Testimony

of

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before the

New York State Senate Committee on Aging
Senator Ruben Diaz, Sr., Chair

regarding

H.R. 3200:
"America's Affordable Health Choices Act of 2009" and Its Impact on Senior Citizens

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My name is Joe Baker and I am the President of the Medicare Rights Center. I would like to thank you Chairman Diaz and the other members of the New York State Senate Committee on Aging for calling this hearing to set forth the facts about the health reform proposals contained in H.R. 3200: "America's Affordable Health Choices Act" and its impact on senior citizens. There has been a considerable effort to misinform and scare senior citizens into opposing health care reform, and your efforts to provide accurate information and informed debate are to be commended.

The Medicare Rights Center is a national, independent, nonprofit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through individual counseling and advocacy, educational programs, and public policy initiatives. We provide services through six different hotlines to individuals, caregivers, and professionals who need answers to Medicare questions or help securing coverage and getting the health care they need. Our work with people with Medicare gives us a unique perspective on the current health reform debate.

Congress has been working to bring affordable health insurance to all Americans. H.R. 3200, which is the product of three committees in the House of Representatives—the Education and Labor Committee; the Energy and Commerce Committee; and the Ways and Means Committee—provides a number of improvements to Medicare coverage for older adults and people with disabilities. While there is a lot of talk about so-called "cuts" to Medicare, the untold story of reform is the approximately $320 million that H.R. 3200 invests in Medicare.

There are three major ways in which this legislation will benefit people with Medicare. The legislation works to make prescription drugs more affordable, improves access to primary and preventive care and broadens access to benefits for people with Medicare who have low incomes.

First, the bill includes a gradual narrowing and eventual elimination of the "doughnut hole" or coverage gap in Part D prescription drug coverage. Narrowing this gap will begin in 2011. In addition, people who are in the doughnut hole will benefit from a new mandatory 50 percent discount on brand-name drugs required by the bill.

This provision will remove one of the concerns we hear most frequently through our work with people with Medicare—the high cost of prescription drugs during the Part D doughnut hole. Currently, over 3.4 million people with Medicare hit this Part D coverage gap each year and must pay the full price for their medicines. We frequently receive calls on our consumer hotlines from individuals who must skip doses, split their pills, or forgo medications altogether because of the high out-of-pocket costs of prescription drugs when they are in the doughnut hole.

Secondly, the bill makes a considerable investment in primary and preventive care, exactly the type of care that seniors and people with disabilities with Medicare need to be active members of their communities. People with Medicare will benefit from provisions that will remove obstacles, such as high out-of-pocket payments, that prevent them from accessing wellness and prevention services covered by Medicare.

The bill waives deductibles and cost-sharing for preventive benefits. For instance, Medicare currently covers 80 percent of the cost of a hepatitis B vaccine after the deductible is met, and the patient is responsible for the remaining 20 percent. HR 3200 would have Medicare cover the full cost, with no deductible. In fact, this bill helps to ensure that people with Medicare are able to get all necessary and federally recommended vaccines, including the relatively new shingles vaccine, by having Medicare Part B pay for them in full. Other preventive care, such as glaucoma screening and diabetes self-management training, would also be covered in full.

H.R. 3200 will also increase reimbursements to doctors who provide primary care, thereby offering them incentives to enter this practice area. The bill also provides incentives to those doctors or groups of doctors who provide a “medical home” to patients wherein they coordinate the care that those patients receive from a variety of providers. According to a 2006 MedPAC report, the average person with Medicare sees five doctors. However, there is no incentive in the current Medicare system for doctors or other care providers to talk with each other. We must often facilitate these conversations through our casework, or our clients must do so for themselves, which can be difficult, especially in times of acute illness. H.R. 3200 provides incentives to facilitate communication among a patient’s multiple caregivers.

Furthermore, the bill provides funding for comparative effectiveness research, which will help health care providers know which treatments are the most appropriate and successful for different conditions. An amendment to the bill addresses the concerns of those opposed to comparative effectiveness research; it specifically prohibits the government from denying care based on this research and prevents CMS from using research to deny coverage based on cost.

Finally, H.R. 3200 expands access to programs that help people with Medicare who have low incomes. Much of our organization’s work focuses on low-income people with Medicare. Currently, eligibility for assistance with drug costs through the low-income subsidy (LIS) and assistance with Part A and B cost-sharing and premiums through Medicare Savings Programs (MSP) is restricted by an asset test that penalizes low-income beneficiaries who have saved for their retirement. H.R. 3200 raises the asset threshold for both programs to $17,000 for an individual and $34,000 for a couple, allowing low-income beneficiaries to maintain very modest nest eggs for their retirement. Due to your leadership, Senator Diaz, along with that of Governor Paterson and your fellow legislators, New York has gone a step further and eliminated the asset test entirely—opening this program to even more low-income seniors who are very much in need of this assistance.

Let me briefly address the issue of the so-called “cuts” that many opponents of the bill mention in trying to drum up opposition to it. These “cuts” are actually savings that providers like hospitals have already agreed can be made in order to trim Medicare’s budget and contribute to health care reform without affecting access to care for people with Medicare. To the extent that some providers disagree about the level of these savings, that is a legitimate debate that we can have, but all agree that they can contribute something. Secondly, and perhaps most importantly, there are no cuts to the actual benefits that seniors and people with disabilities with Medicare will actually receive, nor are there increased costs imposed upon them by this bill.

As you know, there is one specific section of HR 3200, Section 1233, the Advance Care Consultation provision, about which there has been a great deal of discussion, much of it misinformed or misleading. As an organization that is dedicated to helping older Americans and people with disabilities access comprehensive health care, it is troubling that a part of reform that will actually expand access to health care services for people with Medicare may be eliminated from the final bill because opponents have distorted its meaning in order to create fear among the public.

To be clear, the provision provides Medicare coverage for optional patient counseling concerning end-of-life care once every five years, or, if desired by the patient, more frequently, based on his or her changing health status. The benefit is completely voluntary, and any claims otherwise are false. The provision provides Medicare beneficiaries with access to a new, elective service—education and counseling—that is not currently available to them under the Medicare system.

Patients who wish to receive counseling would not be required to sign either an advance directive or an order for life-sustaining treatment. Orders for life-sustaining treatment will always be honored, and patients who wish to create these documents are given counsel and assistance in doing so. The legislation ensures that patients' preferences—whether it is to end treatment or to continue receiving life-sustaining treatment, regardless of the circumstances—are respected and known to their caregivers. This provision does not change the current standard of care, which is to provide life-sustaining treatment unless the patient or the patient's duly appointed representative has indicated otherwise.

In addition, payments to doctors are not based on the outcome of counseling. A doctor merely provides information—patients alone make decisions regarding life-sustaining treatments and the specific situations in which different options are to be pursued. That is perhaps the most important part of this program: educating people with Medicare about the treatment options available to them, while they are still able to make these assessments for themselves.

Health crises have a great and emotional impact on individuals and families; providing counseling will better prepare people with Medicare and their families for these crises and will help ensure that Medicare beneficiaries' individual choices are respected. Oftentimes, these conversations happen too late, if at all, leaving patients and their families few choices and little time to make informed decisions about their own and their loved ones' care. This provision recognizes the autonomy of people with Medicare, and allows them to control choices about the care they wish or do not wish to receive.

Too often, the debate concerning this provision focuses on a narrow, limited subject—whether someone desires life-sustaining treatment or not. But that debate misses a significant and important aspect of Section 1233. The provision adresses not only advance directives and the like, but also provides funding for counseling on the availability of care options such as palliative care and hospice, services paid for by Medicare that are underutilized, and also provides support for conversations about the settings in which patients would most like to receive care.

HR 3200 is not the first bill to include a provision that proposes to allow Medicare beneficiaries access to counseling on end-of-life care, or allowed for the use of orders for life-sustaining treatment. Many states have enacted or are developing similar initiatives at a local or statewide level, including New York.

When state law allows, as New York State law has for over 15 years, conversations covered by Section 1233 could include information about designating proxies or surrogates—someone such as a spouse or adult child, who the patient trusts to make decisions if he or she is unable to do so in a medical emergency. This is the furthest thing from giving the government control over your care.

And in 2008, Governor David Paterson signed into law a statewide expansion of a pilot program established in 2005 under Governor George Pataki, which allowed Medical Orders for Life Sustaining Treatment (MOLST) to be used instead of ‘do not resuscitate’ orders. The New York State Department of Health website states, “Honoring patient preferences is a critical element in providing quality end-of-life care. To enable physicians and other health care providers to discuss and convey a patient's wishes regarding cardiopulmonary resuscitation (CPR) and life-sustaining treatment, the Department of Health has approved a physician order form, the Medical Orders for Life Sustaining Treatment (MOLST).”

In recent years, federal Medicare policy focused on the virtues of providing choice to beneficiaries and allowing people with Medicare to take control of their own care. This is the purpose of the Advance Care Consultation language. The provision attempts to preserve the independence of the doctor-patient relationship by allowing an individualized, thoughtful conversation among doctors, patients and patients’ families about treatment options in the most difficult times of people’s lives.

Many have sought to instill fear by arguing that Section 1233 puts us on a slippery slope that will lead to rationing of care or euthanasia. The same arguments were used against the legalization of health care proxies and other advance directives over the past decades, and yet we have not seen these disaster scenarios become reality.

In conclusion, HR 3200 contains many provisions that would benefit people with Medicare. The bill is long, it is technical, and it is nuanced, but this is an absolute necessity as we are dealing with issues that seriously impact people’s lives. And that is why getting the facts right is so important. Without accurate information we cannot have an honest debate. Playing on the fears of Medicare beneficiaries is inappropriate and disrespectful to the people we serve. Encouraging the dissemination of the correct information not only encourages meaningful debate, but also will lead to better benefits and health care for those most in need. Thank you for holding this hearing so that we can the facts out all work together to better the lives of those with Medicare.