Members of the Committee,

After attending one of Sen. Wyden's Town Halls and expressing my concerns with what I had discovered upon being forced into the Medicare system at age 65, the Senator's representative requested that I provide input on the "Chronic Condition" memo which he sent me.

I must compliment the Committee both on trying to address this problem and on soliciting public input. I have little experience other than my own or that of friends and acquaintances with the health care system, and therefore can only relate anecdotal evidence. Also, it is difficult to assess the economic impact of specific proposed changes in the health care system; one can only hazard a guess really. But given those caveats, I will make what observations I can. My concerns which prompted the request were primarily with issues other than care for chronic conditions, although my objection to the forced limitations on coverage for skilled nursing facilities are certainly relevant thereto. But I will try to comment on the chronic care issue as requested, perhaps touching upon my other concerns in passing, since they did prompt the Senator's request.

Admittedly chronic disease is inevitable with age, in many cases. But my observation is that it is now epidemic, due to failure of prevention and I can cite several examples of why it can - again, by my observation - be prevented. I personally know a number of people, several of them as much as 10 years younger than myself, who have grown morbidly obese and all of whom now have diabetes. One of them has already had a foot amputation at age 55. Another of similar age now needs a walker to get around. This is just typical of what I see in people who refuse to simply diet and exercise to avoid becoming obese.

In contrast, I know a woman of similar age who is vigorously athletic, and who to everyone's complete amazement including her own, was diagnosed with breast cancer. Because of her otherwise healthy constitution she never missed a day of work even during chemotherapy, and stopped her 10 mile a day running only while recovering from reconstructive surgery (which I believe did cost her about a week of sick leave), and has now gone back to her rather amazing regimen of summer sports. Another acquaintance, a Marine who recently passed away at age 92, literally died with his boots on. He lived alone (having outlived three wives - and he was still looking for another one) and would have gone elk hunting the next month if he hadn't abruptly suffered a stroke - and this despite multiple back surgeries for injuries suffered first in the Pacific war and then in a motorcycle accident. The man's considerable backbone was literally bolted and screwed back together, but he simply refused to give up, where someone less determined would have ended up incapacitated decades ago.

The point is that at least by my observation, the requirement for care of chronic conditions is driven as much by the patient's determination to do whatever is required to avoid becoming vulnerable and incapacitated, as it is by unavoidable circumstances - and as a peripheral comment, I have to say that those such as the woman I mention above, who struggle with these illnesses while continuing to work for a living, have little or no sympathy for those others who simply give up. She in particular is infuriated with having to pay for the care of those who complain and demand support (and in many cases, disability payments) for lesser afflictions than hers - with which I can only agree wholeheartedly. (In the interest of propriety, I won't relate what my other friend, the lately departed Marine, thought about that whole situation.)

Again, it's difficult for me to quantitatively assess the economic impact of proposed strategies, but just by my observation the issue raised by item 7 on your list - motivating people to assume responsibility for their own health - may have a far greater impact on the number of people requiring (or merely demanding, as the case may be) supportive care for "chronic" conditions than is apparent on the surface. In any case, as always "an ounce of prevention is worth a pound of cure". I wish I could propose a solution to changing people's attitudes as far as that goes, but it seems clear that a well crafted "carrot and stick" approach is needed - and not mere counseling and cajoling with publications and handouts, but an effective one, with some real incentives and disincentives. Obesity, drug abuse, and any number of other such conditions are self-inflicted, and we should be penalizing rather than rewarding people for such behaviors - particularly when we are asking the innocent to pay for them! It completely mystifies me to see supportive care for self-inflicted conditions being touted as "social justice" - it seems to me it is a gross form of social injustice to make working people pay for care of people who refuse to care for themselves!

That said, there certainly are issues of real need - those who desperately need extended care and can't get it. I recently lost a friend of many years to fulminant liver failure. But the real cause of her death was the failure of the Medicare system - or anyone else, for that matter - to "coordinate" her care. The specialist who had been

treating her for Hepatitis C was not allowed to practice at the hospital where she was admitted. Then the hospital failed to retain her for emergency care, presumably as a "cost-cutting" measure, and sent her to a nursing home where her condition deteriorated irredeemably for several weeks due to incompetent medical care. She had no relatives in the area, and with basically no one of medical competence to "manage" her care she died miserably after a month of illness, having seen only a few months of retirement at age 65 after having worked her entire life. (I'm sure that would greatly please the likes of "Dr." Donald Berwick and "Dr." Ezekiel Emanuel, of course.)

I and any number of others would have moved heaven and earth to help her, but living in distant states and remaining ignorant of her situation during the critical period we were powerless to intervene (and may have been thus restrained in any case, due to the HIPAA regulations which restrict involvement to "family members", even when no such exist!). And that issue probably relates directly to item 5 on your list. Particularly in today's world where families are being progressively broken up and people have no one to rely on other than friends, it can be a matter of life and death to be able to communicate to a circle of friends - even, if not particularly, when one is incapacitated - when a medical emergency arises. The technology certainly exists to provide that capability, but the infrastructure for formalizing such a system does not, and it haunts me that this woman, an expert in computers and communications, died in isolation in such dismal circumstances.

Regarding item 6 on your list, my observations of the issue have involved availability of in-home care representatives, at whatever level of care. Sometimes people in need of assistance just can't find anyone locally who has been vetted or qualified by the "responsible" agencies. If we are going to require licensing of those allowed to provide in-home care, it will be additionally necessary to at least provide incentives for licensees to live in a rural area. There is some hope of accomplishing this, because employment opportunities are often few and far between in rural areas, and becoming an in-home care provider for those with medical or subsistence needs is one employment opportunity in such locations. But the licensing process can be difficult and complicated, especially where different health care agencies are involved, and the bookkeeping and recordkeeping requirements can be overwhelming for an individual provider.

It would also help if the children of aged parents in the rural areas where in-home care is difficult to obtain, were able to obtain some sort of tax credits or advantages for caring for family members with chronic conditions. As it is now even those rural residents who live near their parents and are employed during the day - particularly when both a husband and wife are working - may not be able to stay home to assist an aged parent or other family member in need. Providing some sort of incentive in the form of tax advantages to those family members willing and able to provide such care would at least help. I have personally seen children with aged parents end up putting them in a nursing home because while they lived right next door to them in a rural area, it was an "unsustainable" financial burden to give up their jobs to stay at home and care for them and in-home care was virtually nonexistent due to their remoteness.

Regarding item 1, there is certainly room for enhancement of the Medicare Advantage program to help with both prevention and maintenance for those with chronic conditions. For one thing, I wish I could purchase, even at more expense. long-term care insurance as part of the Medicare Advantage package, in anticipation of eventually needing care for a chronic condition. But as it is now, it seems that the long-term care insurance industry is headed for a crisis which may make such insurance either unaffordable or unavailable, and reduce coverage to insignificance. I would be happy to pay in advance for benefits which I do not use but might need later, with a penalty for not "signing up", as is the case with Medicare part D.

Additionally, in the current environment the insurance companies cannot economically sustain a Medicare Advantage network in areas with a low proportion of health care providers. It would be useful to provide tax advantages for insurers such that they could expand availability of Medicare Advantage coverage into those areas. Additionally, providing incentives for health care providers to contract with Medicare Advantage insurers - particularly in rural areas - by streamlining and reducing the paperwork, increasing the reimbursement amounts so that Medicare Advantage policies become more comparable to ordinary commercial policies, and possibly assuming some of the cost of liability insurance for providers, would help to expand the Medicare Advantage system and thereby make it possible for insurers to expand coverage through economy of scale. (Again, I am hazarding a guess here, not being cognizant of all of the economic factors involved... .)

Another issue is that of "Medicare assignment"... As it is now, any coverage obtained from a doctor who doesn't "accept Medicare assignment" must be paid for entirely out of pocket. I simply fail to understand why we

would want to restrict access to any of the decreasing number of doctors who are even available any more, whether they "Accept Assignment" or not! It should at least be possible for someone to recover the Medicare allowable portion of an "Unassigned" doctor's bill, and then pay the rest out of pocket. Moreover, to the extent that such physicians are located in rural or remote areas, the problem is even more critical. It's hard to imagine that allowing more access to doctors, whether "Assigned" or not, wouldn't have a positive impact on any or all of the items on your list.

In closing, while it is not the direct concern of the committee investigating the issue of chronic conditions, I feel compelled to remind the Committee of the impact of what can only be described as parasitism upon the health care system both by those who will not work and expect a free ride and by the ever increasing number of illegal immigrants who come here to avail themselves of our extremely ill-advised largesse. This impacts health care funding to an extent that I believe is drastically underestimated and may be a major contributor to the shortfalls we are seeing in funding all across the spectrum of health care.

Thank you for your attention, and I hope my commentary is of some value.

Dave Simmons
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