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Good afternoon, Mr. Chairman and Members of the Committee:

My name is Margaret Woerner. I am a Medicare beneficiary and have been a helpline volunteer for the past eight years at the Medicare Rights Center in New York City. The Medicare Rights Center is a national, non-profit organization that works to ensure access to affordable health care for older adults and people with disabilities. As a volunteer, I provide information and counseling to Medicare Part D beneficiaries and their families on a variety of issues. This work is deeply gratifying because I can help solve very real problems. I have seen the positive impact that access to prescription drug coverage under the Part D benefit has had for so many older adults and people with disabilities. Yet, while these benefits are undeniable, many barriers to accessing needed medications still exist. I believe that the Part D benefit can be made even stronger by addressing issues like improving the appeals process and simplifying Part D plans. Improvements like these can help many more access the care we earned.

On a regular basis, I speak to countless beneficiaries who go to the pharmacy to fill a prescription only to find that their Part D plan is refusing to cover the medication. When this happens, most beneficiaries leave the pharmacy empty-handed and without answers. Upon calling the plan, beneficiaries are given any number of reasons for the denial. For example, the plan wants them to try a less expensive alternative first; the drug is not on the plan's formulary; or the drug is being taken for an off-label indication. Other reasons for restricted access to the medication may include quantity limits or requirements for prior authorization. Yet, before a beneficiary can even begin to appeal to have the drug covered, I counsel that she must first

request a coverage determination from her plan and include a letter of support from her doctor. Many of the people I speak to have not received instructions from their plan on how to do this.

Callers often express frustration at the need to jump through so many hoops. Because of these hoops, some will try to pay for the prescriptions out-of-pocket, and others will simply go without their prescribed medication because they cannot afford it. I helped a 75 year-old woman living in Florida because she received a denial notice from her Part D plan stating that they would not authorize a drug for her rheumatoid arthritis unless they received additional medical information. When she had previously been living in Ohio, the same plan covered the same medication, so she was confused and upset as to why they would not fill the doctor's prescription this time. She left the pharmacy without her medicine and it took four weeks for her to fill the prescription. In the meantime, she had to muster through the pain and inflammation caused by her arthritis.

The large number of plans available and the frequent plan changes from year-to-year make it nearly impossible for many of our callers to make the right decision about enrolling in a new Part D plan or keeping their existing Part D plan. I have found that, depending on the year, my out-of-pocket costs for the same coverage and the same medications will vary greatly. I used to help my friends each year, but many no longer ask me for help because they are overwhelmed by the choices they must make. Not only do beneficiaries have to choose from *too* many plans, they have to weigh *too* many variables to make the best choice. Against my advice, many of my friends and my callers simply keep their old plan even if it is not in their own best interest.

I speak to many beneficiaries who attempt to understand their coverage prior to enrollment, only to find out after enrolling that their medication is subject to numerous restrictions or that their costs are much higher than they can afford. To get the most out of your coverage, you must know the differences between preferred brand name drugs vs. non-preferred brand name drugs vs. preferred generic drugs vs. non-preferred generic drugs vs. specialty drugs; you must know how to obtain your drugs from preferred in-network pharmacies vs. non-preferred in-network pharmacies vs. mail order pharmacies; and you must know whether your drugs are subject to any restrictions.

I spoke to one caller, a 66 year-old woman from Maryland, who was denied a request to lower the cost of an MS (Multiple Sclerosis) drug because it was classified in a specialty tier. She was forced to choose between paying more out of pocket for the medication or covering her other expenses. She lives on \$1,800 a month in Social Security benefits, which is too high for federal assistance from Part D's Extra Help program. She is not alone. Many of my callers need extremely expensive drugs, forcing them to make difficult decisions. Many beneficiaries have to split their pills despite their doctor's prescription, choose between purchasing food and purchasing medication, or stop taking their medications completely.

Part D has done many good things for older adults and people with disabilities, but there is much more that can be done to improve the program. Thank you for the opportunity to testify about my experience helping people with Medicare Part D.