STATE WIDE

New York StateWide Senior Action Council, Inc

Improving The Lives of Senior Citizens & Families in NY State

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TESTIMONY OF

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Before the Joint Hearing of the
NYS Assembly Committee on Health
and the
NYS Senate Committee on Health

" The New York Health Act"

Albany, NY
Tuesday, May 29, 2019

My name is Gail Myers and I am the Deputy Director of New York StateWide Senior Action Council ("StateWide.") We are a grassroots organization with chapters throughout the state. In addition to the input of our members, we learn about problems in the aging and health care delivery systems from the two helplines that we operate through contracts from the NYS Office for the Aging as a result of state budget appropriations, the **Managed Care Consumer Assistance Program** (MCCAP) and our **Patients' Rights Hotline and Advocacy Project.** These cases inform us on how the aging and healthcare systems' policies and practices are affecting residents; we then can inform policymakers to see if system corrections can be made.

Before I dive into the topic at hand today, I would be remiss if I didn't share our appreciation for your continued support for funding in SFY 2019-20.

However, I urge you take policy steps, through adoption of the New York Health Act, to make it no longer necessary for the state to spend general fund resources each year to help residents navigate the health care insurance system. Throughout the state, Medicare eligibles and enrollees call upon MCCAP providers and our colleagues in the Health Insurance Information Counseling and Assistance Program (HIICAP) system to assist with the myriad of choices, benefits and costs related to Medicare enrollment. Why – because our current system of insurance coverage is fragmented, hard to understand, and difficult to navigate.

New Yorkers insured under Medicaid or private insurance also seek navigation assistance from state funded programs that would no longer be needed once our health insurance system is simplified for both patients and providers, through the single payer – womb to tomb coverage proposed in the New York Health Act.

Here is a sampling of the questions we assist with, all representing problems with the current Medicare benefits that will be eradicated with the New York Health Act, or as we call it – Improved Medicare for All:

ENROLLMENT ISSUES:

- *Do I qualify for Medicare.*
- *Can I afford to stay with original Medicare parts A & B.*
- *How do I make an enrollment choice that will protect myself from out of pocket costs for deductibles, co-pays and coverage gaps.*
- *There are too many insurance choices – it's too hard to pick what's best annually, so I'll just stay with what I've had for years, even though it no longer may be the best option.*
- *I was receiving health care benefits on the state's exchange through expanded Medicaid until I turned 65 and was no longer eligible. I didn't think I could afford the Part B premium, so I didn't enroll and have no insurance.*

OUT OF POCKET COSTS:

- *How much will my annual Medicare deductibles be.*
- *All these years and I never knew that the EPIC program expanded income eligibility and I could have enrolled and benefited from reduced co-pays between $3 and $20.*
- *Which Medicare Supplemental Plan will best protect me from out of pocket costs.*
- *I am under 65 and enrolled in Medicare due to disability – why won't EPIC help me with out of pocket Part D costs.*

- *After a job loss, I purchased COBRA to continue my coverage. I didn't know that after age 65 I would be charged a late penalty for continuing COBRA instead of enrolling in Medicare. A monthly penalty for the rest of my life!*
- *I chose a Medicare Advantage Plan (Part C) to minimize my out of pocket costs, and now I find my doctors are no longer in network.*
- *I am a dual eligible because I pay a spend down each month to qualify for Medicaid – but I didn't realize that a payment was missed and I was thrown off Medicaid Long Term Care. Now I have lost my home care aide and have to start all over to reapply.*
- *My Medicaid benefit is in jeopardy every month if my spend down payment gets delayed in the mail. I have to make my medical appointments at the end of every month just to make sure they are covered.*
- *I am a legal immigrant and have qualified for Medicare eligibility, but my enrollment in the Medicare Savings Plan keeps getting denied.*

Providing assurance at the state level that Medicare enrollees will be protected from out of pocket costs is particularly important at this time when the White House is proposing to change the way poverty is calculated. The U.S. Office of Management and Budget has proposed an inflationary measure change using an alternative index, such as the chained Consumer Price Index (CPI) or the Personal Consumption Expenditures Price Index (PCEPI). Both measures rise more slowly than the current measure, the CPI for All Urban Consumers (CPI-U) and would result in a lower poverty line, and the gap between the poverty line under the current versus either of the proposed methodologies would widen each year. Seniors and people with

disabilities would lose their eligibility for, or receive less help from, Medicare's Part D Low-Income Subsidy Program(Extra Help) , meaning that they would pay higher premiums for drug coverage and more out of pocket for their prescription drugs. Additionally, seniors and people with disabilities would lose help paying for Medicare premiums, meaning that they would have to pay premiums of over $1,500 per year to maintain Medicare physician coverage.

Medicare's Extra Help and Medicare Savings Programs are subsidies for low income residents to help enrollees save money on premiums and out of pocket costs, if you qualify based on income – and if you hear about these benefits. Under the New York Health Act, if the federal government refuses to grant a waiver to allow Medicare enrollees to enroll in NY Health, the state could expand these programs to be ~~sauniversal benefit for all Medicare enrollees to eliminate cost sharing.~~

Currently, if you qualify for the Medicare Savings Programs (QMB program, SLMB, or QI program,) you automatically qualify to get Extra Help paying for Medicare prescription drug coverage, and in New York State that means with no asset test. In 2019, costs are no more than $3.40 for each generic/$8.50 for each brand-name covered drug. Other people pay only a portion of their Medicare drug plan premiums and deductibles based on their income level. In 2019, you may qualify if you have up to $18,735 in yearly income ($25,365 for a married couple)

Current Medicare Savings Program income limits:

	2019 New York gross monthly income limits		2019 New York asset limits	
Program	Individuals	Couples	Individuals	Couples
QI	$1,426	$1,923	No limit	No limit
SLMB	$1,269	$1,711	No limit	No limit
QMB	$1,061	$1,430	No limit	No limit
Medicaid	$879	$1,287	$15,450	$22,800

These income limits are based on the 2019 federal poverty level (FPL), and include a standard $20 disregard. You may qualify even if your income is slightly higher. Ask a Medicaid counselor about whether you can subtract certain expenses from your income.

PROBLEMS ACCESSING COVERED BENEFITS:

- *My hospital charged my stay to Part B – outpatient services – rather than admitting me under Part A, and now my inpatient rehabilitation benefit is not covered by Medicare.*
- *Why is it that when I call to schedule an appointment with a new doctor the first question is what is my insurance – not what is my medical need.*
- *I am so confused – why are covered immunizations in different parts of my Medicare benefit, and why do I need to pay for some out of pocket to be reimbursed later while others can be administered by my doctor's office without me paying?*
- *My Medicare Part D plan no longer covers my prescription drug, what can I do?*

NEED FOR EXPANDED BENEFITS:

- *Why don't Medicare Supplements cover things that Medicare does not cover.*
- *I can't find dental insurance that is affordable and covers enough of the services that I need.*
- *Medicare covers medical issues of the eyes, but not my everyday need to have glasses to see, to function, to live.*
- *I can't afford quality hearing aids and am feeling lonely and isolated because I am embarrassed to let people know that I can't hear.*
- *After a hospital stay, I was discharged home without any community-based care coordination. A care coordinator would have made a big difference in my recovery.*
- *I thought Medicare would cover my long-term care needs, and now that I need help, I learned that my only option is to go broke paying for my care and become dependent on my grown children.*

And there are stories from our members about how our current "non-health system" is failing residents.

- At the end of his life, my bed-ridden husband was receiving palliative care at our home in town, but faced extreme barriers to living with dignity because we had no first floor bedroom or bathing facilities. But when I helped him fulfill his wish to spend time at our upstate lake home where there was appropriate first floor accommodations, he was denied continued palliative care because we were away from home and out of network.
- As a service coordinator in two HUD Senior Independent Living properties, I see many residents fall through the cracks because of income, just a little too much income to be eligible for Medicaid. I am concerned about the number of residents that are sent home from a hospital with nothing more than medical services in place, with no attention given to activities of daily living and their community based long term care needs. As a result, residents have returned to the hospital in less than 30 days with the same diagnosis.
- Most residents in my HUD subsidized building need to apply for MSP, Extra Help and EPIC to achieve reduced out of pocket costs. Even with all three state and federal programs there are still co-pays that would be eliminated under the New York Health Act.

- The co-payments for physical therapy are prohibitive and many patients discontinue prescribed treatment because of the cost of two to three visits a week over many weeks, each with a co-payment.
- There are some programs available through non-profit organizations to fill gaps. Most seniors are not aware of these various programs or how to apply for them. Often it's a long process and many simply give up. A few have taken out loans, a difficult situation with a low income. Most just go without dentures or hearing aids.
- Most residents in Independent Living find it nearly impossible to get transferred to a nursing home that accepts Medicaid, and too few assisted living facilities are available.

With my client caseload, only dementia patients that were sent to a hospital because they were injured got a proper placement and then only when the family refused to allow the patient to return home.

- A resident with diabetes was sent home from the hospital more than once with swollen legs that leaked fluid when he walked. He could only wear slippers because his feet were so swollen. He was scheduled for services when he returned home, but they were cancelled because he had forgotten to pay his Medicaid spenddown. He was so confused at this point he was unable to remember details like paying bills. He died in the hospital after several return visits.

In reality, no one can predict what their health care needs will be from year to year – there is no crystal ball to be able to know how to keep costs lowest and services broadest. Any one of us

could be moments away from a catastrophic event that could be accompanied by financial distress and bankruptcy due to out of pocket costs. That's why New York StateWide Senior Action Council has supported the passage of the New York Health Act every year since its original introduction. In fact, we were part of a small group of advocates who met with Mr. Gottfried to ask for his consideration of a better way to provide coverage, improve outcomes, ensure quality, address health care planning, and reduce costs. We were delighted in the '90s that he agreed to introduce the solution – the New York Health Act, and we are joined by hundreds of other groups, thousands of advocates with personal stories and public opinion polling that all support getting it enacted before he is in his 90s! Thank you, Senator Rivera, for taking the lead in the Senate.

We support enactment of this legislation for all New Yorkers; it is the right thing to do to guarantee quality health care. We support it for all ages – and we specialize in educating older residents on how it will be a needed improvement over their current coverage as follows:

Affordability – Elimination of the commercial insurer will yield savings to be reinvested in care delivery. The Act is designed to be affordable, with a progressive tax, that will - for the majority or New Yorkers - be less than their current out of pocket obligations that yield less coverage. For those out of the workforce with income under $25,000 – a large percent of the older population – there would be no cost to participate. The progressive tax to support the New York Health Act would apply to those with incomes over $25,000. Medicare enrollees will have no deductibles, premiums or out of pocket costs and therefore no need for a supplemental coverage plan. They will save hundreds of dollars every month.

A May 20th ABC News report compiled the latest projections on costs retirees should anticipate for health care.

- Fidelity Investments expects a couple retiring in 2019 at age 65 will need $285,000 for health expenses, not including nursing home or other long-term care.
- The Employee Benefits Research Institute predicts some couples could need up to $400,000, without including long-term care.
- In 2010, the Center for Retirement Research at Boston College estimated a typical couple could spend $260,000 for medical and long-term care, with a 5% risk that costs will exceed $570,000.

- Vanguard Center for Investor Research estimates that $5,200 is the median amount a typical 65-year-old woman with only medium risk for health care costs could expect to spend annually for premiums and out-of-pocket medical, dental and vision costs in 2018.
- Data analyzed by the Centers for Medicare and Medicaid Services found that per person personal health care spending for the 65 and older population was $19,098 in 2014. [Source: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html]

Medicare premiums and deductibles are not set for one's lifetime, and the costs may go up annually – sometimes the premium increases are offset by a cost of living adjustment in Social Security.
The standard monthly premium for Medicare Part B (medical and outpatient services) is $135.50 for 2019. The annual deductible for all Medicare Part B beneficiaries is $185 in 2019.

Medicare Part A covers inpatient hospital, skilled nursing facility, and some home health care services. About 99 percent of Medicare beneficiaries do not have a Part A premium since they have at least 40 quarters of Medicare-covered employment.

The Medicare Part A inpatient hospital deductible that beneficiaries will pay when admitted to the hospital is $1,364 in 2019. The Part A inpatient hospital deductible covers beneficiaries' share of costs for the first 60 days of Medicare-covered inpatient hospital care in a benefit period. In 2019, beneficiaries must pay a coinsurance amount of $341 per day for the 61st through 90th day of a hospitalization in a benefit period and $682 per day for lifetime reserve days. For beneficiaries in skilled nursing facilities, the daily coinsurance for days 21 through 100 of extended care services in a benefit period is $170.50.

Enrollees age 65 and over who have fewer than 40 quarters of coverage and certain persons with disabilities pay a monthly premium in order to voluntarily enroll in Medicare Part A. Individuals who had at least 30 quarters of coverage or were married to someone with at least 30 quarters of coverage may buy into Part A at a reduced monthly premium rate, which is $240 in 2019. Certain uninsured aged individuals who have less than 30 quarters of coverage and certain individuals with disabilities who have exhausted other entitlements will pay the full premium, which is $437 a month in 2019.

Reducing Senior Poverty rates - StateWide has partnered with the National Council on Aging & the Gerontology Institute at UMass to publish the NYS Elder Economic Security Index (EESI). This Index calculates the average cost for a senior (65 +) to live in the community, measuring how much income is needed for an older adult to adequately meet his or her basic needs – without public or private assistance – based on an elder's housing and health statuses. Our NYS Elder Economic Index reflects that 59% of senior households are not making ends meet today. New York State elders rate 3rd in the nation for seniors who are living above the FPL, but below the EESI – or "in the gap". Seniors living in the gap are not considered poor by government standards, but do not have the resources to meet the average standard of living according to our Index. Th

study also shows that older adults living below the EESI rely on Social Security for 90% or more of their income with 45.6% of singles and 43.7% of couples in NYS falling under this category. The removal of out of pocket health care costs through enactment of the New York Health Act will go a long way to reducing the financial burden on senior households.

Predictability - there will be no more uncertainty about what is covered, no more delay of claims for covered services while insurers delay payments, denials for covered services, lengthy appeals processes and annual costs will be understood. One no longer would need to guess what coverage would best meet their next enrollment year's anticipated medical needs; the NY Health defined benefits will meet medical needs.

Improved benefits – Medicare does not cover long term care, a leading cause of bankruptcy and impoverishment in older households. Medicare does not cover hearing, vision or dental services other than a medical diagnosis or medical intervention. The New York Health Act will include all these benefits – because as the proposed federal bill to expand Medicare benefits known as the "Seniors Have Eyes, Ears and Teeth Act," would suggest, indeed seniors have eyes and ears and teeth, too. Without dental care, hearing aids and eyeglasses, quality of life and health are diminished.

Providers – medical, hospital, nursing home and home care providers will be in network, because there will be no closed network to worry about.

Health planning – regional boards will be responsible to ensure that local needs are being met. Issues such as the shortage of home care workers will be addressed locally, and when a

statewide systemic approach is needed, the regional board will provide advice and advocacy for solutions so that the system responds to the unmet needs of patients. We also face a shortage of primary care and medical specialists that are skilled in caring for older patients. Pain management and palliative care need to improve services to older patients, particularly to avoid ageism in medical care with an underlying expectation that the aging process results in reduced function and increased pain. We expect these issues will be addressed by regional health planning boards, something that was lost with the end of regional Health System Agencies.

Consumer Assistance – everyone would be assigned a personal navigator, not as a gatekeeper - but to ensure that services are being delivered and coordinated.

Thank you for your support for the New York Health Act and your consideration of our comments as you weigh the next steps to improve health care quality, access and affordabilty. NY StateWide Senior Action Council looks forward to the continued opportunity to collaborate with you on solutions that meet the needs of the state's aging population and the health coverage needs of people of all ages. I also thank you for the commitment to hold additional hearings throughout the state. I know you will be hearing directly from our membership who wish to tell their stories themselves. I would be pleased to address any questions you might have.