PUBLIC HEARING

before

NEW JERSEY TASK FORCE ON CATASTROPHIC AND LONG-TERM HEALTH CARE

Examine Federal and State Policy Directions
and Options in Long-Term Health Care

October 1, 1987
Room 341
State House Annex
Trenton, New Jersey

MEMBERS OF TASK FORCE PRESENT:

Assemblywoman Marion Crecco, Chairwoman
Assemblyman William P. Schuber
Paul Langevin
William Ditto
Jeanne Sims
Theresa Dietrich

ALSO PRESENT:

David Price
Office of Legislative Services
Aide, New Jersey Task Force on
Catastrophic and Long-Term Health Care

* * * * * * * * * *

Hearing Recorded and Transcribed by
Office of Legislative Services
Public Information Office
Hearing Unit
State House Annex
CN 068
Trenton, New Jersey 08625

GENERAL ASSEMBLY OF NEW JERSEY
ASSEMBLY MAJORITY OFFICE
2ND FLOOR, STATE HOUSE ANNEX
CN-098
TRENTON, NEW JERSEY 08625
(609) 292-5339

HUCK HARDWICK
SPEAKER

BRADLEY S. BREWSTER
EXECUTIVE DIRECTOR

September 17, 1987

NOTICE OF A PUBLIC HEARING

THE NEW JERSEY TASK FORCE ON CATASTROPHIC AND LONG-TERM HEALTH CARE ANNOUNCES A PUBLIC HEARING TO EXAMINE FEDERAL AND STATE POLICY DIRECTIONS AND OPTIONS IN LONG-TERM HEALTH CARE

Thursday, October 1, 1987
Beginning at 10:00 A.M.
Room 341, State House Annex
Trenton, New Jersey

The New Jersey Task Force on Catastrophic and Long-Term Health Care, established pursuant to Assembly Resolution No. 151 of 1987, will hold a public hearing on Thursday, October 1, 1987, beginning at 10:00 A.M., in Room 341 of the State House Annex, Trenton, New Jersey, for the purpose of receiving testimony about federal and State policy directions and options, and related issues, in regard to long-term health care.

The task force, which is chaired by Assemblywoman Marion Crecco (District 30), is conducting a series of public hearings on long-term health care issues, with a primary focus on national policy directions, state initiatives, the scope of existing programs and insurance policies, and regulatory arrangements.

Questions about the hearing may be addressed to Deborah K. Smarth of the Assembly Majority staff (609-292-5339) or David Price of the Office of Legislative Services (609-292-1646).

TABLE OF CONTENTS

* * * * * * * * * *

pmp: 1-26

ASSEMBLYWOMAN MARION CRECCO (Chairwoman): We're going to start the meeting and hopefully the other members of the Committee will arrive. Unfortunately, some of them are late. But on our Committee this morning, we will have Assemblyman Schuber who we expect to arrive shortly, and Assemblyman Deverin and Assemblyman Otlowski. Also to my right is Theresa Dietrich, who is representing the Commissioner of Community Affairs. To my right is also Jeanne Sims who is representing the Commissioner of Insurance. And to my left is Bill Ditto who is representing the Commissioner of Human Services, and Paul Langevin who is representing the Commissioner of Health. As they arrive, we will announce the other members.

This is our second meeting, as you know. The first one was very productive. The existing public programs will not be adequate to meet the future long-term needs of the elderly, the chronically-ill, and the disabled. The great majority of older persons who need long-term health care receive the support that they need from friends and family members. According to the United States Department of Health and Human Services, family and friends informally care for 70% of the elderly disabled.

Clearly, at the recent findings of the Federal Task Force on Long-Term Health Care Facilities, policies were highlighted. Meeting the needs of the rapidly growing aging population will require a larger private sector role in financing long-term health care. In light of current congressional budget restraints, private insurance will play a significant role in financing long-term care, but it will not be the total solution to the situation.

As we have learned from this Task Force's first meeting, State and Federal governments should promote the development of private insurance through tax incentives and a public education campaign. In addition, some consideration should be given to promote corporate involvement through the

use of employer/employee group plans, State sponsored plans, and the use of pensions, equity conversions, and the like.

We need to look at the development of new long-term care disability systems. As you know, nursing home care is the leading cause of catastrophic out-of-pocket expenditures for the elderly. We need to promote and improve other systems that can provide the appropriate care necessary for good quality of care for our elderly. Finally, we need to protect our elderly by ensuring that the premiums paid into private insurance reap positive benefits. We can only do this by improving various aspects of private policies and ensuring clear language and reducing exclusions and restrictions which have been critiqued in a recent House subcommittee study.

I also want to take this opportunity to inform you that our next hearing is scheduled for October 26. We have confirmed that Congressman Matthew Rinaldo, ranking member of the House Select Committee on Aging, and Steven A. Grossman, Deputy Assistant Secretary of Health from the United States Department of Health and Human Services will provide testimony to this Task Force.

I look forward to your continued input and interest in the deliberations of this Committee. We should start our testimony now. Our first person before us will be Mr. Kenneth Goldman, who is a member of the Advisory Board for New Jersey Cancer Care, Inc. Mr. Goldman?

K E N N E T H G O L D M A N: First of all, I'm here with my most able assistant, Doris Nash, who is the Public Affairs Director of Cancer Care out of New York. I'm new on this Committee in the Public Affairs Department, so bear with me, please.

To the Task Force and the Honorable Marion Crecco: I am Kenneth Goldman, a native of New Jersey and a resident of Maplewood, New Jersey, and a member of the Cancer Care's New Jersey Advisory Board, and I want to thank you for inviting us

to present this testimony on the issues of catastrophic and long-term care. I am happy and proud to be the representative of Cancer Care at this hearing as I feel our organization and your Task Force is going to do a lot to help us in this problem that we all are facing.

Cancer Care, as you may know, is a voluntary agency which for over 43 years has offered comprehensive social services to cancer patients and their families, including individual and group counseling. While the agency traditionally served areas of New Jersey which were considered to be within the Metropolitan New York area, it was only four years ago that a New Jersey office was actually opened. Our main New Jersey office is now in Millburn and there are also part-time offices in Ridgewood and New Brunswick.

Our New Jersey caseload has steadily risen since we opened our office here. Nearly 2000 patients were served during this last fiscal year, and nearly $184,000 was provided in financial assistance to 300 patients. These disbursements are made available to needy patients to help them meet the cost of home care plans and/or transportation to and from cancer therapies.

In addition to its direct services for patients, the agency has also conducted a vigorous public affairs program in the interest of cancer patients and the catastrophically ill. Cancer Care has for many years advocated for adequate coverage for catastrophic illness, with a special emphasis on the desirability and preferability of provision of services to the patient at home. We have stressed the necessity of broadening Medicare's home health services so that patients would not be required to need a "skilled" service in order to qualify. And we have also urged that the part-time and intermittent care requirements be removed, so that Medicare patients could get sufficient and realistic home care to meet their needs.

Unfortunately, we were not only unsuccessful, but the situation has actually worsened what with cutbacks in Medicare's home health services accomplished by exceedingly more stringent interpretations of the Medicare statute. Further, the so-called catastrophic proposals currently before Congress will not change any of this, except for allowing more days of daily home care and increasing the number of covered days in a nursing home. But, we must not forget that under this legislation, chronic care patients will still not be covered in either setting. Thus, help with catastrophic illness and/or long-term care will continue to be unavailable under Medicare.

On the other hand, it is fortunate that the nation and its policy makers seem indeed to have awakened to the urgent problems posed by catastrophic and long-term care illnesses. As you know, this has been sparked by the awareness of the ever increasing number of elderly in the population and the growing number of the very elderly as a result of the dramatic increases in life expectancy. It is heartening to know that New Jersey is also very concerned about these problems as evidenced by the establishment of your Task Force.

Cancer Care knows from its many years of experience the terrible impact of cancer, and how it can cause not only an emotional catastrophe, but an economic one as well. For many patients and families, the cost of cancer can be catastrophic in a very short time. For more well-to-do families, the financial problem may not be so great, but naturally the costs rise as the course of the illness is extended.

Many or our patients in New Jersey come to us with incomes as low as $600 a month. They and their health insurance, if they have coverage, must pay for everything since they are not eligible for any entitlement. This is indeed a catastrophe. We support New Jersey's Medically Needy legislation which was designed to offer Medicaid to the elderly and disabled who spent down sufficiently to become eligible.

But, we all know that this program has been a failure. We hope that the recent legislative proposal to improve it will do just that, but this remains to be seen. Those persons at the lower rungs of the economic ladder need assistance very soon after a severe illness strikes. But it is heartbreaking that patients have to pauperize themselves in order to get on Medicaid, and that the community-based spouses of institutionalized Medicaid patients are forced into poverty. We are not referring here to the all too frequent practice of middle class people turning over their assets to their children in order to be eligible for Medicaid when their time comes to have a catastrophic or long-term chronic illness.

One answer lies in setting higher income levels for Medicaid eligibility. The nation is quite uneven as far as these eligibility levels are concerned, and uniformity in this regard would be more humane. A proposal currently before the New Jersey Legislature, Senate Bill 2972 and Assembly Bill 3765 would raise the Medicaid eligibility level for the elderly and disabled to the poverty level. We hope that this will be enacted as soon as the session is reconvened so that single persons with incomes of up to $5000 could qualify. Other bright spots on the horizon are measures to reduce spousal impoverishment which are part of the Federal catastrophic proposals.

Over the years, sporadic attention has been paid to long-term care health insurance, with health economists speaking to the feasibility of private long-term insurance. Mark Meiners, who has already addressed you, has believed for a long while that there could be a market for the sale of long-term care insurance. Now we have begun to see an increase in the number of long-term care insurance offerings. In fact, by '86, about 40 companies had long-term care products on the market, a significant jump from 16 companies the year before.

Whatever, there is the belief that a fairly large segment of the population can afford to pay for long-term care insurance, especially if they purchase such policies early enough. What will be needed are educational campaigns to inform people that Medicare coverage will really not be sufficient to meet all their future health care needs which will be sparked by the infirmities and illnesses of advanced age. It is our understanding that Dennis De Witt, Executive Director of the Long-Term Health Care Policies Task Force, will be addressing you soon. We would imagine he will describe the recommendations of his Task Force, including the suggested tax incentives for the purchase of private long-term care policies. Cancer Care's Public Affairs Committee will be studying these recommendations soon, and we will be pleased to convey our opinions to you.

In the absence of a comprehensive national health insurance program in the near future, it would appear that, at the least, we must find solutions via both public and private initiatives. It is heartening to know that New Jersey, as evidenced by this Task Force, is concerned about catastrophic and long-term care and is looking for answers to the problems.

In closing, we want to emphasize that long-term care must not be defined only in terms of skilled nursing or intermediate care facilities, but should also include long-term home care programs to prevent institutionalization for as long as possible. We hope, therefore, that this Task Force will recommend that coverage for adequate home care be included in long-term care insurance offerings, and that New Jersey finds ways to increase its Community Care Program for the Elderly and Disabled and the Model Waiver Programs.

We would also like to call your attention to several New Jersey legislative proposals which are designed to increase the availability of home care services. Senate Bill 2132 and Assembly Bill 3177 would significantly liberalize the criteria

for eligibility for the CCPED program. Senate Bill 3455, the Home and Health Community Care Demonstration Program Act, would provide home care services on a sliding scale fee basis. Another proposal, Assembly Bill 4401, would establish a home, health, and community services program in the Division of Aging, Department of Community Affairs. These proposals are deserving of your serious attention, and we hope that you will support them.

I want to thank you for your attention and this opportunity to address you. And I or Doris, I'm sure, is competent to answer any questions that you may have.

ASSEMBLYWOMAN MARION CRECCO: Thank you. Any questions? (negative response) Okay. That was very good. Thank you. It gave us a lot of input.

MR. GOLDMAN: Thank you.

ASSEMBLYWOMAN CRECCO: Our next person to testify will be Mr. Bernard Winstock, President of the New Jersey Coordinating Council of Organized Senior Citizens.

B E R N A R D H. W I N S T O C K: I want to thank you for the opportunity to come here and testify. As you said, I'm President of the New Jersey Coordinating Council of Older Organized Citizens. Our council has unanimously endorsed the need for a catastropic health bill, and I might add that the Task Force of the Department (sic) of Aging has also unanimously endorsed it.

However, our concept of a catastropic health bill is not that of the Administration. We know that unless nursing home and home care are covered in that bill, the bill really does very little, because as the statistics show and have been brought out before the congressional committees and everyone, there is a very small percentage of seniors who would be eligible under an extended hospital stay. And for that, we have to look into how Medicare works. Once you're in the hospital and it is determined that a further stay in the

hospital will not be of any benefit -- that you don't need hospital care -- if your doctor thinks he'd like to have you in there longer, of course he can insist on it.

But I listened to testimony before Senator Pallone's Committee, and several doctors, including the Vice Chairman of the New Jersey A.M.A. admit it -- that hospitals put a terrific amount of pressure on doctors to get these people out. As you know, we're under DRG. DRG says that for every illness and for every injury there's a certain amount of time that you can stay in the hospital. And when that time is up, if you still stay for another few days, the hospital loses money, because the government pays them according to those the conditions. If they can get you out a few days early, they make money, because they get the full price.

The other thing, under the present Medicare rules, there are many illnesses -- Alzheimer's disease, ALS -- many that are not considered to be eligible under Medicare. These are the crippling diseases that last and can last for a long time, which means that if the patient is fortunate enough to be married, at least the spouse can take care of them to the best of their ability.

But you have to remember that we're talking about elderly people. And not only if we say the man is disabled, but his wife is very apt to be almost as old, and when she has to take care of a disabled person who, in many cases, is bedridden, and has to do the cooking and has to somehow do the shopping and has nobody to come in to relieve them, it doesn't take long before that person is on the verge of a breakdown also.

The present rules show that you can get on Medicaid if you spend all your money; your wife spends all the money, sometimes sells the house, and you get on Medicaid. But what happens to the spouse? The spouse is left, very possibly on relief -- welfare. And you know, from a practical point of view, the patient has gone on Medicaid which the government is

paying, and the spouse, very often, has gone on welfare, which the government is paying, and I wonder if any consideration has been given to the fact that there is a large cost involved to the government. We think it's much larger than the cost of a sensible catastrophic health plan.

The other things are-- There are several others. For example, under Medicare, if you are disabled-- I can give you an example of a very lovely young lady that works in Morris County Aging. I live in Morris County. She told me of a man, 85 years old who was in pretty good health, took care of himself, and had an apartment. He came out one winter day and slipped on the ice. He put his hands out to break the fall and badly broke both arms. Oh he was put in a hospital, of course. And the time came when the hospital said, "Well, that's about all we can do. Nature is going to heal you. It may take a month or it could take six months. You're 85 years old, things don't--" Now what does he do? Under Medicare, he is not eligible for a nursing home not even for the 20 or 21 days. Because under Medicare, if the break is above the waist, it is not considered disabling. Now can you imagine an 85 year old person with two broken arms, told to go home in a house by himself, taking care of himself because Medicare says that, "you're not disabled"? Now if he'd broken the legs or the hip or anything below the waist, under Medicare he would have been disabled.

So under the present regulations as they stand, there are so many things that are not right and there are so many things that have to be changed. Nursing homes is one very vital one. A friend of mine came out of the hospital with a triple by-pass and an opened wound. So, his doctor had the nurse come and dress the wound for a couple of weeks, then she showed the wife, who happens to be a very, very nervous person, a very small person, and very, very upset-- She told the wife that she ought to be able to take care of this, and that this

is a very simple procedure and to just to take the bandage off or the plaster off and swab it a little bit. Of course, the man had a very very hard time to take a bath in this condition. His wife weighs about 90 pounds. He weighs about 170. And there was no help. If they could afford to go through an agency and hire someone-- But unfortunately, the majority of our seniors are not in the position to go to an agency and hire someone for $40 or $50 a day.

Oh, I don't know what the answer is except that it has to be that we have a provision in this catastrophic bill which will cover home care, nursing home care, and it must cover what we used to call convalescence. When I was younger, you got out of the hospital and if you didn't need a nursing home; they would say that you would go to a convalescence home -- which is the intermediate -- where they would feed you, they have the room, and someone would help you to dress. But registered nurses and doctors are not needed. But that's very important. We need it.

Now we seniors know that this is going to cost money. No doubt about it. And I think that you will find that the majority of the seniors understand this and we're willing to do whatever we have to do to get what we need and need, very badly. I was sent from an insurance company a catastrophic policy which would have cost me for my wife and myself $230 a month. And I compared it with the AARP policy I have right now for $52 a month for both of us. It was a joke. So, what's happening is insurance companies are now lining up to take advantage of us.

That's another thing that has to be-- Somewhere along the line the State or the Federal government has got to regulate these policies that are put out on the guise that they are going to be very good supplemental policies. The truth of the matter is that the ones that are on the market right now are really, in my opinion, frauds. They cover so little of what has to be covered, and they charge so much.

So, this is our position again. We must have a catastrophic bill. It must cover home health care, nursing home care, and intermediate care. And we also, as I've said, think it would be very nice if the State Department of Insurance would take a firm stand in regulating these supplemental policies, so that when our people buy them, we'd like to feel that they are getting what they are paying for. Thank you very much for allowing me to testify. Any questions?

MS. SIMS: Mr. Winstock, I'd like to assure you that we are very, very concerned about this issue and we'll be addressing this issue.

MR. WINSTOCK: Well, that's very comforting to hear.

ASSEMBLYWOMAN CRECCO: Thank your very much. Can you tell me why there are only eight insurance policies in reference to--

MS. SIMS: In terms of long-term care?

ASSEMBLYWOMAN CRECCO: Yeah.

MS. SIMS: Long-term care insurance is an unforged territory for insurance companies. There's isn't a whole lot of data experience built up, and the result is that there is a reluctance. People are living longer. The demographics are changing. They are coming into this territory slowly and carefully and we are very, very aware of it. We're keeping on top of the policies that are being sold in this State and we're going to be coming out aggressively in that area in the next six to nine months.

MR. WINSTOCK: Well, thank you very much. I'm sure we'll all feel better about that. Thank you again.

ASSEMBLYWOMAN CRECCO: Thank you. Assemblyman Schuber is with us this morning. Thank you for being here. Any other questions? (negative response) Our next person to testify will be Mr. Philip Pearlman, Executive Director for the Union County Division on Aging.

P H I L I P H. P E A R L M A N: Good morning Madam Chairperson and members of the Task Force. Thank you for inviting me to provide testimony to you today. I am Philip Pearlman, Executive Director of the Union County Division on Aging, and President of the New Jersey Association of Area Agencies on Aging, otherwise known as NJ4AA, which is a statewide organization of the 21 county offices on aging.

With your forbearance, I would like to take a minute and explain who county offices on aging are, and what we do. County offices of aging, or divisions or departments on aging are essentially the same. We are part of county government. But we are also designated as area agencies on aging by the New Jersey Division on Aging which make us part of a national network of over 650 area agencies on aging.

This dual designation overlaps in terms of functions. However, the A.A.A. designation carries with it a share of Federal funds from the Older Americans Act which provides the bulk of funds available to us to plan, coordinate, and implement services for the residents of our respective counties who are 60 years of age or older. This planning, coordinating, and implementing of services to the elderly is what we do, and at the risk of sounding immodest, I believe we do it rather well.

There is no other social service network in this State or the entire country which focuses their attention on a segment of our society with the intensity and dedication as the aging network. We are linked together through our association. We are linked to the State, and we're linked to the Federal government which makes us the closest thing to local experts on the needs of the elderly, services available to meet those needs, and the gaps in those services which are really unmet needs.

It is from this perspective of living with and knowing the unmet needs of senior citizens at the local level, that I would like to address this Task Force. As you are well aware,

Congress is focusing on catastrophic issues purely from concerns about acute care. You are also undoubtedly aware that long-term care is where catastrophic costs usually affect greater numbers of people. I therefore respectfully suggest that the State of New Jersey should focus its attention on the long-term care if we want to address the larger problem.

County offices on aging are well aware of the magnitude of long-term care problems, particularly long-term chronic care. Our information and referral units are constantly receiving inquiries relating to both institutional and community-based long-term care. Most if not all county offices on aging are involved in trying to expand community-based services for elderly persons requiring long-term care who wish to remain in their homes.

Medicare which is thought by many to be the answer to health care for the elderly has never provided any significant amount of care for chronically-ill persons requiring long-term care. Medicaid, with its income limitations, forces persons requiring long-term care to pauperize themselves in order to become eligible. Medicaid also is biased toward institutional care versus community-based care which provides a further disincentive for persons requiring long-term care who wish to remain in the community. Medicaid will provide more funds per person for institutional care than it will for community-based care.

New Jersey's elderly, those 65 and over, are rapidly approaching the one million mark. Senior citizens are the fastest growing segment of the State's population, growing at a rate five times faster than the general population. Our median age is the second highest in the nation. According to a 1985 estimate by the New Jersey Division on Aging, about 18% of the elderly, some 166,000 individuals, have severe functional limitations, a figure projected to grow to 213,000 by the year 2000.

Almost all of New Jersey's elderly qualify for Medicare, as do a substantial number of younger persons who suffer from severe physical and/or mental disabilities. In 1985, the latter numbered about 87,000. Unfortunately, Medicare does not cover long-term care for either of the chronically-ill elderly or the disabled.

The greatest unmet need that county offices on aging see in their contacts with chronically-ill elderly persons and their families is more community-based care at affordable prices. We see the need for more home health aides and homemakers, more adult day-care, more home delivered meals, and more specialized transportation for these chronically-ill persons who want to remain in their homes. Many of these people are presently able to remain in their homes because their families are providing the care they need. This places a difficult and sometimes unbearable burden on the care giver. They need relief which means we need more community-based services to provide respite for these overworked care givers. We also are aware of chronically-ill elderly persons trying to remain in the community who have no family to provide care and therefore need these community-based services even more desperately if they are to remain in their homes.

This Task Force has a great deal to accomplish in a very short time. I wish you well and I pledge the support of the 21 county offices on aging in whatever ways we can help you in helping the elderly residents of New Jersey.

Thank you again for allowing me to testify.

ASSEMBLYWOMAN CRECCO: Thank you. I'll ask you a question. What role do you see for private insurance companies in light of this shortfall of Medicare? Do you think that seniors -- if educated about the availability of policies -- you know -- if there are some good conditions applied, you know, would enroll in such policies?

MR. PEARLMAN: I'm sure there are numbers of people who can avail themselves of that. There are going to be those people who will not be able to afford those premiums and I think that's where we have to focus our attention and target our efforts. You hear estimates now, that nationally there are between 35 and 40 million people who have no health insurance of any kind. And that's pretty scary. There are a lot of people who, once they reach senior citizen status, are on fixed incomes, will not be able to purchase these long-term care policies. It may help in the future if people start buying these policies at a younger age when the premiums are much more reasonable. But we have these large numbers of people now who are constantly growing and that's the group that we're concerned about.

ASSEMBLYWOMAN CRECCO: Thank you. Any questions?

MS. SIMS: You might be interesting in knowing we have a Medicare supplemental handbook available to older persons. And we've just completed, a comparison, and it shows in a chart form that long-term health care policies are available. It's a comparative shopping buyers' guide.

MR. PEARLMAN: Yeah. I am aware of it. It's an excellent guide.

ASSEMBLYWOMAN CRECCO: Anyone else? Thank you very much. Our next speaker is Ms. Jill Mueller, member of the Board of Directors of the Home Health Agency Assembly of New Jersey, Inc.

J I L L M U E L L E R: Good morning. Thank you for allowing me to give testimony today. I'm Jill Mueller. I'm here as a member of the board of the Home Health Agency Assembly of New Jersey. I'm also the Executive Director of the Visiting Nurse Association here in Trenton. With me today is Jean Kraemer, one of the staff members of the Home Health Agency Assembly.

The 55 member agencies of the Home Health Agency Assembly provide home health care to citizens of all ages throughout New Jersey. In 1985, licensed and Medicare certified home health care agencies provided 2.6 million home health visits to over 131,000 clients throughout the State. Elderly people constitute the largest patient group representing approximately 75% of all the clients seen by home care agencies.

While a small percentage of aged persons may have to enter a nursing home -- approximately 5% of the aged -- our experience shows that most elderly people prefer to remain in their own home and that home care is an appropriate and a cost-effective alternative to institutionalization. Because of our extensive experience in patient care, community health nurses have a deep understanding of the home health care needs of elderly people. We feel a special need to advocate on their behalf.

For many elderly in our State the catastrophically high cost of long-term chronic illness, such as Alzheimer's disease and ALS, the things mentioned by Mr. Winstock, represents a cost which might very well reduce them to paupers. And this looms as a very terrible prospect for the elderly.

The long-term health care needs are not now covered by Medicare. Private sector insurance is virtually unavailable, and it's really too costly for most elderly. Only Medicaid provides coverage for the very poor, and it's this dilemma that this Task Force must address. Several Federal initiatives are now under consideration in Washington, and they've defined "catastrophic" primarily as those health care costs which are associated with long hospital stays. While this is important for a small number of clients, the real catastrophe for most elderly people is long-term chronic illness. This has been testified to before this morning's hearing.

Provisions for long-term care, whether in the home or in an institutional setting, are expressly excluded from these bills. When the Medicare program was designed 20 years ago, it focused on acute illness. Since that time the elderly population has increased, due in part to improved health care under Medicare. We know that the prevalence of chronic illness and disability increases with age. And it's this demographic imperative which lends urgency to consideration of public policy.

Persons 85 years and older, sometimes called the oldest old, are the fastest growing age group in the American population. Between 1960 and 1980 the oldest old increased by 141%. This compares to just 54% for all persons over the age of 65 and a 26% increase in the general population.

In absolute numbers, the number of persons 85 years of age and older is expected to grow from 2.3 million in 1980 to almost 5 million by the year 2000. In the year 2020, it's expected to reach over 7 million. In the year 2040, when the baby boom generation reaches the threshold of advanced age, there will be nearly 13 million people, 85 years and over. It's evident that ultimately home health care will have to expand to meet the needs of this population.

Economically, the oldest old are disadvantaged in income. Persons 85 years of age or older are twice as likely to be living below or near the poverty line than people between the ages of 65 and 74. How are we going to support the care for our elderly? At this time, agencies such as my own, the Visiting Nurse Association of Trenton, use charitable monies to help subsidize the care for poor clients. But these funds are terribly inadequate and they're going to be even more inadequate in the future.

Ultimately, national health policy must address the issue of supporting long-term care through reform of the Medicare program, or through a more substantive and radical

reorganization of the health care system, or through initiatives and incentives for private insurance coverage. However, in moving to that end, state governments have a crucial and important role to play. State governments can develop model approaches to long-term home care and provide the experimental base on which national policy will be grounded. Indeed, it may be states that are the best unit for the organization of long-term care. Some nations which have developed long-term home care programs, most notably Canada, are using their system based on a provincial or a state level model.

There are several good reasons why New Jersey should take action at this time. New Jersey has already shown that it can be a leader in health policy. New Jersey has a sophisticated and a strong community health service infrastructure, willing and able to translate policy into practice in an effective and timely manner. There is a broad consensus in support of expanded home health for seniors among senior citizens groups and health advocacy groups in New Jersey, and you've heard that already this morning.

The Task Force on Legislative Concerns of the New Jersey Commission on Aging ranks expanded home care as its leading issue. Most importantly, the casino fund provides revenues which can be applied to support long-term care. A legislative commission which met in 1986 and is meeting in 1987 to develop recommendations on the expenditures of casino revenue funds, identified expanded home health care and rental assistance as its top priority. What is needed now is the political will to turn these recommendations into a reality.

There are already several bills in the legislative hopper which would open up funding sources for long-term care, and the Home Health Agency Assembly of New Jersey supports them all. These have been discussed already this morning: primarily there's the Senate Bill 2972 and Assembly Bill 3765. These raise the Medicaid program eligibility level for seniors

to the poverty line. The State Medicaid program, as mentioned before, does provide long-term care, raising eligibility levels would bring more poor seniors under its protective umbrella.

Another bill is Assembly Bill 3177 which would expand the Community Care Program for the Elderly and Disabled. This is also Senate Bill 2132. My agency, the VNA of Trenton, is the case manager for the CCPED program in Mercer County. I'm very familiar with this program, and I feel that it has really been effective in beginning to address some of the gaps in the health care system. Right now, it's designed to meet the needs of the a very specific population, people who, I know, otherwise would have been in a nursing home.

And we've demonstrated that frail elderly can be maintained safely at home. The people who are under the program are really very happy. In Mercer County, there are now 90 slots for people in this program, and there's always a waiting list.

Furthermore, the CCPED program requires that costs overall be less than they would be if expended in institutional care. This was referred to earlier this morning. So, the State is spending less on home care for Medicaid eligible claims than it would if those people were in an institution. So it's saving money, and it's also promoting healthier and happier seniors.

We strongly urge the Task Force to support the needs of another portion of the population. We see people who are not yet eligible for institutions and who belong at home, yet need some home health care to remain there safely and decently. A-3455 would address the needs of persons who do not qualify for CCPED because their health status is not yet fragile enough, or because they're not yet sufficiently pauperized to qualify for the CCPED's financial eligibility criteria. This is a large population that is still being left uncared for.

These persons need help because they have debilitating chronic conditions and require assistance in carrying out daily activities. Clients with Alzheimer's often fall into this category. Without proper health care supervision and help with daily activities, we find that these people deteriorate and do eventually become hospitalized or otherwise institutionalized.

Under the Senate Bill 3455, a statewide demonstration using casino funding money would subsidize care to a variety of existing community agencies. In addition to expanding public funds, insurance coverage ought to be available under private plans. Today's home care insurance benefits do not meet the needs of the aged consumer. At the present, the few policies that do exist which cover home care frequently are limited to just private duty nursing and only under conditions of extreme medical necessity. The coverage should include nursing care, nursing supervision, and home health aide services, which are the services that people more frequently need if they are in a home setting.

Further, Mark Meiners and other insurance experts have already testified, long-term care insurance is expensive. We recommend that the private insurance industry persevere in its efforts to market it to a younger age group in order to broaden the premium base. And I think your comment, Ms. Sims, about the State trying to tempt younger people to do that, is really one that should be done wholeheartedly. Another approach would be for the State, of course, to subsidize some private insurance premiums for those unable to pay for it themselves.

In summary, expansion of home health care for the chronically-ill is the key to planning for long-term care. And as the population requiring long-term care is diverse in its financial resources and its health care needs, there's no single program solution. While it's important to expand the Medicaid programs for the very poor, it's equally important to

address the needs of the working poor and the working class and the middle class elderly who often becomes impoverished and end up falling into the welfare system. Early planning for long-term care through private insurance should be encouraged for those who can afford it. Thank you very for allowing me to testify this morning.

ASSEMBLYWOMAN CRECCO: Thank you. Any questions?

MS. DIETRICH: Excuse me. I would like to ask a question about the CCPED waiting list that you have. Do you have any idea of how long the waiting list is, and do the people who are on it stay on it and eventually get picked up after how long?

MS. MUELLER: Sometimes they do and sometimes-- The actual size of the list at this point in time-- I can't give you a number, but I could get that information to you. There is a good deal of time that passes from the time the client is identified to when they're actually admitted into the program. For one thing, having the family meeting to fill out all the financial eligibility forms often is a time-consuming task and it requires constant persistence on the part of the nurse and the social worker to encourage the family to complete those forms, because it holds up the whole process. And clients sometimes end up needing to be institutionalized while they are waiting for the CCPED program to come into effect.

I think it's a fairly efficient process that I think has made tremendous improvement for people who otherwise would have been institutionalized right away. I do support the program. I think we're still working out the kinks.

MS. DIETRICH: Thank you.

ASSEMBLYMAN SCHUBER: I think that particular program and the other segment of the population that you highlight in the latter part of your remarks with regard to those people who do not necessarily fit the criteria for an institutional

setting or institutional care, but at the same time, see a need for day-to-day home health care. I think it's very significant. We have seen in the course of the last hearing just in my office alone, a significant number of individuals who would fit that criteria, who we have tried to coordinate and help, ourselves, from our own office. Yet there's a significant health benefit for them to be in their home or their own apartment with regard to the fact that there are friends next door, there are family members that are readily accessible.

It's something that we really haven't addressed completely here in the Legislature yet. Certainly, this Mercer County program that you alluded to is certainly one aspect of that. I know some years ago we sponsored the bill with regard to the guardianship for the frail elderly which is just one segment of that, but there's been a considerable amount of lag time on that.

So, I think this is something that I would like to see the Committee look at in more depth, because it certainly is a significant part of the population which falls in-between the cracks and that you don't see them every day. There's not enough of it in the media. Maybe you don't even run into these types of folks on a day-to-day basis, but they're there and they need help.

MS. MUELLER: We're really happy to hear that. We feel that CCPED has begun to address the problem, but now we need to move to the next portion of population. Thank you very much.

ASSEMBLYWOMAN CRECCO: Are there any questions? (negative response) Thank you very much. The next person to give testimony is Mr. Frank Power, Bergen County Office on Aging. (no response) He's not here. All right. We have Mr. Tom Carney, Essex County Division on Aging.

UNIDENTIFIED MEMBER OF AUDIENCE: He went out to put money in the meter.

ASSEMBLYWOMAN CRECCO: Oh. We'll wait for Mr. Carney. Perhaps we'll take a five minute break. He'll be right in, I'm sure. Would anyone else like to speak while we're waiting for Mr. Carney? Is there someone here who has not put their name on the slip? (negative response)

(RECESS)

AFTER RECESS:

ASSEMBLYWOMAN CRECCO: Mr. Carney, we'd like for you to give your testimony. Mr. Carney is from the Essex County Division on Aging.

T H O M A S C A R N E Y: Good morning and thank you for the opportunity to speak. I got your notification of this meeting too late to hand in any prepared statement, so I'm going to speak off the cuff.

We're talking about catastrophic illness. HR-2941, as is presently written, is a catastrophe for the elderly. That's the only thing I can say about it at the present time. Nothing much is going to be done for the elderly until one thing happens with Medicare and that is the deletion of that portion of the Medicare law that will not pay for custodial care. That one little sentence in there has bred a whole new industry in the state and in the country.

Your nursing home industry -- they are the ones that are making the money off the seniors. It can cost you anywhere from $25 (sic) to $3000 a month if you go to a nursing home. They're the only ones that will give you nursing home care --

custodial care. We had all these other agencies in place, but because they weren't paid for, they couldn't do it. So until that part of the law is amended, nothing else can be done either by our people down in Congress or at the State level.

Once they start fighting for the custodial dollar, the cost of health care will go down. But before then, they can talk all they want down in Washington, about catastrophic health care, but nothing is going to be done about it. As it is right now the way that bill is written, there's a mixture of apples and oranges. This is an insurance program. And I get damned mad. I'm a senior; I fought for the seniors for the last 13 years. And by God, every time we ask for something or need something, there's has to be a means test. Why? Why are we subjected to this kind of treatment? That's what I want to know. There's no reason in the world for it. We're citizens of the United States and we should not be discriminated against. That's all I'm going to say about that right now.

I'll a little bit out of breath because I had to go down and put some money in the meter for my car. And that bill-- There's no provision made for nursing home care. I wrote to Bill Bradley and I told him that this thing cannot work the way that they are planning it. This is an insurance program. And I don't give a darn if you're a millionaire or a pauper, as long as you pay the premium for the policy -- that everybody gets the same treatment -- there should be no means test in there according to your income. But this is what they are trying to do. Anybody that makes over $6000 is going to be taxed. Now this is mixing apples with oranges. As I said before, this is an insurance program.

Social Security is an insurance program. So therefore, there should be no taxing whatsoever about these benefits. It should be done on a actuarially sound basis. But of course our people down there in Washington don't work that way. I don't know what happens to you when you get elected to

be a public official -- what happens to their thinking? This should not be partisan. This should be nonpartisan. What's best for the elderly of this country -- the same ones who built up all our institutions, paid their taxes, and they're still paying their salaries. Yet every damn time we need something, we have to be subjected to a means test. And I'm sick and tired of it and I want it stopped. Thank you very much.

ASSEMBLYWOMAN CRECCO: Thank you. Any questions? (no response) I agree with you. This is a very serious problem and this is why we are having this Task Force and it certainly has to take priority in the Legislature.

MR. CARNEY: (speaks away from mike) There's means test here. I mean, if you're on prescriptive drugs, you're only $400. It doesn't mean anything for that extra money you're going to pay for. If your doctor's total is less than $1043, you don't get nothing out of it. There's 33 million people on Medicare. And I think I have a few facts here. About 5.5 will receive prescriptive drugs; 1.1 will have maybe two deductibles a year; and 2.3 of the 3 million will have bills over $1043. So that means that everybody else is taxed for those few people. This shouldn't be.

You people are going to be aged one day yourselves and you should be taxed a little bit yourselves out of your pay to pay for all of this too. It shouldn't be on our shoulders. We don't have a (inaudible) more to do. We're living on fixed incomes. And if the elderly haven't got it-- If you think we have, take a look. Get the book -- a little book from the Billers (phonetic spelling), "On the Other Side of Easy Street." Write to the Billers Foundation and get a few of the facts they publish in that book. I think you'll have a pretty good idea of what the situation is with the elderly is in this country. Thank you.

ASSEMBLYWOMAN CRECCO: Thank you. For those of you who are here, I would encourage you to attend the next

scheduled meeting which is on October 26. And as I said, we will have Congressman Matthew Rinaldo here -- and he's a member on the House Select Committee on Aging -- and also Steven L. Grossman, who is the Deputy Assistant Secretary of Health of the United State Department of Health and Human Services. This meeting is adjourned and I thank you.

(HEARING CONCLUDED)

APPENDIX

NEW JERSEY CO-ORDINATING COUNCIL OF ORGANIZED OLDER CITIZENS, INC.

An association of senior citizen organizations at the state and county levels

Oct. 1, 1987

Dear Assembly Woman Crecco;

Thank you for the opportunity to testify before this committee. I am Bernard H. Winstock, President of the New Jersey Coordinating Council of older organized Citizens. Our council considers the passage of a Catasthropic Health Bill the most important problem Seniors are faced with today. We believe that unless this bill covers Home Care and Nursing Home care it will be very lacking in what is needed.

Under the present DRG rules hospitals put pressure on doctors to discharge patients before their time. This has been attested to by doctors appearing before Senator Pallones Committee.

As the rules are now if a patient has recovered to a point where the determination is that no further recovery will be made in the hospital then the patient will be discharged, this even tho he or she is still bedridden or unable to care for themselves. Medicare has a provision to allow nursing care for 21 days or if the patient is sent home for some help but not nearly enough. Further many deseases are not covered by Medicare. If the paerson who has one of these has a spouse they do all they can but the time comes when rhe patient must go to a nursing home.

We have heard testimony before committees from people who retired with what they thought was enough to enable them to live a comfortable life and then such a case occured and they were forced to spend all they had to help the ill spouse .. The other question is what happened when there was no spouse?/ How many of our seniors with no help gave up and welcomed death as a friend? We know ther were many and so we have a question for you and all our people in public office.

When are you going to consider life more important than money? Surely if we have Billions for Defense and we agree that is necessary, we have money for life.

We seniors realize this will cost and we are prepared to pay a reasonable part of this cost. Remember it is far less expensive to keep us in our homes than in a nursing home and when our money is gone we go on Medicaid and you pay.

Bernard H. Winstock
18 Mountain Ave
Rockaway NJ 07866

IX

New Jersey
Business & Industry
Association

102 West State Street • Trenton, New Jersey 08608 • 609-393-7707

TESTIMONY

OF THE

NEW JERSEY BUSINESS & INDUSTRY ASSOCIATION

TO THE

NEW JERSEY TASK FORCE ON CATASTROPHIC AND LONG-TERM HEALTH CARE

September 1987

2X

New Jersey Business and Industry Association, the largest association of employers in the State, welcomes this opportunity to present its views on *catastrophic and long-term health care.*

Before we can discuss the direction New Jersey should take on this subject, we should examine the existing federal program and the direction the federal program is taking. Because of the cost involved, we must be certain that there is no duplication of effort or a state program which would restrict the ability of employers to compete in both national and international markets.

The Medicare Program: Public-Private Sector Cooperation

From its inception in 1965, Medicare was designed as a cooperative effort between the federal government, private employers and American workers. A payroll tax of 1.45 percent (levied on a wage base of $43,800 in 1987) is paid by individual employers and their employees to finance hospital services, skilled nursing care and home health. (Part A).

Part B (physician services) of Medicare is financed through a beneficiary paid premium covering 25 percent of program costs with general revenues making up the rest. Initially, the premium was intended to finance 50 percent of program costs, but, rapidly growing health care inflation quickly convinced lawmakers to enlarge the federal commitment.

NJBIA strongly supports these cost management efforts to maintain the long-term financial integrity of Medicare. It is important to recognize that the Medicare Trust Funds, while financially solvent at present, face an uncertain future.

It is clear that the federal government is in no position to assume increased costs involving an expansion of Medicare services, nor should employers be expected to assume increased responsibilities when they are already struggling to maintain their position in global markets.

Inappropriate shifts of responsibility sometimes produce unintended consequences. An amendment to the Age Discrimination Act in 1982 required companies with 20 or more employees to continue to provide health insurance to workers 65 to 69. Employers were made the primary payer of health care benefits for this category of workers. Previous to passage of the amendment, firms with 100 employees or more had employed three-fourths of workers aged 65 to 69. This figure declined to two-thirds a year later.

Further shifting of federal costs to the private sector should be avoided. Government should continue to be the primary payer of health care benefits for retired persons age 65 and over.

The Private Sector and Post-Employment Health Benefits

In addition to sharing support for Medicare through payroll taxes and general revenues, the private sector has assumed substantial responsibility for providing health benefits to their retirees. Today 84 percent of employees of large firms and nearly half of those working for firms with 100-250 employees participate in health plans that continue health coverage after retirement. Currently, nearly seven million retired Americans and their dependents are covered by these health benefits.

Generally, corporate plans provide coverage to retirees and their families until age 65. After that age the plan is adjusted to recognize what Medicare provides. Often employers pay the Medicare Part B premium for their retirees. Many provide benefits to supplement Medicare (e.g., paying deductible or benefits after Medicare is exhausted).

The federal government has not offered much incentive for the private sector to provide post-employment health benefits. For example, the Deficit Reduction Act in 1982 severely limited the ability of employers to prefund post-employment health insurance for retirees. Prior to that time, certain tax incentives were available. For the private sector to continue its commitment to retirees, incentives such as those lost through DEFRA, should be restored. Such measures will assure continuation of private-public sector cooperation in providing health insurance protection for this group and avoid costly government expansion in this area.

Medicare and Catastrophic Medical Expenses

The prognosis for catastrophic medical expenses for the elderly is not good. Americans 65 and older will more than double between 1980 and 2040, and those 85 and older who are at greatest risk for chronic illness will increase an expected 20 percent over their numbers today. The need for sophisticated medical technologies, prescription drugs and similar items and services will grow while more people dependent on Medicare will severely strain the system.

Thus, it is timely to begin consideration of supplemental alternatives to provide protection for catastrophic medical expenses for the Medicare population. It is also obvious that cost constraints must underlie the program design which should be confined to Medicare covered services only. While the need for long-term non-acute custodial care is significant, federal and state commitments should not at this time use limited resources for this purpose at the expense of providing basic acute care protection. Coverage of other non-acute care services should be maintained through the private insurance system. Commercial insurers and Blue Cross/Blue Shield should continue to improve their products to serve the market they are best suited to handle and limit further expansion of government entitlement programs.

Catastrophic Insurance Proposals

There is a growing consensus for passage of catastrophic health insurance for Medicare beneficiaries. This discussion should recognize that resources are limited to provide currently promised benefits, while health care inflation continues its rapid increase -- 10.7 percent of the GNP or an 8.9 percent increase over the previous year. Thus, it is essential to narrowly define any new program expansion.

Congress is making progress in moving legislation to expand coverage under the federal Medicare program to protect beneficiaries from catastrophic medical costs. The House passed a bill on July 22, 1987 (summary attached) which includes two very controversial provisions: one to impose a mandatory "surtax" on wealthy Medicare beneficiaries to pay for the new benefits; the other

provision would extend broad coverage for outpatient prescription drugs. The Senate version will be considered this fall and a conference committee should iron out differences before the end of the year.

State Legislative Initiatives

Task force recommendations, in our opinion, should be limited to the education of beneficiaries as to programs available. We also suggest that insurance carriers licensed to do business in New Jersey marketing catastrophic and long-term care insurance, should be required to prepare and distribute a complete description of their coverage in simple language. The description of the coverage should also be approved by the Department of Insurance.

Beyond an education program, the State of New Jersey should not involve itself because its past record on health care is poor. The State has *not* resolved the issue of funding for uncompensated hospital care, nor has the State properly funded its Medically Needy program. The first thing that should be done is a review of funding priorities.

Summary and Conclusions

NJBIA supports selected expansion of Medicare to provide catastrophic protection to Medicare beneficiaries for services presently covered by Medicare. Such initiatives must recognize rapidly rising health care inflation, a growing elderly population demanding increased resources, a relatively diminished pool of workers to support Medicare participants in the future, and large federal budget deficits. Program financing must be adequate to: insure that costs not increase; government fiscal responsibility is not shifted to employers; scope of coverage is limited while the private insurance market is encouraged to continue providing supplemental protection; and the program design must adhere to strict cost containment principles. NJBIA strongly opposes any attempts to make employer plans primary for retired Medicare participants.

New Jersey
Business & Industry
Association

102 West State Street • Trenton, New Jersey 08608 • 609-393-7707

Confusion: Care For The Elderly and Catastrophic Insurance

This is a widespread misunderstanding as to what is catastrophic insurance coverage. The confusion, in part, stems from various interpretations of what constitutes a financial catastrophe.

What Is Catastrophic To Whom?

Protection against financially catastrophic health care expenditures has been considered in one form or another for decades, but no consensus has been reached on the definition of catastrophic. Catastrophic medical costs are large and unpredictable health care expenses that can be measured either in flat dollar amounts, for example $5,000 in medical costs in a 12-month period, or in percentage of gross income, generally defined as costs exceeding 10 percent gross income. What is critical in this first differentiation of catastrophic is that a medical cost of $5,000 can be devastating for a lower income family but not account for 10 percent of a more affluent family's $60,000 income. An additional difficulty in understanding this issue is that large out-of-pocket health care costs are not associated solely with rare illness events. A 1986 study using data from the 1977 National Medical Care Expenditure Survey (NMCES) found that low income and poor health insurance coverage accounted for catastrophic expenditures in four out of five families who spent 10 percent or more of their income on medical care. Therefore, there is a tension between the notion of a high cost catastrophic illness event and the severe catastrophic financial burden on a particular individual or family. Since incomes, debts and savings are unequal, one person's inconvenience can be another person's catastrophe.

One proposal under consideration suggests that a fixed dollar amount of out-of-pocket burden for the over 65 population in its catastrophic illness coverage proposal. Another proposal is to enhance existing coverage and varying the financing by ability to pay without defining catastrophic as a percentage of income. Many economists support this concept that a percentage of income is a more equitable definition from a social welfare prospect.

The U.S. Department of Health and Human Services suggests that the most useful definition of catastrophic expense to be a flat dollar cap that permits the identification of illness costs that can be borne by individuals and families without having to "significantly change their expectations of living standards in the future." The DOH&H rejected a percentage of income threshold as unsatisfactory because for extremely low income populations, it would define as catastrophic the expense levels associated with routine and normal health care costs.

Poor Elderly at Greatest Risk

Today, older Americans are spending a higher proportion of their incomes on health care than was the case when Medicare was first enacted in 1965. Twenty-two years later, catastrophic health care costs have been identified

once again as a major problem for the nation's elderly. The real issue is in the way the root of the financial hardship is understood and approached. According to the Congressional Budget Office (CBO), not including nursing home and other long-term care, the elderly spent an average $1,055 on their own medical expenses in 1984 -- more than three times the amount ($310) spent by persons under age 65. Counting nursing home costs, average out-of-pocket health expenses reached $1,075 per year for the elderly -- more than five times the cost experienced by others. As alarming as these figures are, they provide little insight into the distribution of economic pain experienced by this nation's seniors.

Except for nursing home needs and unusually long hospitalizations, Medicare has been an effective cornerstone in meeting daily medical needs of the elderly with incomes above $20,000. Used in conjunction with private supplemental insurance, Medicare has kept health care costs for the higher income elderly to a very manageable portion of their budgets. The opposite is true for lower income seniors. Contrary to beliefs about the greening, that is, the growing wealth of the aged, millions of older Americans are experiencing dwindling resources as a result of out-of-pocket medical costs frequently ranging from one-quarter to one-third of their incomes. This certainly is true for a large portion of the 3.3 million elderly poor. It also is the case for a substantial portion of an additional 8.1 million economically vulnerable seniors, whose incomes fall below 200 percent of the poverty line, which, for an elderly person living alone, is $5,360 per year. For these 11.4 million lower income aged, who comprise 42 percent of the elderly population, catastrophically high health care costs are common occurrences. These hardship conditions may be exacerbated, not ameliorated, by most of the pending catastrophic health care proposals.

Medicare Gaps Widening

Medicare out-of-pocket expenses fall into two categories: services that Medicare does not cover; and expenses such as deductibles, premiums and coinsurance. Medicare fails to cover a wide array of health care needs that are essential to the aged population, such as prescription drugs, dental care, basic preventive services, prosthetic devices, eye glasses and hearing aids. Chronic nursing home and other long-term care also are excluded.

Although the scope of Medicare's protection has not changed materially in recent years, the effects of its coverage gaps have been exacerbated by skyrocketing health costs. This is clearly evident for prescription drugs. The elderly account for 28 percent, or approximately $8 billion per year, of all prescription drug costs even though they constitute only 11.7 percent of the population. From January 1980 through 1985, prescription drug costs rose by 66 percent. It is not unusual now for an elderly person with a common health problem like angina, diabetes or arthritis to pay $50 or more per month for drugs. For lower income elders particularly, prescription drug costs alone can represent a very significant percentage of their income. This summer, the House of Representatives approved an amendment to the catastrophic bill that allows for some prescription drug coverage.

Also, the services that are covered by Medicare -- hospital care (Part A) and physician services (Part B) -- require elders to share the costs and these out-of-pocket expenditures have increased dramatically in recent years. For example, for each "spell of illness" in a hospital, Medicare requires the patient to pay a deductible of $520. This figure -- up 189 percent in the last seven years -- is a significant burden, especially for approximately 20 percent of beneficiaries who have no supplemental insurance.

8X

Ironically, congressional efforts to control Medicare's hospital costs have had the unintended effect of increasing the Part A deductible and other out-of-pocket costs for elders. In 1983, Congress introduced the prospective payment system (PPS), which forced hospitals to be much more cost conscious in their patient care. As a result, hospital administrators have every incentive to discharge Medicare patients much sooner. Since PPS began, average hospital stays by Medicare patients have decreased by approximately two days. Patients discharged earlier now must shoulder a wide variety of health related costs in the home -- costs that previously were picked up by Medicare's hospital coverage. In a 1987 report, the Prospective Payment Assessment Commission (ProPAC) identified a $550 million cost shift to beneficiaries as a result of PPS.

Elderly individuals also are paying a substantial amount under Part B, and pending catastrophic proposals would add to that cost sharing in the future. To receive Part B coverage, seniors must pay a premium, which has risen from $115.20 in 1981 to $215 currently -- an increase of 86 percent. Once enrolled, Medicare's coverage starts only after beneficiaries pay a deductible of $75, up from $60 in 1981.

Beyond these initial costs, patients covered by Part B must pay 20 percent of all physicians' bills up to Medicare's reasonable charge levels. The federal government does not prohibit physicians from charging fees in excess of those levels, and approximately 70 percent of all physicians charge some or all of their Medicare patients higher amounts, called balance billing. These patients must pay the full amount of the excess. In fact, Health Care Financing Administration (HCFA) actuaries indicated that 22 percent of the out-of-pocket costs for beneficiaries expending $2,000 or more was a result of balance billing. The rock bottom cost experienced by a hospitalized beneficiary -- involving only Medicare's deductibles and premium -- is currently $810. Add to this the normal 20 percent coinsurance, plus the full brunt of physician charges above the reasonable charge level, and the expenses are likely to be considerable. When prescription drug bills and costs associated with the services uncovered by Medicare are factored in, the potential for economic catastrophe is significant.

The impact of these costs is dramatically different for lower income seniors than it is for their brethren who are better off. For the higher income aged, these out-of-pocket expenses may be an undesired irritant, but generally are a fraction of annual income. Additionally, the vast majority of higher income seniors purchase private supplemental -- that is, Medigap -- insurance, which, although not usually cost-effective, insulates them against Medicare's deductibles, copayments and in some cases prescription drug costs. Thus for higher income elders, adequate protection exists if they do not need nursing home or other long-term care, and if they are not in the one percent of the aged who require hospitalization for more than 60 days a year.

Constraints Under Medicaid

Perhaps the least understood facet of lower income elderly's health costs problems, however, is the inadequacy of Medicaid, the health care program for the poor. It is mistakenly believed that Medicaid covers impoverished and economically vulnerable elders for virtually all medical costs and thereby acts as an effective wraparound policy to Medicare. Unfortunately, this assumption generally is not true. Although Medicaid provisions vary from state to state, for a majority of the aged poor, Medicaid

provides no relief at all. According to the U.S. Census Bureau 1984 Current Population Survey, only 36 percent of the noninstitutionalized aged poor participate in Medicaid. This means that two out of three impoverished elderly not in nursing homes receive no Medicaid assistance, thus bearing the full brunt of Medicare's deductibles, premium, cost sharing and uncovered services.

Medicaid coverage does eliminate the out-of-pocket physician and hospitalization costs for some elderly in most states. Currently 2.8 million seniors are dual eligibles, that is, Medicare at least has purchased the Part B premium on their behalf but does not necessarily pay the deductibles and coinsurance. In general, aged Medicaid beneficiaries are likely to receive help for some of the services not covered under Medicare, such as the partial prescription drug coverage offered under Medicaid in 46 states and the District of Columbia. Thus, the potential for significant health care relief is present under Medicaid.

Usually, seniors must meet the extremely low income and liquid asset levels set for the Supplemental Security Income (SSI) program to qualify for Medicaid assistance. In most states the annual income eligibility limit for a person living alone is $4,080 and, in the minority of states that have higher limits, only three -- California, Connecticut and Massachusetts -- have eligibility standards above the poverty line. Additionally, an aged person fails to qualify for SSI if his or her liquid assets exceed $1,800, a standard that limits program eligibility to the financially destitute. Of those who fall within these standards, many do not participate because they are unaware of the program's existence and requirements. Hence, senior participation in SSI and in Medicaid is limited to some of the poorest of the poor. Most impoverished elders, and an even larger portion of the economically vulnerable, receive no protection from growing catastrophic health care costs.

Most Americans generally are unaware that neither Medicare nor their private Medigap insurance covers the high costs of long-term care. Of the $35.2 billion in nursing home expenditures in 1985, Medicare paid only 1.7 percent; the rest came from Medicaid and personal resources. The reason for Medicare's small contribution to financing nursing home lies in the very nature of the program's nursing home benefit, which limits coverage to hospital extended acute care and does not include custodial care.

Although Medicare does pay for unlimited numbers of home health visits without a prior hospitalization requirement, coverage is restricted to those who are homebound and are in need of skilled nursing care, physical therapy or speech pathology under physician supervision. In addition, because it recognizes only a medical model of home health care, Medicare does not pay for many of the social support services that might allow more elderly impaired individuals to remain in their own homes.

Medicaid, on the other hand, is the largest public financing mechanism for long-term care. Accordingly, Medicaid payment for nursing home services in 1985 amounted to almost $15 billion. Added to the personal pain and suffering individuals experience as they decline in their ability to perform even the basic activities of daily life is the fact that long-term care is the leading cause of catastrophic health care expenditures. Data from CBO show that an estimated 47.5 percent of elderly receiving Medicaid in nursing homes were not eligible when they first entered. This figure alone illustrates the number of individuals who have spent down to poverty levels to receive any type of coverage for their nursing home care. Many find the notion of exhausting a lifetime of savings and applying for public assistance a severely demanding and overwhelming prospect in their old age.