

TESTIMONY  
OF  
ILENE LIEBERMAN  
COUNTY COMMISSIONER  
BROWARD, FL  
BEFORE THE  
NATIONAL ASSOCIATION OF COUNTIES  
WORKING GROUP ON HEALTH SYSTEM REFORM  
DECEMBER 3, 2008

Broward County Commissioner Ilene Lieberman has had an influential and well respected political presence in Broward County since she became a Lauderhill City Council Member in 1984. Commissioner Lieberman's accomplishments in the political arena as well as her commitment to community service have been well recognized.

Commissioner Lieberman is Vice-Chair of the National Association of Counties' (NACO) Large Urban Caucus steering committee, the Vice-Chair of NACO's Housing subcommittee and a member of the organization's Community and Economic Development steering committee. She is the 1st Vice President of the Florida Association of Counties, as well as a member of their Board of Directors. Commissioner Lieberman is a past President of the Florida League of Cities and currently and also sits on the Board of Directors. She was Chair of the Florida Association of Counties Urban Caucus and Chair of Florida's Complete Count Committee. She is on the Board of Directors of the Boys and Girls Club and maintains memberships with numerous service clubs and community organizations that benefit from her involvement. She is the Board of County Commission appointment to the Resource Recovery Board, the South Florida Regional Planning Council, which she chairs, the Management and Efficiency Study Commission, and the Broward County Value Adjustment Board.

Commissioner Lieberman is a member of the VisionBROWARD Executive Board. VisionBROWARD was launched when the Commissioner served as the Mayor of Broward County in 2003-2004

A mother of three, Commissioner Lieberman attended and graduated Summa Cum Laude from Nova Southeastern University Shepard Broad Law Center in 1989 and was the class Valedictorian.

As we have heard, NACo's advocacy in furtherance of transforming the American Health System is broad; reaching across a multitude of arenas. Our overall mission remains concerned with our most vulnerable populations, while seeking to enhance our current system using innovation and evidence-based approaches to the most complex social problems of our day. NACo leadership and county governments across the country face daunting economic

challenges, requiring all of us to make difficult funding choices as we seek to improve accountability and identify efficiencies.

The health care system is one of the most costly responsibilities of County governments—and as local government officials we struggle each day to find creative ways to maintain quality benefits for our employees, contain jail health costs, and manage the unfunded mandates passed along to us by states and the federal government related to health care requirements and match costs (Medicaid, etc.).

As a result of these crises, local governments and their officials must commit to identifying creative ways to anticipate the future health care needs of our constituencies, while ensuring cost-containment. The first issue on which I address you today—Living Organ Donation—meets these criteria: ***It is highly effective both from a cost- and life-saving standpoint.***

In addition to the exceptional federal legislative platform and White Paper distributed in advance of these hearings, the NACo Health Steering Committee adopted an item I sponsored relating to Living Organ Donation. Because of my own personal experience, I believe living organ donation should be added as a priority to NACo's systemic reform platform and become a more viable medical option—***encouraged by federal policy.***

As a mother of an organ recipient, I was highly receptive to an opportunity to champion these issues; so when a South Florida resident approached me last year and asked that I work to find ways to encourage organ donation by living donors, I was pleased to do so.

The constituent, Kevin, who met with me, described a process of donating a kidney to his brother in another state, which was—to say the least—onerous. To determine compatibility, Kevin underwent a series of physical tests—none of which were covered by insurance. When it was determined that Kevin was a suitable donor, he was then required to be examined for psychological fitness—which was again not covered by his insurance. When it came time to actually donate his kidney, Kevin had to travel to New York, where his brother was hospitalized, to complete the operation and recuperate. None of his travel expenses were covered. And while the surgery itself and medical costs associated with follow-up care and anti-rejection medication ***were covered*** by Medicare for 90-days after surgery, Kevin suffered extensive complications. When he required additional hospitalization, nearly six months after the donation took place, he was denied coverage by Medicare and his own private insurance, and forced to pay the costs out-of-pocket.

Unfortunately, ***Kevin's story is not an anomaly.*** One of the major barriers to living organ donation is its associated, un-reimbursable costs. As was the case with Kevin, costs of the actual surgery are usually covered by insurance or, for the uninsured, the recipient's Medicare coverage; however, attendant and unexpectedly high costs associated with pre-surgery ***are not.*** Organ failure is catastrophic, and the costs associated with preparation for a transplant—both from a donor and recipient standpoint—are often staggering. As described previously, recuperation time may be significant for the donor and involve debilitating physical complications, requiring leave from employment. Unfortunately, many employers do not extend Family Medical Leave to living organ donors, especially if the recipient is not an immediate

family member, since the decision to donate is a voluntary one and not a “medical necessity”. Further complicating the situation are health insurance coverage limitations of the pre-surgical testing requirements.

### **Living Organ Donation should be added as a priority for federal health system reform.**

Our NACo Resolution supports federal legislation sponsored in the 110<sup>th</sup> Congress:

**HR 2808--** *The Living Organ Donor Job Security Act*, seeks to extend FMLA leave to living organ donors, including time spent for: (1) tests to determine medical suitability of the employee for donation; (2) physical, psychological, and social evaluations; (3) pre-transplant outpatient services; (4) postoperative inpatient and outpatient transplantation services; (5) travel in connection with such tests, evaluations, and services; and (6) recuperation.

**HR 1035--***The Living Organ Donation Tax Credit Act* creates a nonrefundable tax credit in an annual amount not to exceed \$5,000 for un-reimbursed costs and lost wages incurred by an organ donor. The bill defines a qualified life-saving organ as a kidney, liver, lung, pancreas, intestine, bone marrow, or any part thereof.

In addition to those two pieces of federal legislation, I have directed my staff to develop *state advocacy strategies* to assure insurance coverage parity for donors and recipients, as well as to advocate for policies that will encourage living organ donation—like specialized “leave banks” for donors who do not meet FMLA criteria.

***But you may be asking--- Why is this a federal issue, worthy of being added to the NACo platform and prioritized?***

Because existing federal law allows most organ recipients to be covered under the Medicare umbrella, so 83% of all transplant patients (both successful recipients and wait-listed persons) **presently receive Medicare.**

The fiscal impact to taxpayers at the federal level to maintain one person with kidney failure on dialysis is **\$55,000 per year**. Living Organ Donation is a highly cost- effective alternative because waiting time for a deceased donor kidney is approximately 4 years longer than a living donor kidney. If we embraced and encouraged living organ donation through policy, ***we could save Medicare roughly \$220,000 for each living kidney transplant!*** Kidney cost estimates can be extrapolated to other organs that can be donated by living persons, such as a liver, lung, pancreas, or intestine.

But looking at the savings in tax dollars is myopic—as elected officials and leaders, we rely upon compassion in making public policy. There are substantial human costs associated with remaining wedded to a system that relies on deceased donors as living donation has reduced wait time, associated costs pre-transplant and expanded the number of available donors. Many of you may personally know someone who has been waiting for an organ transplant, agonizing over finding a good “match”—and then there are those who are lucky enough to survive until they receive their donated organ, only to reject it. Living organ donation uses cutting edge scientific breakthroughs to offer a future where there has been so little hope in the past.

When my son had a transplant (not all that long ago) the science was still not advanced enough to allow for the partial removal of a living donor kidney or liver. Now, I could donate part of my organ and it would re-grow in me to full capacity, and also grow to full size in the recipient! The technological advancements are extraordinary! At this time of mounting budgetary pressures, rising inflation and escalating national deficits, counties must make this fiscally responsible issue a federal priority.

I also want to touch upon the absolutely critical need for NACo to encourage passage of legislation that would *address critical shortages in the medical community and encourage physicians to choose high-need practice areas*. County government struggles to ensure that residents receive adequate and appropriate health care. Certainly, as many of you know, in South Florida we have an extremely diverse population—both from an age and ethnicity perspective. We also have the highest medical malpractice insurance rates in the country—which has made the practice of obstetrics virtually impossible in my community. A region's vitality centers on its ability to attract industry and residents, and one of the critical factors in a decision to relocate or remain in a community has to do with health care.

Research indicates that medical students carrying student-loan debt are far less likely to pursue general practice and internal medicine, but that does not even take into account the moderate- and low-income *prospective* medical student who chooses not to pursue medicine at all, when faced with the reality of tuition costs. Physician diversity is absolutely critical and when there are vast shortages of skilled nurses and doctors, it encourages unsafe practices like moonlighting by residents.

I am urging NACo to add support for two pieces of legislation that were introduced in the 110<sup>th</sup> Congress to its platform.

**Senate Bill 896** by Murkowski (co-sponsored by Stevens, Schumer, Sanders) sought to use the Public Health Service Act to authorize appropriations for FY2008-FY2012 to:

- (1) carry out the National Health Service Corps Scholarship Program and Loan Repayment Program to assure an adequate supply of physicians and other health professionals to provide primary health services;
- (2) assist schools in supporting programs of excellence in health professionals education for underrepresented minority individuals; and
- (3) assist individuals from disadvantaged backgrounds to undertake education to enter a health profession.

The bill also allowed the Secretary of Health and Human Services to (a) make grants to community health centers, (b) award grants to recipients of financial assistance for area health education center programs to improve effectiveness, and (c) amended title XVIII (Medicaid) of the Social Security Act to make changes to the direct and indirect graduate medical education provisions (regarding costs for the training program for purposes of counting the number of residents in a non-hospital setting).

The other piece of critical legislation proposed last Session was **S. 1066** by Dodd (co-sponsored by Feingold, Kerry, Durbin, Sanders), was called the **Medical Education Affordability Act**, which would have revised regulations regarding student loan repayment deferment with respect to borrowers who qualify on the basis of economic hardship and are in *postgraduate medical or dental internship, residency, or fellowship programs*. I would urge NACo to support these efforts.

The next generation will be the first in US history with a shorter life span than their parents---*We are missing the boat in health care from a variety of standpoints* like accessibility, affordability, and prevention. But if we don't have trained physicians to meet the health care needs of our constituents, no amount of systemic reform will matter. The single most critical component of health system reform must be encouraging a skilled, diverse medical workforce and making medical education affordable!

Thank you so much for the opportunity to address you today (closing. . . .)