PUBLIC HEARING

before

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

Federal and State Policy Directions and Options
for Financing Long-Term Health Care

October 26, 1987
Room 403
State House Annex
Trenton, New Jersey

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Assemblyman William "Pat" Schuber, Acting Chairman
Paul Langevin
Marian Bass
Jeanne Sims
Theresa Dietrich

ALSO PRESENT:

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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 FOR FINANCING LONG-TERM HEALTH CARE

Monday, October 26, 1987
Beginning at 9:30 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 Monday, October 26, 1987, beginning at 9:30 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 catastrophic and long-term health care.

The task force, which is chaired by Assemblywoman Marion Crecco (District 30), is conducting a series of public hearings on catastrophic and long-term health care issues, with its primary focus on the financing of long-term health care. The task force is examining 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).

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ASSEMBLYMAN WILLIAM "PAT" SCHUBER (Acting Chairman): I would like to call this hearing to order of the New Jersey Task Force on Catastrophic and Long-Term Health Care. Good morning everyone. My name is Assemblyman William Schuber. I will be chairing the meeting today. This is the New Jersey Task Force on Catastrophic and Long-Term Health Care's third meeting with regard to the issue of long-term health care for the citizens of our State.

Let me state at the outset of the hearing that the members of this Task Force are very pleased and honored to have as our first speaker today Congressman Matthew J. Rinaldo, of the 7th Congressional District -- who is a ranking member of the House Select Committee on Aging -- and Mr. Steven A. Grossman, the Deputy Assistant Secretary for Health in the U.S. Department of Health and Human Services. Their participation at this hearing occurs at an appropriate time. Just about a month ago the Federal Task Force on Long-Term Health Care Policies released its recommendations. The full Senate may soon consider its catastrophic care proposal, drawing near to a House/Senate conference negotiation between the House passed version and the Senate version. I hope when it's all said and done, this conference committee will draft a compromise that establishes an appropriate cap on out-of-pocket health payments by Medicare beneficiaries, and comes to grips with other areas such as: coverage for hospital inpatient services, skilled nursing facilities, home health care, the scope of drug benefits, and the best and most efficient means for financing proposed new benefits.

I commend the efforts of Congressman Rinaldo in introducing legislation that clarifies certain tax code provisions. By removing such tax code barriers, we provide an impetus for insurance companies to formulate and market long-term health care policies that will be affordable and provide quality benefits.

I also want to take the opportunity to mention that the technical work group on private financing of long-term care for the elderly -- chaired by Assistant Secretary Steven A. Grossman -- came up with a good analysis of future strategies in their report issued last November. I am certain that this Task Force will take a hard look at some of these concepts in drafting its final proposal.

We expect to hold our final hearing in November -- the date is tentatively November 24 -- at which time we will receive statements from each of the Departments represented on this Task Force, as well as insurance companies registered with the Department of Insurance offering Medigap and long-term health care policies.

Again my thanks to all who are testifying today, and those of you who have been following the proceedings of this Committee, as well as all of the members of this Committee. Your insights will contribute a great deal to the scope and direction of our final report.

Joining me today on the panel are Paul Langevin, the Assistant Secretary for Health Facilities Evaluation, the Department of Health; Marian Bass, who is the Director of the Office of Program Evaluation, Analysis and Strategic Planning of the Department of Human Services, representing the Commissioner; Jeanne Sims, who represents the Commissioner of Insurance and is a special Deputy Commissioner, Department of Insurance, and Theresa Dietrich, representing the Commissioner of Community Affairs, who is a Program Development Specialist.

We are honored and privileged to have as our first guest, Congressman Matthew Rinaldo, and we welcome you, Congressman.

C O N G R E S S M A N M A T T H E W J. R I N A L D O: Thank you. Chairman Schuber, and members of the New Jersey Task Force on Catastrophic and Home Health Care (sic). It's a pleasure to be here this morning to discuss what may be the

single biggest, largest threat to the financial security of thousands of senior citizens and their families, the financial nightmare of long-term home health and nursing home expenses.

The costs of long-term care are expected to increase both in price and as a percentage of total health care costs. In 1980, there were nearly 7 million elderly in need of care, of whom 1.4 million resided in institutions. In the year 2000 the number of institutionalized elderly will double, and the number needing care overall will rise to almost 10 million. In New Jersey alone, the elderly will account for 14.7% of the population, and at least half will spend some time in a nursing home. By the year 2040 approximately 4.4 million aged individuals will be in nursing homes, and there will be nearly 20 million impaired elderly. Looking at it another way, in 1980 only one in every 200 Americans was an elderly person in a nursing home, but by 2040, one in 15 Americans will be so.

You've asked me to review the Federal response to this tremendous demand on our nation's health care resources, and give you a sense of what direction I foresee Congress moving in anticipation of these trends. The major vehicle -- as you mentioned earlier -- for legislative action on long-term care this year was the Medicare Catastrophic Health Insurance Bill, which was ostensibly designed to protect the elderly and disabled from financial devastation caused by illness. However, as I'm sure you know -- and as senior citizens are discovering -- the catastrophic bill fails utterly to protect against the single greatest source of catastrophic health care expenses faced by those 65 and over -- long-term home health and nursing home care.

The legislation passed by the House in July would cover all Medicare approved medical and hospital expenses beyond $1798. Additionally it includes broadened home health care, protection against impoverishment for individuals whose spouses must enter a nursing home under Medicaid, and provides

a new benefit under Medicare for prescription drugs. Under a compromise reached just last week with the Administration, the Senate agreed to include provisions in its version of the bill, which would raise the catastrophic index from $1798 to $1850, The drug deductible from $500 to $600, and index annual Medicare premiums to this catastrophic program's costs. Unfortunately, there will be no legislation coming out of Congress this year to establish a system of long-term nursing home or home health care for seniors. I strongly believe, however, that we've got to start constructing such a system now.

During the floor debate on the catastrophic legislation, the House considered a more comprehensive proposal -- which I helped to author -- that would not only have reduced the cost of the bill to both seniors and Federal and state governments, but also would have helped to protect seniors against the potentially devastating costs of long-term home health and nursing home care. We would have accomplished this by establishing a joint venture between the Federal and state governments and the private sector; a sort of three legged stool for long-term care. There is growing recognition that all three elements are necessary in order to ensure that whatever the final solution, it will be balanced, and capable of bearing up under the needs of increasing numbers of senior citizens.

When Congress first started to develop the catastrophic proposal, I think we began by asking all the right questions. Along the way, though, we got nervous about the answers we were receiving, and about the enormity and complexity of the solutions they demanded. During Committee and House deliberations on the bill, we were told again and again by health care professionals, researchers, providers, and consumers, that long-term home and nursing home care were the most definitive catastrophic expenses; that this was the protection seniors needed most. However, Congress was not then prepared to deal with the awesome proportions of this need.

Now real movement seems possible in the House. The framework for a constructive dialogue is in place, and indeed that dialogue has already begun in several important committees. There's a willingness among both congressional leaders and the Administration health care officials to explore questions about the appropriate roles of the Federal government, the states, and the private sector, respectively, in the financing and delivery of long-term care services.

On October 15 I introduced legislation to provide incentives for private insurers to design and market more comprehensive and affordable long-term care policies, to encourage employers to offer, and individuals to purchase, private long-term care insurance policies for their own protection, and to create a national risk pool for insurance companies who underwrite such policies. The immediate goal of my bill is to develop an extensive private long-term care insurance market to help reduce the elderly's dependence on public assistance. Stimulating the growth of an affordable private insurance market and providing incentives to purchase long-term care policies, not only benefits the elderly, but frees up scarce public funds which can be funneled back into the system for individuals who truly can't afford to purchase such coverage for themselves.

My legislation takes several important steps toward stimulating the development of private long-term care insurance, especially employer sponsored coverage, which has the greatest potential for reaching the most people. The bill is designed generally to provide tax treatment similar to that afforded health insurance, which has resulted in over 90% of the insured population under age 65 receiving their health insurance through the workplace, with all the advantages of employer sponsored coverage.

Perhaps most importantly, it is designed to make the premiums for long-term care policies more affordable to consumers, and to encourage product innovation in the marketplace through a risk pooling mechanism called "reinsurance." Reinsurance would allow underwriters to issue policies and assume risks, which for lack of data, actuarial experience, or sheer magnitude of claims, might otherwise severely jeopardize the financial solvency of the company. Under my legislation, a separate corporation would be chartered by the government, which would reinsure primary underwriters against excessive losses in a new and unfathomed long-term care insurance market. Reinsurance would be conditioned upon certain minimum benefit standards being included in the policies.

Mr. Chairman, and members of the Task Force, these are the broad outlines of Federal action, but I would like to make some immediate suggestions to you as State legislators. First, insurance regulators should identify regulatory restrictions that inhibit product innovation, and eliminate them wherever necessary. I commend to your attention a model act developed by the National Association of Insurance Commissioners and industry representatives for adoption by state legislatures. Nine states have already enacted some version of that act for long-term care insurance, and I would urge you to review it as a basis for rules which strike the necessary balance between regulatory flexibility and consumer protection.

Secondly, both the states and Federal government must look to new and innovative methods of private long-term care financing and delivery. Methods which include risk pooling at the community and state level, such as continuing care, retirement communities, and social health maintenance organizations, hold great potential for the future; and will be the focus of much attention at the Federal level. The Garden State Health Plan certainly has the possibility of becoming a nationally recognized model for this approach.

In addition, home and community-based services which complement and sustain family care giving efforts, must receive serious attention at all levels. These services represent cost savings, both to individuals, and to state and Federal treasuries.

Thank you again for the opportunity to appear before you this morning, and I'll be happy to answer any questions you may have.

ASSEMBLYMAN SCHUBER: Congressman Rinaldo, we, on behalf of the Committee, would thank you very much for being our principal speaker today. We applaud your efforts in Congress with regard to the new legislation that you have introduced, and recognize it as just part of a long standing list of support that you have given to the seniors and disabled of our State, and we appreciate that. We just have a couple of questions we might ask you. And I recognize that your schedule today is a little tight.

With regard to long-term health care legislation: In the past we have given tax incentives to individuals to allow them to contribute to pension plans and things like that, even though that's kind of not the same any more under the new tax code, but do you see any support for legislation that might provide some tax incentives for individuals to contribute to insurance policies for long-term health care along those same lines?

CONGRESSMAN RINALDO: Quite frankly, I think it would be difficult to enact legislation of that type, specifically because of the Federal budgetary deficit. The legislation that I have introduced is practically revenue neutral. By that I mean obviously there is no burden on the Treasury. Now, one might ask, and the obvious question is, "How can it be revenue neutral when you're going to set up in effect a new corporation, a new agency of government to provide reinsurance?" And it can, specifically because all of the

models that we have worked with so far indicate that the savings as a result of fewer people going on Medicaid should even out the expenses from the Federal government. Under the worst case scenario that was provided me, we would have accrued an actual expense of under $500 million. I think that's one of the reasons why the Administration -- despite the massive deficit problems that they are confronted with -- is backing this particular legislation.

ASSEMBLYMAN SCHUBER: Do you find any sentiment in Congress to maybe create a new medical assistance program on the Federal level, with Federal/state contributions similar to Medicare or Medicaid, but different than that, just exclusively for long-term health care?

CONGRESSMAN RINALDO: No. There's sentiment for the legislation that passed, but not much sentiment to go beyond that. And once again I've got to say that in some respects Congress is treading rather cautiously. I don't agree completely with the thrust of the bill. I recognize the support it has. But on the other hand, I don't think most of the seniors, and even many of their organizations, in this country really understand the implications of the bill that is presently being enacted. For example, there are about 30 to 32 million people on Medicare in the United States today. If that bill were law right now, only two to three percent of that 30 to 32 million people would actually be beneficiaries in the sense that they will receive the benefits from the bill that it provides. At the very least, however, it does provide some coverage for prescription drugs. It does enable people to pay for extended hospital stays. And I guess you can say with some degree of certainty that it provides a tremendous amount of psychological relief. But I feel it's a rather high price tag to pay for that kind of psychological relief. I'm reminded of the fact that in hearing after hearing -- and I attended just about every hearing that we had. We had hearings all over this

country. We had at least one I know, I chaired in Elizabeth, New Jersey -- hearings in other states, hearings in Washington, time and time again the question was posed to witnesses as to what is the greatest problem -- what is the greatest expense faced by seniors? And in every single instance, no matter how the question was framed, the answer was nursing home care, and long-term home health care. It's unfortunate that the bill doesn't address those problems.

One of the reasons why it doesn't -- in all fairness to people on both sides of the aisle -- is specifically because the bill was in some respects rushed through. I remember back in 1972 I was a member of the State Legislature down here in the Senate, and running for my first term in Congress. One of the big three issues that year was catastrophic long-term home health insurance. We were talking about it then. It sort of fell by the wayside because of budgetary deficits. It was revived when President Reagan brought it up and made a commitment in the State of the Union address. It was picked up by House and Senate leaders on both sides of the aisle. So it achieved a certain amount of political momentum. But then unfortunately -- or fortunately, depending on your perspective -- it was rushed through without really giving enough thought to how we could satisfy the real needs of the senior citizens out there.

Some people may question -- and anticipating that question -- "Well didn't Claude Pepper, for example, have a bill?" He did, to provide for long-term coverage, but that bill would have cost probably about $90 billion in the first year, and there was no way of getting $90 billion out of the Federal Treasury, and there's no way you can tax people to bring in $90 billion more. We'll be lucky if we'll be able to achieve the $23 billion in savings that we're currently negotiating this week.

ASSEMBLYMAN SCHUBER: Just to amplify it a little bit, would your legislation provide for Federal tax incentives for employers to offer long-term health care for their employees, or is there another proposal in Congress that would do that?

CONGRESSMAN RINALDO: There are other proposals. I don't really know whether any of them will be enacted. But what we're doing is, by providing the incentives-- And I might mention parenthetically, most of the incentives that we want to provide to the insurance companies; and there's a long list and I don't have the time, and I don't think we have to go into each of them at the present time -- most of them are already provided to insurance companies. Now that seems like the strange part of this whole equation. If they're already provided, why do we need legislation? Well, many of them are provided as a result of just an approved plan by the Treasury Department, but no insurance company is going to go out and sell what I consider an affordable policy -- and "affordable" means somewhere in the realm of $15 per month as opposed to the currently excessively high premiums that people pay -- unless the current regulations put out by Treasury are codified into law. So that's one of the reasons. We've received assurances from many insurance companies that they would be very willing to market the policies, particularly when the high risk factor is taken out by the reinsurance corporation.

We also anticipate, as a result of testimony and discussions we've had, that employer sponsored plans would really be a completely new avenue to this approach, and that we would emulate what's already taking place in the health policy field.

ASSEMBLYMAN SCHUBER: Are there any questions from any members of the Committee? (no response) Congressman Rinaldo, we thank you very much for being here, and we appreciate your comments, and again we applaud your legislation.

CONGRESSMAN RINALDO: Thank you very much.

ASSEMBLYMAN SCHUBER: Thank you.

CONGRESSMAN RINALDO: It's been a real pleasure being here. Let me add, if along the way in your deliberations if there's any other information you need from me personally or the House Select Committee on Aging, don't hesitate to get in touch with us, because we want to cooperate with you as much as possible.

ASSEMBLYMAN SCHUBER: We appreciate that very much. Thank you.

CONGRESSMAN RINALDO: You're welcome.

ASSEMBLYMAN SCHUBER: Our next witness will be Mr. Steven A. Grossman, The Deputy Assistant Secretary for Health, in the U.S. Department of Health and Human Services.

S T E V E N A. G R O S S M A N: Good morning, Chairman Schuber, members of the Task Force. Before I begin I'd like to take a moment to thank you for inviting me to talk with you today. I'm pleased to see New Jersey is in the forefront of states that have recognized, and are attempting to do something about, the need to develop appropriate financing for the long-term care needs of tomorrow. I'm convinced that there will be few more important issues over the next several decades. Your interest and leadership can help chart the course for New Jersey, and perhaps for other states as well.

While I appreciate your invitation to appear here today to share my expertise, I feel very modest about what I can contribute to your deliberations. As all of us who work on this problem soon learn, the challenges of finding suitable, effective, and affordable financing strategies for long-term care are formidable. I feel workable strategies are as likely to be developed by individual states working with the circumstances of their own environment, as by the Federal government. My remarks today will focus on the issues relating to financing long-term care among the elderly -- defined as the over 65 population -- rather than on catastrophic health care

expenses in general. However, much of what I will talk about is certainly applicable to individuals in their 50s and 60s. As part of President Reagan's request of Secretary Bowen to develop a catastrophic health care initiative, Secretary Bowen asked me to chair the sub group that worked on long-term care for the elderly. That's the basis on which my remarks will be given today.

In addition to our own work -- which I've brought several copies for the Committee and will be arranging to get you down some more. This was a report we put out that was completed a little less than a year ago, an attempt to bring together just about everything that we knew was available with regard to long-term care; including a number of studies, a number of data bases, that have never been put together in quite the same way before. In addition to our own report, my staff and I have also been working with a congressionally mandated Task Force on Long-Term Health Care Policies, chaired by Daniel Bourque. The Task Force's report on long-term care insurance and other risk pooling financing mechanisms, was sent to Secretary Bowen and to Congress only last month. I believe you all have copies of this as well.

It's important to stress that this report was put together as part of a congressional mandate, and it's not a Department work product. Although I think there's much that the Department is pleased by in the report, it is independent of the Department. It was presented when it was completed to both Congress and the Department simultaneously. We are still reviewing the recommendations of this Task Force, but its work and the prior work of the Department are remarkably consistent; especially considering the very different approaches to the problem each used. The findings of both the Department report and the Task Force, favor balanced development of public and private sector initiatives, and identified employee based long-term care insurance as the most likely vehicle to reach a

large number of people in the near term. Both work groups recommending the judicious use of tax incentives to help stimulate the private market.

From here on out, I'll focus on the Secretary's report, the one in which I was a participant. That's the report that you have copies of now. We considered four types of possible financing mechanisms as part of this report.

The first mechanism are risk pooling options such as long-term care insurance, continuing care retirement communities, and social health maintenance organizations. Each involves a set of individuals contributing into what amounts to a common fund in order to pool their risks, so that in the aggregate there is enough money to pay for the expenses of whichever individuals in that pool need long-term care.

The second approach that we looked at we called "Resource Mobilization Strategies." These would be such things as home equity conversion plans, and employee benefit options for employees. Here, what we're talking about is trying to find resources that exist in some other form and mobilizing them specifically for long-term care.

A third approach we looked at was cash accumulation strategies. The most notable would be an individual medical account similar to an IRA that would be available for long-term care expenses.

Fourth we looked at care givers support strategies, such as tax allowances for home care, and development of organized volunteer systems.

Finally, we also considered various combination approached that would blend the attractive features of two options, such as tax favored IRAs in which a portion of the funds saved are used to purchase an insurance policy which extends protection after the period covered by personal savings. Thus, cash accumulation would be blended with risk pooling.

During the course of my work, I've accumulated a wheelbarrow full of facts and figures on long-term care -- facts on what long-term care is, who needs it and for how long, how needs are changing, who pays for it, and so on. All of this information is useful and important, and much of it is compiled in this report. But I think after two years of intensive submersion, I think there are about five facts that are predominant in controlling and looking at what the future will look like. In essence, I'd like to give you a fast forward summary of the Department's learning curve on this issue. I will try to be brief.

Fact 1: The number of persons most likely to need long-term care is large and growing. As undoubtedly you've heard from many other speakers, the number of older persons is going to increase from 11% of the population in 1984, to 21% of the population by the year 2030. What's more, the number of persons over age 85 -- those most likely to need long-term care services -- will increase three to four times as fast as the general population during the same period. Those over 85 are four times as likely to be in a nursing home, and 15 times more likely to need assistance with personal care.

Fact 2: Even conservative estimates of the future cost of providing long-term care services are enormous. In 1985 the nation spent roughly $38 billion on long-term care services for persons of all ages, including about $26 billion for nursing home care for the elderly. By the year 2020, costs for nursing home care alone are expected to exceed $100 billion in today's dollars. So that does not reflect any inflation but merely the difference in the demographic shift over that time period. You'll have about a threefold increase in cost.

Any extensive long-term care financing system that replaces a portion of today's out-of-pocket expenses, whether public or private, must also deal with the problems that increased demand for services and a rise in overall cost will

result from any formal system for paying for these costs. For example, in our report we used what we though was a very conservative 11 to 38% increase that we believe private financing options would cause in the way of increased demand. It's what's called a noose demand; that is, when there is a mechanism to pay, the amount of services increases. So that when, for instance, we calculate out the cost for 2020 and figured about a threefold increase, we also had to add in as well some figure for induced demand. That is, as mechanisms are there, more of the services will be used. We think that 11 to 28% is probably quite conservative in that regard, and the difference between 11 and 38 varied for difference mechanisms; depending on, for instance, things like deductibles, and co-payments that affect the amount of induced demand.

My third fact: Federal and state government funds already account for almost half the nation's nursing home expenditures, a level of effort that is comparable to the current public sector contribution toward acute care costs for the elderly. The major difference between nursing home care and acute care is how the other half is paid for. In acute care the bulk of it is paid for through insurance mechanisms. Whereas in long-term care the bulk of it is paid out-of-pocket. Private insurance pays less than 1% of long-term care costs presently, and I will come back obviously to that issue.

Fourth fact: Long-term care is fundamentally different from acute care. The term encompasses services and needs that are both medical and social in nature. Unlike acute health care which most often depends on services that can only be delivered by highly skilled professionals, long-term care often involves people and services that can be delivered by you and me. People needing long-term care often have alternatives that acute care patients do not have. Various combinations of services and living arrangements can often be packaged to serve

a chronically disabled person's needs. In contrast, for instance, a person needing his or her appendix out has little choice. They need doctors, nurses, a variety of other specialized workers in a hospital, and they need it quickly.

The amount of long-term care services needed is also highly variable, dependent not just on the patient's condition, but on living arrangements, the availability of family and friends, whether community services are available, and on a host of other non medical factors. Each contributes to what the need for long-term care is in any given circumstance. Also some of the degrees of variability inherent in long-term care is evidenced by the often quoted point, that for every person who lives in a nursing home, there are estimated to be two times as many people in the community with similar disabilities and care needs. If you just say, "individuals with these needs will need a nursing home," you miss a lot of people, and you miss the point that a lot of people can be helped in a variety of settings. All of these factors make it difficult to objectively predict or uniformly regulate what, how much, and when service will be needed; particularly for long-term care services other than nursing home care.

My fifth fact is that long-term care is not inherently catastrophic to the individual. The great majority of disabled older people -- 4.6 million Americans -- live in their own homes and communities, and receive most of the care they need from family and friends, at little or no direct financial cost to them or to the public. That's 4.6 million disabled older people living in the community. Based on the strength of this informal care system, financially catastrophic home care expenses are relatively rare.

Information from the Department's 1982 national long-term care survey indicates that of those 4.6 million disabled elderly living in the community, fewer than 600,000 were estimated to have paid for any formal home care services

out-of-pocket. A similar number of disabled received some form of long-term care services, but they were provided at no cost to the individual. Of those who did purchase some formal home care services, median expenses were about $40 a month, and the average -- askewed by a small number of households with high costs -- were about $164 per month. And only about 1% of the disabled elderly -- about 60,000 individuals -- were estimated to have had payments for home care of over $400 a month.

I recognize that these figures do not take into account acute care expenses, or other emergencies which can drain the financial resources of the elderly. However, they do indicate that the vast majority of disabled elderly live in the community, and that the cost of their home care appears to be modest in comparison to the cost of nursing home care. It is nursing home care that is the largest single out-of-pocket health care cost for the elderly, and for which protection is most needed.

Let me hasten to add -- since I delivered somewhat similar remarks at a forum the other day and was misunderstood on this point -- that while the financial cost of home care services may not be catastrophic for most individuals, the physical and emotional stresses are. In addition, while the Department's extensive research on the impact of home and community-based services indicates that such services do not reduce or offset aggregate nursing home expenses -- that is, home care does not offset nursing home costs in the aggregate -- it is clear that home and community-based services do improve the quality of life for the disabled individual, and that most elderly individuals would prefer to be at home. These considerations may well justify expanded public support for home and community-based services, even with a lack of a documented cost saving effect.

Taken together, what do these five selected facts suggest? First, they suggest that state, Federal, and local policy makers should view the problem of long-term care with considerable urgency. We probably have a fairly short window -- five to ten years -- in which to set up financing mechanisms and begin building up reserves for the significantly increased number of elderly we will see in the 21st century. Otherwise, as a society we may be in a position of trying to fund rapid increases in the need for long-term care services out of current income. Rather like companies which have failed to pre-fund promised health benefits, and as a result face bankruptcy when a large number of employees begin to retire, not dissimilar from the difficulties that the social security system faces in the 21st century from being on a current funded basis, and right in the last few years finally starting to deal with the need to build up reserves.

The second conclusion I draw from these facts is that state and Federal governments are paying half the costs of nursing home care, and thus the public sector is already playing a major role in financing. Our main immediate emphasis should be on seeking to broaden the base of financial contributors.

Third, the diversity of need and circumstances of long-term care, and the importance of informal care provided by family and friends, suggest that the financing options we adopt must be carefully designed to preserve choice and flexibility in services and settings; to support and expand rather than replace individual responsibility -- and most of all family care giving.

Fourth, the facts suggest that to the extent that we intend to shield families against catastrophic expenditures, public monies should be built on a base of coverage for nursing home services. As I indicated earlier, there may be other reasons to provide support for home care other than the

catastrophic issue. But to the extent you focus on catastrophic, the catastrophic expenditures are almost exclusively in the nursing home setting.

Finally, the facts suggest that in today's economic climate, long-term care is too costly for a significant expansion of the public sector as a primary payer. I'm not, let me hasten to add, suggesting that Federal and state governments retrench and pay less for long-term care. The question, "Should we pay more for long-term care in the public sector?" needs to address a number of issues. Should we pay more in the public sector before we try to develop private financing alternatives that can mitigate the impact of long-term care costs for individuals? If we do this -- if we do it hastily -- we risk using public funds for those who can afford to pay to protect themselves purchasing long-term care insurance, and we risk using public funds to pay for those whose primary goal is to preserve their estates relatively intact for their children. In short, if we act in haste, we could wind up paying more for people who can afford to pay for their own care.

Instead, I think changes in existing public programs should concentrate on the traditional responsibility of government, discovering whether there are needs and how to address them; to pay more for those persons who have no private resources, and for those whose needs are based on the fact that despite advanced planning and resources, they've encountered long-term care costs well beyond ordinary means.

At the Federal level the debate as to action is just beginning. On one side of the discussion are those who favor use of tax incentive and education to develop markets for savings and insurance mechanisms. On the other side are those who favor social insurance, fully Federal approach to financing. I feel fairly confident in predicting that a fully public sector comprehensive solution will not be enacted

anytime over the next several years. Even advocates of that approach -- of which I am not one -- concede that the budget deficit, combined with high costs, make that approach too difficult to manage when it comes right down to a concrete proposal with large concrete numbers attached. I believe Congressman Rinaldo mentioned one such number -- $90 billion.

As a result of the Department's catastrophic illness expense report, President Reagan asked the Treasury Department to study the tax implications of a series of recommendations from the Department of Health and Human Services, designed to encourage personal savings for long-term care, and for the purchase of long-term care insurance. We expect the Treasury Department study to be completed by the end of the year, and we will certainly share that with our colleagues in New Jersey.

Meanwhile, the Department is also working on public/private sector initiatives to increase consumer awareness of the need for better protection. The Department continues to work with researchers, insurance companies, and actuaries, as well as state Medicaid programs, to improve the data on long-term care needs and financing -- particularly on the Medicaid spend-down phenomenon.

Where does the possibility of Federal level initiatives leave the states? I believe it leaves you in a critical position. Adequate development of private financing mechanisms is going to take both state and Federal initiatives, hopefully working in partnership. I think Congressman Rinaldo referred to several that he had in mind. Long-term care insurance is an example of whether or not a package of Federal tax incentives -- such as that introduced by Congressman Rinaldo -- passes in Congress sometime soon, states will still have to decide whether to provide tax incentives of their own, whether to deal with some of the regulatory problems that still exist at the state level with regard to such policies, and states will also have a key role in helping to increase

consumer awareness. They will also be responsible for ensuring that the consumer is protected from worthless insurance products and fraudulent sales practices. Also, states can play a critical role in support of the informal network of care provided by family and friends.

In addition, and certainly related, our study found a lot of opportunities for improving that family and friend care giving system by increasing the use of volunteers. This is an untapped resource that can be cost-effective if volunteers are adequately trained and supervised. This is particularly an area where local support is needed, and where grass roots efforts would work best.

In closing, I would like to suggest that you not try to find "a solution," nor focus solely on insurance options. We all need to work on several fronts at once. No one approach is going to meet everybody's needs. In particular, we need better data on long-term care, and ultimately we probably need to support strategies which encourage the most efficient management and delivery of acute and long-term care services on a coordinated basis. The problem of financing long-term care is so difficult it can be frustrating and discouraging. However, I think we can take heart in the fact that, unlike many issues in the public sector that we struggle with, this one is likely to be of great personal importance. With any luck, we will all grow old and enjoy the fruits of our labors.

This concludes my prepared remarks. I'd be happy to answer any questions.

ASSEMBLYMAN SCHUBER: Are there any questions from the members of the Committee? (affirmative response) Yes?

MS. SIMS: I have a question. What advice would you give to us as a State that's considering looking at various options in terms of legislation for long-term care and private insurance, specifically loss ratios -- referring to the amount an insurer has to pay in terms of benefits on the average

premium dollar? What advice would you give with respect to that particular point?

MR. GROSSMAN: Okay. I think there are two places to look. The issue of loss ratios was not addressed in any lengthy manner in our report, but it is addressed in the Task Force report that you have, as an issue. In fact that was part of their congressional charge. In addition, the National Association of Insurance Commissioners has also looked at that issue. The difficulty, as you're probably aware, is that you're trying to deal with a situation in which the need to build up significant reserves in the early years, is critical to the actuarial soundness of the policies and of the investment, from the company's point of view. As a result, traditional analogies in terms of, for instance Medigap policies, and trying to regulate the policy through a benefit loss ratio, are probably not appropriate for the regulation of long-term care insurance policies. But I would refer you to the much longer discussion of that in the Task Force report. And I would also think that's an issue you might want to address with the State Insurance Commissioner.

ASSEMBLYMAN SCHUBER: Yes, go ahead.

MS. BASS: I know that your work was not specifically aimed at the perspective of the State, but if you could take a minute to think about what you might recommend to a State such as New Jersey? What would be the key components of a policy we might establish? What would that look like to foster the design and sale of good policies in long-term care insurance?

MR. GROSSMAN: Again, I think probably the Task Force report, for that specific question is probably more useful than our own. Our own was an attempt -- as I indicated -- to pull everything together, culminating in a set of recommendations for the President. We focused primarily on the financial aspects of private insurance and methods of creating an adequate market for them. I think the Task Force report really

addresses that at much greater depth, and is accessible. In terms of working with the Federal government, I think there will be opportunities in that area. I think that your own State's insurance regulations may be a fruitful place to look. I'd advise getting some companies in here, if you haven't already, and ask them-- Acknowledging that obviously they're going to give you an answer that deals with the world as they look at it. Nonetheless, I think they can give you some ideas of what barriers they see.

I think that one consideration that you need to keep in mind as you listen to their answers, and as you discuss among yourselves what policies represent good answers, is that there are a lot of variables in those policies. Among the questions that need to be answered are, will they cover Alzheimer's disease, for instance. There are exclusions in some policies that don't. That's a problem. Some of them have prior hospitalization stays. In our report, for instance, we analyze -- and I don't remember the exact percentage, but from an actuarial standpoint, a policy with a three-day prior hospitalization is 10 or 20% or whatever, less expensive than a policy with no prior hospitalization. I think reasonable people can differ, though, whether that's an appropriate place to be making a distinction in putting those kinds of policies together. I think there are ways to make these policies less expensive, particularly making them more attractive -- perhaps with tax incentives at the state level.

ASSEMBLYMAN SCHUBER: Yes?

MS. DIETRICH: I look forward to seeing your report, because in listening to the comments that you've made -- which were most interesting -- still I come up with the idea that many of the solutions suggested are more in the long term, which is very important because the greater burden, as you suggest, is coming after the turn of the century. But still that leaves us with the issue of what to do between now and the

time that the reserves can be built up so the payments are realistically generated through an insurance program. You mentioned encouraging private savings. The problem that I come up with is that right now nursing home costs in the State are around $30,000 a year. I find it difficult to imagine a tax incentive program that can help working class people to generate the kinds of savings that will be adequate for that kind of expense. So I'm a little disappointed to hear you say that public monies have kind of gone as far as they can go, and the rest is up to individuals, and some kind of private sector mechanisms. I'm kind of puzzled as to how we in the State can encourage mechanisms that will generate the kind of money that is really needed?

MR. GROSSMAN: Let me address that in two ways. First of all, there are policies currently available that are generally -- although certainly not affordable to everybody -- are generally affordable. For instance, there was recently a circulation on behalf of a policy through the AARP, and my recollection is that for those 60 to 64 the policy cost was in the $300 range, and for those 65 to 69 the policy cost was in about the $600 range, and policies were available through, I believe, age 79 or 80 -- although admittedly at an increasing cost. So when we're talking about the immediate problem, we're still talking about people under 70 being able to address their problem through insurance at relatively reasonable costs.

Another consideration with regard to the $35,000-- I don't think that for very many individuals, saving the entire amount is very realistic. Our report suggested that the best way is to combine savings mechanisms with risk pooling. That is, the risk of a nursing home stay is somewhere between 20% and 40%. That's the lifetime risk. The risk of a long-term -- 90 days or greater -- nursing home stay, is about half that. So that from a pure risk pooling point of view, it is possible to create risk pools. We may still need to be able to

encourage people to save the money, to put it aside, so that they can afford those policies.

MS. DIETRICH: Well, in terms of the policies that are not now available in New Jersey, most of those policies really cover very little outside of skilled care, and the skilled care requirement eliminates all the people who are mainly in nursing homes because they need personal care. They might cover skilled care for three years of four years, and a minority of them will also cover custodial level of care if you have already been admitted to a nursing home because you need skilled care. Many people need to be admitted to a nursing home without having the skilled care requirement immediate-- You know-- They don't qualify, in other words. Most people could buy those policies and still not be qualified for coverage because of that skilled care -- the gatekeeper mechanism.

MR. GROSSMAN: As I indicated earlier, there's still certainly room for improvement, not only in the cost but in the coverage of insurance policies. And I think that may well be an area where states can take a lead, through their Insurance Commissioner, through their own state regulation of what is available for sale in the state. I think NAIC has started to do a lot of good groundbreaking work in that area, although more needs to be done.

MS. DIETRICH: The industry has a long way to go, I think.

MS. SMARTH (Assembly Majority Staff): I just wanted to ask one question, Mr. Grossman. You mentioned, and we all know, that nursing home care is the leading cause of out-of-pocket expenditures for the elderly. What does your report -- in either of your reports -- refer to in any detail the sorts of action that state governments may take to promote further the development of other non institutional long-term care settings like the CCRCs, the HMOs?

MR. GROSSMAN: Our report contains a fairly extensive analysis of each-- I referred to four different types of financing mechanisms and then a couple of examples under each. Our report, but not the Task Force report, goes in some depth to an analysis, for instance, of what is currently known about CCRCs. I don't think that we reached a conclusion that would say, "and here is a blueprint for the states." But I would think that if you were interested in looking further into the potential for CCRCs -- for continuing care retirement communities -- I would think that the chapter in our report would probably be a very useful place to start, and would send you to all the additional people in each of these areas who would be helpful to you. And we would of course also be happy, through my office, to provide you with suggested leads for people on any topic in that area.

Assemblyman, there was one other point that I thought might be useful to make in response to Ms. Bass' question earlier. And that is that one of the other unknowns here, and perhaps an area in which especially a State like New Jersey which has a considerable medical research infrastructure and a large number of health care corporations might want to be conscious about; and that is that all of the data that I've given you is premised on assumptions that the age related disability rate will stay the same 30 and 40 years from now. There is hope if we can make a major breakthrough on Alzheimer's, if we can do better in dealing with the incontinence problem that many elderly experience, that we can do better. That by itself would do much to improve these numbers and to make the insurance policies more affordable, the percentage going into nursing homes smaller, etc.

MS. BASS: Is the NIH putting more money into gerontological research?

MR. GROSSMAN: We're working on it. We're working on it. But there also is a very large presence on a number of those issues in New Jersey as well.

ASSEMBLYMAN SCHUBER: In the course of your deliberations, have you come up with any recommendations on an issue that I heard Congressman Rinaldo discuss briefly in passing this morning, which is the issue of home equity conversion for seniors as a means or providing financial assistance?

MR. GROSSMAN: Well, let me talk from a personal viewpoint because I don't think the Department report comes to any particular conclusion about that. I went through an up and a down and an up on the issue of home equity conversion, as I referred earlier to the Department's learning curve; and we really did have a learning curve. The potential for home equity conversion is enormous. Although there's a full discussion in the report, the number I remember is the elderly have $700 billion locked up in home equity in their homes. The proportion of the elderly that own their own home is in the range of 70%, and about 80% of those own their homes free and clear. Clearly, when we started the report the notion of being able to untap some of that-- That is, it's a resource mobilization strategy: to be able to tap some of that to be able to pay for long-term care was highly attractive.

As we went on through our learning curve, I came to a sort of down about it because the history of the programs have been that they really have not taken off. They've been very difficult to make work, both through an economic point of view, and also from the point of view of the willingness of elderly individuals to participate. For many of them, their home represents a culmination of their life in a lot of ways, and doing anything that might in any way jeopardize it -- even if it would not be during their lifetime -- is a problem. So there's been both financial problems -- how to make it work so that it's a good deal for both the individual participating and the company making the loan is one issue. Another has been whether it could be made palatable, and enough demand could be

created. During that period of our study I was kind of down on the prospects. I think since then -- in the years since our report came out -- I think there are some signs that people are rethinking the problem of how to tap that equity in a way that would work. I think it's worth your looking into further, with a little skepticism, but with some possibility that there may some things there that are worth doing.

ASSEMBLYMAN SCHUBER: Oh I think it represents a great potential. I recognize what you're saying, however; the fact of the cautionary admonition that you've given us with regard to the fact of whether this has worked in the past, and the fear that seniors might have with regard to the utilization of their properties in those manners. But I think as anything goes, I think it's a matter of education and a matter of building up confidence in a type of program like that. I think it does hold a great deal of promise in this particular area, but we'll have to see as time goes on.

MR. GROSSMAN: As I said, I started up. I've come down on it, and then of late I've begun to have some hopeful thoughts. So I hope you're right. I don't know, is that something that's being considered within New Jersey?

ASSEMBLYMAN SCHUBER: It's something we're looking at anyway.

MR. GROSSMAN: Okay, good.

ASSEMBLYMAN SCHUBER: Are there any other questions? (no response) Thank you, Mr. Grossman. We appreciate your being here. We recognize that you had to travel by car very early this morning to be here, and we appreciate that very much. Thank you.

Our next witness is really a carry-over from the last hearing. Mr. Frank Power, of the Bergen County Office on Aging-- Is Mr. Power here?

F R A N K P O W E R: Yes. Good morning, Mr. Schuber.

ASSEMBLYMAN SCHUBER: Good morning, Mr. Power. Thank you for being here.

MR. POWER: I'm glad that Mr. Grossman ended on an upbeat with regard to home equity, because that's the issue that I would like to talk about.

ASSEMBLYMAN SCHUBER: We'd be very pleased to hear more on that.

MR. POWER: I would like to preface my remarks simply by saying that whatever I'm going to talk about with regard to home equity, is simply a way to help the individual senior homeowner pay for whatever is available. I'm not going to be talking about the pros and cons of any other program, whether it be the CCPED or whatever is planned by the Home Health Assembly, and so on. So my remarks should not be taken either pro or con of any of those other ideas.

My name is Frank Power, I am a Senior Planner at the Office on Aging, the Bergen County Division on Aging, I also represented all of the offices on aging in the State of New Jersey on the Task Force on Senior Housing Options during the last year. A report is going to come out very soon from Commissioner Richmond to the Governor on housing options, and one of the principal options that we looked at was home equity conversion with regard to a tax deferral program.

I would like to preface my remarks with another personal statement, that I'm speaking on my own behalf, of course with the knowledge of my director, but not in terms of represesnting an official position of the Advisory Council, the Office on Aging, or the Bergen County Freeholders or anybody like that. It's simply the fact that I have spoken more to seniors on home equity than I believe anyone else in the State of New Jersey -- outside of perhaps American Homestead personnel, who are in this for the profit motive, but also in terms I find it very humanistic.

I have spoken to well over 200 seniors in Bergen County on home equity and how to achieve a way to pay for their expenses from the equity in their house. As you may know, the

only existing local program for equity is a bank in Bergen County -- the Boiling Springs Savings and Loan -- which gives up to 70% of the equity in the home over a three-year period. I have referred many seniors in Bergen County who come in to our office, in a situation where all of a sudden mother or dad needs home health care, and they need it now. They're not eligible. The waiting lists are long, and they need it now. They're able to go the bank, and negotiate something in a relatively short time to pay for the home health care that those individuals need. So I am speaking with firmness and assertiveness, because I know that many seniors have benefited from this program, and once they understand the concept of the appreciation factor, then they go for it.

And a specific example: A lady who was about to lose her house this week -- a disabled senior with an 82-year-old mother -- was able to forestall that problem because of the ability that she had in a house that is valued at over at quarter of a million dollars -- to understand that she can remain in the home, take the appreciation of that home eventually, and pay for the loan at 10%, and cleared her debt of nearly $45,000 in order to stay in her home.

So I'm going to say that one of the things that came out of the Task Force is directly related to this long-term care issue, and that is, tax deferral. I took depositions from many seniors in Bergen County for public hearings in this State, and most of them are using the money for one of two reasons. There are people in the IRMA Program -- the American Homestead Mortgage Company private program, or they are in the Boiling Springs program. They're using the money for two main reasons: One, to pay their taxes, and two for home health care.

So, the Task Force on Housing Options-- We have designed a tax deferral program. I'd like to begin there, because if a senior is able to keep -- and I'm talking principally of those seniors at the upper end of the age

spectrum -- if they're able to keep that $2000, $3000 in their pocketbook and use it for their needs, they are going to take care of their teeth; they're going to get their eyeglasses changed; they're going to see their physician. They're going to make the calls into the health care system that they are going to neglect if they have to keep that $2000 and pay it to the tax collector. So that's the preliminary move into the long-term care system, because as you well know, that chronic disease and disability is the major health problem. And as the older adults find themselves coming into arthritis -- or whatever the case may be -- they know there's going to be only so much money at their disposal because of their relatively fixed incomes, so they put the money aside for the tax collector so the sheriff won't come to the house -- at least if they perceive that -- and take their house away. They cut down on their food. They neglect the socialization factor, and a whole host of other things, which we learned at an independent living center in Bergen County, which I used to direct. People are avoiding the health life styles that they should be doing in order to preclude or at least delay, the chronic health care issue.

What I'd like to talk about is money. There is not enough money in the New Jersey Treasury; there's not enough money in the casino revenue funds, to pay for the home health care that is going to be necessary in the State of New Jersey. I would like to simply augment and favor the remarks of the lady from Connecticut, who spoke to you on the long-term care issues. I have studied those materials, and I believe they are quite applicable for New Jersey.

I'd like to talk about the 45% of the 60-plus household owner occupied, over 60 population in New Jersey. There are 275,000 owner occupied households, 60-plus, with incomes of less than $20,000 single, or $25,000 couple. That represents 400,000 persons. Or, if you want to start at the

other end of the spectrum, or at the 70 age, rather, you have another 275,000. This seems to be in the statistics -- and I'll leave you some copies of this material which kind of became our bible work sheet for the Task Force. This 275,000 owner occupied households in the over 70 population, where, as you know, the graph begins to change markedly toward the need for home health care, and eventually nursing home care. Of these, 250,000 are married, and 150,000 are single. Now I just want to throw out what is the appreciation of these homes in New Jersey. It's $2,750,000,000 a year. That's just the appreciation of these 275,000 owner occupied households.

I'll go now to the 80-year-old population in the State of New Jersey. We have 60,000 owner occupied homes in New Jersey, whose owner occupiers are 80 years plus. That represents about 80,000 people, because a portion of them, obviously, are married. Now the appreciation on those homes -- and that's the 10% of the senior population plus 80 -- is $600,000,000 per year. My simple point in drawing out these tremendous figures is that if one grasps that once the senior understands -- it takes a while, but once they understand that somehow there must be a mechanism to take that appreciation and turn it into cash, which is the home equity conversion, and use it to pay their taxes, or use it to pay for home health care, they say that is a wonderful idea. When they don't understand it, they are afraid of foreclosure. They are afraid of having nothing left to pass on to their heirs.

I want to address very specifically -- the previous speaker talked about -- why people do not go into home equity programs. That's a serious issue, because only about 6% of the people who were eligible in the State of Oregon, in the State of Illinois, in the State of Wisconsin, have actually gone into the programs. That's why it's the downer, because people aren't doing it. But the problem is that most of these people live through and experienced foreclosures during the

Depression, and they have a great fear in their heart of hearts that this could happen to them. So they don't want to get into it. If New Jersey is going to try to capitalize on this equity and covert it into long-term care and tax deferral programs, one has to have a couple of structural things. And one of those structural things is that there's got to be an up-front notion that there's not going to be foreclosure. The speaker from Connecticut I think probably addressed that, so I'm not going to belabor that. But that has to be clear in order to get the 6% up to a more reasonable percentage, say 25, 30%, 1/3. That's the first thing.

The second thing that has to be there before they will go into it, is the notion that there's going to be something left over for Johnny -- Johnny is the son, or Mary the daughter, or the grandchild. So there has to be at the other end of the spectrum a -- and I think the speaker from Connecticut mentioned this -- there has to be a kind of something left over. There has to be a part of the equity that will be there. And in talking to many many seniors in the American Homestead Program, this is where it's really at. They don't mind spending some of the money, but they don't want to spend the money if there's not going to be something left for Johnny or Mary. It's unfortunate perhaps that they think that way in one sense, but that's the way they think. So I want it to be very clear that whatever system is devised in terms of looking at home equity conversion, foreclosure has to be eliminated, and there has to be something left over.

So the question is, is there a way to convert this tremendous amount of money in which you have older adults in Bergen County who paid $30,000 for a home, and it's now worth $300,000? You have seniors in Bergen County living on food stamps, whose homes are appreciating at the rate of $25,000 a year. It's just an insane situation in one sense. So what I'm saying is that I know, and believe firmly from what I have

experienced, that the experts -- and I'm talking Ken Scholein from the Madison Program; talking Katie Sloan from the AARP Program in Washington; I'm talking Leo Baldwin formerly with the AARP who introduced the equity conversion and the CHISS Program here in Jersey, in Bergen County, in our office--

This book on housing the elderly edited by Hancock, has a strong chapter on equity conversion, and I just want to read you a couple of sentences from this chapter. "First Mortgages": All right. Here it is. "A complete and thorough counseling at origination should screen individuals so that those who choose to take out reverse appreciation mortgages are not only aware of the possibilities, but find their personal objectives coincident with them." That's what I'm talking about, their inner heart, personal heart objectives. They know there'll be something left over. They know the fear of foreclosure will be forestalled. Then they will give a more mindful appreciation of whoever -- a person like myself, or whomever -- will be talking to them about the reverse mortgage.

The other thing they have to say is, that the people who need it most -- that is the 80-plus population -- they're the ones that have the most equity. And in terms of the longevity issue -- even though we know that the elderly are going to live longer, so this is not something that you can do overnight -- but, nevertheless, the people who need it most, okay, are going to have the most money in their equity, and the payout period should be lessened. So that we are thinking in terms of tax deferral of a 70-- You can't get into this program until you're 70, and possibly it could even be higher in terms of the long-term care issue.

Forty percent of the low income elderly are homeowners. Fifty percent of the low income homeowners in America are elderly. I'm not sure that those statistics apply in New Jersey, but I have a feeling that they're relative to New Jersey. So one of the things that I want to look at is,

how are we going to help these people who are poor already and own a home, who are neglecting their health, who are neglecting to go to their physicians or go to their health care system, or whatever the case may be? How can we help them get at the equity in their homes?

So I want to encourage this Task Force to look favorably, to read the report that the Senior Options Task Force is about to publish -- sent to the Governor -- and look at the tax deferral thing in there. What we put in there is this. We want to answer the fundamental problem that seniors are complaining about, their taxes. So the tax deferral element is prior. But in a secondary way, you take 50% of the appreciation, or the equity factor, 50%, and you put that on the table over here and say, "Okay, we will help you defer your taxes. The State will set up an appropriation" -- the initial appropriation we talked about is $5.5 million -- "and then the State will pay the local townspeople their taxes. Nobody has to know about it. It's your business and the tax collector's business. And then there will be no payback until after the house is sold." That's the first part.

The second part is, that they can sign onto a senior health care equity line. Once they are enrolled in this program -- and the people would be under $20,000, perhaps $25,000 couple annual income, or they could be the PAAD people -- which is a little lower in terms of the finances. Once they're into the program, then they can begin to get credits, For example, if they come into the program at 65, a $5000 a year credit can be allocated for them on a deferred basis. They don't use it, fine. The second year there would be $10,000. The third year $15,000. The fourth year there would be $20,000. This is not real money. It's not going out. But when the time comes, they will be able to get the money to pay for the home health care that they need, and it's not a giveaway program. It's not Medicaid. They don't have to go

into impoverishment. They don't have to go on a welfare program in order to get this money. The money then also would eventually return to the State of New Jersey, and interest can be charged to the money until the time that it is paid.

So what I would like you to think about is simply to open your vista in terms of the equity issue. Six billion dollars a year is the equity appreciation of senior homeowners. We're not proposing, obviously, that you don't do all the other things that all the other speakers are talking about. We're not trying to rip off the seniors in terms of taking that money and paying for the home health care. We're saying that the option for seniors and their families to stay at home, it was the number one option; to be cared for by loved ones, which is their first thing; to delay or preclude institutionalization, which they desperately want; they can do if the money is available to pay for those home health aides when they need it.

One other thing. Most of the problem with home health aides in the Medicaid program is that they're poorly paid. There's a terrific turnover. I see a way for there to be with a program of this nature a sharing of the costs for home health care, to give more money to those providers of the home health care so that they will be paid better. Many of them might be women that are in the REACH Program that are now trying to get back into the work force, that they can be better paid, that they can have a more steady job. Instead of getting $5 an hour, they can get $7.50 or $8 an hour.

My final remark has to do with Mr. Peter Wessel. Peter Wessel spoke to the Housing Task Force. He was a very bright young man. He works for Prudential-Bache. He was involved with the American Homestead Marketing Program, and then Prudential-Bache decided that Prudential did not want to get into the insurance business with long-term care. So, I'm not too favorable on insurance companies, but anyway, maybe

they will. What he did was, it seems that when you catch on the equity and long-term care, you catch on fire so to speak. It really gets to you. You know that somehow there's a solution here. He pointed out that if you can take about $10,000, you can take this $10,000 and if you can get it in some way out of this equity on a deferred basis, you'll be able to buy that instrument that insurance instrument that is going to take care of either the home health care or the nursing care. If you do it early enough, it's going to give you this kind of build up that this gentleman was talking about.

Insurance companies need a lot of money to get a lot of money for themselves, before they want to give some of it back to the people that gave it to them. That's the problem. But if you can do it in such a way that New Jersey could do this on a deferred basis, then eventually they could get the instrument -- if there is one that's worthwhile purchasing, and that would have to be up to the State to look at that -- then they could get into that insurance program, pay for the long-term care either in the nursing home or in the home, and then eventually the State would recoup that money after the house is sold. I don't know the figures because I don't have the time, or even the expertise, to deal with it; but I believe that the Medicaid system, which is paying the freight here, can make dollar for dollar -- it will save a dollar for every dollar that comes out of equity. Somehow, if you can get the people who want that option, to spend the money to remain in their home, eventually the Medicaid program down the road will save a dollar, because it will preclude altogether going into the nursing home, or it will be significantly delayed in time before they go into the nursing home. That concludes my remarks.

ASSEMBLYMAN SCHUBER: Thank you, Mr. Power. I appreciate it. Are there any questions from any members?

MS. SIMS: I have just one quick question.

ASSEMBLYMAN SCHUBER: Yes?

MS. SIMS: First of all, I found your discussion very interesting and very informative. How would you advise a person, a senior, who was facing the decision of whether to go into a CCRC or to consider this option? What would you to say to that person?

MR. POWER: Basically, I try to find out what they really want to do, and I find that the overwhelming -- and I'm talking maybe 85% of the people I talk to -- it's clear they want to remain where they are. Okay? In terms of the family members that are trying to deal with what are we going to do with mother, they are more apt to be more disposed to consider a continuing care retirement community. But the seniors themselves, they don't want to do that. I think it's possibly because of a perceived notion that the nursing home, or even the community care program, is a step out of their home. It's a step towards death. They just don't want to handle that.

MS. SIMS: Thank you.

ASSEMBLYMAN SCHUBER: Thank you, Mr. Power.

MR. POWER: You're welcome.

ASSEMBLYMAN SCHUBER: We appreciate your coming down. We appreciate your enlightening the Committee on an issue that we're quite interested in, which is the home equity conversion. Thank you.

Our next witness, Mr. James Cunningham, President of the New Jersey Association of Health Care Facilities.

Mr. Power would you bring the figure--

MR. POWER: Sure. Let me just mention that the contact person at the State level for this is Mary Bentivegnia, Division on Aging.

ASSEMBLYMAN SCHUBER: Okay, fine.

MR. POWER: She has all this material that you can tap into.

ASSEMBLYMAN SCHUBER: I appreciate it. Thank you. Thank you, Mr. Cunningham.

J A M E S E. C U N N I N H A M: Thank you, Mr. Chairman. I'm Jim Cunningham, President of the New Jersey Association of Health Care Facilities. We appreciate the opportunity to present our comments relative to Federal and State policy directions and options for financing long-term health care.

As a representative of New Jersey's long-term care industry, whose organization numbers approximately 200 long-term care facilities, I was privileged to serve on a national task force whose job was to study the feasibility of private insurance for long-term care, and hopefully, spur development of such policies. Others who have testified before you -- such as Dr. Mark R. Meiners and Kim Bellard -- served on that same body. I firmly believe that four symposiums conducted around the country under the auspices of this task force did much to create interest in catastrophic long-term health care insurance.

From the national perspective, it appears obvious neither the Federal government, nor the general public, is ready to adopt a program covering long-term care at home, or in the nursing home, for all Americans. An employer/employee financed plan, similar to the social security system, does not appear to be in the immediate future either. That leaves only private insurance for long-term care as the viable option to eliminate devastating pauperization of those elderly citizens who eventually must use long-term care services for their health needs. In fact, the final report of the U.S. Health and Human Services Task Force on Long-Term Health Care Policies -- established through section 9601 of the Consolidated Omnibus Reconciliation Act of 1986 -- makes that same conclusion. We have attached an executive summary of that report for your use. I think this is probably the report that Mr. Grossman spoke about in detail.

ASSEMBLYMAN SCHUBER: It is. Yes, we were looking at it before. It is.

MR. CUNNINGHAM: The full report is available through their auspices, but I think they charge you $18 for it.

ASSEMBLYMAN SCHUBER: I think we have that also.

MR. CUNNINGHAM: Well, that's good.

ASSEMBLYMAN SCHUBER: No expense is spared by the Committee in obtaining this information.

MR. CUNNINGHAM: Another reference you might want to acquire is "What Legislators Need to Know About Long-Term Care Insurance." This publication is available from the Beverly Foundation, 99 South Oakland Avenue, Suite 227, Pasadena, California. It was sponsored by that organization, the Health Insurance Association of America, and the American Association of Retired Persons' Women's Initiative, and was written by the National Conference of State Legislators.

Private insurance for long-term care is currently a viable, affordable solution for financing long-term care. A person from 55 to 59 years of age can purchase coverage for less than $400 annually, with yearly costs being less than $600 for someone 60 to 64 years old. This does increase if you wait until 70, 75, 80 years old, to purchase it. This is a small price to protect one's assets. These quotes are from a policy available from the American Republic Insurance Company, a company with a Best rating of A+ Superior. Policies are also available from Aetna, Travelers, Prudential, and many others. Only through such protection can the elderly, forced to utilize long-term care, be spared pauperization and expenditures for private care estimated at $15.8 billion in 1984. This is just the amount that the private paid patients paid, not those parts by the government under their programs. It's probably much much higher at the current time because that was a 1984 figure.

However, the Federal and State governments, along with the long-term care industry can, and must, do things to stimulate the growth of such insurance. The two reports mentioned earlier, clearly outline what must be done. I highlight a few for your consideration:

1) Consumer education: Since policies are now available, one of the last steps is marketing the product by educating the public as to why they need such coverage. President Reagan urged a campaign in conjunction with private insurers. Our own Association is embarking on a statewide speaking tour to all nonprofit groups -- that's the seniors, the Lions, Kiwanis, Rotary, any nonprofit group that's listed in the State of New Jersey -- regarding this subject. The U.S. Task Force recommends other methods.

2) Promote availability through employment: Tax incentives, and encouragement of employer cooperation is necessary here. We understand AFSCME -- one of New Jersey's State employee unions -- unsuccessfully attempted to negotiate State payment of policies for their members.

3) Permit use of Pensions, IRAs, or death benefits, for purchase of long-term care insurance: Transfers of such funds for this purpose should not be taxed. Mr. Al Wurf's testimony at your first hearing touched on the use of death benefits for this purpose by State workers. It appears he has not as yet been successful in convincing State government officials that it's a good idea.

4) Allow tax credits both State and nationally for those purchasing such insurance: New Jersey's Legislature could move legislation to accomplish this on the State level. We applaud Congressman Matthew Rinaldo for his efforts in this direction in Congress.

5) New Jersey Medicaid purchase policies for Medicaid recipients: We understand Commissioner Altman of the Department of Human Services indicated an interest in doing

so. About, I think six or eight weeks ago I read comments by him in the media in this area. This could possible save New Jersey taxpayers a sizeable amount of money due to reductions in the Medicaid budget, since the State would not have to assume long-term care costs for those people for four years.

We hope these suggestions, and others contained in the reports attached or referenced, are of help to you in your deliberations. It appears clear that private insurance for long-term care is an idea whose time has come. Thank you.

ASSEMBLYMAN SCHUBER: Thank you, Mr. Cunningham. Let me ask you a question. The insurance policies you were discussing at the beginning of your remarks that are currently available, what type of coverage do they give? Do they cover just certain types of nursing home care, or do they cover the full gamut of long-term health care?

MR. CUNNINGHAM: Some have some limitations. Some of the portions of the Prudential policy have some limitations. The better policy though that should be looked for -- and I heard this discussed before, and you will find it in the American Republic policy -- is no three-day hospital stay. That was always used as a limitation and control of coverage, and one of the problems that Medicare still has today, and has not changed. You'll find that the better policies will not have a three-day hospital stay before you can get that coverage.

The better policies will cover usually about four years of coverage. The premium will alter, dependent upon the amount of coverage you want per day, and possibly your age. The policy amounts that I quoted, you can see do vary by age and they were quoted on paying a rate of $80 a day in facility which can buy you the coverage in this State today. It would vary, dependent upon what coverage you want per day, and in some other parts of the country it might be $50 a day and you might take a lesser amount. You can buy up to $120 a day, dependent upon the premium you wish to pay. It is an indemnity

type of thing, where that money goes to the recipient, even if the rate is not that high. Also, coverages are preconditions, which I don't know that any of them -- probably other than this one policy would cover -- that does cover preconditions if they've been dormant for six months. So it is an advantage also. But some of these types of things are there, and it should be designed that the definition of the coverage and the care should come right out of the long-term care manual in that state.

ASSEMBLYMAN SCHUBER: To your knowledge, are there any waiting periods for these policies before the benefits are paid?

MR. CUNNINGHAM: Most do have waiting periods. They would usually be 30-, 60- days type of thing, in order to eliminate abuse of use of them.

ASSEMBLYMAN SCHUBER: Any questions?

MS. BASS: Yes. I'd like to ask for a little bit of clarification. You state that you understand that Commissioner Altman of the Department of Human Services has indicated an interest in purchasing long-term care policies for Medicaid recipients. Could you--

MR. CUNNINGHAM: I saw that comment in a newspaper story, where he commented on several items and that was one of them. I'm sure I retained it, and probably have it in the office. I can tell you, though, from serving on the National Task Force that I mentioned for about four years -- and up until about four years ago -- we've had a number of discussions with the Medicaid Director in this area, and one of his earlier comments was, it would pay Medicaid to pay the premium for the Medicaid people at least after a certain age. You wouldn't pay for your 21- or 25-year-olds. That comment coming from the Commissioner in the media-- You'll find it was in a Star-Ledger story.

MS. BASS: Because I know he has expressed an interest in seeing the Department become active in helping to find some policy solutions to the more general problem, but I'm not personally familiar with any statement of this nature.

MR. CUNNINGHAM: I was somewhat surprised that it came from him. I would not have been surprised if it had come from Tom Russo.

ASSEMBLYMAN SCHUBER: Any other questions? (no response) Thank you very much, Mr. Cunningham. Our next witness is-- Is Mr. Peloquin from the State Health Plan for the Elderly here? (affirmative response) Did you wish to testify?

E D W A R D J. P E L O Q U I N: Please. I have an associate with me also.

Assemblyman Schuber, and members of the Task Force, I appreciate the opportunity to bring to you today a document that I think you will find very interesting. I have the privilege of appearing not only as representative of the local health planning organization for the six counties in central New Jersey, but as the Project Director for the State Health Plan for the Elderly, which provided me with a statewide perspective on the issues that you're dealing with today.

To my right, I'm pleased to introduce Dr. Kenneth Maugle, who is the Project Coordinator for that particular effort. That effort was over two years in development at the local level. It was released through the Health Department just this summer. The documents in the red binder represent the most comprehensive and complex look at long-term care in all settings and services, this State has every undertaken. It recommends in that $21 million in monies to be spent over the next three years for several projects that are short-term in nature, that would have long-term solution potentials for the State.

For the moment I would like to have Dr. Maugle give you a little outline of what the project and the results were about, and then I'll return back to my prepared remarks on three suggestions that I have to make to the Committee.

D R. K E N N E T H M A U G L E: Thank you. Honorable ladies and gentlemen, it's my pleasure to tell you about this project, and it was a pleasure to pull it together.

This project focused on the New Jersey elderly health care system, an analysis of it, the related mortality and morbidity factors, their estimates and projections to the year 2000, in the State as a whole and in the regionalized HSA parts of the State. The purpose of the project was to analyze these factors in the elderly population, and to identify major health status and health system problems from which we can develop recommendations for fundable projects for resolving these problems. To do so, we used a grounded study method -- one that brings together public, private, and consumers, with expertise in this area -- developed five community-based task forces, and organized and staffed them in the HSAs -- or the Health Service Areas -- to gather local data, to tap some new data bases, and to bring together data in new way, in ways that had not been looked at before, we think. So this is the most current inventory of services, and of health status available, which is specific to New Jersey. I think it provided a very good blueprint for a series of recommendations.

This systematic study suggests a variety of interventions in targeted health service areas, and proposes policy changes which will maximize existing social health related and nonmedical services. It defines objectives and fundable projects within each HSA that can meet the projected needs of the elderly population as a whole, and the unique needs of smaller locales as well. The community-based teams and the professional health planners concluded that support for a variety of community-based health services, the installation

of several appropriate data bases, and the initiation of a case management system for the elderly, would provide a progressive and responsive health system for the elderly in the future.

If the funding priorities of the health system are changed as recommended in State Health Plan for the elderly, and are implemented, we believe that lower costs compared with the projected cost of today's system will be realized from the increasing support of home and community-based services, and the resulting reduction of long-term care costs associated with the current dependence on institutional costs. Thank you. Thank you for your attention.

MR. PELOQUIN: The summary that Dr. Maugle was referring to in the State Plan for the Elderly, was as a result of some 120 of varying disciplines and expertise throughout the State pulling together a document that ultimately covers some 40 different subjects in long-term care; everything from institutions to home based service to particular problems of women and veteran elderly for example, in the system.

The document itself represent really a culmination for me of over 12 years of experience in dealing with all the local problems of long-term care. In that 12 years I've come to three central conclusions:

The first conclusion is that the piecemeal solutions that have been enacted by State regulations reimbursement changes are helpful, but do not address the major solution which is reform of the organization, regulation, and financing of long-term care facilities.

The second is that the public's perception about inpatient long-term care, and especially nursing homes, needs to be changed dramatically.

Third, there is a critical need to continuously educate and inform the consumer about long-term care options, and help them obtain detailed information where and when they need it the most.

I can provide the extensive data and information from New Jersey's own experience to support these three conclusions, but in the time allotted I'm just going to offer suggestions for solutions.

In regard to the first conclusion, I suggest very strongly that reexamination be made of the levels of inpatient long-term care. Currently there are still five classifications of care: There is Nursing Home Skilled Care, Intermediate Level A Care, and Intermediate Level B Care, the Residential Health Care Facility, and the Class C Boarding Home. A 1983 statewide task force -- of which I was a member -- addressed these levels and concluded the persons in nursing home level B, Residential Health Care Facilities, and Class C Boarding Homes, were very similar in their needs. I proposed, and the Task Force accepted, the concept of developing a new type of facility to consolidate the three classifications of facilities. The generic name was Residential Service Facility. By doing this, reimbursement amounts would go further; staffing -- especially with registered nurses -- would become more affordable; and the quality of life would be improved immeasurably. The details of this concept are available in the Task Force report, and I won't go through it today. I will say that it is just as important today as in was in 1983/84 and perhaps even more important to the deliberations in the future.

A related issue to reforming the long-term care inpatient facilities is, who will regulate the new facilities? Currently, from my perspective, we see the Department of Community Affairs, the Department of Health, and the Department of Human Services, all having some control and influence over the five existing levels of care. What I propose, the Residential Service Facility would require only one department to have primary responsibility. It is obvious this raises problems because the State agencies would have to change the

way they do business. And I would say this was, and is, the biggest impediment to restructuring the system that exists today.

The second suggestion is to continue looking at long-term care in toto -- as we are all doing, in this Task Force and other groups -- but accept the fact that nursing homes are a sensible and special alternative for many persons to receive medical care with dignity, and quit knocking nursing homes. They're needed. That's a simple statement I could make out there. You do more disservice to the public's perception of home equity conversion, the public's perception of financing care, if you keep telling them that nursing homes are not the place to go. Home health care, or other things, are the preferred alternative. They may be the preferred alternative, but there's a place for nursing homes for a full 5% of the public. You're not going to help the overall situation by continuing to take negative attitudes towards nursing homes. Correct the ones that are deficient, sit on the ones that are not doing their jobs, but at the same time, give credit where credit is due for the ones that are doing their jobs, and doing them quite well.

Too many times we hear complaints about nursing homes, when in reality people are talking about boarding homes, about group homes, or non-licensed residential facilities. They're talking about them all as nursing homes in the generic sense. They are not what we are talking about.

Or perhaps more important, when we hear about the quality of care problems, the cause is not the facility management, but the growing shortage of interested and qualified personnel to staff the nursing homes. I stress interested personnel. There is a growing shortage of interested personnel. There is in my opinion, a real problem now that will become worse. In specific, I speak to the lack of registered nurses to staff all the new beds now being built

and still being approved. A 1981 Central Jersey Health Planning Council study indicated such a problem would occur as early as 1985 if the needed facilities were approved. It is only because of the lag time in construction of new facilities caused by economic recession, that this problem has been postponed to now.

Let me move to the third suggestion. The third suggestion is to make major improvement in the availability of and access to information about long-term care facilities and alternative services and payment for health care. In 1985, I spoke in favor of developing a consumer guide for selecting a nursing home and a new high tech information method to keep the guide up-to-date while delivering information where and when needed most. A description of my proposal is attached to the presentation today. I am pleased to say the Department of Health did produce a guide, but it did not go far enough.

Therefore, with our meager reserve funds, the Central Jersey Health Planning Council initiated the first of its kind statewide telephone information system called the Medicare Toll Free Information Service -- MTIS for short. Through our test period we have spoken to over 10,000 concerned persons, running at two and half hours a day, five days a week, and provided them with the information when they had the most need for it; including information about nursing homes, and home health care, offices on aging service, and others. In return, we have gained a much better insight about their fears and frustrations than anyone in the State of New Jersey.

I want to take special note of referrals to the offices on aging, which have been excellent cooperators with us; and in turn when we have a complex problem that needs hands on care, the local office on aging is the one that responds and does an excellent job. In addition, there is a program in the Department of Insurance, the SHIP Program, which we also refer to, and in turn we provide technical assistance over the phone

to many of the people there, and they do an excellent job. The linkage through a telephone system is the common denominator, and linkage through Medicare is the common attraction to generate 10,000 calls in that short a period of time.

Needless to say, we believe the MTIS system, properly linked with routinely updated long-term care consumer guides, would be the best way to start the consumer education in his or her request for quality long-term care. We are now starting to seek funds to expand MTIS to a full service demonstration project, that will reach 50,000 to 60,000 senior citizens and their families in the very first year. That's a conservative estimate of the 900,000 potential callers out there.

In regard to the charge to this Task Force, specifically, "To examine and develop recommendations on the issues, options, and programs related to the financing of catastrophic and long-term health care" I wish to state that it is my opinion more money is needed to solve the problem, but -- and I emphasize this -- but if reforms such as suggested in the State Health Plan for the Elderly, are not started now and continued, the additional money will not, in and of itself, correct the basic causes of the problems experienced today. And all the solutions to creative financing will just be putting money after an inefficient organized system of health care, that does not provide for an efficient and appropriate informed consumer to use it in the most effective way. You'll simply be dumping more money after something that can never be afforded.

That concludes my formal testimony. I will be glad to answer any questions that may come of this. Dr. Maugle is available also. I will leave with all of you -- because it is an operating service -- a brochure on the MTIS line. We have several constituents from the legislators and congressmen call us over the last year, and it's been extremely helpful to them.

MS. SMARTH: Assemblyman Schuber had to step out for a minute, but if anybody has any questions-- (no response) Do you have a copy of your testimony?

MR. PELOQUIN: I have copies right here.

MS. SMARTH: Oh, okay. Great. Emma Quartero, Director of the Gerontology Program?

D R. E M M A Q U A R T E R O: Might I ask a question? What time does the Task Force generally plan lunch? I will try to be briefer than I had planned, if you were planning to go at 12.

MS. SMARTH: We only have two other speakers, so we'll probably wrap it up.

DR. QUARTERO: Okay, great. I still will try to be as brief as I can. I want to thank you very much for the opportunity to join you today. I am Emma Quartero. I am the Chair of the Department of Social Work, and the Director of the Gerontology Program at Seton Hall University. I work with a colleague who has addressed you at one of your earlier hearings, Dr. William Brandon. I must say I was impressed by the summary he provided for you, which I think drew very well the wide contours and parameters of the problem with which you're dealing. I don't envy you your task.

Although my credentials are probably more academic, I come to you not so much as an academician, but as a practitioner as a social worker in the field of aging. My experience comes from hospital bases primarily -- from Bird S. Coler Hospital on Welfare Island in New York, from Montifiore Hospital in the Bronx, and from Lyons Veterans Hospital here in New Jersey. I learned firsthand -- and I think very painfully -- what some of the issues are, and how complex the issues are. I think I've held the hand of more patients and family members in my early career -- even before, by the way, wards on these hospitals were called geriatrics. Twenty five years ago we called them the back wards of the hospital. I am happy to

say that medical care has progressed in the last 25 years, so that we in fact know more about what it is we are trying to do. We may not be doing it any better than we did before.

When I think about what I have to contribute to your work, I will try to summarize it really in three points, some of which have been made by others previously From my practitioner/teacher perspective, may I urge you these foci:

1) Whatever you do, however much money you can make available from whatever source, it is crucial to see the new as part of the existing whole which is a sadly fragmented morass and not a whole at all. The health care non-system is so uncoordinated, that if you let it, it will baffle you at every turn. Please don't just fill in the gaps in Medicaid coverage. Don't extend the coverage nor the reimbursement patterns. Don't only extend the eligibility requirements, nor perhaps introduce bigger and better waivers. Please don't only encourage private insurance, or private pension arrangements. These may be important and inevitable, but these will not be enough to help clients, families, and service providers, make sense of the maze of policies and programs; some of which service inadequately, and some of which do not serve at all; some of which are counterproductive. As you enlarge existing programs and create new ones, please build in the monitoring mechanism which are absent in some programs and do not work very well in other programs.

As was said a few minutes before, more money alone will not solve the problem we face. In our universities and in our literature, we have developed very sophisticated functional assessment technology, which can help us in the endeavor that we face. We have the tools. We can at any moment say, fairly precisely, what it is that we need for any given client or given family. The problem is that often that ideal health plan cannot be implemented. We know what we need, but often it is nonexistent, or has long waiting lists, or is of such poor

quality that we cannot move forward. We need more group home residences, good medical and social day-care, more respite services -- which can postpone and perhaps prevent the need for long-term care and institutionalization. Between total independence and total dependence, is a wide array of health states. These need to be understood and addressed as we examine long-term care options.

Perhaps you already know -- and it was referred to a few minutes ago -- that the non system of health care in this country has become so unmanageable, with so many uncoordinated units and sub-units, that a new technology has been developed to deal with it. It's called case management. It sounds good. Theoretically, it is good. But it doesn't work, at least many times. Why? It is related to the second point I need to make with you, and that is: As you make your plans, please consider that the two major professions, already delivering service, or supervising the delivery of service to older persons, are those in nursing and social work -- both of which are in crisis.

Both these women's professions responded more than any other profession to the needs of our changing population. Both professions are poorly paid; have very difficult work conditions; are losing its old-timers to burnout, and its new recruits to other occupations and professions. Unless we do something about the problem of women's work in our society, we will not continue to attract bright dedicated young women and the few men who are attracted to this field. The brightest and the best are becoming physicians and lawyers, and they're not specializing in geriatrics or an aging law. Also as you consider the manpower dimension of long-term care, do please review the sorry state of compensation, training, and supervision of paraprofessionals in this service field. I refer here to homemakers, home health aides, LPNs, and community advocates. Another -- and the largest source of

service manpower -- are family care givers, usually women, who courageously give of themselves often to the point of exhaustion, loss of morale, and the stability of their own nuclear family. We need to train these care givers, support them, and perhaps in some way, pay them.

The third point I need to make can best be made through a story I've heard before, but which was recently told in the September 1987 Carrier Foundation Newsletter. I thought I might not relate this story, but I felt as I sat in the back that it's especially important because of what I'm hearing; the pessimism about the likelihood that we will have a social insurance program at the Federal level to care for catastrophic illness and disease. I truly think that that is the major issue before us, and that is not only the question of what happens to us as we grow older, all the age related diseases and conditions we know about, but catastrophic illness and disease is perhaps the single -- I think, from my own professional experience -- the single most devastating source of pain and suffering in this country. It doesn't have to happen at 50, 75, or 80. I'm thinking about the problems of people who are stricken with catastrophic illnesses, choose whichever one you'd like, whatever it is -- whether it's multiple sclerosis, or mental retardation, or SIDs, or any of the others -- it pulls a family apart. This country cannot afford not to look at this issue across-the-board.

So the story goes something like this: In a comfortable house not far from town, and old woman lived with her daughter and grandson. Month by month the old woman grew more frail. Her eyesight and hearing dimmed. Her memory began to play tricks on her. She forgot the faces of friends she knew well. Instead of the help she had been around the house, she became a burden. Her daughter grew more and more exasperated. One day after her mother had broken yet another costly china plate, the daughter commanded her son to go into

town to buy grandma a wooden bowl. The boy hesitated. Wooden bowls were used by peasants and servants, not by fine ladies like his grandmother. But being an obedient boy he did as he was told. He returned from town with two wooden bowls. His mother asked angrily, "Didn't you hear what I told you? I told you to buy one bowl." The boy quietly replied, "I know. I used my own money to buy a second one so there will be one for you when you grow old."

The moral of the story is clear, and all too real. But I always think when I hear this story, why didn't this thoughtful boy buy a third wooden bowl, not only for his own old age, but to prepare for a disability and a catastrophe which could happened to him at any age?

We need to universalize the concept of long-term and catastrophic illness. These are not the exclusive domain of the over 50, or over 65 -- however you want to define elderly. We have whole populations of human beings of every age who need long-term care, some of whom recover, some not. Some examples: The newborn requiring several months of very expensive in hospital intensive neo-natal care. It's very expensive, and we're paying for it. The mentally retarded who need shelter and special accommodations, the seriously psychotically ill who remain that way or slip into it periodically and without warning. These are catastrophic illnesses at any age, not to mention, I forgot, AIDS. That's costing us a lot of money too. These diseases are no less important than Alzheimer's disease, cardiovascular illness, cancer, diabetes, and all of the conditions that we associate with age. Age related diseases must not be seen as special cases. All of these situations, all of these catastrophes, cost a lot of money, and a lot of time, and a lot of pain.

Some of these catastrophes are even more poorly provided for than the elderly who need skilled care. And I need to make this point because there seems to be a good deal

of optimism about private insurances. From my own experience as a social worker, let me tell you that it is very difficult to find private insurance policies. The questions from the Task Force members were really very good in this regard. I haven't seen a really good policy, certainly to cover one of the catastrophic illnesses. Take the instance of mental illness. Most policies have limitations, have waiting periods, and have very low coverage levels. Not that that may not be a way to approach your task, but we need to be careful that we don't move into private insurance policies and find that they serve us as well as the Medigap insurance policies, which I find have deluded so many of my elderly clients. There may be something in the private insurance pool that will be helpful to us, and we need to examine that, but we also need to be very careful that we don't fall into the current notion that anything the government does, cannot be done -- or can be done better than private interests.

Most insurance policies, for instance in the issue of mental illness -- and we're seeing it now with Alzheimer's disease -- cover only a small portion of the cost of care of mental illness. My experience has been most policies, unless the policy comes from a very large corporation, or a corporation related to the pharmaceutical companies, most policies have very low lifetime limitations. Most policies I see have lifetime limitations of $10,000, one time, lifetime coverage; then it's SSI or SSD. Families with mentally ill members can be totally devastated.

I know this Task Force needs to focus on the health care needs of our elders, but our elders know their future is inextricably intertwined with that of the young, the middle-aged, all of us. A humane society does not categorize its dependents. Our elderly, and this Task Force-- And by the way, I said I didn't envy you your task, but I envy you your position, because you have gathered -- from what I can tell in

your hearings so far -- very much, very important information. You are in a position to see it as a total, as I really don't think anybody in New Jersey can do. I am really hopeful that you will in fact use that information well.

It is my profound hope that by focusing on the health care dependency needs of the dependent old, we will better understand the needs of all, and respond better to them. This is the heritage that the new old of this generation, and the new old of generations to come, can give to us. Thank you very much.

ASSEMBLYMAN SCHUBER: Thank you, Mrs. Quartero. Are there any questions from members of the Committee? (no response) We thank you very much for your testimony.

DR. QUARTERO: You're welcome.

ASSEMBLYMAN SCHUBER: Our next presenters are-- Is it Maureen McCarthy and Al Evanoff? Do I have both of those? (confers with aide)

M A U R E E N M c C A R T H Y: Mr. Chairman, and Task Force, thank you very much for inviting me to speak here today. I'm Maureen McCarthy, and I'm the health care organizer for New Jersey Citizen Action. I'm here today on behalf of New Jersey Citizen Action, which is a statewide coalition of church, labor, senior citizen, and consumer organizations who share a common goal in improving the quality of our lives and our communities. Currently New Jersey Citizen Action represents about 85 organizations. We have about 65,000 individual members throughout the State.

New Jersey Citizen Action has been working to improve the quality and accessibility of health care in New Jersey for several years now. Our membership represents many of the population sectors that are currently under-insured, and uninsured, in our State -- the poor, the low income workers, and the elderly. Today I'm here to share their heartfelt concerns about catastrophic and long-term care. I realize the

Task Force has already heard many facts and figures from previously received testimony in regard to the lack of public and private protection from devastating cost of catastrophic and long-term care. But I would like to share just a few more that I find particularly shocking.

First, according to a study prepared by the National Center for Health Services Research, 16 million Americans -- that's one out of five families -- incur catastrophic, out-of-pocket health care expenses that exceed 5% of their annual income. Further, it is true that state and Federal programs such as Medicaid and Medicare, were major steps forward in their time. Medigap insurance, a small step forward in the right direction. However, due to cutbacks in government funding, economic problems, flawed private insurance coverage, and the high cost of health care today, these sources are increasingly incapable of assuring access to quality medical care.

In New Jersey, though the government has recently moved to expand the Medicaid program, it still does not cover all senior citizens and disabled people under the poverty level. In other words, many people who desperately need long-term and catastrophic care are excluded. As of 1986, Medicare was paying only 2% of long-term costs. That was covering only 100 days of medically necessary skilled nursing facility care, and there is a co-insurance cost for the days 21 through 100. Further, I think we would all agree that Medicare provides a very narrow scope of benefits for home health care. They only provide benefits for recuperation of acute illness.

Finally, we come to what private insurance has been offering, and that is Medigap insurance. Medigap insurance was created to cover co-payments and deductible costs of Medicare. However, Medicare coverage itself imposes a large out-of-pocket cost in the form of premium payment, and often does not cover services such as long-term care, or items such as

self-administered prescription drugs.

Our health care system in America greatly resembles a patchwork quilt. We have lots of projects, lots of programs for individual people, and individual needs. We tend to treat each identified gap in the health care system by developing specific programs that only benefit a small population of the medically needy. The result is costly in terms of dollars, and human needs. For example, on the Federal and state level there are a number of pieces of legislation recently introduced to address some of the catastrophic and long-term needs. Unfortunately, almost all of the proposed legislation only would benefit a small select group of people, and would demand further out of cost expenses from the recipients.

New Jersey Citizen Action is here today to ask the Task Force to focus on developing a comprehensive solution to New Jersey's health care problems. We believe that all the citizens would be better served by implementation of a State health care program that would include catastrophic and long-term care coverage. In this way, we could assure high quality and affordable health care for all our State citizens.

There are currently 843,000 uninsured New Jerseyans, 11% of our State's population. Who are the uninsured in our State? Fifty nine percent are employed, full-time or part-time; 26% are children 18 years of age; the rest are unemployed, uninsurable due to poor health, homemakers, students, and those unable to work.

There is a whole other segment of the population, too, that are under-insured. Nationally, there's about 53 million Americans who have no catastrophic cap on their vulnerability to out-of-pocket health care costs, and are potentially at risk in the event of serious illness.

Several other states have realized that it is time to look at comprehensive solutions to their residents' health care needs. I know of at least three other states who are

considering legislation to introduce a program that would be comprehensive. It would provide comprehensive state health care. That's the states of Oregon, Washington, and Massachusetts. I've collected some information from the states, and I'd be more than happy to share that information with the Task Force.

I would like to thank you again for allowing New Jersey Citizen Action to address you here today. We look forward to helping you sort through all of the piles of information that you've collected, and to help give you a citizen perspective on what our needs are. Thank you.

ASSEMBLYMAN SCHUBER: Thank you very much. Mr. Evanoff?

A L E V A N O F F: All right. Chairman Schuber -- or Assemblyman Schuber -- and Task Force members. I'm glad that you're giving me the opportunity to speak here today. I'm the Cochair of the New Jersey Health Care Coalition. It's an organization of trade unionists, health providers, church groups, and senior citizens. We assembled for the purpose of dealing with certain health matters, and certainly the questions that are before this Task Force are of interest to us. I would certainly second the idea that you have a tremendous task before you, and appreciate the role that you have to play in trying to come out of these hearings and conferences that you have with something that makes sense.

I would like to cite a number of things, and not repeat very much of what has been said to you, and even said here. And I've listened to all of it today.

When we talk of insurance and we talk of the Medicare program, there is one aspect of the Medicare program that seniors basically react to, and we have pleaded with the Legislature in this State to do something about it.

For months, legislative persons have said to us they do not know whether mandating doctors to take Medicare assignments is legal. When the Committee heard this in the Assembly, we had a five to no vote not to consider the bill. I say to you as a Task Force, that unless this Assembly does something with the overcharge by doctors of Medicare patients, you cannot go to a senior and talk of insurance policies when the basic insurance policy we have committed to us in 1965, was a 20% co-payment. And if you please, a three dollar deductible. It's now a $75 deductible. The $75 is understandable, but that 20% is today a 40% payment by seniors because of the overpayment, overcharge, that doctors place on seniors. The bills have been introduced, and they lay around like there's no concern for seniors at all.

You talk about poverty, I don't think that the Assemblymen and Senators in New Jersey, even those that are seniors, fully grasp the thrust of this overcharge. When a senior is overcharged in payments in his health needs, he knows that he can't confront those costs, and therefore he postpones the visit. Postponed visits mean serious illnesses, usually emergency room illnesses. The cost then becomes-- Well, I don't have to explain it to you. A doctor's visit is much cheaper than an emergency room visit, and certainly much cheaper than a hospital admission. But that's what's happening today in this State.

And between you and I, the idea that is projected by some Assemblymen and some Senators that seniors are well off, I think is just hogwash. We could talk about the houses we own -- and I've heard the statements of the summer homes, and cars, etc. Well, I think that everyone that sits at that side, or is younger than 65, will appreciate the fact that when you work 40 or 50 years you accumulate a certain amount of wealth, you'd like to pass on some of that. But the fact is, that the average wage in this State for seniors is $14,800. Those are

the facts that are gathered by the Office on Aging. That includes-- I used to use the figure of the one millionaire or billionaire. I see according to Forbes we have four of them living in our State who obviously go into that average. Therefore, the better figure is the mean figure. Our seniors need relief in this. And if there's relief in this you can talk about maybe using that money which they can save in this expenditure, and try to educate them in using insurance, etc., etc.

I would like to go a step further with this Committee. I think we've been talking about it, and hinting about it. There is such a huge amount of persons in this State who are working, and have no insurance whatsoever; which taxes our uncompensated care system, and taxes the hospital system. It's fortunate that in New Jersey we've moved into the uncompensated care, and hospitals are now going bankrupt because they treat persons who are uninsured. I would like to appeal to this Committee to, in their considerations, in some form or fashion, endorse the Kennedy/Waxman bill; which would mandate coverage by employers for every worker working in any establishment in this State and throughout the country. It would relieve this State of approximately 480,000 persons who are working, and not receiving any health care coverage. This in turn is a problem that would affect most seniors also, because it's coverage that we think that same money could be used in other ways in helping seniors.

Of course I would like to just, without repeating anything that was said by the person who testified just before me -- not Maureen, but the social worker or the doctor from Seton Hall, Emma Quartero -- on the needs. I would like to say to this Task Force, there is no way in which you're going to solve the problems before us by using Band-Aids, and we've been using that. Maybe the best example of a Band-Aid program is the medically needy. We spent more on administration than on

actual benefits, because of a quick program without too much thinking, and without taking some steps to change that. But the expenditures there are on record.

I would like to suggest to you that we follow the lead of Massachusetts. And if we frankly think of a comprehensive program for Jersey, we may not be able to be the first state in that regard, but we may be able to be the second state, so that every citizen would be provided.

There's been mention of all the kinds of programs that we have and all the kinds of needs, but frankly we spend so much money-- If you just imagine what happens in any hospital. There's a Medicare person, there's a Medicaid person, there's an insurance person, and then there's a private payer person. If any have entered a hospital you know that the first question is not "What hurts? Where are you ill? What's the matter with you?" It's, "How are you covered?" Well I'd like to ask this Task Force to begin to change the process in Jersey to a situation where the first question asked in the hospital or anywhere else is, "What is hurting you?" and "Where are you ill?" That I think can only be accomplished by a comprehensive plan which covers all Jerseyites for every bit of care; catastrophic, home health, the home provider, the elderly individual who stays home or works only part-time to take care of an elderly parent.

That kind of program is the kind that I think we need, and the kind that this Task Force should examine. Maybe you can't come forward with it now, but I would accept the estimates made by national people that say that kind of a program for the nation is very far off, but I believe in our progressive State, in a State that's far ahead on other things in health care, that we can possibly think of putting that into effect, and be the second state on record to actually entertain a comprehensive health care program for every citizen of New Jersey. Thank you.

ASSEMBLYMAN SCHUBER: Thank you, Mr. Evanoff. Are there any questions? (no response) I appreciate it. Thank you. I thank both of the witnesses.

This concludes our testimony for today. I would like to thank the members of the Committee, Mr. Langevin, Marion Bass, Jeanne Sims, and Theresa Dietrich, for joining me today on our Task Force hearing. I would inform the folks in the audience that I believe our next hearing is going to be on November 24 at 9:30, here. I thank everybody for coming.

(HEARING CONCLUDED)

APPENDIX

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EXECUTIVE SUMMARY

The challenge of meeting the needs of our disabled and aging population requires immediate attention. Few individuals can finance an extended nursing home stay or other long-term care services entirely out of their assets and incomes. Many people, however, may be able to provide for nursing home and other long-term care services through buying long-term care insurance.

At age 65 people are estimated to have more than a 43 percent risk of entering a nursing home some time during the rest of their lives. However, financing long-term care is not just a problem for older persons. In the year 2000, 40 percent of functionally dependent Americans will be less than 65 years old. Besides the high cost of financing institutional care, disabled and older persons living in the community will need long-term care services to remain at home.

The Task Force on Long-Term Health Care Policies strongly recommends that both public and private sectors take steps immediately to encourage expansion of private financing for long-term care services through long-term care insurance. Even during the Task Force's deliberations, and partly in response to its initiatives, the development of long-term care insurance has moved forward, but the pace of development needs to accelerate. The Task Force offers its recommendations as a blueprint for more rapidly developing and expanding a private system for financing long-term care.

Long-term care includes a wide range of medical and support services for people who suffer physical or mental disorders causing functional limitation or disability and therefore need assistance for an extended period to maintain or promote functional well-being. Long-term care ranges from informal in-home services to institutional skilled nursing.

Spending on long-term care has grown rapidly and will continue to grow as the population ages. Almost half the institutional costs for long-term care are paid directly out-of-pocket, while less than 2 percent is paid through insurance.

The statute creating the Task Force requested recommendations for action in the areas of education, market development, and consumer protection to improve and foster the growth of long-term care insurance.

The Task Force accepted the definition of long-term care insurance adopted by the National Association of Insurance Commissioners (NAIC) in their Long-Term Care Insurance Model Act (Model Act). This definition requires insurance to offer benefits for not less than 12 consecutive months in a setting other than an acute care unit of a hospital. The Task Force added explanatory notes to the definition to clarify certain points: 1) services are covered in various settings—at home or in the community, as well as in institutions; 2) long-term care insurance does not duplicate Medicare coverage for those eligible; 3) covered services include personal care to maintain activities of daily living; 4) future policies may bring arrangements not yet envisioned; and 5) the Task Force encourages development of both the products covered by the definition and other forms of risk pooling.

Private long-term care insurance can protect people against large out-of-pocket expenses. It gives individuals the opportunity to retain choices and develop a flexible, planned response to a potentially ruinous event that will confront many people over 65 as well as many disabled people under 65. Insurance offers the most cost effective, collective approach to meeting financial risks that often devastate individuals.

The Task Force believes a broad market for long-term care insurance can and should be developed. While very few disabled and older persons have obtained long-term care insurance, no other private financing mechanism appears to offer a more cost effective and viable means of meeting long-term care costs.

The Task Force acknowledges that private long-term care insurance cannot provide a total solution for financing long-term care. For the foreseeable future long-term care will continue to be provided by formal and informal caregivers, in institutional, home, and community settings, and financed by a mixture of public and private expenditures. When the Task Force reviewed integrated public/private approaches, especially those significantly expanding government financial support for catastrophic episodes of long-term care, it concluded that more information was needed to determine the viability of a joint public/private approach.

The Task Force identified and analyzed market factors that promise to stimulate an active private long-term care insurance market with attractive and affordable products and, at the same time, provide reasonable protection for consumers. In the judgment of the Task Force, the critical factors are these:

- **Public Awareness**—Consumers need to be more aware of several key topics: 1) the absence of long-term care coverage under Medicare, Medicare supplement insurance, and most acute care insurance and prepaid health programs; 2) the potential costs of long-term care over their lifetime; 3) the range, cost, and availability of long-term care insurance products; and 4) the advantages and limitations of various insurance features. In particular, the Federal government has a responsibility to inform Social Security beneficiaries that Medicare does not cover long-term care services.
- **Consumer Protection**—The Task Force found that the Long-Term Care Insurance Model Act developed by the National Association of Insurance Commissioners provides a sound basis for balancing the interests of product development with adequate protection for consumers. However, greater consumer protection can be provided through more stringent requirements for renewability of individual long-term care insurance policies and through the regulation of the reserves for continuing care retirement communities.
- **Market Development**—The absence of basic data on the use of long-term care insurance by an insured population and the need to define benefit levels present problems for insurance companies in designing products that meet certain needs: 1) cover services in expanded settings like homes and communities; 2) prevent overuse of services (induced demand); and 3) avoid creating a risk pool weighted too heavily to those most likely to require long-term care (adverse selection). The Task Force generally concluded that insurance companies must be given latitude to experiment with benefit design and utilization controls if they are to develop products that will be affordable and attractive to consumers.
- **Epansion of the market through employer-sponsored long-term care insurance**—Offering long-term care insurance through employment has the greatest potential to cover large numbers of people, but penetrating this market will require overcoming impediments and providing incentives.
- **Tax incentives**—Existing rules must be clarified in several respects: the tax treatment of reserves for long-term care insurance and interest on those reserves and the tax treatment of long-term care insurance in general. Tax incentives are especially important to encourage development of long-term care insurance through employment-based plans and vested retirement funds. Compared to other approaches, employement-based plans would make more attractive and affordable products available and extend coverage to the largest number of people.

Efforts of the NAIC have significantly advanced the work of the Task Force in developing recommendations to assure responsible marketing practices and prevent sales abuses. In adopting the Model Act, the NAIC has established an appropriate vehicle for protecting consumers. The Task Force was able to

further NAIC efforts by developing an additional recommendation to give Insurance Commissioners greater authority over cancellation and renewability of long-term care insurance policies

The Congress charged the Task Force to recommend ways to assure a reasonable relationship between premiums and benefits, and this task presented marked difficulties. The NAIC draft regulations dated June 22, 1987, rely on loss ratio to test premium reasonableness, but the Task Force concluded that this test is of limited use at present. Further developing actuarial tables on frequency and duration of nursing home stay and utilization may prove to be more helpful in judging the real value of long-term care insurance.

The Task Force adopted 41 recommendations. Taken together, they provide practical directions for strengthening long-term care financing through private insurance. They vary in difficulty of implementation, effect on the issues, cost effectiveness, political acceptability, and budget impact. Particularly important recommendations cover seven areas, and their implementation should command the highest priority

1. **Inform Consumers that Medicare, Medigap, and acute health care insurance do not cover long-term care.** The Department of Health and Human Services should communicate directly to all current and new Social Security beneficiaries the exact nature and limitations of Medicare long-term care coverage, as well as available alternatives. Effective communication will require developing appropriate information and referral capabilities.
2. **Encourage States to adopt the National Association of Insurance Commissioners' Long-Term Care Insurance Model Act.** A number of States have already adopted the Model Act, and all other States are strongly encouraged to do the same. The Task Force believes, however, that the cancellation provision should be more limited than permitted in the Model Act.
3. **Promote the availability of long-term care insurance through employment.** Offering long-term care insurance through employment is an effective way to make attractive, affordable coverage available to large groups of working-age people. A number of approaches promise to help accomplish this objective. Tax incentives and encouragement of employer cooperation will be essential to these efforts. At a minimum, the present restrictions on buying long-term care insurance through cafeteria plans and flexible spending accounts should be removed.
4. **Develop long-term care insurance financing through vested pension funds.** Both before and after retirement, individuals should be permitted to use vested pension and retirement savings (including IRAs, Keogh plans, and others) to purchase long-term care insurance. Transfers from such funds should not be taxed or subject to penalties.
5. **Use Federal and State tax codes to encourage the purchase of long-term care insurance.** Most desirable would be broad-based measures that effectively encourage purchase of long-term care insurance without unduly reducing government revenues. The most important incentive in lowering the cost of long-term care insurance depends on clarifying whether tax exempt status applies to long-term care insurance reserves held by insurers and to the investment earnings credited to them.
6. **Encourage new approaches to determine eligibility for long-term care insurance benefits.** The level-of-care and service definitions currently in use are unreliable in determining eligibility for long-term care insurance benefits. The Task Force believes that developing need assessment systems, based on ability to perform activities of daily living, offers a useful alternative in deciding eligibility for benefits.
7. **Encourage greater cooperation in the collection and sharing of long-term care data.**

The Task Force, with the cooperation of the Department of Health and Human Services and the Veterans Administration, has taken steps to increase the sharing of Federal data and recommends further Federal, State, and private efforts to improve the quality and availability of actuarial data.

Chapter I

RECOMMENDATIONS

The Task Force adopted recommendations to promote and develop a market for long-term care insurance and to assure consumer protection against possible market abuses. Not every member of the Task Force fully agrees with every recommendation, but all recommendations were supported by a substantial majority of Task Force members. These recommendations may vary in difficulty of implementation, effect, cost effectiveness, political acceptability and budget impact. Taken together, however, they provide a desirable direction for States, the Federal government, and the private sector to follow in strengthening private financing of long-term care.

The Task Force considers several recommendations particularly significant. These major recommendations affect both individual and group policies. Recommendations that would reduce costs do so for both types of policies. The consumer protection section focuses particularly on the individual policy, as group policies derive much of their consumer protection through negotiation at the time they are established. The Task Force emphasizes the following steps as its major recommendations:

- Communicating the information that Medicare, Medigap, and acute health care insurance do not cover most long-term care services.
- Encouraging States to adopt the National Association of Insurance Commissioners' (NAIC) Long-Term Care Insurance Model Act.
- Developing employer-sponsored long-term care insurance.
- Developing long-term care insurance financed through vested pension funds.
- Using Federal and State tax codes to encourage development of long-term care insurance.
- Encouraging innovative approaches to determining eligibility for long-term care insurance benefits.
- Encouraging greater cooperation between the public and private sectors to improve the quality and availability of actuarial data on long-term care.

Following are specific Task Force recommendations. They focus on elements of the Congressional mandate to the Task Force. They are listed by category, generally in the order the issues are discussed in Chapters III through VII.

CREATING AWARENESS

1. When discussing the Medicare program, the Federal government, including the Congress, must be careful to communicate accurately the limited nature and extent of long-term care coverage.
2. Public information campaigns are needed to make people aware that Medicare, Medigap (Medicare Supplement Insurance), and existing health care policies provide little or no coverage for long-term care services.
3. The Department of Health and Human Services should:
   a. Tell all current and new Social Security beneficiaries, through direct mailings and use of Social Security District Offices, that Medicare does not cover most long-term care services.
   b. Publish a separate Medicare guide describing the limited Medicare skilled nursing facility benefit and home health benefit, which are oriented toward providing post-acute care.
   c. Develop a long-term care insurance buyer's guide.
   d. Develop a model public information program for use by States.
   e. Provide assistance in implementing such programs at the request of States.
   f. With the NAIC, create a clearinghouse for sharing knowledge of successful information programs.

g. Assist businesses and unions in educating employees about long-term care insurance.

4. State Insurance Commissioners should:
   a. Require Medigap policies to state the extent of, and limits on, long-term care coverage.
   b. Develop and distribute long-term care insurance buyer's guides, individually or through the NAIC.
5. Insurers and their trade associations should:
   a. Review their informational and promotional materials to ensure that they accurately describe long-term care needs and coverage.
   b. Develop educational programs explaining long-term care needs and financing options.
6. Long-term care service providers, individually and through their organizations and associations, should develop and distribute public information programs dealing with long-term care needs and financing and delivery.
7. Consumer groups and organizations representing older people should develop materials that deal specifically with the need for long-term care services and the options for financing and delivery of this care.
8. Insurance companies, provider groups, consumer groups, and organizations representing older and disabled people should work with groups and associations of physicians, nurses, lawyers, estate planners, and others with whom people consult for advice and assistance on financing long-term care needs, to increase awareness and improve knowledge of long-term care insurance.

AVAILABILITY AND SCOPE OF PUBLIC PROGRAMS

9. The President should designate a lead agency to direct all Federal agencies providing health care benefit programs to inform beneficiaries clearly about the limited nature of any long-term care benefits provided under these programs.
10. Publications on Medicare, Medicaid, Medigap, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and Veterans Administration programs should more clearly explain the coverages and limitations of these benefits with respect to long-term care.

STIMULATING DEMAND

11. Federal, State, and private public information efforts should:
    a. Target the messages to specific age groups, such as pre-40, 40-65, and post-65.
    b. Focus on the need for people to plan early for financing long-term care.
    c. Emphasize that long-term care includes non-institutional as well as institutional services.
12. Public information programs should work with organizations that represent or serve older people to increase the effectiveness, coordination, and penetration of educational efforts.
13. Federal and State governments should make long-term care insurance available to their own employees and retirees through existing group mechanisms.
14. States should consider how their Medicaid eligibility requirements might create incentives or remove disincentives to purchasing long-term care insurance.

CONSUMER PROTECTION

Adoption of the NAIC Model Act

15. State governments should adopt the National Association of Insurance Commissioners Long-Term Care Insurance Model Act. The NAIC Model Act was designed to protect consumers, promote product availability, and encourage benefit experimentation, and its provisions make appropriate distinctions between group and individual coverage. However, the Model Act should be amended as follows: Individual policies should be cancellable only for the most unusual and compelling reasons and therefore,

only with the permission of the State Insurance Commissioner. At the same time, the insurer should be entitled to adjust rates in the same manner as they are adjusted on guaranteed renewable policies.

16. The State Insurance Commissioner should have the authority to permit cancellation of a long-term care insurance policy by class, but only when it is determined to be in the best interest of the public to do so.

Preventing Sales Abuses

17. State governments should continue to be responsible for vigorously protecting consumers from fraudulent, unfair, or illegal sales or claims practices. The Federal government should not impose on States requirements for regulating long-term care insurance in the absence of a showing that the States are failing to meet their responsibilities for consumer protection.
18. As the NAIC Model Act recommends, States should require that disclosure materials in long-term care insurance policies:
    a. Meet specific standards for readability, content, location, and layout.
    b. Contain an "outline of coverage," including limitations on coverage and provisions for renewal.
19. Insurance organizations that provide training and/or continuing education for insurance agents, such as insurance companies, the Association of Health Underwriters, and the Association of Life Underwriters, should develop specific programs on long-term care insurance, long-term care financing, and the legal and ethical considerations of selling insurance.

Portability

20. Insurers should be encouraged to develop employment-based group insurance policies and other types of group-sponsored coverage for long-term care that enable policyholders to contine the coverage or convert to individual policies or make other acceptable arrangements if employment terminates, an insured group is disbanded, or the master long-term care policy in which the individual is participating is cancelled.

Adequacy of Reserves for Continuing Care Retirement Communities (CCRC)

21. States should enact legislation based on the standards for CCRCs established by the American Association of Homes for the Aging and by the American Academy of Actuaries to:
    a. Review the actuarial fitness and financial viability of the CCRCs as they begin operation.
    b. Assure appropriate actuarial and financial planning to cover long-term care health costs and residents' needs.
    c. Require CCRC developers and managers to disclose fully all services and care to be provided and method of financing, currently and in the future.

Market Value Measures

22. At this time, loss ratios are based on relatively crude projections and are not a good measure of market value. The Task Force therefore discourages undue reliance on such estimates. To the extent a regulator is committed to using a target loss ratio, however, the parameters recommended for long-term care insurance by the NAIC should be used.
23. As the NAIC Model Act recommends, State Insurance Commissioners should continue to review new long-term care insurance filings carefully to assure that such policies are not deceptive or misleading.

Policy Design

24. Long-term care insurance companies should offer purchasers the option of buying benefits that cover long-term care provided in the home or community, as well as in institutions.
25. Insurers and States, through the NAIC, should work together to develop stan-

dard definitions for levels of care and services which could be used in long-term care insurance policies.

26. Insurance companies should be encouraged to determine eligibility for benefits using an "activities of daily living" need assessment scale. Insurers using level-of-care definitions to determine benefit eligibility should seek to avoid making coverage for institutional services depend on distinctions among skilled nursing services, intermediate care services, and custodial services.
27. Long-term care insurers are encouraged to use the case management approach to determine and coordinate the most appropriate level of care in the most cost effective manner.
28. Minimum eligibility and benefit standards should be limited to those set forth in the NAIC Model Act and regulations and such additional standards as may be necessary to protect against offering illusory benefits.
29. Consistent with the NAIC Model Act:
    a. State legislatures and regulators should recognize the experimental nature of long-term care insurance and allow reasonable flexibility to insurers in developing eligibility criteria and benefit levels for long-term care insurance.
    b. State laws and regulations should provide insurers reasonable latitude to develop new products designed to limit insurance-induced demand and adverse selection, situations in which the existence of the insurance creates a demand for it and attracts buyers who are more in need of its protection than the population at large.
30. As the NAIC Model Act recommends, State regulation of long-term care insurance should not universally prohibit making a prior hospital stay and/or prior nursing home stay prerequisite to eligibility for payment of benefits. However, insurance companies should be encouraged to develop alternatives that permit insured persons with equal need for long-term care to have equal access to insurance benefits, regardless of prior hospitalization or nursing home stays.

TAX INCENTIVES AND EMPLOYMENT ISSUES

31. The U.S. Department of the Treasury should formalize its position regarding the tax treatment of the long-term care insurance reserves held by insurers and the investment earnings credited to them. Such reserves should be treated in the same manner as similar reserves supporting traditional life insurance products, that is, additions to the reserves and earnings on them should be tax-deductible to the extent that reserves are required to support benefits under the contracts.
32. Premiums paid, including amounts paid by employers on behalf of employees, and benefits received under long-term care insurance policies and plans should be treated in at least the same manner as medical care benefits for tax purposes. The idea of treating premiums paid by individuals as partially tax-deductible, apart from the exemption for general medical expenses, should be considered.
33. Federal tax laws should be clarified or modified to remove impediments to employer sponsorship and to funding long-term care coverage as an employee benefit:
    a. Long-term care insurance should be a permissible benefit under Internal Revenue Code Section 125 cafeteria plans.
    b. Incentives for employers to pre-fund retiree health benefits, including long-term care benefits, that were eliminated in the Deficit Recovery Act of 1984 (DEFRA) should be restored. Specifically, deductible employer contributions to pre-fund retiree medical benefits plans should be allowed to take into account future medical inflation, and the earnings on funds set aside for such benefits should not be taxed if retained in fund.

c. Employers should be allowed to transfer assets from over-funded pension plans to fund retiree welfare benefit plans without penalty or taxation.

34. Individuals should be allowed to make tax-free transfers from vehicles that finance retirement income to buy long-term care insurance. Such transfers should be permitted both before and after retirement and should include transfers from:
    a. Pension funds.
    b. Life insurance funds.
    c. Individual Retirement Accounts (IRAs).
    d. Keogh plans.
    e. Annuities.
    f. Stock bonus and employee stock ownership plans.
35. Retirees should be allowed to transfer a portion of their post-retirement income tax-free to purchase long-term care insurance.
36. The range of financing options should be expanded by allowing funding of long-term care as a contingent benefit under pension plans and life or disability insurance contracts.
37. States are encouraged to offer tax-fav treatment for long-term care insuranc the same manner recommended to Federal government.

DATA NEEDS

38. Federal and State government agenc should share long-term care data in an e peditious and open manner with eac other, with the insurance industry, ar with other interested parties.
39. The Department of Health and Huma Services should request input from States the insurance industry, and other interested parties when planning new long-term care surveys.
40. Insurance companies, trade associations, the Veterans Administration, States, and the Department of Health and Human Services should cooperate with the Society of Actuaries in its efforts to collect long-term care data.
41. The Department of Health and Human Services should continue to sponsor periodic long-term care data conferences to provide information on recent Department surveys.

Central Jersey
Health Planning Council, Inc.
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CONSUMER'S GUIDE FOR SELECTING A NURSING HOME

A consumer's guide to nursing homes should be available where and when needed in a timely manner. Usually this need occurs when a medical decision is made that a person needs care available in a nursing home. The decision to select the nursing home most often falls to a relative, and probably one who is younger than the patient. The majority of nursing home patients are in the hospital when the medical decision is made. This is the primary point where all parties are together: patient, hospital discharge planner, relative/friend and physician. It is at this point that a consumer's guide should be made available, through the discharge planning unit.

The guide must be current, factual, non-judgemental, easily obtainable, and capable of being updated on an annual basis, but preferably every six months.

The Consumer Guide should have three types of information: details about nursing home organization and operation, sources of financial resources, and questions which can be used by the consumer to aid him/her in making a selection. The following illustrates the concept.

NURSING HOMES:	Name of facility
	Type of ownership/Administrator's name
	Geographic location/address
	Telephone number
	Area map
	Physical description of building/grounds
	Level of care
	Number of beds/SNF/ICF
	Date of latest certificate/license
	Other long term care services on site
	Nearest hospital
	Name of physician(s) on call and location
	Payment information/charges
	Waiting list
	Number of Medicaid patients
FINANCIAL SOURCES:	Eligibility requirements for Medicare/Medicaid
	Private Sources
	Treatment of personal assets

QUESTIONS FOR CONSUMER SITE VISIT:

Buildings & grounds
Rooms
Personal Care
Medical Care
Social/Recreation
Food Service
Sanitation/maintenance

GLOSSARY OF TERMS IN CURRENT USE:

SNF
Respite Care
Medical Day Care

PREPARED BY:

Edward J. Peloquin
October 11, 1985

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  - . Skilled Nursing facilities
  - . Hospice Services
  - . Physicians' Services
  - . Long-term care facilities.
- o Help with inquiries about Medicare denials or partial payments.
- o HMOs as a Health Care option.
- o How to seek second medical opinions.

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Endnotes

1. "Families with High Out-of-Pocket Health Services Expenditures Relative to their Income," National Center for Health Services Research, January 30, 1985.

2. Nancy Gordon, Assistant Director for Human Resources and Community Development, Congressional Budget Office, March 26, 1986, testimony before the House Subcommittee on Health and Environment, pg 13.

3. "Demographics of the Uninsured: A Comparison of 1984 National Data and 1986 New Jersey Data", N.J. Department of Health, Division of Research, Policy and Planning, 1987, pg 13.

4. Senator Edward M. Kennedy, Fact Sheet on Senator Edward M. Kennedy's Proposed Minimum Health Benefits for All Workers Act of 1987, pg. 1.