SOCIAL POLICY

1. ERA (Equal Rights Amendment)

Equality of Rights under the law shall not be denied or abridged by the United States or by any State on account of sex.

Adopted_____

- The effort to grant equality to women in the Constitution of the United States of American began in 1776 with Abigail's letter to John. A much astonished John wrote back, "Depend upon it, we know better than to repeal our Masculine systems…"rather than give this up,…I hope General Washington, and all our brave Heroes would fight (against it)." And so it was.

2. Thus ended the first attempt for equality for women.

- But not for long. Sixty years later Elizabeth Cady Stanton, at the first Women's Rights Convention, proclaims "all men and women are created equal." Now, after 213 years, still trying at intervals, succeeding in getting the vote in 1920, we are still

here and trying. The majority of **people** in the United States favor ERA. The majority of the **legislators** in the states which have not passed ERA, do not. We need only three more States

- With acceptance of the Equal Rights Amendment as part of the Constitution, I believe that the discrimination against women will come to an end (not suddenly, but with increasing frequency); we will lose our second class citizenship because we will then be protected by the Constitution, as men are today.

III MEDICARE AND PRESCRIPTION DRUGS

1. Defined Benefits

- Owl believes that a prescription drug benefit is needed for all seniors. Not just any plan, but one which becomes part of Medicare and
  - defines the benefits,
  - is voluntary, comprehensive and universally available,
  - keeps co-pays, premiums and deductibles affordable,
  - indexes benefits to inflation,
  - provides adequate stop-loss protections and catastrophic coverage,
  - allows dropped beneficiaries to avoid late enrollment penalties, and,
  - provides additional financial assistance for low-income beneficiaries.

2. Medicare + RX=Impossible?

- A devastating blow occurred in early summer; placing a huge tax cut above guaranteed health benefits. The United States government remains the only industrialized nation to continue to deny this human good to its citizens.
- As prescription drug prices continue to rise at an alarming rate, 19% this year, quality health care will soon be unattainable for increasing numbers of our citizens.

3. **Which will it be, I Win, You Lose? People or Profits?**

- There have been many ideas about **our** problem floating around this spring and summer. Some have been in the form of Bills, some have been only plans not yet turned into bills, some at this point are only fledging ideas. All of us need to be talking with each other about those ideas.
- We also need to be in communication with our Legislators. An email, a note, a telephone call, a visit in the office? Can each side give something---less profits---more taxes? One time isn't enough to communicate; we will have to be involved as the discussion progresses.
- Remember, if it is good for women, it is good for all of us.
- Senator Carnahan, thank you for getting the ball rolling.

7

- Oh yes, I promised that Olivia would be here and HERE SH**ECOMES**(pull 18 to 20 inch stuffed owl from bag) Oh wait—Here is a baby OWL for Senator Carnahan. And remember, Senator, Olivia, Jr. is a "GIRL'S BEST FRIEND!"

Senator CARNAHAN. Thank you very much. I am sure there is more there that we would all like to hear, but we probably should move on back to the topic here of drug coverage.

There is one part of this that I would like to ask your opinion on. We haven't had much discussion about Medigap, but do you feel, as some people do, that it is unrealistic to think that Medigap is going to provide coverage for our seniors? What would a typical Medigap policy cost?

Mr. SCHMALFELD. I am sorry. I can't respond. I don't know. Those who are—it would depend upon age and a number of other things, and I don't have that information in front of me. Maybe others do.

Senator CARNAHAN. So you never tried to get Medigap coverage or——

Mr. SCHMALFELD. Fortunately, I am with that small group of employers that continues to provide insurance, and so I stand in a minority here because I worked for a large university which continues to make prescription drugs available to me at—still, I share in the cost, but—so I do not have a Medigap program myself.

Senator CARNAHAN. I am sorry. Over here?

Ms. STEELE. I can tell you my husband spends $130 a month.

Senator CARNAHAN. $130 a month.

Ms. STEELE. [Inaudible comment off microphone.]

Senator CARNAHAN. Do you know which plan that is of the ten plans, which one——

Ms. STEELE. [Inaudible comment off microphone.]

Senator CARNAHAN. Thank you.

Mr. Bougeno, as a new retiree, I am sure you are planning on relying on your employer's drug benefit. Do you have any fears that it might be cut or eliminated? Would you talk into the microphone, please?

Mr. BOUGENO. I feel it is being cut on a daily basis—not quite daily, but monthly basis. We are losing just little bits here and there. There used to be gray areas that the insurance companies would go ahead and pay. Today they are just moving those over to the side. They will not pay them. And those are areas that we have been used to all these years paying, and they were not actually negotiated items, and they were in what they call—they call it "gray area." So now they are not paying them. So we are losing just a little bit with each passing day.

Senator CARNAHAN. I noticed that you advocated a Medicare benefit—I am sorry, a prescription drug benefit under Medicare as opposed to a private insurer. Would you tell us your thinking on that?

Mr. SCHMALFELD. Why it should be in Medicare?

Senator CARNAHAN. Yes.

Mr. SCHMALFELD. We believe that presently the Medigap programs that there are have basically eliminated prescription drug as a covered item, and that practically the only choice that remains ahead of us for having any hope of having coverage at all is through Medicare.

Going back historically, I don't think any of us could have imagined 36 years ago the degree to which prescription drugs would play a part in terms of managing health conditions. That has grown considerably. There have been many breakthroughs that

have made using prescription drugs the treatment of choice that one could not have imagined.

With this has come a great increase in terms of cost. A new drug coming on the market, the pharmaceutical company will get as much as it can for as long as it can before allowing it to become a generic drug. In fact, we have seen some instances where the Congress has taken action to extend the patent period for certain drugs, which makes it even more difficult for people to be covered. I think it is the only choice that remains ahead.

Earlier this month, on the occasion of the 36th anniversary, AARP went to all of the offices of Senators and representatives, including yours in St. Louis, and presented a cake with a piece out of it, which said prescription drugs—and that piece out was the prescription drug benefit that is yet to be enacted. And we hope that the Congress will move toward enacting this, particularly since monies have already been identified and are just waiting for a bill to be introduced that utilizes those monies appropriately.

Senator CARNAHAN. I did hear about the cake that was delivered, and I hope that I will be able at some point to return you a slice of cake and say this is what we have done, we have put it all together. [Laughter.]

Mr. SCHMALFELD. Thank you. We look forward to that.

Senator CARNAHAN. Mrs. Steele, I certainly admire what your organization is doing on behalf of women and the studies that you are making. In drafting a Medicare prescription benefit, though, are there certain issues that we need to focus on that would be particularly helpful to elderly women?

Ms. STEELE. I believe that it has to be stable and it has to be protected so that inflation—so that with inflation the amount of coverage for prescription drugs will increase also. I think it has to be—in order to pay for this, we are going to have to have everybody in the pot, because you simply cannot pay for it if only the sickest choose coverage.

So those are the things that I see, and, of course, that everybody gets the kind of care they need; instead of saying we are going to cover this, this, and this, you have a menu of choices.

Senator CARNAHAN. Well, how can we—you say we need the low-cost beneficiaries in there as well to expand the pool. How can we make this benefit more attractive so that more people will want to take part?

Ms. STEELE. Well, I think even those who have—well, let me say that I am one of those who no longer is insured by a former employer. When my husband retired in 1987, we were told we would have lifetime coverage. That ended in 1997, and we knew it was going to end in 1993.

Senator CARNAHAN. So the stability factor is a very important one.

Ms. STEELE. Yes. But it also means that I have to go out and find my own. I am not part of a group anymore, which makes it much more difficult.

So I just think we have to be able to count on a community. We are a community. We need to work together as a community to protect everybody in that community.

Senator CARNAHAN. Mr. Schmalfeld, would you like to comment on that, how we can make it more attractive?

Mr. SCHMALFELD. Obviously it has to—the Congress needs—it is a very daunting job. They have to devise something that will be attractive to——

Senator CARNAHAN. And affordable.

Mr. SCHMALFELD. And affordable to everyone. And I think this is a kitchen-table kind of issue, that when the plan is devised, that people will sit around the kitchen table and say this is what we are paying now, this is what is proposed under this system, does this look like it is moving in the right direction? Does this make it interesting and affordable and appropriate for us to adapt? Until a program is devised, it is really hard to comment and say this is the way, this is the deciding factor that I am going to decide to sign up because it is a good deal, not because it is something that I am going to pay more on. Or you weigh out the difference. You say, well, my insurance costs—which I didn't say earlier. You asked about the cost and so forth. I failed to mention that over the years since I have retired in 1996, my insurance rates have increased by more than 45 percent. So while I am still covered, more of my resources are being spent to provide that benefit. And I heard recently in a newsletter that that cost is going to go up even more.

So I think people are going to be very practical about this. It is a money issue, and it is like look at what the details are, what it is going to provide, what is the deductible, what are we paying now, what has our history been with drug costs, is it going up, are we likely to lose our insurance benefit, as one of our panelists has talked about, or be reduced. Are we on a better path going into this?

I think the other thing is that as a program is offered, those concerns—then companies that offer prescription benefits now as part of retirement benefits are going to have decisions to make. Hopefully they will continue them. If they don't continue them, one of the options is going to be perhaps to pay the cost of that, whatever the charge is under Medicare, and also to provide wrap-around things.

Another thing that AARP is concerned about is low-income persons, people who need additional help to pay for the cost of insurance, which is true now in terms of Medicare Part A. If you are in a certain low-income basis, you have that premium paid.

So there are options out there that I think common-sense people—it is a money issue. They are going to have to look at all the details, and they are going to have to decide whether it is worthwhile or not. But if we don't attract the large numbers, then it is not going to work.

Senator CARNAHAN. Well, thank you so much for sharing these experiences with us today. We are going to have to move on to the third panel. I notice we are running out of time. But, again, thank you very much for being here. [Applause.]

Our final panel will explore in greater detail the serious impact that high prescription drug costs are having on Missouri seniors.

Our first witness today will be Dr. Lanis Hicks, professor in health service management at the University of Missouri School of Medicine. Dr. Hicks has been involved in several projects with

rural hospitals, conducting environmental assessments and market strategies. She also conducts research into the cost-effective delivery of health services in rural areas. Welcome, Dr. Hicks.

Dr. Stephen Zweig is—did I say that, pronounce that—Zweig, I am sorry. Dr. Stephen Zweig is a professor and associate chair and coordinator of geriatric activities at the Department of Family and Community Medicine at UMC. He is also director of the Care and Aging Program at the UMC Hospital and Clinic. Dr. Zweig has received numerous awards and honors and has focused much of his career and training around geriatrics, and we are very honored to have these distinguished panelists with us today.

Again, your written testimony will be received into the record, and I ask you to make your presentations—keep them limited to 5 minutes.

Dr. Hicks.

STATEMENT OF DR. LANIS HICKS, UNIVERSITY OF MISSOURI SCHOOL OF MEDICINE

Dr. HICKS. Thank you for the opportunity to be here today to discuss the issue of seniors and prescription drugs. My name is Lanis Hicks, and I am a professor of health economics in the Department of Health Management and Informatics at the School of Medicine.

As this first graph shows, there has been a rapid increase in expenditures on health care, and the expenditures on the prescription drugs has been increasing even more rapidly. In 1996, they accounted for 6.5 percent of total expenditures. In the year 2000, they were up to 8.9 percent. And by 2010, they are expected to account for almost 14 percent of the health care expenditures.

These rising expenditures on prescription drugs are not necessarily bad, but the implications of the increases have to be examined. Prescription drugs are increasingly used as components with our other medical interventions as complements to improve patient outcomes. They are used as immuno-suppressants used with organ transplants. Other prescription drugs are used to substitute for more invasive procedures, such as lipid-lowering drugs to reduce the need for bypass surgery, and to treat medical conditions that previously we weren't able to treat, such as Parkinson's disease.

Furthermore, as our knowledge and understanding of genetics grows, pharmaceuticals are expected to grow exponentially. These changes in pharmaceutical products are expected to have a disproportionate impact upon the seniors since seniors represent the cohort relying mostly on prescription drugs to manage their multiple health problems. Seniors not only have more problems with their health, but their health problems tend to be those that respond to drug therapy.

In 1996, 89 percent of seniors reported having one or more chronic health problems, and almost 10 percent reported having five or more chronic problems. Chronic health problems have major implications for expenditures on prescriptions. Currently, seniors account for about 13 percent of our total population but incur about 43 percent of our total prescription drug expenditures.

There is discrepancy in the utilization of prescription medications and the expenditures on prescriptions between Medicare beneficiaries that have insurance coverage and those that do not have

insurance coverage. As this graph shows, the dark line is those that do not have any kind of benefit coverage, and the other ones are those that have benefit coverage.

As the data show, individuals with insurance coverage filled on average 24.4 prescriptions while those without coverage filled 16.7 prescriptions. These same discrepancies hold even when the adjustments for health status, economic conditions, and chronic conditions are considered.

Under all circumstances, individuals with insurance coverage on average utilized more prescription medications than individuals without insurance coverage. As shown, non-covered seniors living below the poverty level only utilize about half the number of prescriptions as covered seniors below the poverty level use. Non-covered seniors indicating poor health status use about a third fewer prescriptions than covered seniors in poor health.

These data indicate the critical role that insurance plays in the utilization of prescriptions medications by seniors. Non-covered individuals with five or more chronic conditions average $1,051 on prescriptions while covered individuals with five or more chronic conditions average about a little over $1,800, about 75 percent more, although covered individuals pay only $595, or 56 percent as much out of pocket.

As with the other end, seniors without a chronic condition but with insurance coverage spent almost 70 percent more for prescriptions than non-covered beneficiaries, although their out-of-pocket expenses are only about half as much.

From the data available, it is not possible to determine the appropriate level whether or not some individuals are spending too much and others too little. But what we have been able to look at through some of the research is that non-covered beneficiaries with hypertension were 40 percent less likely to purchase anti-hypertension medication, and we have also shown that about three-fourths of drug-related hospitalization by seniors could have been avoided with the proper use of medications.

Rural populations tend to face exacerbated access and financial problems, with other half of senior residents living at 200 percent of the poverty level compared to 41 percent.

All of these are problems that we are encountering within the health care industry, and the problem, as we try, you know, to work toward solving these problems, is to recognize what is going to happen in a very short period of time when the elderly increase from about 13 percent of our population to over 20 percent. And that is going to have increasing medical—you know, in terms of trying to make it an affordable plan.

Thank you.

[The prepared statement of Dr. Hicks follows:]

University of

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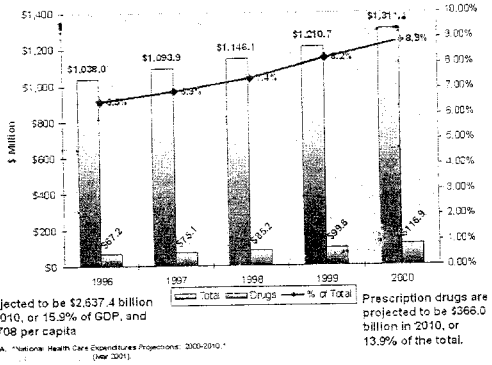
SENIORS AND PRESCRIPTION DRUGS

Lanis L. Hicks, Ph.D.

Thank you for the opportunity to be here today to discuss the issue of seniors and prescription drugs. I'm honored. My name is Lanis Hicks, and I'm a Professor of health economics in the Department of Health Management and Informatics, School of Medicine, University of Missouri–Columbia.

There has been a rapid escalation in spending on prescription drugs in recent years, and this trend is expected to continue, or accelerate, in the future. As the data in this first graph show, total health expenditures in the US have risen from $1.0 trillion in 1996 to $1.3 trillion in 2000, and are projected to increase to more than $2.6 trillion by 2010. Expenditures on prescription drugs have been a major contributor to rising costs, accounting for 6.5% of the total expenditures in 1996, but increasing to 8.9% in 2000. By 2010, prescription drugs are expected to account for 13.9% of the larger total expenditures.

GRAPH 1: INCREASING HEALTH EXPENDITURES



HCFA, "National Health Care Expenditures Projections: 2000-2010," (Nov 2001).

The rise in prescription drug expenditures in 2000 can be attributed to three major factors: 42% to the number of prescriptions filled, 36% to a shift in the type of prescriptions filled (from older to newer, more expensive drugs), and 22% to rising prices. The number of prescriptions increased 7.5% between 1999 and 2000, to a total of 2.9 billion scripts, or an average of 10.4 prescriptions per person. In 1998, Medicare beneficiaries averaged 22 prescriptions per person. Per capita expenses on prescription drugs were $417 in 2000, but seniors spent approximately $1100 per person on prescriptions.

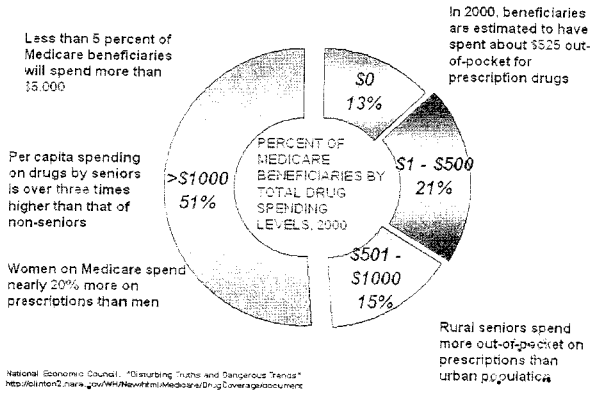
Rising expenditures on prescription drugs are not necessarily bad, but the implications of the increases must be examined. Prescription drugs are increasingly used as complements with other medical interventions to improve patient outcomes (e.g., immuno-suppressants used with organ transplants). Other prescription drugs are used as substitutes for more invasive procedures (e.g., lipid lowering drugs to reduce the need for bypass surgery) and to treat medical conditions that previously could not be treated (e.g., Parkinson diseases, AIDS). Furthermore, as our knowledge and understanding of genetics grow, pharmaceuticals are expected to grow exponentially.

These changes in pharmaceutical products are expected to have a disproportionate impact on seniors, since seniors represent the cohort relying most on prescription drugs to manage their multiple health problems. Seniors not only have more problems with their health, but their health problems tend to be those that respond to drug therapy. In 1996, 89% of seniors reported having one or more chronic health problems, and almost 10% reported having five or more chronic problems. Chronic health problems have major implications for expenditures on prescription medications.

As the data in graph 2 indicate, substantial variations occur in expenditures on prescriptions among seniors. In 2000, only 13% of Medicare beneficiaries did not incur prescription expenditures, and another 21% had annual prescription costs of $500 or less. However, over one-half (51%) of Medicare beneficiaries incurred prescriptions costs of more

than $1,000; but less than five percent had costs exceeding $5,000. Women tended to spend about 20% more on prescriptions than men, partly because of longer life expectancy.

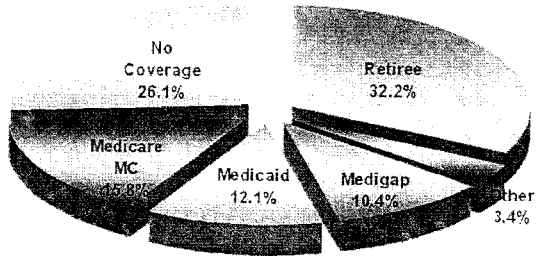
GRAPH 2: BENEFICIARIES' SPENDING ON PRESCRIPTIONS, 2000



Currently, seniors account for about 13 percent of the total population, but incur 43% of total prescription expenditures. Because Medicare does not provide an outpatient prescription drug benefit, pharmaceutical expenses are a substantial and growing financial drain on seniors, even for those with private or public supplemental prescription coverage. About one fourth (26%) of seniors do not have any prescription drug coverage, and only about one-third (32%) of seniors have coverage through employer-sponsored insurance as a retiree. The remaining 42% have various types of coverage, as indicated in graph 3. These types of insurance tend to be less stable and more expensive than employer-based insurance plans. The costs of private coverage under Medigap insurance are rising and, also, premiums increase with age, making them less affordable to individuals who need them most. Three Medicare HMOs plans provide prescription drug coverage, but availability for enrollment is limited. Benefit coverage under private insurance has been declining in recent years, and is expected to continue to do so as employers reduce their commitment to retirees. All of these factors portend more financial

burdens and access problems for seniors in the future, and are impacting current utilization of prescription medications.

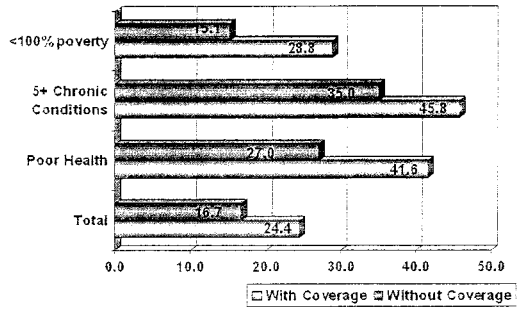
GRAPH 3: SENIOR DRUG COVERAGE, 1998



Poisal and Murray (2001). "Growing Differences between Medicare Beneficiaries with and without Drug Coverage." Health Affairs 20(2): 74-85.

As the next two graphs show, there is a discrepancy in the utilization of prescription medications and the expenditures on prescriptions between Medicare beneficiaries who have insurance coverage and those who do not have coverage. As the data in graph 4 show, individuals with insurance coverage filled, on average, 24.4 prescriptions, while those without coverage filled 16.7 prescriptions. These same discrepancies hold, even when the adjustments for health status, economic conditions, and chronic conditions are considered. Under all circumstances, individuals with insurance coverage, on average, utilize more prescription medications than individuals without insurance coverage. As shown, non-covered seniors living below the poverty level only utilize about half the number of prescriptions as covered seniors below the poverty level use. Non-covered seniors indicating poor health status use about a third fewer prescriptions than covered seniors in poor health utilize. These data indicate the critical role that insurance plays in the utilization of prescription medications by seniors.

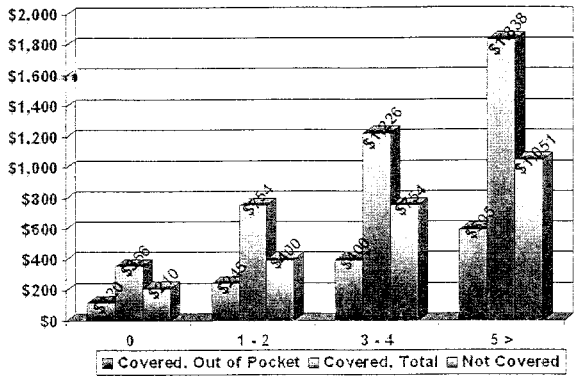
GRAPH 4: AVERAGE NUMBER OF PRESCRIPTIONS FILLED BY BENEFICIARIES, 1996



Poisal and Murray (2001) "Growing Differences between Medicare Beneficiaries with and without Drug Coverage." Health Affairs 20(2): 74-85.

Graph 5 illustrates the variations in expenditures between beneficiaries with prescription medication coverage and beneficiaries without coverage. As shown, differences in total spending widened as the number of chronic conditions increased. Non-covered individuals with five or more chronic conditions averaged $1,051 on prescriptions, while covered individuals with five or more chronic conditions spent $1,838 (75% more), although covered individuals paid only $595 (56% as much) out of pocket for these prescriptions. At the other end, seniors without a chronic condition but with insurance coverage spent almost 70 percent more for prescription medications than non-covered beneficiaries, although their out-of-pocket expenses were only about half as much. These differences exist regardless of the number of chronic conditions. However, as the number of chronic conditions increases, the percent of total expenditures on prescription medications paid for out of pocket by covered beneficiaries remains relatively stable, at about one-third, but the dollar amount paid out of pocket increases substantially. In addition, in recent years, covered beneficiaries have been paying a larger percentage of total prescription costs out of pocket as benefit coverage has eroded.

GRAPH 5: SPENDING BY BENEFICIARIES BY NUMBER OF CHRONIC CONDITIONS



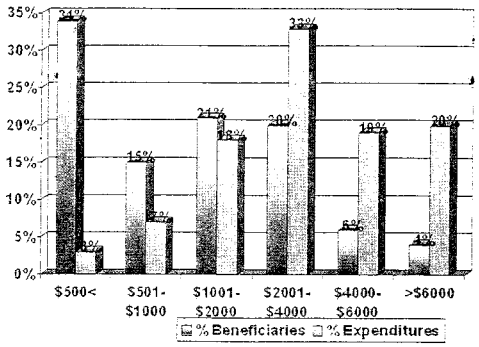
Poisal and Murray (2001). "Growing Differences between Medicare Beneficiaries with and without Drug Coverage." Health Affairs 20(2): 74-85.

From the data available, it isn't possible to determine the appropriate level of spending for or utilization of prescription drugs – do covered individuals use too many or non-covered individuals use too few? However, the variation in spending for similar conditions between covered and non-covered beneficiaries is an area of concern, especially since other research has shown that non-covered beneficiaries with hypertension were 40% less likely to purchase anti-hypertension medications. Such lower utilization is likely to result in negative health outcomes for the non-covered population, since appropriate utilization of medications reduces the negative consequences of the disease. For example, researchers concluded that over three-fourths of drug-related hospitalizations by seniors could have been avoided with proper use of necessary medications.

Graph 6 provides information on the distribution of beneficiaries relative to total prescription expenditures. As indicated, slightly more than one-third (34%) of beneficiaries spent $500 or less on prescriptions in 2000, but these 34% accounted for only 3% of total expenditures on prescriptions. Another 15% spent between $500 and $1000 on prescriptions,

resulting in 49% of beneficiaries accounting for 10% of total expenditures. On the other end, 10% of beneficiaries spent more than $4000 on prescriptions in 2000, and this 10% accounted for 39% of total expenditures on prescription drugs.

GRAPH 6: DISTRIBUTION OF BENEFICIARIES AND TOTAL PRESCRIPTION EXPENDITURES, 2001



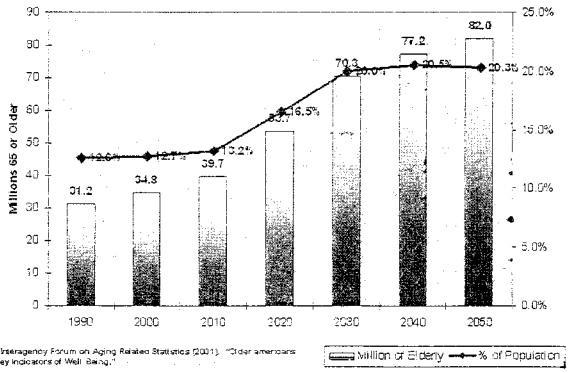
Kaiser Foundation, Medicare and Prescription Drug Fact Sheet, May 2001
www.kff.org

Rural populations tend to face exacerbated access and financial problems. Over one-half (52.3%) of senior rural residents live below 200% of the Federal poverty level, compared to 41.2% of senior urban residents. However, in 1996, 32% of rural seniors spent more than $500 out of pocket for prescription medications, compared to 24% of urban seniors. Rural beneficiaries are much less likely to have prescription drug coverage than their urban counterparts. In 1996, for example, 37% of rural beneficiaries were without coverage, compared to only 23% of urban beneficiaries. Only 16% of rural seniors had access to Medicare+Choice plans with drug coverage, compared to 79% of urban seniors. All of these factors contribute to creating less access to appropriate prescription utilization for rural residents.

In the future, expenditures on prescriptions are projected to continue increasing at a rapid rate. The growing number of seniors in the population will fuel much of this increase. As

indicated by the data in graph 7, the senior population is expected to increase sharply between 2010 and 2030, growing from 39.7 million (13.2% of the total population) to 70.3 million (20.5% of the total population). Expenditures on prescriptions are projected to reach $82.5 billion in 2010, a 62% increase over the $50.8 million spent in 2000. Early estimates have predicted that health care expenditures will reach $16 trillion by 2030, and prescription drugs will reach $288 billion. Such increases have serious implications for the senior population, and for funding sources for these expenditures.

GRAPH 7: INCREASING ELDERLY POPULATION



The data presented so far reflect national trends in population and prescription drug expenditures. However, the implications hold for Missouri, since Missouri is not substantially different from the conditions experienced nationally. In 1998, national per capita expenditures on prescription drugs were $335; in Missouri, per capita expenditures on prescription drugs were $334, only one dollar less than the national average. In terms of per capita spending on prescription drugs, Missouri ranked 23rd in the country, even though Missouri ranked 14th in the number of individuals age 65 and over. Between 1990 and 1998, spending on prescription drugs increased at a slightly lower rate in Missouri than in the nation. Nationally, per capita

expenditures for prescription drugs increased 121.9% between 1990 and 1998; in Missouri, the increase was 111.4%.

The expenditures on prescription drugs in Missouri need to be evaluated in terms of the characteristics of the population. Missouri has a slightly older population than the nation, and it also has a slightly more rural population. These two characteristics may mean that because of lack of prescription drug coverage, the population is using fewer drugs than their counterparts for the same medical conditions. Additional research is needed to evaluate the implications of the lower rate of expenditures on prescription drugs in Missouri to determine if it is having a negative impact on the health status of Missourians.

In conclusion, then, access to affordable prescription drugs is a growing concern among senior citizens, as well as for financing entities. The expected growth in the number of seniors between 2010 and 2030 is going to put substantial additional financial stress on the system, as will the exponential growth in pharmaceutical products expected from the increased understanding of human genetics. Affordability of appropriate prescription medications for seniors will continue to be a major concern.

Again, I wish to thank you for the opportunity to present this information on seniors and prescription drugs. I would be happy to try to answer any questions.

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Senator CARNAHAN. Thank you.
Dr. Zweig.

STATEMENT OF DR. STEPHEN ZWEIG, DEPARTMENT OF FAMILY AND COMMUNITY MEDICINE, UMC

Dr. ZWEIG. Thanks, Senator Carnahan, for this opportunity to testify before this Special Committee on Aging. This is an important problem, and we hear your genuine concern and appreciate that.

I am privileged on a daily basis to work with older people, to help to teach medical students, residents, fellows in geriatrics and others about the importance of caring for elders and how to do that in a cost-effective way. I don't know how I can speak more articulately about this program than those patients and family members that have come before me. It is a serious problem.

The Congressional Budget Office estimates that spending on prescription drugs by Medicare beneficiaries from all sources will equal $1.3 trillion between 2004 and 2011, and that includes spending by beneficiaries and insurers on their behalf.

As has been pointed out previously, purchase of Medigap policies that cover prescription drugs are expensive. They have deductibles, high copays, and benefit caps. And as Ms. Muhleman pointed out, these are often out of the reach of many people who need them.

Prescription drugs spending is increasing at a rate 3 times that of professional and hospital spending for Medicare. Not only are many patients filling prescriptions, but the cost of those prescribed drugs is very high. In fact, the 25 most heavily advertised and promoted drugs accounted for 40 percent of the increase in retail drug spending in 1999.

As has been pointed out, Medicare beneficiaries fill prescriptions, 86 percent did in 1995, and a Family USA study found that in the year 2000, the number of prescriptions filled by the elderly averaged 28.5 per year, including refills.

As Ms. Sowells pointed out, it is not surprising that those people with many chronic conditions, such as heart disease, high cholesterol, and diabetes, spend much more, over $3,000 a year out of pocket compared with an average of $1,343.

While the majority of Medicare recipients have some form of insurance, this insurance is not adequate to cover the cost of most beneficiaries. Unfortunately, there is little relationship between the cost of the drug and the benefit it may afford. But the absence of needed drugs may precipitate loss of function in the elderly, resulting in increased disability and dependency.

So, in summary, the number of prescriptions is up. The cost of those prescriptions is up. Costs are higher for those without insurance coverage. Total expenses, however, are higher for those with good insurance coverage, and those with multiple chronic diseases have more need.

Unlike other insurance policies, out-of-pocket expenses for prescription drugs are unlimited in most circumstances, and as has been pointed out, 65 percent of beneficiaries have some form of insurance and 60 percent of them have supplemental plans. Most are employer-sponsored, but this is also decreasing. The statistic that

I had read included only 30 percent of elderly with employer-sponsored plans in 1998.

Twenty percent are members of Medicare HMOs, which have historically had the most generous prescription drug coverage, but more recently they have limited these benefits. And as Mr. Lakes' experience testifies, high prescription drug users are more likely to disenroll from Medicare HMOs and may not qualify now for their former Medigap plans, leaving them without any coverage at all.

As has been also pointed out, those most likely to be without coverage have low income, to be of fair or poor health status, and to be older than 75. And even though the Medicaid program covers 17 percent of elderly living in the community, a very, very fine prescription drug program, many poor people don't receive Medicaid benefits. In fact, in 1999, an estimated 45 percent of community living Medicare beneficiaries within incomes below the Federal poverty level received no Medicaid benefits.

Dr. Hicks has articulately described the population trends. Our population is aging. By 2020, 20 percent of Americans will be 65 and older, and the largest growing population in the United States is that in the 85-year-and-older group. As our population ages, the prevalence of chronic disease will also increase, which means more prescription drug use and higher costs.

Valuable pharmacologic research is fueled by a promise of a drug that will be preferred by both patients and physicians, and it will be expensive. While Medicare has limited payments to physicians and hospitals, there has been no such limit on the cost of prescription drugs.

I have a nurse colleague in our practice named Rebecca Raskar who coordinates the care for about 230 of the most frail and complicated older patients that we care for living in the community. And I asked her this morning what I should tell this group, and she said, "Tell them these poor old people can't afford those expensive drugs."

Indigent drug programs that are sponsored by pharmaceutical companies are valuable, but they are full of gaps and delays, and they are incomplete. Frequently, our patients and us cobble together programs which are associated with discontinuity and possible injury, and I will be happy to give examples.

Drug samples are free at first and costly much later. As Mr. Lakes pointed out, they are not available long term. And the Medicaid spend-down program has helped many, but is not available to all those who need it.

I will stop there.

[The prepared statement of Dr. Zweig follows:]

Comments before the Special Committee on Aging
Monday August 27, 2001

Steven Zweig, MD, MSPH
Professor and Associate Chair
Department of Family and Community Medicine
University of Missouri-Columbia, School of Medicine

FACTS

1. Medicare is a health insurance program available to virtually every US senior.
   - -Part A is free and covers hospital care, limited skilled nursing stays, and specific home health services.
   - -Part B costs $45.50/month and covers professional services with accompanying copays and deductible charges.

2. Medicare does not cover outpatient prescription and over the counter drugs. Privately purchased Medigap policies are expensive costing an additional $300-$500/year or more with an annual $250 deductible, 50% copayment, and an annual benefit cap of $1250 or $3000.

3. Spending on prescription drugs is increasing at a rate far exceeding professional and hospital spending. Between 1990 and 1998, hospital and physician spending increased 57% and 50% respectively and prescription drug spending increased 140% (Health Care Financing Administration data quoted in *USA Today*, 9/28/2000).

4. The 25 most heavily promoted drugs accounted for 40% of the increase in retail drug spending in 1999. Physicians are much more likely to prescribe these heavily promoted drugs (34% more vs. 5% more for all other drugs) (National Institute for Health Care Management data quoted in *USA Today*, 9/28/2000).

5. 86% of Medicare beneficiaries filled at least one prescription in 1995 (*Health Care Financing Review* 1999[Spring]:15-27). Each person fills an average of 18 prescriptions/year. While the average total cost is $1343, the average person with coronary artery disease, high cholesterol, and Type 2 diabetes spends over $3000/year (*Health Affairs* 2000;19:198-211).

6. 65% of Medicare beneficiaries (those not in nursing homes) have some form of insurance coverage for prescription drugs. Of those with coverage:
   - 60% have supplemental plans
     - 47% are employer sponsored
     - 13% are privately purchased Medigap policies
   - 20% are members of Medicare HMOs
   - 20% are covered by public programs
     - Medicaid 17%
     - Other – VA, Department of Defense, state assistance 3%

   (*Health Affairs* 1999 [Jan-Feb]:213-243)

7. Those without coverage are more likely to have lower incomes (<200% poverty), to be of fair or poor health status, and to be older than 75 years (AARP PPI analysis using Medicare Benefits Simulation Model 1999).

8. Out of pocket spending is greater for those without coverage (mean $590 vs. $320/year). [*A Medicare Prescription Drug Benefit*, Medicare Brief #1, National Academy of Social Insurance, April 1999]. Those with privately purchased Medigap policies have the highest out of pocket costs (mean $570/year). Even those with Medicaid for a portion of the year or QMB supplement have high out of pocket costs ($380 and $205/year). Those with employer-sponsored plans have high costs ($320/year), but they also have the highest total drug spending.

9. Employer sponsored plans are declining, 35% of seniors in 1995, only 30% in 1998 (*Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans 1998: Report of Survey Findings*, p.38).

10. Medigap policies may only be available to those enrolled less than 6 months in Medicare. High prescription drugs users are more likely to disenroll from Medicare HMOs and may not then qualify for their former Medigap plans leaving them with no insurance for prescription drugs (*JAMA* 2000;283:2163-2167).

11. Many poor people do not receive Medicaid benefits. In 1999, an estimated 45% of noninstitutionalized Medicare beneficiaries with incomes below the federal poverty level received no Medicaid assistance (*Issue Brief* no. 39, AARP).

IMPERFECT SOLUTIONS

1. Indigent Drug Programs

I care for an 81-year-old retired journalist who by virtue of a good break on his rent lives in a small apartment at Tiger Columns in Columbia. He has Parkinson's disease and is increasingly frail. He cannot afford prescription drug coverage and does not qualify for Medicaid. We have arranged to get his Sinemet (a medication to treat Parkinson's disease) from the maker through an indigent drug program. After substantial initial paperwork, every 3 months, we reenroll him in this plan and they send the drugs to me, which I give to him. This past week I received a letter from the company telling me this drug would no longer be available under the plan. While my patients and I appreciate these programs they have several problems:

- Each company has a different application process, requesting different information, and different income levels to qualify.
- Most chronically ill elderly take more than one drug.
- Physicians and patients may not know about these plans or do the work required to apply for them.
- Only drugs without generic alternative are usually available.

- The time delay between application (or renewal of prescription) and receiving the drugs can lead to weeks to months without medications.
- Plans can be terminated at any time.

At University Hospital, we have had a program staffed by a social worker to help patients enroll in these plan and to get needed medications. This is a very time consuming process and is not reimbursed. (The best website for such information with phone numbers, addresses and eligibility information for drug companies producing over 900 medications is: www.needymeds.com)

My patient may soon be faced with paying his rent or getting his life-saving medications. Without his medications he will literally freeze-up due to his disease, he will fall, and may suffer serious injury. His only solution may be to enter a nursing home, soon qualify for Medicaid and thereby receive his medications, but at a substantial cost to the Medicaid program (over $3000/month).

2. Cobbled together plans – discontinuity and injury

My 83-year-old father in law, who recently died, had congestive heart failure, coronary artery disease, type 2 diabetes, and treated prostate cancer – fulfilling many of the characteristics of a typical World War II veteran. He had a good doctor in this city and supplemental insurance of a retired state employee that did not cover prescription drugs. While he did not qualify for full VA health benefits because his income was too great, he made periodic visits to a VA physician to get some of his prescriptions filled. After weeks of abdominal pain and weight loss, we discovered that his VA doctor had put him on an arthritis drug that his regular doctor did not know about. This drug had caused an ulcer. This discontinuity of care precipitated by efforts to get discounted prescriptions caused significant injury that could have been life threatening.

3. Use of drug samples

In my role as the medical director of a multidisciplinary geriatric assessment clinic at the University (SAGE clinic), I frequently encounter patients who have been given drug samples for chronic health problems by their well-intended physicians. Unfortunately the only samples provided by drug companies are expensive newly marketed drugs. While the first week or month of the drug may be free, the patient is now committed to an expensive drug, which may be far less affordable than a much less expensive alternative not available as a sample.

4. The Medicaid "spend-down" problem

Changes in state regulations made it impossible for Medicaid recipients to receive more than 31 days of medications from the pharmacy. This meant that many people who reached their spend down by purchasing 3 months of medications at one time, could no longer qualify for Medicaid – and therefore, were not be able to afford to get all or even a portion of their prescribed drugs.

This regulation was changed, but it points to the significance of the Medicaid program and its regulations regarding prescription drugs for poor seniors.

Summary

Prescription drugs are increasingly more expensive. This is true in part because of the higher cost of many new drugs, some of which have been very helpful in treating the chronic diseases accumulated by many older people. Medicare is an incomplete insurance program that does not cover these or many other costs of health care. While the majority of Medicare recipients have some form of insurance for prescription drugs, this insurance is not adequate to cover the costs of most Medicare beneficiaries. It is difficult for even a very poor elderly person to qualify for Medicaid, unless they have become a pauper through a long-term nursing home stay (it takes an average of just 7 months in the nursing home to qualify for Medicaid). Unfortunately, the absence of needed drugs may precipitate institutionalization due to loss of function.

Expectations for medical care increase each year in the US. It is clear that additional pharmaceutical benefits will expand the use of prescription drugs. As physicians, we should make sure that our patients are only taking medications that will show demonstrated benefits for out patients. Physicians must be familiar with drug costs and the least expensive good alternatives. They also need to engage patients in the decision making process of taking these medications or not. As a wealthy society, which fuels these high expectations for health and health care, we must address particularly the care of those most in need.

Senator CARNAHAN. Well, thank you very much, Dr. Zweig.

Dr. Hicks, in your testimony, you said that those without a prescription drug benefit fill fewer prescriptions than those who do have those benefits and that this might indicate that people are not filling prescriptions, not taking the medicines that have been given to them. And we have seen some examples of that already today of people having the medicine or only taking it every other day.

What are the possible health implications of this kind of behavior?

Dr. HICKS. Well, I think we have seen—part of it, as you look at some of the research, if you cut your medication in half, you know, someone said that, well, maybe the—their view was that, well, at least it would give them half of the benefit. Oftentimes medications if taken in half give no benefit because the dosage is given at a point that is needed to make the difference, and if you don't take it at that dosage, you really don't get any benefit.

I think we see it where the hypertension that took 40 percent fewer prescriptions, we then see an increase in strokes, heart problems, and very expensive hospitalizations because they haven't been able to afford the preventive type of care.

Senator CARNAHAN. And what would you recommend, then, for those people who simply can't afford to have their prescription refilled?

Dr. HICKS. I think it is the same thing we have been talking about of trying to get some type of an affordable prescription drug benefit so that everyone has the basic coverage as an elderly individual as part of a Medicare plan.

Senator CARNAHAN. Some are fearing that if the Government provides a Medicare drug benefit, private employers will tend to scale back and not provide programs. In fact, there are already some indicators now that they are beginning to cut back on coverage.

I was wondering if both of you would comment on this trend and how you believe the creation of a Medicare drug benefit would impact the private sector.

Dr. HICKS. I think we are already starting to see the private sector cut back on the packages that they make available for their retirees. You know, there is a lot of data already out there that shows this is happening, and it is happening without the protection of the Medicare program to pick up the difference. It is falling on the individual to make up that difference as the private companies cut back.

Yes, I think the answer is we probably would see private insurance companies cut back if Medicare—very similar to what we have seen as Medicare has picked up other costs.

Senator CARNAHAN. You don't think they would offer a supplemental of some kind, they would just let it go?

Dr. HICKS. There is obviously the potential to offer a supplemental like our Medigap programs that will help pay for the deductibles and copays. I think on your prescription drugs, just because, you know, the large number and the increasing expense of those packages that would be—they would be less inclined to offer the supplemental.

Senator CARNAHAN. I was wondering if you would comment, Dr. Zweig, on the advantages and disadvantages you see of a drug benefit under Medicare as opposed to private insurance.

Dr. ZWEIG. Obviously not everyone has private insurance now, so that would be certainly a major difference. I think this is an incredibly tough problem, and anything that we do will be very expensive.

As we look at the costs of administering health programs, the cost of administering the Medicare program has historically been much less than that associated with other private insurance programs. I am not a health economist like Dr. Hicks, and I can't predict what employers or health insurers will do. I support universal health insurance for everyone in this country and I believe that——[Applause.]

Senator CARNAHAN. I think you have an audience that agrees with you.

Dr. ZWEIG. I believe that as we try to take money out of different pockets, as we are constantly doing, in trying to care for people, and particularly older people, not only with regard to drugs but with regard to long-term care and hospital care and home care, it becomes very complicated.

I think that we will need to replace the existing support for the two-thirds of the population if we go with a universal Medicare plan, and those who are contributing to those existing plans will have to contribute in some way.

I think that we have to do something first for those people who have greatest need.

Senator CARNAHAN. Let's move on to something that affects people who live in rural areas, and I think they have certain special problems in many areas, access problems and certainly access to prescription drugs is one of those. And one of the principles that we laid out early on regarding a benefit was that it should be accessible so that all beneficiaries, no matter where they live, have access to prescription drugs.

What do you see as the challenges in providing prescription drug benefits in rural areas? Either one of you, or both.

Dr. HICKS. I think obviously one of the problems we have is the same problem we have with all other health care, is just availability of the medications. Especially if a rural elderly takes a medication that is somewhat unique and different and rare, it becomes almost impossible to get that in a local pharmacy because of the problems they have of getting it and keeping it and the low volume. So I think that is going to be an area that we really have to worry about with our rural elderly, is the lack of volume in a lot of the different kinds of medications and getting that in.

Dr. ZWEIG. Just to add to that, rural practitioners tend to be the most overwhelmed of all. We have been very fortunate to have social workers within our program who help people to sign up for indigent drug programs which have afforded them some services that they may not have otherwise had.

The transportation to accessible pharmacies at low cost is a challenge. If people like Mr. Lakes need to get their prescriptions every 2 weeks because they can't afford it, that certainly adds a tremendous challenge to being able to get a 3-month supply of medications

that will both reduce the cost of those drugs and also make it more likely that the person won't have gaps in their treatment.

I think people are less likely to take those drugs for which they see a direct positive effect, and they may not be the ones that are the best ones to choose to not take.

Senator CARNAHAN. On the affordability side—again, I have asked this of some of the other panels as well—how can we make a benefit that is both attractive and affordable? I would like to have your opinion on that as well.

Dr. HICKS. I guess my response is I really don't know. The affordable part of it, with all of the new drugs coming on the market that are extremely expensive, the growing elderly population is going to make it hard to make it affordable.

I think one of the difficulties we always face with any kind of governmental insurance program is that it can become an easy target, because suddenly we have the information in front of us about what it is actually costing because it is a Government program, and we avoid some of that in the private. It doesn't make it any less affordable. It just makes it less of a target to be able to hit.

And so I think trying to find an affordable one is doing things that you talked about earlier, and that is, I think it will be necessary to have some type of copayment and to have some type of deductible. I would, however, really not like to see any kind of cap put on it, saying a maximum benefit, because unfortunately what you do with a maximum benefit is you max out the people that need it the most, and those are the ones that are spending the most. [Applause.]

Senator CARNAHAN. I might move on to another point that we mentioned, that is, the point of stability. It seems like the seniors get to where they are relying on a program, and it is very unsettling to have the coverage change. So I was wondering if you might comment on how we can best create a drug benefit that is stable and one that is reliable as well.

Dr. ZWEIG. Well, that is clearly the advantage of doing it through the Medicare program instead of a private insurer in terms of that stability. It seems to me any plan is going to need to include some combination of deductibles and out-of-pocket limits and premiums. I think there has to be meaningful price reform with regard to expenses and costs for drugs. I think—— [Applause.]

Senator CARNAHAN. You have got a real following here.

Dr. ZWEIG. Yes. I think we have to be careful to not divert support to prescription drugs away from other aspects of the Medicare program. I think the formulary has to be comprehensive but evaluated by health care providers who know most about that. And I think that we should support drugs in particular that target significant symptoms and prevent disability in older people.

I am concerned that if we only have a program that supports the poor that the program will become a target, as the Medicaid program has become in political circles. And, honestly, I am concerned about the recent economic forecasts as to how much money we will have for such a program. And I applaud your interest in continuing to try to pursue this very great challenge.

Senator CARNAHAN. One of the things that you mentioned earlier was the use of drug samples. It seems like doctors will often, in all

good intent, provide these samples for someone with a chronic health problem, and they use it for a month or so, and they get committed to the drug, and then it is a very expensive drug for them to follow up with.

Are there ways that we can educate our seniors and their caregivers to consider these cost issues up front when they are setting up a treatment program?

Dr. ZWEIG. I think this is an incredibly important problem. You know, in general, the samples left in physicians' offices are the newest and most expensive ones. Some of those are very valuable drugs for which there is no alternative. Many of them are not. Advertisements for these drugs help to support medical journals and provide a lot of the costs for supporting education and continuing education.

Most recently, as you know, these drugs have been now prescribed on television and on radio, so patients come to me on a daily basis saying, "Why aren't I on this one?" And they are always among the most expensive drugs available.

I do think that patients need to be informed, but the effect of the advertising and the unfiltered attention of the media to the promises of medical science, the cure of cancer of the month, has created incredible expectations that we cannot meet at this point.

I think our job as physicians is important. We have to make sure that our patients are taking the drugs that show really the most demonstrated benefit and to negotiate with them about that. And what we are trying to do in medical school and residency training is to help our students evaluate new information and practice in an evidence-based way so that they can then communicate that effectively with patients. And we have to be familiar with costs. I mean, it is inexcusable for physicians to say, "I don't know what that drug is going to cost" and not put that into the context of their prescribing plan. [Applause.]

And in the process, then, engaging patients and making those kinds of choices about—and there is a creative program that I just learned about in Ohio a couple of days ago using some of the same techniques of pharmaceutical sales representatives, where it is an organization called Generics First. A generic drug company is going around and spending time with physicians informing them about cost comparisons of drugs and helping them to learn the least expensive alternatives. And I think that that is incredibly important. This is a program that some researchers at Harvard discovered a few years ago. If we help to train physicians about those things, they can help their patients as well.

Senator CARNAHAN. Well, thank you very much. We are about to run out of time, and I was determined that we would be able to finish here at noon. But I appreciate your being here very, very much, and I want to thank you for sharing this with us. I will make a closing statement, and we will adjourn for the day.

But before we adjourn, I want to thank all the witnesses who have been here to share their thoughts and their opinions with us on the problems of prescription drug costs.

For those of you who have other thoughts on the subject and would like to share them with me, there is a table out in the hall

where you can write comments, and I will take those back to Washington with me and read those and get back with you.

I think you have conveyed a very clear and a very forceful message today. We need a prescription drug benefit under Medicare, and we need it now. [Applause.]

This benefit should be universal, that is, it should cover every Medicare recipient who wants to participate; and it should be affordable, and it should be available to all. And it should be something we can rely on for many years into the future.

I will be returning to Washington next week following the Labor Day break, and we will begin to struggle to craft a prescription drug benefit that works. It will be a difficult battle because we are in tight budgetary times. But I assure you that I will remember what has been said here today, and I will see that those in Washington know what you think.

I want to close by reading a portion of Mrs. Ruengert's very fine written testimony that she submitted for the record. I mentioned it earlier. She is caring for her 91-year-old aunt in her home. Her aunt, Mrs. Dorothy Creighton, lost her husband some years ago. Mrs. Creighton was able to live by herself for a while before her own health began to fail. And at this point, she sold her house and she spent her savings to move into an assisted living home, where she stayed for several years until her expenses became too burdensome.

Because of the rising costs at the home and rising cost of medical expenses and her reduced savings, she could no longer afford the arrangement. At this point, Mrs. Ruengert invited her aunt to live with her in Jefferson City, and in testimony submitted to this committee, Mrs. Ruengert writes, and I quote, "Even with my help, things are financially hard for her. She didn't want to tell you that she was overdrawn at the bank 3 weeks ago when she sent a check to AARP to pay for medicine. But I told her this committee needs to hear about all your financial problems due to your medical bills. I ask you, What do the elderly do when they have no family member who can help them?" Yes, what do the elderly do when they have no family member to help them? That is a haunting question, and that is the question I am going to take back to Washington with me because that is the question we need to find the answer to.

This hearing stands adjourned. [Applause.]

[Whereupon, at 11:45 a.m., the committee was adjourned.]

APPENDIX

Written Presentation
United States Senate Committee, on Medical Assistance for Senior Citizens
Presented by Doe Ruengert for
Dorothy Creighton

Introduction/Greeting

Thank you, Senator Carnahan for giving me the opportunity to submit this paper to you today, on behalf of my Aunt, Dorothy Creighton. Mrs. Creighton is Ninety-one years old, and has been living on a fixed income since she turned 65 in 1975. She became a widow in 1984 when my Uncle, Ray Crieghton died. Most of you are aware of the fact, that when a spouse dies your fixed income is reduced even more.

Please allow me at this time to give you a little background information about Mrs. Creighton's finances. What I am about to tell you could be the life history of most Senior Citizen's living in the United States. In your near future you may be able to insert your own name or someone close to you into this story, give or take a few facts.

Before my Uncle passed away he had to be placed in a nursing home and in order to get some financial assistance Mrs. Creighton was required to spend a certain amount of their savings in order to meet the income standards set by the Government to get financial aid for the nursing home. This was done by paying for some unnecessary repairs on their home. They lived in an older neighborhood that was becoming very run down and the value on the homes had been declining steadily for years. Nevertheless she spent the money, so she could met the criteria for financial assistance at the nursing home.

He lived in the nursing home for four years, during that time a portion of their joint fixed income had to be payed to the nursing home. This left her with less to pay for her own daily expenses. She still needed to eat, pay taxes, buy car, house, life & medical insurance. Pay for her medicine, (which included diabetic supplies, glasses, hearing aid, Doctor visits, hospital expenses, for surgery on her fallopian tubes, glaucoma in both eyes.) Utilities (gas, water & electric/sewer,) telephone & trash service. Car repairs, gasoline, tires, oil changes, tune ups. Personal items for herself and her husband (which included clothes, shoes, slippers, sleeping apparel, toiletries, socks, nylons, watches, flashlights and batteries.) Household items, (laundry, personal & dish soap, cleaning supplies, toilet paper, paper towels, vacuum & trash bags.)

Repair or replace household appliances, stove, refrigerator, washer/dryer, vacuum cleaner, toaster, blender, clock, stamps, and a lot of them, Dorothy is from the old school, where people correspond with one another through the mail, she remembered and sent birthday, anniversary, get well, and sympathy cards and letters to all seven of her brothers and sisters, her nieces and nephews, and great, and yes to her great, great nieces and nephews, (she always sends a few dollars in the children's birthday cards.) She has many friends, and she writes and sends them cards for all their special occasions also. You may be bored with all these facts, but I included them because Dorothy Creighton, or for that matter any other senior citizen is much more than just facts figures and statistics. They, like you have wants, needs, and desires and you don't suddenly change who you are when you start collecting Social Security, and start living on a fixed income. Yes, you do have to cut corners financially, but all the items mentioned above are the no frills, day to day expenses, everyone encounters.

After my Uncle Ray Creighton passed away his funeral expenses reduced her savings even more. For a few years Dorothy Creighton lived by herself, until her own health began to fail. For a time she paid someone to come and help her a few times a week, as time progressed she needed help on a daily basis and at that time she moved in with relatives. This was a less than ideal situation and the decision was made for her to move into an assisted living home. While she was away from her home most of her things were stolen from her house, and as often happens with the elderly, she was swindled out of quite a bit of her savings. So in order to help pay for the Assisted Living Home into which she was moving, she sold her house, and in spite of all the improvements she made on the house a few years back, she received far less then the fair market value for it, due to the declining neighborhood.

Dorothy Creighton lived at St. Peters Assisted Living Home for several years. And during that time her day to day expenses became more and more of a burden to her, the home raised it's prices several times, her health began to decline, therefore her Doctor, hospital, dental and medical expenses kept rising. These life changes and expenses weighed heavy on her mind and her personality began to change. She used to be a very pleasant, bright and funny 89 year old woman. Now she was depressed, she complained a lot, focused on her health and financial problems, and was generally not a very nice person to visit with. Many of her family and friends started to avoid her, and this confused and hurt and depressed her even more. Neither she, or her family, or friends really understood

what was truly going on in her life. Now in retrospect, we all see that her finances were literally worrying her to death.

And this is were I enter into this narrative. Because of her finances she could no longer stay at the Assisted Living Nursing Home. She is a childless widow, having suffered six miscarriages, with sisters and brothers who were all in their middle to late eighties, there was no one to care for her. I am her niece, and also a nurse, I specialized in Geriatrics, and worked at Villa Marie Nursing Home for 8 years. I love my Aunt very much, as she played a great part in raising me, so I invited her to come live with me. And even with my help things are financially hard on her, she didn't want me to tell you that she was overdrawn at the bank three weeks ago, when she sent a check to AARP to pay for medicine. But I told her this committee needs to hear about all your financial problems due to your medical bills. (I ask you, what do the elderly do when they have no family members that can help them?)

As we age we need more and more assistance to be comfortable, more medicine, stronger glasses, special diets, artificial teeth, frequent Doctor or dental visits, medical tests, hospitalizations, hearing aids. And we are less able to do things for ourselves and need more help from others; to cook meals, do the laundry, clean ourselves, and our homes. We also need more equipment just to get around; a cane, or walker, wheel chair, lifts, electric chairs, stools to sit on in the bathtub. Some even need ramps made just to get into or out of their houses or special beds to sleep in. Some need expensive equipment; oxygen, feeding tubes, liquid diets, intravenous medicine and supplies, indwelling catheters, wound care supplies, medicine and machines to assist with breathing. And you know this list could go on and on. All these "things" cost money, lots of money, but keep in mind that even though we may need all this extra help and equipment or medicine, the income remains the same. There are no raises, bonus, or promotions, and even if you had a little 'nest egg' tucked away, it quickly gets gobbled up by the old fire breathing monster called 'old age, or declining health,' some more aptly call the monster '**fixed income.**'

On the following pages you will see a detailed account of Mrs. Creighton's income, and medical expenses. Keep in mind two things, most senior citizens do not have relatives to live with, and have other living expenses as well, and most of you setting on this committee will never have to worry about what is being considered today. You have the future of many senior citizens in your hands, what you decide today, could affect your children or grandchildren's futures also.

Page 4
Dorothy Creighton's Medication and Cost

Medication	Generic or Not Available in Generic	Monthly Cost
Actonel	N/A/G	$149.52
Prilosec	N/A/G	$110.54
Glnotrol	G	$10.80
Relafen	N/A/G	$129.59
Buspar	G	$23.60
Lactose Digestive	N/A/G	$8.78
Aspirin	G	$3.69
Gelatin dietary supplement	G	$20.99
Extra strength Tylenol p.m.	N/A/G	$3.27
Metamusel	G	$6.50
Stool softener	G	$3.10
Glycerin suppositories	G	$6.96
Anusol Hemorrhoidal ointment	can't use generic	$8.34
Xylocaine 2% viscus solution	N/A/G (Discontinued 7/01)	$15.95
Hydrocort Visceral cream 0.2%	N/A/G (discontinued 7/01)	$32.95
Multi Vitamins	G	$3.00
Vitamin E	G	$3.00
Vitamin B12 injections (&needles)	N/A/G	$5.00
Benadryl allergy capsules	G	$3.95
MediSense 2 /blood glucose machine	N/A/G purchased 2-29-01	($152.99)not monthly
Glucose test strips	N/A/G	$50.89+shipping $5.
Diabetic cough syrup	N/A/G	$7.34
Diabetic cough drops	N/A/G	$8.50 @ $1.70 x 5
		+ 621.26 sub-total***

Dorothy Creighton's Medication and Cost

Medication	Generic or Not Available in Generic	Monthly cost
Neosporin ointment	cannot use generic	$5.69
Capsaicin 0.25 % ointment (feet)	cannot use generic	$7.45
Capsaicin 0.75 % ointment (hands)	cannot use generic	$12.99
Ambrotose capsules	N/A/G	$49.50
Phyt-aloe	N/A/G	$25.65
Mannetec Plus 1	N/A/G	$25.65
Nasonex Nose spray	N/A/G	$47.47
Eye drops	G	$3.95
		+178.35 sub-total***
		621.26***
		+178.35***
		=$799.61 Monthly

These figures are fairly accurate, some medications last a little longer than one month, give or take a week or two, it was just easier to add on a monthly basis, and of course we only need to buy a Glucose machine every five years or so. $799.61 is just for medicine, she has other expenses as well.

I can't see the Government supporting all Senior Citizens medical expenses, other measures could be taken also. Like controlling what Drug Company's charge, setting shorter limits on when generic drugs are available, making it easier for the elderly to contact the Drug Company's to ask them for a price break.

I want to thank you again for allowing the citizens of Missouri to address you concerning this issue. It's an issue that cannot be ignored, because statistics prove that in the near future there will be more Senior Citizens, than any other age group. I encourage you to act now before it's too late. The U.S. Government waited to long to do something about Social Security, let's not compound that by ignoring the issue of medical assistance for the elderly.

God bless you,
Doe Ruengert