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PUBLIC HEARING ON HR. 3200: AMERICA'S AFFORDABLE HEALTH CHOICES ACT OF 2009 AND ITS IMPACT ON SENIOR CITIZENS

SENATOR RUBEN DIAZ, SR
CHAIR, COMMITTEE ON AGING
SEPTEMBER 8, 2009

CSCS is the central organization in NYC with over 200 member agencies providing a broad array of community-based services for 300,000 older New Yorkers including: multi-service senior centers, nutrition, case management, home care, health and wellness programs, adult day services, NORCs, transportation, elder abuse services, intergenerational programs, housing, mental health services, bill paying, ESL and services for immigrants, cultural and educational events, voluntarism and other services.

It is widely recognized by Americans across the country that our health care system is broken. Millions have no health care coverage with 14,000 people a day losing their coverage. Millions more have inadequate coverage and find themselves fighting with their insurer at a time they should be concerned about getting proper treatment and healing. Thousands of Americans file for bankruptcy due to inability to pay their medical bills. As a candidate, President Barack Obama made health care reform a priority so it is no surprise that he has made it a top priority in his administration. Americans voted him in as President and gave Democrats a majority in both houses of Congress – they want meaningful action on health care reform.

Some say it isn't the right time. However, we've heard it isn't the right time since 1935 when President Franklin D. Roosevelt tried to include universal health care as part of Social Security. It wasn't the right time until 1965 when President Lyndon Johnson got Medicare and Medicaid passed. It wasn't the right time in the early 1990's when President Bill Clinton and Hillary Clinton tried to get health care reform through Congress. Here we are in 2009 and we are still hearing it's not the right time for health care reform. If you have ever had a problem with the American health care system or know people who have, you know that not only is it the right time now – but we are way overdue for dramatic changes. Shameful and life threatening stories abound as we all know well.

Medicare, as one of the most successful public programs ever initiated in this country, is largely responsible for increasing both the quality of life and longevity of Americans. It is a very popular government-run single-payer program.

The “debate” on health care reform is really about reforming health insurance. A single payer system, a “Medicare for all” has not even found a place at the legislative table in Congress or the White House. Already, this is a substantial compromise on the part of many Congressmembers and Americans.

Instead of a thoughtful, meaningful debate on health care reform, we are subjected to radical, false claims about what HR3200 would do to senior citizens. Phrases like “death panels” and “pull the plug on grandma” have become part of our daily lexicon when talking about health care reform. The latest targets of scare tactics have been veterans and women with breast cancer – claims being made these groups would not get proper care. These claims are intended to scare people into opposing health care reform and, unfortunately, they have an impact. But leadership is about not accepting these scare tactics and standing up against those who foster them, not pandering to them as too many elected officials are doing at town hall meetings and other forums across the country.

After reading Section 1233, “Advance Care Planning Consultation”, in HR3200, it is evident that the idea of “death panels” is totally ungrounded:

- Section (5) “actionable medical order relating to the treatment of that individual that”…section (5)(A)(ii), “effectively communicates the ***individual’s preferences regarding life sustaining treatment*** (emphasis added)***,*** including an indication of the treatment and care desired by the individual;”.
- Section (5)(B) states, “The level of treatment indicated under (A)(ii***) may range from an indication for full treatment to an indication to limit some or all specified interventions.*** (emphasis added)This section goes on to delineate a variety of interventions a person may choose “among other items”.
- Section (5) goes on to state, “…the Secretary shall ***include quality measures on end of life care and advanced care planning that have been adopted or endorsed by a consensus-based organization, if appropriate.***” (emphasis added) So, no one person is making any determinations of appropriate end of life care.

I have a living will and health care proxy. So does my 91 year old mother and other members of my family and friends. It is progress to have Medicare cover the cost of individuals developing their end of life plan with a health care professional and was originally inserted as part of the Medicare Part D legislation passed in 2006 under President George Bush. No one objected to this then and some now objecting voted for this as part of the Medicare Part D legislation without a problem. So, why are the voices so loud opposed to this now? Rather than a “death panel”, this should be called “end of life dignity”. For politics not to

rise above the seriousness of the issue of advance care planning is shameful and damaging to the lives of millions of Americans and their family caregivers at the most sensitive time of their lives.

We all want to be in control of our decisions for as long as possible. We also know that at some point we may have to leave those decisions to those we trust. In the middle of a serious or terminal illness is not the time to put the family through this difficult process. Again, the voice of the individual whose life this is should be heard above all in advance of a crisis situation.

According to the Medicare Rights Center, HR3200 strengthens Medicare:

- Adds five years of funding to Medicare's Hospital Insurance Trust Fund, which is now projected to run short of money by 2017. It strengthens Medicare's finances primarily by reducing annual increases to hospitals, nursing homes and home health agencies. It also brings subsidies to Medicare private plans in lines with costs under the original Medicare.
- The government will not come between you and your doctor to make health care decisions and nothing in HR3200 rations care or prevents Medicare from treatment for a terminal illness.
- HR3200 eliminates copays and deductibles for preventive services. It allows low income people to receive financial assistance for their medical and drug costs and to still keep some personal savings.
- The bill will reduce the number of individuals who return to the hospital because they were not provided with an appropriate discharge care plan. The bill makes hospitals financially responsible for ensuring Medicare recipients receive proper care after discharge.
- HR3200 increases Medicare payments for consultations with primary care physicians and specialists as well as providing bonuses to primary care doctors. The bill funds over $200 billion in Medicare payments to doctors as well as other benefits.

Additional Medicare benefits in health care reform package:

- Eliminates the Part D "donut hole" over 15 years starting with a $500 reduction in 2011. The additional cost will be paid for by negotiating prices (rebates) with pharmaceutical manufacturers. This is an issue Senator Diaz has worked on on a state level.
- Permits Part D enrollees to make a mid-year change if their coverage is reduced or cost sharing is increased for a drug.
- Establishes new penalties for false or misleading marketing by Part D plans.
- Increases the asset limit for low income older adults for Medicare Part D and Medicare Savings programs to $17,000 for individuals and $34,000 for couples, effective January 1, 2012 and indexes the asset limit to inflation. This is a significant increase in the asset level. Also extends the Qualified Individuals (Q1) program that provides Part B premium assistance to low income Medicare beneficiaries.

- Allows individuals to self-certify income and assets (with administrative verification) when applying for the Low Income Subsidy (LIS) under Part D as of 2010. The complexity of the application process has been a major barrier to enrollment for low income seniors.
- Requires drug companies to provide rebates for dual eligibles enrolled in Part D plans.
- Eliminates a 21% cut in physician fees planned for 2011, and provides increased reimbursements for primary care, as stated previously. Overall, 72% of increased Medicare spending over the next ten years is for physician payments.

Need to discuss community-based longterm care –
CSCS' recently released policy paper, "No Time to Wait: The Case for Long Term Care Reform: Recommendations for Modernizing Long Term Care in New York", includes 31 major policy and programmatic recommendations to build a sustainable, consumer-friendly, community-based long term care system in NY. It is these issues that need substantive discussion and action to ensure that older New Yorkers can age in place in their homes and communities with dignity and the services they require. The full report is on the CSCS website – www.cscs-ny.org

***The CLASS Act (H.R.1721/S.697)* – Longterm care insurance coverage -**
According to the Elder Economic Security Standard Index, an initiative through Wider Opportunities for Women, the cost of home and community-based services range from **$7,322 per year to $41,871** per year depending on the level of care required. Seniors who cannot afford the home and community-based services they need must spend down their retirement savings to become eligible for public assistance, most often state and federal Medicaid dollars, to pay for the care they need. Enactment of the CLASS Act as part of health care reform is a top priority for national and local aging organizations.

Budget Neutral - In today's economic climate, spending concerns are a top priority. The CLASS Act offers a fiscally responsible approach that is both budget neutral and limits Medicaid spending.

Balanced - The CLASS Act works within the current health care system by sustaining the role of private health and long-term care insurance while creating a public long-term care insurance program. Lack of affordability to purchase longterm care insurance is a major barrier right now. As such, the CLASS Act is not designed to cover the full cost of long term care services. The bill acknowledges the role for private insurance and/or personal savings in covering the remainder of costs. Estimates show that services provided under the CLASS Act will cover one quarter to one half of the cost for home and community-based services. In sum, the bill balances the responsibility of the public and private sectors to ensure the health and economic well-being of our nation's seniors.

The status quo is not an option. We cannot let ourselves as government and community leaders, and as a nation, get distracted by purposefully misleading, scare tactics that will result in decades more of a health care system that is sorely broken, shameful and not cost-effective. The health care system will grow increasingly unsustainable in cost and its inability to provide health care for all Americans.

Older Americans also care about health coverage for their families. Those adults, who haven't quite reached Medicare age 65 yet, also often need affordable health care coverage. Both House and Senate proposals would reform the private health insurance market through changes such as:

- Prohibiting pre-existing conditions
- Requiring an annual out-of-pocket spending limit for individuals and families
- Preventing different premiums being charged based on gender, health status or occupation
- No annual lifetime limits on coverage

Websites providing independent, objective information about health care reform:

- www.kff.org - the Kaiser Family Foundation
- www.politifact.com – a project of the St. Petersburg Times to check the accuracy of certain political statements
- www.factcheck.org – a project of the Annenberg Public Policy Center

Wendell Potter, the former head of public relations with Cigna, one of the largest health insurance companies, is now a chief whistleblower speaking out on the abuses of health insurance providers. His interview with Bill Moyers is very revealing as to how the health insurance industry has worked to use less and less money to pay claims and keep the status quo in current efforts to reform health care: http://www.youtube.com/watch?v=Mv1FwOCNoZ8

Thank you for the opportunity to testify on this most pressing national problem – the need to enact meaningful health care reform.

Leadership Council of Aging Organizations

September 2, 2009

The Honorable George Miller, Chair
Committee on Education & Labor
2181 Rayburn House Office Building
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Charles B. Rangel, Chair
Committee on Ways and Means
1102 Longworth House Office Building
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Henry A. Waxman, Chair
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairmen Miller, Rangel and Waxman:

Thank you for your attention to the needs of older adults in H.R. 3200, America's Affordable Health Choices Act. This legislation makes major advances in our health system's capacity to provide high-quality care for all Americans. The undersigned members of the Leadership Council of Aging Organizations (LCAO) support those provisions of the bill that help seniors, but we urge you to consider some additional changes to ensure that quality health care is affordable for older Americans. The LCAO is a coalition of 60 national not-for-profit organizations concerned with the well-being of America's older adults, the fastest growing population segment of our country.

We strongly support and urge you to maintain provisions for:

- Elimination of the coverage gap in Medicare Part D;
- Mandatory Medicare Part D price rebates;
- Discounts of 50% for brand-name drugs for enrollees in the "doughnut hole," in the interim as the gap is closed;
- Requiring the Secretary of HHS to negotiate drug prices under Medicare Part D (Schakowsky amendment, Energy & Commerce Mark-Up);
- Establishment of a new asset test ($17,000 for individuals and $34,000 for couples indexed annually by CPI) for low-income individuals for eligibility determinations for the Part D Low-Income Subsidy (LIS) and the Medicare Savings Programs;
- Authorization of information sharing between the IRS and Social Security Administration to assist SSA in outreach to individuals who are eligible for the Part D LIS;
- Use of an enrollment process for subsidy-eligible individuals into Part D plans that takes into account the quality, cost and/or formulary of the plan;
- A temporary reinsurance program for retirees;

- Limitation of beneficiary cost-sharing amounts under Medicare Advantage plans to cost-sharing amounts under traditional Medicare;
- Reducing excess payments to Medicare Advantage private plans;
- Nursing home transparency requirements;
- Criminal background checks for direct care staff in long-term care facilities (Schakowsky amendment, Energy & Commerce Mark-Up);
- CLASS Act provisions (Pallone amendment, Energy & Commerce Mark-Up); and
- Independence at Home Medical Practice Pilot Program (Markey amendment, Energy & Commerce Mark-Up).

We encourage you to continue to consider the needs of older Americans as you amend and work to reconcile the reports of H.R. 3200 by the three committees, including in the following areas:

Medicare: Policy proposals that emerge from any new Medicare commission or council should be evaluated and approved by Congress under the rules that apply for most legislation. In addition, global spending targets and mandatory benefit cuts should not be employed to achieve program savings. Rather, efficiency and quality should be enhanced through careful delivery system reforms. Any payment innovations and cost containment efforts should be shared among all health purchasers, including Medicare and private health insurance plans participating in the Exchange. Policies to adjust provider payments should ensure that beneficiaries maintain access to quality health care and that providers' essential operations – such as recruiting, training, and retaining qualified staff – can be sustained. It is crucial that access to high quality care be maintained across outpatient, hospital, post-acute, and community settings.

Affordability: For many Americans over the age of 50, but not yet eligible for Medicare, the cost of health insurance is prohibitively high. We urge you to balance the different parts of the affordability equation in ways that address this barrier to appropriate and affordable health care. In particular, we ask that you pay special attention to the needs of those moderate-income people over 50 who may not qualify for Medicaid or subsidies, yet still cannot afford to pay substantial percentages of their incomes for premiums and out-of-pocket expenses. We urge you to eliminate provisions allowing age rating, to provide a stop loss benefit for all Americans, and to broaden eligibility for subsidies in order to ensure that health care reform truly provides comprehensive and affordable coverage for older Americans.

Low-Income Individuals: We applaud provisions in H.R. 3200 to raise the Medicaid income eligibility level to 133 percent of poverty for individuals under age 65. However, we urge you to include people over the age of 65 in this expansion in order to avoid the unintended consequence of low-income individuals experiencing greatly-increased health care costs when they become eligible for Medicare. Alternatively, these individuals could be assisted by raising the income eligibility level for the Qualified Medicare Beneficiary program to 133 percent of the federal poverty line.

Prevention and Wellness:
LCAO appreciates the breadth and depth of the prevention and wellness elements of the House draft bill. However, we have concerns about all of the nation's prevention and wellness funding being solely distributed through the Centers for Disease Control and Prevention (CDC). We urge you not to exclude or override existing programs already proven to be effective, such as

evidence-based health promotion and disease prevention programs led by the U.S. Administration on Aging (AoA) since 2003 and delivered locally through the Aging Services Network. In addition to CDC and AoA, there are additional Department of Health and Human Services (HHS) agencies doing effective work in the prevention and wellness arena (e.g., the Substance Abuse and Mental Health Services Administration, the Centers for Medicare and Medicaid Services, and the Agency for Healthcare Research and Quality). We urge you to ensure that the language on prevention and wellness programs gives authority to the Secretary of HHS to best determine which agencies should administer particular programs; respects existing, proven programs already at work in communities; encourages a role for groups representing the interests of targeted populations; and makes clear the role of AoA and the Aging Services Network in programming directed toward the age 60 and older population.

Improve Long-Term Supports and Services Provisions:
LCAO believes that any major health reform legislation must include strong provisions on long-term services and supports (LTSS). We simply cannot wait to address this area of health care, which is a major driver of costs and is of critical importance to Americans of all ages. Our current system forces people into institutions inappropriately, requires many to spend-down into poverty before receiving the help they need, fails to provide realistic opportunities for personal planning, and fails to support family caregivers adequately. For many Americans, private insurance plans for disability and long-term care are simply an unavailable or unaffordable option. True reform must include substantial reforms of how long-term services and supports are delivered – strengthening Medicaid home and community-based services, improving the financing and administration of effective programs, and establishing a new, voluntary national long-term care insurance program. LCAO supports several bills that should be included in your health reform legislation, including the CLASS Act (H.R. 1721, some provisions of which were included in the successful Pallone amendment to H.R. 3200), Empowered at Home (H.R. 2688), and *Project 2020*: Building on the Promise of Home and Community-Based Services (H.R. 2852).

Thank you again for your work to bring affordable, quality health care to every American. Please do not hesitate to call on us for any additional information you may require as you continue movement toward a final package.

Sincerely,

AARP
AFSCME Retirees
Alliance for Retired Americans
American Association of Homes and Services for the Aging
American Federation of Teachers Program on Retirement and Retirees
American Society on Aging
Association for Gerontology and Human Development in Historically Black Colleges and Universities
Association of Jewish Aging Services of North America
B'Nai B'Rith International
Center for Medicare Advocacy
Easter Seals
The Gerontological Society of America

Gray Panthers
Lutheran Services in America
National Academy of Elder Law Attorneys
National Alliance for Caregiving
National Asian Pacific Center on Aging
National Association for Hispanic Elderly
National Association of Area Agencies on Aging
National Association of Foster Grandparent Program Directors
National Association of Professional Geriatric Care Managers
National Association of State Long-Term Care Ombudsman Programs
National Caucus and Center on Black Aged, Inc.
National Committee to Preserve Social Security and Medicare
National Council on Aging
National Hispanic Council on Aging
National Indian Council on Aging
National Senior Citizens Law Center
NCCNHR: The National Consumer Voice for Quality Long-Term Care
OWL - The Voice of Midlife and Older Women
Service Employees International Union
Volunteers of America
Wider Opportunities for Women (WOW)