TOWARDS A STRATEGY FOR LONG-TERM CARE FINANCING AND SERVICE DELIVERY: MEETING THE CHALLENGE AND THE NEED

Findings and Recommendations of the

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

Honorable Marion Crecco, Chairperson

December 23, 1987

Governor
Speaker of the General Assembly
President of the Senate
Members of the Legislature

Ladies and Gentlemen:

I am very pleased to transmit with this letter the report of the findings and recommendations of the New Jersey Task Force on Catastrophic and Long-Term Health Care.

The task force, which was established pursuant to Assembly Resolution No. 151 of 1987, sponsored by Assemblyman Haytaian and myself, conducted an intensive study of catastrophic and long-term health care issues over a period of five months. The task force held four public hearings to gather information about federal and State policy directions and options, initiatives launched by other states, the scope of existing public programs and private insurance coverage, and regulatory arrangements, with a primary focus on long-term care financing and the unmet needs of elderly and disabled persons who require chronic, long-term care.

The response to our request for information by individuals and organized groups was very gratifying. The task force wishes to thank the federal and State government officials and elected representatives, senior citizens, county offices on aging, insurance companies, health care providers and planners, academicians, labor and business representatives and others who provided extensive information to us. Their testimony was invaluable to the task force in fulfilling its mandate.

I would like to thank my fellow legislators and the representatives of the Departments of Community Affairs, Health, Human Services and Insurance who served with me on the task force. Their participation in the task force hearings and their careful consideration of the issues discussed were essential to the deliberations which resulted in the enclosed report. It has been a pleasure for me to have had the opportunity to work with these knowledgeable and dedicated individuals.

On behalf of the task force, I would like to express our appreciation and thanks to the staff persons from the General Assembly and the Office of Legislative Services who were involved in our work. In particular, I would like to thank Deborah Smarth of the Assembly Majority staff, Mary Messenger of the Assembly Minority staff, and David Price of the Office of Legislative Services for their contributions to this effort.

I am hopeful that the findings and recommendations of the New Jersey Task Force on Catastrophic and Long-Term Health Care will assist the Governor and the Legislature in developing innovative and effective policies to meet the long-term care needs of senior citizens and disabled persons. The need of these people today will be the need of many of us tomorrow, and the challenge of our government and our society is to respond to this issue with all of the creativity, compassion and common sense that are within us. I believe that we can respond to that challenge, and that we must do so now.

For this reason, I intend to introduce legislation early in the 1988-89 session of the State Legislature to implement a number of the recommendations contained in the task force report. I hope for prompt action on these measures and pledge my best efforts to work with all interested and concerned parties to ensure swift passage in the General Assembly and the Senate and approval by the Governor.

Sincerely,

Marion Crecco

Honorable Marion Crecco
Chairperson

MC:dp

MEMBERS OF THE NEW JERSEY TASK FORCE

ON CATASTROPHIC AND LONG-TERM HEALTH CARE

HONORABLE MARION CRECCO, Chairperson,
Assemblywoman, District 30

HONORABLE WILLIAM P. SCHUBER,
Assemblyman, District 38

HONORABLE THOMAS J. DEVERIN,
Assemblyman, District 20

HONORABLE GEORGE J. OTLOWSKI,
Assemblyman, District 19

MARIAN BASS (representing the Commissioner of Human Services),
Director, Office of Program Evaluation, Analysis and Strategic Planning,
Department of Human Services

THERESA DIETRICH (representing the Commissioner of Community Affairs),
Program Development Specialist, Division on Aging,
Department of Community Affairs

PAUL LANGEVIN (representing the Commissioner of Health),
Assistant Commissioner for Health Facilities Evaluation,
Department of Health

JEANNE SIMS (representing the Commissioner of Insurance),
Special Deputy Commissioner,
Department of Insurance

PERSONS AND ORGANIZATIONS SUBMITTING TESTIMONY TO THE NEW JERSEY TASK FORCE ON CATASTROPHIC AND LONG-TERM HEALTH CARE:

ELECTED OFFICIALS:

HONORABLE MATTHEW J. RINALDO,
Member, U.S. House of Representatives,
District 7, New Jersey

HONORABLE JOSEPH L. BOCCHINI, JR., Assemblyman, District 14

HONORABLE JOHN E. ROONEY, Assemblyman, District 39

FEDERAL GOVERNMENT OFFICIALS:

STEVEN A. GROSSMAN, Deputy Assistant Secretary for Health,
U.S. Department of Health and Human Services

MARK R. MEINERS, Ph.D., Senior Research Manager,
National Center for Health Services Research and
Health Care Technology Assessment,
U.S. Department of Health and Human Services

SENIOR CITIZEN REPRESENTATIVES:

ESTHER C. ABRAMS, Chairperson,
New Jersey State Legislative Committee,
American Association of Retired Persons

THOMAS H. CARNEY, New Jersey Federation of Senior Citizens

AL EVANOFF, Cochairman, New Jersey Health Care Coalition

BERNARD H. WINSTOCK, President,
New Jersey Co-ordinating Council of Organized Senior Citizens, Inc.

COUNTY OFFICES ON AGING:

EDWARD HUBSCHMITT, Advisory Council, Passaic County Office on Aging

PHILIP H. PEARLMAN, Executive Director,
Union County Division on Aging

FRANK POWER, Senior Planner,
Bergen County Office on Aging

HEALTH CARE PROVIDERS:

JAMES E. CUNNINGHAM, President,
New Jersey Association of Health Care Facilities

JILL MUELLER, Member, Board of Directors,
Home Health Agency Assembly of New Jersey, Inc.

ACADEMIA:

WILLIAM P. BRANDON, Ph.D., M.P.H.,
Associate Professor of Political Science,
Center for Public Service, Seton Hall University

STEVEN CRYSTAL, Ph.D., Director, Division of Aging,
and Associate Research Professor,
Institute for Health, Health Care Policy and Aging Research,
Rutgers University

EMMA QUARTERO, D.S.W., Director, Gerontology Program,
and Chairperson, Department of Social Work,
Seton Hall University

ANNE SOMERS, Ph.D.,
Adjunct Professor of Environmental and Community Medicine,
UMDNJ-Robert Wood Johnson Medical School

BUSINESS AND INSURANCE:

RICHARD W. LLOYD, Director, Public Relations,
Blue Cross and Blue Shield of New Jersey, Inc.

New Jersey Business and Industry Association

JAMES O'BRIEN, The Prudential Insurance Company of America

CHRIS PETERSEN, Assistant Counsel,
Health Insurance Association of America

LINDA SCHOFIELD, Assistant Director for Government Affairs,
The Travelers Companies, and
Senior Consultant and Research Director for the Connecticut Governor's Commission on Private and Public Responsibilities for Financing Long-Term Care for the Elderly

ORGANIZED LABOR:

AL WURF, Representative on health care issues,
New Jersey State Chapter,
American Federation of State, County and Municipal Employees

HEALTH PLANNERS:

KENNETH MAUGLE, State Health Plan for the Elderly

EDWARD J. PELOQUIN, Executive Director,
Central Jersey Health Planning Council, Inc.

OTHER:

ED DAVIES

KENNETH GOLDMAN, Member, Advisory Board for New Jersey,
Cancer Care, Inc.

MAUREEN McCARTHY, Health Care Organizer,
New Jersey Citizen Action

ELEANOR B. STONE, Director of Government Relations,
Association of Jewish Federations of America

ASSEMBLY RESOLUTION No. 151

STATE OF NEW JERSEY

INTRODUCED MAY 18, 1987

By Assemblyman HAYTAIAN, Assemblywomen CRECCO, Cooper, Assemblymen Singer and Paterniti

AN ASSEMBLY RESOLUTION establishing the New Jersey Task Force on Catastrophic and Long-Term Health Care.

WHEREAS, The Medicare program, pursuant to Title XVIII of the federal Social Security Act, Pub. L. 89-97 (42 U. S. C. § 1395 et seq.), provides very limited coverage to meet the costs of acute catastrophic illnesses or disabilities or long-term health care, either at home or in a skilled nursing facility, and, as a result, the Medicare program pays for less than half of the total health care costs of senior citizens; and

WHEREAS, In spite of the Medicare and Medicaid programs and their private health insurance policies, senior citizens, about 20% of whom are hospitalized each year, must use their own funds to pay approximately one fourth of their health care costs; and about 25% of them will at some point require care in a nursing home, at a cost of approximately $22,000.00 a year, with only 16 weeks of nursing home care being required for an average senior citizen to deplete his life's savings and be forced to rely on the Medicaid public assistance program to pay for that care; and

WHEREAS, The importance of the issue of catastrophic and long-term health care coverage and the need for legislative remedies to address this issue have been highlighted by the recent proposals at the federal government level and by several legislative bills now being considered in the United States Congress; as well as being vividly illustrated in this State by the findings of

the New Jersey Home Health Care Task Force established by Congressman Dean Gallo and by the recent hearings in New Jersey conducted by the Select Committee on Aging of the House of Representatives, which was presided over by Congressman Matthew Rinaldo and attended by Congresswoman Marge Roukema, a member of the House Republican Leadership Task Force on Health Care, and by the Subcommittee on Health and Long-Term Care of the Select Committee on Aging under the chairmanship of Congressman Claude Pepper; and

WHEREAS, There is a clearly demonstrated need for a bipartisan effort on the part of the legislative and executive branches of State government, working in conjunction with the ongoing efforts of the members of the United States Congress, to examine and develop recommendations on the issues, options and programs relating to the financing of catastrophic and long-term health care which impact upon the citizens of this State; now, therefore,

BE IT RESOLVED *by the General Assembly of the State of New Jersey:*

1. This House establishes the New Jersey Task Force on Catastrophic and Long-Term Health Care, which shall consist of eight members as follows: four members of the General Assembly to be appointed by the Speaker of the General Assembly, no more than two of whom are members of the same political party, and, upon the request of the Speaker of the General Assembly, the Commissioners of Human Services, Health, Insurance and Community Affairs, or their designees.

The chairman of the task force shall be selected by the Speaker of the General Assembly.

a. It shall be the responsibility of the task force, working in conjunction with the ongoing efforts of the members of the United States Congress, to examine and develop recommendations on the issues, options and programs relating to the financing of catastrophic and long-term health care which impact upon the citizens of this State, including, but not limited to, the following subjects:

(1) The current costs of both institutional and home and community-based long-term health care delivery options that are available or potentially feasible, and various means of financing these options;

(2) Methods for encouraging private savings to meet at least a portion of the costs of catastrophic and long-term health care;

(3) The feasibility of developing private health insurance policies to cover the costs of catastrophic and long-term health care;

(4) The feasibility of developing a State program to provide catastrophic health care coverage for portions of the general population; and

(5) Appropriate and necessary reforms of existing State programs, or the development of new programs, to provide assistance in meeting the costs of long-term health care, with an emphasis on providing home and community-based care.

b. The task force shall present a report of its findings and recommendations to the Governor and the Legislature by January 1, 1988.

2. Duly authenticated copies of this resolution, signed by the Speaker of the General Assembly and attested by the Clerk of the General Assembly, shall be forwarded to the Governor and to each of the members of the Congress of the United States elected from the State of New Jersey.

STATEMENT

This resolution establishes the New Jersey Task Force on Catastrophic and Long-Term Health Care to examine and develop recommendations on the issues, options and programs relating to the financing of catastrophic and long-term health care which impact upon the citizens of this State. The task force will present a report of its findings and recommendations to the Governor and the Legislature at the conclusion of the current session of the Legislature. The task force is to consist of eight members, including four members of the General Assembly, two from each party, and the Commissioners of Human Services, Health, Insurance and Community Affairs, or their designees, at the request of the Speaker of the Assembly.

HEALTH CARE FACILITIES AND PROVIDERS

New Jersey Task Force on Catastrophic and Long-Term Health Care.

TABLE OF CONTENTS

SUMMARY OF RECOMMENDATIONS BY THE NEW JERSEY TASK FORCE ON CATASTROPHIC AND LONG-TERM HEALTH CARE:

- PRIVATE LONG-TERM CARE INSURANCE: Stimulate the development of a private long-term care insurance market in the State.

- EMPLOYER SPONSORSHIP: Offer long-term care insurance coverage to State employees and retirees, and encourage similar plans among private employers.

- TAX INCENTIVES: Provide tax incentives to employers to offer long-term care insurance benefits to their employees and retirees, to individuals to purchase these types of policies, and to insurance companies to market them.

- CONSUMER PROTECTION: Provide for appropriate regulations by the Department of Insurance to protect consumers against substandard policies and sales abuses in the marketing of long-term care insurance policies, including a requirement of clear disclosure of policy provisions, as well as preparation of a buyer's guide by the department.

- REGULATORY FLEXIBILITY: Encourage the development of innovative long-term care insurance products through regulations by the Department of Insurance that are sufficiently flexible to allow for new design features and to encourage the development of various private sector approaches to providing long-term care coverage.

- RISK-POOLING ARRANGEMENTS: Encourage the development of various risk-pooling arrangements to provide private long-term care insurance coverage, including consortia that involve senior citizen organizations, labor unions and employers.

- HOME EQUITY CONVERSION: Educate the public about home equity conversion as a resource for elderly and disabled homeowners to finance long-term care.

- INDIVIDUAL MEDICAL ACCOUNTS (IMAs): Amend the State income tax law to allow individuals to save for their medical, dental and long-term care needs through tax-deductible contributions to IMAs.

- ALTERNATIVES TO INSTITUTIONAL LONG-TERM CARE: Facilitate the development of home and community-based alternatives to nursing home care through the creation of residential service facilities, the expansion of alternative housing arrangements for elderly and disabled citizens and enactment of the Home Care Expansion Program.

- SOCIAL HEALTH MAINTENANCE ORGANIZATIONS (SHMOs): Require the Commissioners of Health and Human Services, contingent upon the results of current demonstration projects in other states, to undertake a joint study of the feasibility of developing a SHMO demonstration project in New Jersey.

- PUBLIC EDUCATION: Establish a coordinated public education campaign between State government and the private sector to notify consumers about the risks, costs and financing options available in regard to long-term care and the limitations on Medicare and Medicare supplemental (Medigap) insurance and traditional health insurance coverage for long-term care.

- LONG-TERM CARE STUDY COMMISSION: Establish a study commission to develop specific solutions in the context of a long-range strategy for financing long-term health care, to include representation from the Legislature, the relevant State departments, the business and insurance communities, organized labor, senior citizens, academia and health care providers and consumers.

- LONG-RANGE STRATEGY FOR FINANCING LONG-TERM CARE: Design a long-range strategy, preferably through the efforts of the proposed study commission, in such a way as to encompass preventive measures to reduce and delay the need for long-term care (particularly institutional care) by our elderly population. These should include various means of maintaining and strengthening the social supports, economic independence and physical and mental well-being of this population, e.g., facilitating extended employment of older adults, disease prevention and health promotion, expanded research into the diseases of old age and support for enhanced gerontological training of health professionals.

I. INTRODUCTION

The New Jersey Task Force on Catastrophic and Long-Term Health Care was established pursuant to Assembly Resolution No. 151 of 1987, sponsored by Assemblyman Garabed "Chuck" Haytaian and Assemblywoman Marion Crecco, which was approved by a vote of the New Jersey General Assembly on May 18, 1987.

Pursuant to the above resolution, the task force included eight members as follows: four members of the General Assembly who were appointed by the Speaker of the General Assembly, no more than two of whom were to be members of the same political party; and, upon the request of the Speaker of the General Assembly, the Commissioners of Human Services, Health, Insurance and Community Affairs, or their designees. The Speaker of the General Assembly appointed Assemblywoman Marion Crecco as chairperson of the task force.

Assembly Resolution No. 151 directed the task force, working in conjunction with the ongoing efforts of the members of the United States Congress, to examine and develop recommendations on the issues, options and programs relating to the financing of catastrophic and long-term health care which impact upon the citizens of New Jersey, including, but not limited to, the following subjects:

(1) The current costs of both institutional and home and community-based long-term health care delivery options that are available or potentially feasible, and various means of financing these options;

(2) Methods for encouraging private savings to meet at least a portion of the costs of catastrophic and long-term health care;

(3) The feasibility of developing private health insurance policies to cover the costs of catastrophic and long-term health care;

(4) The feasibility of developing a State program to provide catastrophic health care coverage for portions of the general population; and

(5) Appropriate and necessary reforms of existing State programs, or the development of new programs, to provide assistance in meeting the costs of long-term health care, with an emphasis on providing home and community-based care.

Assembly Resolution No. 151 further directed the task force to present a report of its findings and recommendations to the Governor and the Legislature by January 1, 1988. This report is submitted pursuant to that mandate and reflects the substantial and insightful testimony presented to the task force from a variety of interests and perspectives, including those of federal and State government officials, members of the United States Congress and the State Legislature, the insurance and business communities, health care providers, senior citizens, county offices on aging, organized labor and academia. This testimony was presented in a series of public hearings conducted by the task force: on August 31, October 1, October 26, and November 24, 1987.

The establishment of the New Jersey Task Force on Catastrophic and Long-Term Health Care was based on a demonstrated need for a bipartisan effort on the part of the legislative and executive branches of State government. Working in conjunction with the ongoing efforts of the members of the United States Congress, the task force has examined and developed recommendations on the issues, options and programs relating to the financing of catastrophic and long-term health care which impact upon the citizens of this State. In that spirit, the task force presents this report for consideration by the Governor, the Legislature, the relevant departments of State government and the public.

The task force has focused its efforts on long-term care financing and service delivery issues because long-term care is the major cause of catastrophic health care expenditures, and because the federal government, through the Medicare program, provides more coverage for acute care than for either institutional or home and community-based long-term care. In regard to the financing of acute catastrophic care, the task force is encouraged by recent legislative developments at both the federal and State levels. These include the passage by both Houses of Congress of legislation to expand Medicare coverage for hospital care and provide a Medicare prescription drug benefit, and the passage by the New Jersey General Assembly and Senate of Senate Bill No. 1550 of 1986 (DiFrancesco) to establish a Catastrophic Illness in Children Relief Fund.

This report is not intended to provide a specific blueprint to guide the details of policy implementation but, rather, to set a tone and direction for State government, the insurance and business communities, and individuals as potential consumers of long-term health care services. A new century draws near, and we face the prospect of a continual aging of our population through at least the first third of that century, accentuated by the "graying" of the "baby boom" generation. It is estimated that by the year 2000, people 65 years of age and older will constitute 14.7% of the population in this State, and that by the early 21st century, one in five New Jerseyans will be a member of this age group.

It is time to forge an effective and creative strategy, using the resources of both the public and private sectors, with the ultimate objective of insuring that every person who is in need of chronic, long-term health care has the means to finance that care, either in an institutional setting or in the person's home or community, without destituting himself or his family.

II. BACKGROUND

The Medicare program, enacted in 1965 as Title XVIII of the federal Social Security Act, Pub. L. 89-97 (42 U.S.C. § 1395 et seq.), is the health care program most closely associated with the elderly.

Medicare provides hospital insurance under Part A of that program, and supplementary medical insurance to cover physician fees and other medical services and supplies under Part B of that program, to some 31 million beneficiaries, including people 65 and over, persons eligible for Social Security disability payments for at least two years, and certain workers and their dependents who require kidney transplantation or dialysis. Medicare provides limited coverage, however, for acute catastrophic illnesses or disabilities or short-term rehabilitative care and severely limited coverage for long-term care, either at home or in a skilled nursing facility.

The Medicare program pays for less than half of the total health care bill of the elderly because of limitations on Medicare payments for covered services, and because of the lack of Medicare coverage for certain medical care services. The limitations on Medicare payments include: the current deductible of $520 for the first day's stay in a hospital and coinsurance amounts of $130 a day for hospital stays of between 61 and 90 days and $260 a day for those hospitalized even longer, in addition to monthly premiums, the current annual deductible of $75, and a 20% coinsurance payment and payments for a physician's billed charges that exceed the Medicare "reasonable charge" for Part B services. In addition, Medicare does not provide coverage for: skilled nursing care over 100 days, any custodial or intermediate long-term care services, outpatient prescription drugs, routine physical examinations, eyeglasses, hearing aids and nonsurgical dental care.

Because Medicare does not cover the chronic care needs of the elderly and because Medicare supplemental policies and private long-term care insurance cover less than 2% of national nursing home expenditures, the burden of an unprecedented demand for long-term care services falls on the elderly through out-of-pocket expenditures and on state governments through the Medicaid program, which is the major public funding mechanism for long-term care in this country. In 1984, 50.4% of nursing home expenditures were paid out-of-pocket and 41.5% were paid by Medicaid. Nursing home care is the leading cause of catastrophic out-of-pocket health care expenditures by the elderly; however, most persons who enter nursing homes as private pay patients quickly deplete their savings and "spend down" to meet the Medicaid asset eligibility limit, at the same time depleting most of the assets of the non-institutionalized spouse.

Current long-term care service delivery is tilted towards nursing home care because of the institutional bias of the Medicaid program. In 1985, total Medicaid nursing home expenditures nationwide were $16.3 billion, while home health expenditures totaled only $1.1 billion. Home and community-based alternatives that can more appropriately serve less disabled persons, and which survey data indicate are preferred to nursing homes by most people in need of long-term care, are still being developed and are not available in some communities.

In New Jersey, expenditures for institutional care represent the single largest component (32%) of the Medicaid budget, but provide care for only 14% of Medicaid recipients. Medicaid expenditures for nursing home care in this State increased at an average annual rate of 18% from FY 1981 to FY 1987, from $218 million to $452 million. At the current rate of increase, by 1992, private citizens and the State Medicaid program will spend over $2 billion a year on institutional long-term care.

Even with Medicare, Medicaid and private health insurance coverage, the elderly pay about one quarter of their health care costs out-of-pocket. One of every five elderly persons is hospitalized each year, and some 22% reenter the hospital within 60 days. In addition, one of every four elderly persons will at some point require nursing home care, at an average annual cost of about $22,000.

It is clear, then, that many senior citizens are forced to incur huge out-of-pocket expenses for health care services and are at risk of a long debilitating illness which could deprive them of their financial independence and force them to become dependent on public assistance or seek support from their children. The latter may be "young elderly" persons with their own health care needs (about 10% of the elderly have a son or daughter who is also over 65).

There has been, in recent years, a growing awareness among our nation's elected representatives of the imperative need to provide some kind of catastrophic health insurance protection to senior and disabled citizens, as reflected in the legislation now pending in the 100th Congress. The importance of the catastrophic health care issue was underscored by the recommendations for federal action made by the United States Secretary of Health and Human Services to President Reagan in November 1986, and has been highlighted in this State by the public hearings which were conducted here by the Select Committee on Aging of the House of Representatives and its Subcommittee on Health and Long-Term Care.

The catastrophic health care legislation now being considered by Congress would place an upper limit on the liability of Medicare beneficiaries for deductibles and coinsurance under that program and would remove the limits on covered inpatient hospital days, in addition to providing some coverage for prescription drug costs. At this point, similar bills have passed

both the House of Representatives and the Senate and must be reconciled in conference. Substitute legislation, which was rejected in the House of Representatives, would have also provided tax incentives to stimulate the development of a private long-term care insurance market by encouraging insurers to offer, and beneficiaries to purchase, these kinds of policies.

The legislation which has passed both the House and the Senate provides for a new method of financing additional Medicare benefits for acute care and prescription drugs: supplemental premiums for beneficiaries based upon their income level. According to some critics of the legislation, these supplemental premiums, which would be collected by the Internal Revenue Service along with individual income taxes, constitute a new tax on the elderly. In addition, the legislation does not provide Medicare coverage for chronic, long-term health care or incentives for the expansion of private insurance coverage.

It is apparent from the congressional debate over catastrophic health care legislation that our nation's lawmakers will weigh their growing awareness of the needs of those persons who lack adequate long-term care insurance coverage against the need to limit public expenditures in order to reduce the enormous federal budget deficit. Therefore, any strategy for addressing the issue of chronic, long-term care financing at the State level must assume that substantial additional federal funding for long-term care is highly unlikely in the foreseeable future. The findings and recommendations of this report are based on that assumption.

III. PRIVATE LONG-TERM CARE INSURANCE

State governments are currently examining a wide array of private sector financing initiatives in order to reduce the burden of long-term health care financing on their respective Medicaid programs. These initiatives include long-term care insurance, home equity conversion, individual medical accounts, life care communities and social health maintenance organizations. Even modest changes in the availability and use of these alternatives by New Jersey's elderly and disabled citizens would protect some of them against the threat of impoverishment from long-term care expenses while resulting in substantial savings to State government.

The development of a private long-term care insurance market can assist in moderating the rate of increase in public expenditures for long-term health care at both the federal and State level. Such a market also has the potential to provide affordable coverage for people in need of such care. Unfortunately, according to a 1987 report by the United States General Accounting Office, policy restrictions and limitations on long-term care policies that are currently being marketed tend to reduce the benefits available to policyholders, and the lack of uniform standards and marketing requirements means that consumers have little protection against substandard policies and sales abuse.

In New Jersey, only six insurance companies currently offer nursing home policies for sale. Only two of these companies sell policies which cover custodial nursing home care, and only three sell policies which cover home health care. In each case, there are restrictions, e.g., a requirement of skilled nursing care and waiting periods ranging from 15 to 100 days before coverage begins, or severe coverage limitations, e.g., one half of the daily nursing home benefit chosen for home health care.

According to information provided by the Department of Insurance, only one company currently offers a nursing home policy for sale in New Jersey which covers both custodial nursing home care and home health care. Based upon figures supplied by the department, a New Jersey resident buying a nursing home insurance policy from that company would pay an annual premium ranging from $21 to $208 at age 55 (depending upon the degree of coverage), from $52 to $517 at age 65 and from $153 to $1,532 at age 75. Under the terms of the policy, however, custodial care must occur within 30 days after a skilled nursing facility stay of at least 20 consecutive days, and home care must occur after 90 days of skilled, intermediate or custodial care.

The rates on premiums for long-term care policies vary widely among products depending upon the age at the time of purchase, the features of the policy, the actuarial assumptions underlying the marketing strategy and the overhead charged by the insurer. The wide range of premiums indicates a lack of standardization and a clear need for consumers to be well informed about the limitations, restrictions, exclusions and benefits of various policies.

Consumers considering the purchase of long-term care insurance need to be aware of the various features of available policies, such as benefits, scope of coverage, premiums and restrictions, which contribute to the complexity of this issue. Insurers have used a variety of means to control or limit the degree of risk entailed in the sale of nursing home policies. These include the use of specific service definitions to determine the benefit amount, prior hospitalization requirements, requiring physician review of the continuing need for care, screening for pre-existing health conditions, exceptions to coverage for such items as mental disorders without demonstrable organic cause (which could exclude Alzheimer's disease), providing for possible premium adjustments and not providing guaranteed renewability of the policy.

There are several barriers to the development of a market for long-term care insurance products. Insurers are wary of "adverse selection," i.e., the purchase of policies largely by those most likely to use them. Insurers are also concerned about "insurance induced demand" or "moral hazard," i.e., the greater use of services simply because coverage is available. Companies have also been reluctant to enter this market because of the lack of historical data on which to base actuarial projections and the fear that inaccurate rate setting could result in substantial losses. The lack of case management systems to ensure the appropriateness and cost-effectiveness of home and community-based long-term care services is another disincentive to insurers to offer coverage for that kind of care.

In addition to these obstacles, many elderly persons are unwilling to purchase long-term care insurance coverage because they believe they will not need long-term care or that if they do, Medicare or their Medicare supplemental policies will cover them. Also, some elderly persons have used the Medicaid program as an estate-planning tool, knowing that Medicaid will cover their nursing home care if they transfer their assets to their children at least two years before they become nursing home patients.

In spite of these barriers, there are encouraging developments which indicate an improving climate for the development of a private long-term care insurance market and have promoted a more positive attitude among insurers and long-term care policy analysts about the feasibility of developing this market. In 1986, the American Health Care Association reported that as many as 25 long-term care insurance products were being sold, and that many of these products had entered the market in the past year. Estimates of the total number of policies sold range from 50,000 to 300,000.

Survey results indicate an increasing interest in long-term care insurance among consumers. Also, as data have become available to analyze and compare alternative prototype benefits, an increasing number of insurers nationwide have begun to sell long-term care policies. In addition, according to several studies, a general increase in the incomes of the elderly during the last 15 years indicates the potential for a private long-term care insurance market. For example, a 1983 study by Mark R. Meiners of the National Center for Health Services Research estimated that seven million people over age 65 (about one quarter of the nation's elderly population) could have afforded to pay the annual premiums for long-term care coverage in 1980.

Furthermore, several studies have shown that cash income alone significantly underestimates the elderly population's real income potential, which tends to be in the form of non-liquid assets such as home equity (discussed later in this report). Combining home equity conversion or tax-favored savings accounts with private long-term care insurance coverage may enable more elderly and disabled persons to afford long-term care policies. Encouraging tax-favored savings for long-term care insurance could motivate consumers to purchase long-term care policies, and could be achieved by linking tax-sheltered individual medical accounts (discussed later in this report) to long-term care insurance.

A long-term care financing work group in the United States Department of Health and Human Services has conducted a series of special analyses designed to test the potential of linking individual medical accounts and long-term care insurance by examining the features and costs of various prototypes. The work group reported on these evaluations in its November 1986 report to the Secretary of Health and Human Services on private financing of long-term care for the elderly, but did not make specific

recommendations based upon these evaluations. The concept of combining tax-favored savings and private insurance in one long-term care financing mechanism clearly merits further evaluation and consideration.

A regulatory vacuum exists in most states, including New Jersey, with regard to the sale of long-term care insurance. The states have adopted minimum regulatory requirements for the sale of Medicare supplemental policies, including loss ratios (the proportion of premium income paid to policyholders as benefits), prior hospitalization requirements, the scope of mandated benefits and advertising and marketing restrictions. Insurers have claimed that similar requirements for long-term care policies would make it more difficult for them to price and market these policies, although many companies have endorsed modest regulation of advertising and marketing practices.

The National Association of Insurance Commissioners (NAIC) has taken the lead in the effort to develop consumer protection regulations for long-term care insurance through its adoption of the Long-Term Care Insurance Model Act in December 1986 and subsequent revisions in June 1987. As of June 30, 1987, 10 states had adopted the model act, and the September 1987 report to Congress and the Secretary of Health and Human Services by the federal Task Force on Long-Term Health Care Policies "strongly encouraged" the other states to follow suit.

The NAIC model act establishes a new class of insurance, setting forth its purpose and scope, and some of its limitations and administrative procedures. The model act defines long-term care insurance and provides specific disclosure, format and performance standards for long-term care policies which include consumer protection requirements. In addition, the model act stipulates different requirements for group and individual policies in some respects.

The Department of Insurance has been analyzing the model act and its applicability to New Jersey. The department has not, to date, officially indicated its position with regard to supporting or opposing adoption of the measure.

The New Jersey Task Force on Catastrophic and Long-Term Health Care recommends that the State adopt the NAIC model act or legislation which closely resembles the model act that is modified to meet the circumstances of this State.

In addition, the task force recommends that State government take the following actions to promote the development of a private long-term care insurance market in New Jersey.

1. The State should provide a tax incentive to encourage employers to offer long-term care insurance coverage to employees and appropriate dependents through employer-funded plans or on an employee-pay-all basis. Over 80% of those persons with private health insurance are covered through employer-sponsored plans, and encouragement of employer group insurance for long-term care is critical to the widespread availability of this kind of coverage. Employer-sponsored plans generally have lower premiums than individual coverage and provide the insured with greater consumer protection because of the employee benefits manager's expertise in selecting high quality insurance plans for employees. Over the long term, the loss in State tax revenues from providing this incentive should be offset by a reduction in the rate of increase in Medicaid long-term care expenditures as a consequence of increased private financing for this care.

2. The State should provide for a State income tax reduction (as a tax

deduction or as a credit up to a specified maximum dollar figure or percentage of the annual premium paid) for purchases of long-term care insurance policies that are certified as meeting minimum standards established by the Department of Insurance. Legislation of this kind, which was enacted in Colorado in 1986, could provide a significant incentive for consumers to purchase long-term care coverage. Over the long term, the loss of State income tax revenues should be offset by a reduced rate of increase in Medicaid long-term care expenditures as a result of this legislation.

3. The State should provide for a premium tax reduction for insurance companies selling long-term care insurance policies that are certified as meeting minimum standards established by the Department of Insurance. Reductions in premium taxes for long-term care insurance policies could encourage purchases if part of the savings were passed on to consumers in the form of reduced premiums. In addition, lower taxes on premium income would encourage insurers to sell more long-term care policies. (Colorado is currently the only state to have enacted such legislation, providing for a 1% tax reduction on long-term care insurance premium income.)

4. The State should offer to its employees and retirees the option of purchasing group long-term care insurance. As the largest employer in New Jersey, State government should take the lead in the sponsorship of group, employee-pay-all, long-term care coverage by offering such coverage to its employees and retirees in the same manner as the existing voluntary disability insurance plan.

5. The State should encourage the private sector, including insurance companies, health maintenance organizations and continuing care retirement communities, to develop and offer a variety of risk-pooling mechanisms for the private financing of long-term care. Because there is great diversity with

respect to the long-term care financing needs and capabilities of the consumer population, the State should encourage private industry to meet the needs of as many segments of the long-term care insurance market as possible by exploring different approaches to the development of these products, including life insurance policies, pensions, pre-paid managed care, group coverage and riders to property-casualty insurance products, e.g., home and automobile policies.

Risk-pooling mechanisms to finance long-term care could include insurance consortia that involve senior citizen organizations, labor unions and employers. Arrangements of this kind have been established in other states, such as Illinois, and appear to be quite promising.

6. The Department of Insurance, in the process of developing regulations to govern the sale and content of long-term care insurance products and reviewing product applications for approval, should encourage flexible and innovative products, and should recognize the existing constraints on developing new products because of the current lack of adequate historical data and experience. Long-term care insurance regulations should seek to ensure consumer protection by requiring clear disclosure of policy provisions. At the same time, these regulations should be flexible enough to facilitate the development of innovative products that will ultimately better serve consumers through design features that may be very different from the current product norms.

7. The Department of Human Services should consider seeking a waiver of federal Medicaid asset eligibility requirements to allow the Medicaid program in this State to waive asset eligibility requirements for persons who have used up the benefits provided by private long-term care insurance policies that are certified as meeting minimum standards established by the Department of Insurance. Such action should be taken only after a careful

analysis of the projected financial impact to the Medicaid program. This waiver could encourage consumers to purchase long-term care insurance, reduce Medicaid expenses and protect elderly and disabled persons from having to pauperize themselves in order to meet Medicaid asset eligibility standards.

The discussion of necessary public education efforts later in this report indicates other actions which should be taken by the Department of Insurance to provide greater consumer protection with respect to the purchase of long-term care coverage. These include the preparation of a buyer's guide and a disclosure requirement for Medicare supplemental policies sold in this State.

As can be inferred from the preceding discussion, the Department of Insurance must play the lead role in furthering the development of a private long-term care insurance market in New Jersey, with the active cooperation of the relevant State departments. In that capacity, the Department of Insurance faces the dual challenge of attempting to protect consumers while at the same time encouraging the development of innovative products that will shelter consumers from the overwhelming expense of long-term care and alleviate the growing burden of long-term care expenditures on the Medicaid program.

IV. HOME EQUITY CONVERSION

Home equity conversion permits elderly homeowners to convert the equity in their homes into cash without having to vacate their homes. This income could be used to finance long-term care by paying for that care directly or by purchasing long-term care insurance. Because home ownership is the largest asset of the elderly (even a majority of poor elderly own their homes), home equity has considerable potential in this regard. In 1984, 75% of households headed by elderly persons were homeowners, and about 80% of these owned their homes free of debt, while the average home equity for persons 65 years of age and older was $54,700. Testimony presented to the New Jersey Task Force on Catastrophic and Long-Term Health Care indicates that a significant number of elderly homeowners in New Jersey have experienced a substantial appreciation in the equity held in their homes.

There are a number of home equity conversion options which have been developed to date. These include reverse annuity mortgages (RAMs), which allow homeowners to borrow against the equity in their homes at a defined interest rate for a defined time period (usually 5 to 15 years), at the end of which the homeowner must repay the loan or sell the property to repay the loan.

Sale-lease back plans allow the homeowner to sell his home to an investor who then leases the home back to the seller for life. Payment to the seller for his home is usually discounted, and the seller receives a negotiated down payment and regular monthly payments minus the rent, until the sale price has been reached. In most cases, the investor is responsible for taxes, insurance and major repairs to the home. In addition, the investor must purchase an annuity to ensure that the seller will receive monthly payments during his lifetime to meet rent and living expenses, once all of the monthly mortgage payments to the seller have been made.

Shared appreciation reverse mortgages are similar to RAMs but calculate anticipated increases in property value in the payment formula. Payment is based upon life expectancy, property value and the amount of appreciation of the property value shared by the homeowner and the lender. In exchange for the homeowner sharing in the future appreciation of the property value, the lender usually guarantees payments to the homeowner for as long as the homeowner remains in the home, even if all home equity has lapsed.

Unfortunately, public awareness and acceptance of the various home equity conversion options is still low and product availability is limited. There are currently two home equity conversion plans available in the State through private lending institutions, which are assisting about 400 elderly homeowners.

The Department of Community Affairs recently analyzed various conversion plans through its Task Force on Housing Options for Senior Citizens. The members of that task force agreed on the tremendous potential benefit of home equity conversion for older homeowners and recommended consumer education and protection activities in regard to home equity conversion plans.

The task force sees a clear need to educate older homeowners about home equity conversion and its potential as a financing mechanism for long-term health care. Elderly homeowners are often wary of the new and complex financing arrangements and the assumption of new debt involved in home equity conversion, and are concerned with being able to pass their homes on to their heirs.

At the same time, the task force recognizes the concerns of potential home equity lenders. Mortgage lenders are wary of evaluating their financial risk based upon life expectancy, and insurers familiar with such risk are

unfamiliar with mortgage lending. Neither are familiar with housing investments that are based on future, rather than present, value. A lending institution could suffer significant losses by underestimating the life expectancy of an older homeowner to whom it provides a home equity loan.

In order to address these issues surrounding the use of home equity conversion as a long-term care financing mechanism, the task force recommends the establishment of a home equity conversion education project in the Division on Aging of the Department of Community Affairs. This recommendation was also made by the Task Force on Housing Options for Senior Citizens of the Department of Community Affairs.

The education project should seek to disseminate information about home equity conversion options Statewide through the county offices on aging and encourage private lending institutions to develop and market a variety of home equity conversion products. The project should also provide or make available consumer counseling to elderly homeowners considering home equity loans and technical assistance to lending institutions. This kind of public-private partnership can help to develop home equity conversion as a viable strategy for addressing at least part of the need for long-term care financing among the residents of this State.

V. INDIVIDUAL MEDICAL ACCOUNTS

As indicated previously in this report, the task force assumes that there will not be substantial additional public funding available for long-term health care in the foreseeable future, at least at the federal government level. The task force has concluded, therefore, that private mechanisms, such as long-term care insurance, which may help to prevent the impoverishment of senior citizens and other persons with long-term care needs should be encouraged to the maximum extent feasible. It may be possible to combine a private insurance mechanism with a tax-advantaged private savings plan for those persons who can afford to set aside savings specifically designated for medical care. The revenues lost to the State through this tax concession would be recouped through savings in Medicaid long-term care expenditures, which could then be more appropriately targeted on the indigent and those persons who cannot accumulate substantial private savings to meet the expenses of long-term care.

The concept of Individual Medical Accounts (IMAs), or Individual Retirement Accounts (IRAs) for medical care, is a relatively new one, although it has received a good deal of attention from long-term care policy analysts in recent years. IMAs would:

(1) give account holders increased control and choice with regard to meeting their long-term care needs, which would tend to increase competition in the health care provider marketplace and develop efficient providers;

(2) increase savings capital for business investment, thereby contributing to general economic growth; and

(3) encourage individual responsibility to save for one's future needs and those of one's family.

The report of the Secretary of Health and Human Services to the President on catastrophic illness expenses in November 1986 recommended amending the federal income tax law to permit IMAs; however, such action is extremely unlikely in the aftermath of the 1986 federal tax reform act and in the context of the federal budget deficit.

The New Jersey Task Force on Catastrophic and Long-Term Health Care recommends that legislation be enacted to permit taxpayers in this State to establish Individual Medical Accounts which could be used to pay the medical, dental and long-term care expenses of the account holder. The legislation should include the following features:

1. An individual would be able to contribute up to $2,000 each for the account holder and spouse, and up to $1,000 for each dependent child, annually.

2. Contributions to an IMA would be deducted from income subject to the State income tax, and interest earned would be exempt from the State income tax.

3. Withdrawals from an IMA by an individual age 59 1/2 or older would be tax-free when used to meet the expenses of medical, dental or long-term care, including nursing home care and home and community-based care.

4. Withdrawals from an IMA by an individual age 59 1/2 or older would be taxed at marginal rates if withdrawn for any use other than paying for medical, dental or long-term care.

5. Withdrawals from an IMA by an individual younger than age 59 1/2 would be taxed at marginal rates, regardless of the purpose for the withdrawal.

6. Withdrawals from an IMA by an individual at any age would be subject to a penalty if withdrawn for any other use than paying for medical, dental or long-term care.

7. If mutually agreed, an employee could have his employer contribute to an IMA, or the employee could contribute to a health insurance policy or program designed for this purpose.

In May 1986, Colorado became the first state to establish a medical savings account for individuals ("The Individual Medical Account Act of 1986," House Bill No. 1102, General Assembly of Colorado), which exempts interest earned in an IMA from state taxes, but not the original contribution. An amendment to allow a deduction of a taxpayer's IMA contribution was introduced in 1987 in order to create a greater incentive for taxpayers to establish these accounts.

Judging from the experience of IRAs, the anticipated rates of participation and savings in IMAs would increase sharply with income, and, therefore, IMA's would be used by a much greater proportion of affluent taxpayers than those of moderate and low incomes. Still, it is worth noting that most IRAs are held by persons with moderate incomes. For example, in 1984, almost 40% of the tax returns with IRAs had adjusted gross incomes (AGIs) of $30,000 or less, and about 75% had AGI's of $50,000 or less.

To the degree that individuals contribute to IMAs and are able to accumulate substantial savings for their long-term care needs, IMAs would improve their quality of life in their later years and enable them to retain maximum flexibility in fulfilling those needs. These persons would be able to maintain the sense of dignity that results from being able to take responsibility for one's future and that of one's family.

At the same time, IMAs can assist in moderating the increase in public expenditures on long-term care and lessen the bias of the long-term care system towards institutionalization by directing more funds into home and community-based care and stimulating the development of these alternatives. The result would be a more efficient and humane long-term health care system.

VI. ALTERNATIVES TO INSTITUTIONAL LONG-TERM CARE

As the Governor's Nursing Home Task Force indicated in its 1983 report, there is a need to upgrade residential health care facilities (RHCFs) as health care facilities that can provide an intermediate level of care for people who need more nursing and health maintenance and monitoring services than are supplied in a boarding home but who do not require the level of care provided by a skilled nursing home or an intermediate care facility.

The Governor's Nursing Home Task Force recommended restructuring and upgrading residential health care services as an alternative to institutional long-term care by consolidating Class C boarding houses (currently regulated by the Department of Community Affairs) which can meet a new upgraded standard of care and the RHCFs (regulated by the Department of Health) into a new category of residential service facilities (RSFs). RSFs would provide enhanced nursing and personal care services under Department of Health regulations. This recommendation was endorsed in a 1984 report on boarding home reform by the General Assembly Corrections, Health and Human Services Committee.

The New Jersey Task Force on Catastrophic and Long-Term Health Care recommends the creation of residential service facilities pursuant to the report of the Governor's Nursing Home Task Force. RSFs would be licensed and inspected by the Department of Health and would provide regular on-site professional nursing services for health maintenance and monitoring, as well as personal care services for residents provided directly by RSF employees or by contracted providers. Personal care services would include assistance with bathing and dressing, instruction in daily living skills, medication monitoring and rehabilitative day programming. The nature and level of care provided by RSFs would be less medically intensive than that offered by nursing homes but more health-oriented and supportive than that currently provided by Class C boarding houses or RHCFs.

The State may realize significant savings by being able to divert from institutional care a substantial number of the less impaired Intermediate Care B (ICF-B) level nursing home patients who can function well in a less costly setting such as a RSF. A study completed in 1977 for the State Medicaid program concluded that 35% of the Medicaid ICF-B level patients in the State could be discharged if appropriate alternatives were available, and the alternative most frequently mentioned was RHCFs that could offer a higher level of care than is currently provided in those facilities.

Even if the proportion of nursing home patients who could be appropriately cared for in an alternative setting is half of what the 1977 Medicaid study concluded, better placements in more appropriate settings would result in substantial savings and a more efficient long-term care system over the long term. For example, the average cost of constructing an RHCF bed is less than half that of constructing a nursing home long-term care bed. Building fewer nursing home beds as a consequence of patients being cared for in RSFs instead of ICF-B settings would translate into significant capital cost savings. In addition, according to figures supplied by the Department of Health in 1983, providing residential health care to 35% of the then ICF-B level patient population (approximately 5,280) and the monthly list of Medicaid-eligible persons waiting for a nursing home bed (then 2,740) at the then current SSI payment rate of $450.20 a month would have cost less than $15.2 million annually, compared with a cost of $39.2 million annually at the ICF-B level. This represents an annual savings of 62% in State and federal SSI expenditures.

In addition, caring for a nursing home patient in a less restrictive environment that is appropriate to his health care needs would be beneficial to that person and, in most cases, consistent with his wishes.

The task force has received considerable information about various community-based alternatives to institutional long-term care. These include innovative housing arrangements for the elderly, such as group homes, congregate housing, shared housing, adult foster care homes and accessory apartments built into existing family homes, which have been increasing in number in recent years and which have great potential for enabling senior citizens to remain in their communities instead of becoming institutionalized. These shared housing alternatives may substitute directly for nursing home care or delay institutionalization for elderly persons of modest means who cannot continue to live alone because of inadequate income, a lack of funds for housing maintenance or the need for assistance with activities of daily living.

"Life care communities" or "continuing care retirement communities" (CCRCs) are an innovative approach to long-term care coverage, combining comprehensive health care services with residential housing and a variety of social and recreational programs. Although CCRCs represent an attractive concept, their utility has been limited to date by the relatively high cost of initial entry and monthly maintenance fees. The average CCRC entry fee is currently about $100,000, and the average monthly fee is about $1,200. CCRC residents have generally used the proceeds from selling their homes to pay their entry fee. According to a Congressional Research Service analysis of 1981 census data, however, only 22% of families headed by persons over 65 years of age, and 6% of those living alone or with non-relatives, had enough income to pay the average CCRC monthly fee. Currently, there are seven CCRCs in New Jersey, with another six under construction.

The task force recommends the continued expansion of alternative community-based housing arrangements for elderly and disabled citizens and

urges State government to facilitate their development. For example, State government should encourage the removal of local zoning restrictions which prohibit accessory apartments in single family neighborhoods. Residents of accessory apartments have an average five-year length of stay. These apartments provide them with security, support and companionship and have little effect on the aesthetics of the neighborhood or the value of property.

The task force has noted that there appears to be a broad consensus on the need to facilitate the development of home health care services in New Jersey. The 1985 report of the Casino Revenue Fund Study Commission recommended that casino revenue funds available for new programs be utilized to implement a home health care services program for eligible elderly and disabled persons, which was seen as one of the most pressing needs of this population.

State government has responded to the home health care needs of New Jersey's elderly and disabled through the Medicaid Community Care Program for the Elderly and Disabled (CCPED) and other programmatic initiatives. Under a waiver of federal Medicaid income eligibility standards, CCPED has, since October 1983, provided home and community-based services to 4,475 people who would have otherwise been forced to enter a nursing home. CCPED expenditures for FY 1987 were $11,687,875.

In addition to CCPED, three model waiver programs for disabled and blind children and adults have provided similar services to 206 people, at an annual cost of $3,883,119. Also, a Statewide respite care program has been enacted into law (P.L. 1987, c. 119), which will serve an estimated 1,200 to 1,500 frail or severely disabled adults annually at a cost of $4 million (half federal, half State), as a follow-up to a demonstration program in five sites which was begun in May 1984 and expired on June 30, 1986 (pursuant to P.L. 1983, c. 284).

The Department of Human Services operated a personal attendant services pilot program for physically disabled adults who are employed, preparing for employment or seeking to avoid institutionalization (pursuant to P.L. 1985, c. 207), which recently expired. Legislation to establish a permanent Statewide personal attendant services program has passed both Houses of the Legislature and is now pending before the Governor.

In spite of these efforts, there remains a substantial number of frail elderly and disabled persons whose home health care needs have not been met and who are at risk of institutionalization because they lack the funds to pay for the care that they need to remain in their homes, and because their resources exceed the very restrictive asset eligibility requirements of both the Medicaid program and CCPED.

The task force recommends enactment of the Assembly Committee Substitute for Senate Bill No. 2132 OCR (Van Wagner) and Assembly Bill No. 3177 (Azzolina, Singer), which would establish the Home Care Expansion Program in the Department of Human Services. This measure has received broad bipartisan support in the Legislature and passed the General Assembly unanimously. The program would incorporate, whenever possible, the features of CCPED, including eligibility criteria, with the exception of Medicaid resource and income limitations. As with CCPED, the cost of care for a service recipient could not exceed a percentage of the cost of a comparable level of care in a skilled nursing or intermediate care facility under Medicaid.

The services to be provided under the Home Care Expansion Program would include: case management and a comprehensive assessment of the need for long-term home care services, home health care, medical day care, non-emergency medical transportation, social adult day care, homemaker care and respite care. The program would be funded through an appropriation of $15,500,000 from the Casino Revenue Fund.

Establishment of the Home Care Expansion Program would demonstrate the commitment of State government to a new direction in long-term health care policy and would be a significant step forward in improving the quality of life for many senior and disabled citizens in New Jersey. By supporting the expansion and upgrading of home and community-based alternatives to nursing home care, State government can ensure that those persons in need of long-term health care are served in settings that are more humane and appropriate to their health and social needs as well as less expensive and less restrictive to the individual.

VII. SOCIAL HEALTH MAINTENANCE ORGANIZATIONS

Social Health Maintenance Organizations (SHMOs), which are modeled after health maintenance organizations (HMOs), attempt to extend the HMO acute care model of case management and capitation to encompass long-term care by offering personal care and social services in addition to traditional HMO services. A SHMO is a single provider entity which assumes responsibility for a full range of acute inpatient, ambulatory, rehabilitative, extended care, home health and personal care services (including homemaker, personal health aide, medical transportation, medical day treatment and respite care) under a fixed budget that is prospectively determined.

SHMOs are a new long-term care concept developed by Brandeis University under the sponsorship of the federal Health Care Financing Administration and private foundations. There are currently four federally financed SHMO demonstration projects operating in California (Senior Care Action Network in Long Beach), Oregon (Kaiser Permanente Medical Care Program in Portland), Minnesota (Ebenezer Society in Minneapolis) and New York City (the Metropolitan Jewish Geriatric Center in Brooklyn), utilizing different organizational arrangements to test the efficacy of a managed system of acute and long-term health care services. Each of these demonstration projects covers a different package of long-term care services, but they all offer several innovative features, including voluntary enrollment of a broad cross-section of the elderly population, pooled financing from Medicare and Medicaid and from private sources, the enrollment of Medicaid recipients (including those at risk of institutionalization), central case management and capitated rates for all types of services (including long-term care). Private SHMO enrollees pay monthly premiums ranging from $29 to $40. Copayments are required, and benefits are subject to an annual dollar maximum ranging from $5,000 to $12,000.

Because SHMOs (like HMOs) provide all services for a fixed, monthly pre-paid fee, their profitability depends upon their ability to deliver services for less than this fixed fee. This creates strong incentives for SHMOs to provide cost-effective care, early treatment and health promotion and to utilize alternatives to institutional care such as day care, home care and support services to the degree that these are cost-effective.

Since the four SHMO demonstration projects have only been operating since March 1985, they are still in their infancy and will not be evaluated for several years. It is, therefore, too soon to determine whether SHMOs can offer more extensive long-term care benefits than other alternatives in a cost-effective manner. In addition, the service delivery arrangements involved in SHMOs are very complex, and it is still unclear whether these entities can be developed without considerable government sponsorship and support (including revision of the Medicare and Medicaid laws).

SHMOs do, however, offer several major advantages over fee-for-service providers of long-term care services:

(1) SHMOs provide a unified approach to delivery of care by including acute and long-term care services and case management, which should improve access to appropriate services and facilitate coordination and continuity of care for individuals with multiple service needs, as well as controlling inappropriate utilization. By combining acute and long-term care services into a single system, SHMOs eliminate the arbitrary boundaries between Medicare-covered physician and hospital services and the personal care and social services needed by long-term care recipients;

(2) SHMOs provide a long-term care insurance mechanism, pooling risk among plan members;

(3) SHMOs combine financing from several sources; and

(4) SHMOs have a strong incentive to deliver care in a cost-effective manner because of their pre-paid financing arrangement.

The task force believes that, to the maximum extent possible, the State should examine various innovative and flexible long-term care service delivery options and facilitate the development of those that appear to be cost-effective and responsive to the needs of long-term care recipients. Although they are still in their nascent stages, the advantages that are inherent in the concept of SHMOs are worthy of serious consideration by State policy makers. The New Jersey Task Force on Catastrophic and Long-Term Health Care recommends that, contingent upon the results of the four current SHMO demonstration projects, the Commissioners of Health and Human Services undertake a joint study of the feasibility of developing a social health maintenance organization demonstration project in New Jersey at the earliest possible date and report to the Governor and the Legislature within six months on the results of their study, including recommendations for legislative or administrative action.

VIII. PUBLIC EDUCATION

The testimony presented at the public hearings held by the task force clearly indicates a need to increase general public awareness of the potential need for long-term health care among our aging population and alternative methods for financing this care, and to correct a widespread public misconception that the Medicare program covers long-term health care services. The activities necessary to meet this need should be a shared responsibility of the federal and State governments and the private sector. These activities should be designed to educate people about the nature of long-term health care, the risk of needing this care, its potential cost and the potential financial liability if a person is not protected, the availability of long-term care insurance policies (as these products are refined and become more widespread), and the need to plan for this potentially enormous financial burden well in advance of retirement.

The New Jersey Task Force on Catastrophic and Long-Term Health Care recommends that State government work with the private sector to educate the public about the risks, costs and financing options available in regard to long-term care and the limitations on Medicare, Medicare supplemental (Medigap) insurance and traditional health insurance coverage for long-term care services.

The Division on Aging in the Department of Community Affairs should establish public education programs throughout the State in cooperation with other State departments. This educational effort should include both information directed at the elderly and their families, to be provided by the Division on Aging through the county offices on aging and senior citizen organizations; and information targeted to middle-aged and younger individuals, to be provided through commercial health insurers and Blue Cross and Blue Shield of New Jersey, Inc., and coordinated by the Department of Insurance, working in cooperation with the Division on Aging.

The components of this public education campaign should include:

a. The use of radio, television and printed materials to convey information about the risks, costs and limitations of available long-term care coverage;

b. Educational and promotional efforts to encourage private savings for long-term care and the purchase of long-term care insurance coverage;

c. Informational materials to assist consumers in understanding and selecting financial protection for their long-term care needs, including preparation of a buyer's guide by the Department of Insurance which will enable the public to make prudent choices when investigating and comparing long-term care insurance products;

d. A requirement, to be implemented through regulations adopted by the Department of Insurance, that all insurance companies selling Medicare supplemental policies in New Jersey inform consumers specifically that these policies provide little or no long-term care coverage;

e. Cooperative efforts with private companies, directly and through business organizations and trade associations, to encourage the development of educational programs for use by private employers, to be coordinated when possible with the offering of employment-based group or individual long-term care insurance; and

f. Actions by the Department of Insurance to encourage private insurers to develop long-term care insurance policies that can be offered to New Jersey State employees on an optional basis, and to develop an education program to make State employees aware of their potential long-term care needs and the limitations of their existing benefits.

The task force believes that a public education campaign of this kind is essential to the development of a market for private long-term care insurance in this State and to encourage New Jersey citizens to plan in advance for their long-term care needs.

IX. LONG-TERM CARE STUDY COMMISSION

The New Jersey Task Force on Catastrophic and Long-Term Health Care has, in a brief period of time, attempted to analyze the major concerns and issues with respect to the financing of long-term health care and develop recommendations based on the testimony and additional information received. The task force believes, however, that a subject of such complexity and importance requires further analysis, utilizing the resources of the relevant State departments in a cooperative effort to develop effective policies for the next decade and beyond.

For this reason, the task force recommends the establishment of a long-term care study commission to develop specific solutions in the context of a long-range strategy, utilizing the resources of the Departments of Human Services, Insurance, Health and Community Affairs in a cooperative effort. The study commission should consist of no less than 15 and no more than 25 members, and should include representation from the State Legislature, the Departments of Human Services, Insurance, Health and Community Affairs, the business and insurance communities, organized labor, senior citizens, academia and health care providers and consumers. The study commission should be given a period of two years in which to complete its work and report to the Governor and the Legislature on its findings and recommendations.

The proposed study commission should coordinate its work with related studies by any of the State departments in order to avoid duplication of effort. For example, the work of the study commission could complement the long-term care insurance demonstration program which the Department of Human Services (DHS) is proposing to design, in cooperation with the Departments of Insurance, Health and Community Affairs, through a grant from the Robert Wood Johnson Foundation and funds requested for the FY 1989 DHS budget.

The task force sees its efforts and those of the proposed study commission as part of a necessary ongoing effort to effect policy changes in the financing of long-term health care and to develop long-range solutions which rely on inter-agency coordination among the relevant State departments. This kind of cooperative effort can make an important contribution to the development of long-range policy.

The establishment of a study commission should not, however, preclude timely action on the other recommendations included in this report. There is a clear need to translate these proposals into reality now. The development of a private long-term care insurance market, the promotion of home equity conversion as a mechanism for financing long-term care, the establishment of individual medical accounts, a vigorous Statewide public education campaign and enactment of such measures as the Home Care Expansion Program should not be contingent upon the report of the proposed study commission. At the same time, the State needs to build upon these other recommended actions by developing an innovative long-range strategy, based upon careful analysis and planning through the coordinated efforts of the relevant State departments. A study commission with the proper expertise and resources would be an appropriate vehicle for developing that strategy.

In addition to emphasizing the need for a coordinated inter-agency approach, the task force recommends that a long-range strategy for financing long-term health care be designed, preferably through the proposed study commission, in such a way as to encompass preventive measures to reduce and delay the need for long-term care (particularly institutional care) by the elderly. These should include various means of maintaining and strengthening the social supports, economic independence and physical and mental well-being of this population, e.g., facilitating extended employment of older adults, disease prevention and health promotion, expanded research

into the diseases of old age and support for enhanced gerontological training of health professionals. Such measures, which can only be effectively promoted through the coordinated efforts of various State agencies, will help older people to maintain their independence and dignity as members of the community, and thereby reduce the need for institutional long-term care.

X. SUMMARY

The testimony received by the New Jersey Task Force on Catastrophic and Long-Term Health Care and the recommendations contained in this report reflect the need for new policies to address the growing problem of how to finance catastrophic and long-term health care for our aging population. These policies must be based upon a creative partnership between State government, insurers, employers and employees and health care consumers and providers. In addition, these policies should seek to promote alternatives to institutional long-term care, which is the largest source of catastrophic health care expenditures, in order to develop a long-term care system that is more humane and responsive to the needs of elderly and disabled citizens, as well as being more efficient and cost-effective.

In the long run, the states must look to the federal government to provide additional public funding for long-term health care services as the national population in need of these services expands significantly. Although the need to address the federal budget deficit will preclude such action in the near future, the states must urge the federal government, as actions are taken to reduce the deficit, to begin to provide the leadership on long-term care financing policy that will be needed in the years ahead.

In the meantime, New Jersey, as the state with the second oldest median age in the nation (32.2 in 1985, second only to Florida), must mobilize its own public and private resources to move in the direction of a more flexible long-term care system which offers more home and community-based service delivery options to frail and vulnerable senior citizens and disabled residents. The task force hopes that this report will lend impetus to that movement and urges action on its recommendations as soon as possible.