

Thank you Senator Kelly, Chairman Casey, Ranking Member Scott, and members of the Special Committee on Aging for inviting me to speak today on this vital topic, the high and ever-rising costs of medication for our seniors.

My career has been dedicated to serving communities with health disparities. I spent six years at UCLA's County Hospital and was a clinical professor at the David Geffen School of Medicine training our next generation of doctors.

Since moving to Phoenix, I have worked exclusively in Federally Qualified Health Centers. As the Chief Medical Officer of Valle del Sol Community Health in Phoenix, we serve a large number of Latinos, African Americans, Asian Pacific Islanders, and Native American patients, all of whom are disproportionately impacted by high cost medications.

As a physician who's cared for families and seniors-in medically underserved communities for the past 20 years, I know firsthand that this is an issue that affects the lives of not just many of my patients but also tens of millions of my fellow Americans.

As the members of this Committee know, within Part D prescription drug program's standard benefits, patients must pay the initial \$480 out-of-pocket deductible for medications before the initial coverage phase begins.

Regrettably, for many patients, that initial deductible is enough of a barrier for them to choose not to purchase the prescription and forego needed treatment. The Low-Income Subsidy program, known as LIS, allows some patients facing financial hardships to either automatically qualify or apply for premium and cost sharing assistance, but many patients are not forthcoming with their healthcare providers about their financial limitations because they are embarrassed.

Some even choose not to return to their doctor when they cannot afford to buy their medicine for fear of reproach. Community health centers like Valle del Sol are starting to realize the need to screen for financial challenges and other social determinants of health upfront to address them early rather than waiting to discover these problems after a patient develops a complication due to lack of treatment.

Unfortunately, screening for financial challenges and getting patients to apply for the Low-Income Subsidies is not enough to solve today's problems. The application process is often too complex for patients to navigate. If they do manage to get through the application process, they may find they do not qualify for full benefits. In one instance, a patient I treated had to choose between paying for insulin or buying gasoline to get her grandchild to work because the rent was due and the grandchild was the sole breadwinner in the household.

These are the types of scenarios we see day in and day out in community health centers and other facilities that treat seniors on fixed incomes.

Patients who have grown to trust their health care providers often turn to us for help. I can't tell you the number of times I have heard my patients say, "Doc or *Doctora*, please look at all of these meds and tell me what I can skip. It costs me too much each month and I need to stop at least two or three of them."

But when a patient has had a heart attack with a stent, breast cancer, and a blood clot, every one of her meds is critical for keeping her alive. These are hard decisions for patients, but also medically and ethically difficult for the doctors and other health care providers who routinely confront these circumstances.

Another scenario we often see play out involves patients who *can* afford their regular daily meds and initial \$480 out-of-pocket deductible, and can also meet the initial coverage phase where they're responsible for the 25% of medication costs. But when they've reach the federal \$4,430 dollar-threshold — the Medicare coverage gap better known as the infamous "donut hole" — patients are then still on the hook for 25% of the costs until they hit \$7,050 dollars in out-of-pocket spending, when catastrophic coverage takes effect. And then even after spending this much on medications, these seniors are still responsible for 5% of the cost of their meds without a cap until the year ends and the cycle begins again.

For patients with complex conditions like rheumatological disorders or cancers that require specific high-cost medications, the coverage gap and no limit on how much they

might have to pay out of pocket causes real problems. Many patients who have moderate financial resources are unable to get treatment because of medications totalling thousands of dollars — putting those specialized treatments out of reach.

In some cases, patients ask for treatment regimens that are not evidence-based in order to make it more affordable. Those same patients with moderate resources may ration the treatment in order to afford it. One example I can share is about a patient of mine who had Ulcerative Colitis, an inflammatory bowel disease that causes bloody diarrhea and often leads to colon cancer. She was having 10+ bloody stools a day without treatment. However, thanks to a Disease Modifying Anti-Rheumatologic Drug, her disease was controlled and the blood in her stool eliminated.

Unfortunately, while she could afford the deductible and the 25% share of costs during the initial coverage phase, when she reached the “donut hole” she could not cover the full cost of the specialized medication and could no longer afford her treatment.

My patient saved up enough to fill one month of her prescription, but she started to take the medication every few days. Now she had the bloody diarrhea only three to four times per day, but didn't tell me or her gastro-intestinal specialist. She didn't understand that cutting her dosage put her at increased risk of colon cancer, and she now needed a blood *and* iron transfusion because of her profound chronic blood loss. As a result, she had to be hospitalized, even though all of it could have been prevented if she were able to stay on her medications.

So how do we address these issues?

There are several prescription drug policy changes proposed by Senator Kelly that could improve the lives of my patients. For example, allowing the federal government to negotiate prices for some high-cost drugs covered under Medicare Part B and D. This alone could achieve nearly \$79 billion dollars in Medicare savings over 10 years and help reduce the cost of medications for people with complex conditions like those I previously cited.

Another policy that could have a profound impact on our seniors' lives is the cap on out-of-pocket spending for Medicare Part D enrollees and other Part D benefit design changes. This redesign would continue with the initial deductible, but once you are in initial coverage, you only have to pay a 23% share of the medication costs with a maximum out-of-pocket cost of \$2,000. When you enter into catastrophic coverage, the patient would no longer have a share of the costs. This is a much more reasonable solution to the coverage gap and high-costs that seniors currently face. It could have allowed the patient I referenced to stay on her treatment while avoiding the transfusions and hospitalization.

Something that would be extremely helpful to the millions of seniors with diabetes, including patients I have personally cared for, is the proposal to limit insulin copays for people with Medicare and other commercial insurance at \$35. Significantly bringing

down the cost of insulin and would allow families to plan and obtain life sustaining treatment.

Eliminating cost sharing for adult vaccines covered under Part D requiring adult vaccines recommended by the Advisory Committee on Immunization Practices, or ACIP, be covered at no cost, aligns well with this topic of making medication affordable to prevent complications in the future. It also aligns with other Affordable Care Act provisions like preventative screening being covered if recommended with sufficient level of evidence by the U.S. Preventive Services Task Force.

Additionally, requiring drug companies to pay rebates when they prices increase faster than the rate of inflation aligns with a provision that is already built into Medicaid and has resulted in savings in that program. So it is logical to duplicate the process when it is already in place and effective in another federal program.

I close today with this thought: I believe we have a duty to care for our nation's seniors, especially those who cannot care for themselves. Our seniors are not only our parents and grandparents, the people who nurtured and raised us, they are the reason we are all here today. And, we should remind ourselves, we will be in their position later on. You don't need a physician to tell you that none of us escapes the aging process, and as such we may soon find ourselves facing the very difficulties I've described today. In that sense, our duty to society and our seniors is also a duty to ourselves.

I thank the Special Committee for allowing me to speak today, and I'm willing to take any questions.