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before

SENATE COMMITTEE ON AGING

on

"Issues and Concerns of Senior Citizens"

March 30, 1989
Hudson Hall
West New York, New Jersey

MEMBER OF COMMITTEE PRESENT:

Senator Christopher J. Jackman, Acting Chairman

ALSO PRESENT:

Anita M. Saynisch
Office of Legislative Services
Aide, Senate Committee on Aging

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SEN. CHRISTOPHER J. JACKMAN (Acting Chairman): Kathy Chasan will be our first witness.

I know there are some Hispanic people in the audience. If there's anybody who doesn't understand what was said, we'll capsulize it. We have a young lady here who speaks Spanish. She'll give you the interpretation. Is that all right with everybody? (no response)

The reason we're going to do it now is because some people have to leave around 11:30 to go to lunch. I want to thank you for coming.

Kathy, you may start, okay? (applause)

K A T H L E E N C H A S A N: Thank you for this opportunity. The subject of my statement this morning is Senate Bill No. 342. This is legislation to support the establishment of outreach programs to reduce functional illiteracy among older adults. I urge members of the Assembly Appropriations Committee to consider the information presented here, and to act on this bill accordingly, and with dispatch.

I am the Coordinator for the Essex County Older Adult Literacy Program. Funding for this Program comes through the Essex County Division on Aging from the State Division on Aging. Volunteer tutors are trained in a one-day training session, and then matched with a student 60 years old, or older. Tutor and student then begin meeting for an hour a week. The current literature describes programs such as this one as the way to reach the estimated 450,000 State residents over 60 years old who are functionally illiterate.

Before I give the reasons why this Program works, let me describe the people we are talking about. Functional illiteracy means reading at or below the fourth grade reading level. Nationwide, it is estimated that 4.2

million people between the ages of 60 and 65 are functionally illiterate. How did this happen? Many senior citizens grew up in times and places where they received very little formal education in their early years. In some large families, half the children picked cotton, while the others went to school. Many more senior citizens came here from foreign countries, or their parents spoke a language other than English at home, and this caused learning problems at school.

Another problem is undiagnosed and untreated dyslexia. And others say, in our complex society, older Americans have been the victims of rapid change in literacy requirements. Due to technological advances, minimum literacy requirements are way above where they were only 10 years ago.

In real life, who are these people? They are the ones who always say: "I left my glasses home. It takes me too long. I'll take this home to read. Here, you read better than I do." They may rely on a friend or family member to handle their affairs. I'm sure if you think of trusting someone to handle your own affairs, you will see how vulnerable these people are. Please understand that low-level literacy skills do not necessarily indicate low intelligence.

How do we remedy the situation? I can think of only one way not to use it.

I was employed a while ago by a health insurance company. This company was a carrier for Medicare Part B. The Beneficiary Relations Department, the people who dealt with customer service complaints of patients, was being taught to write letters at an eighth grade reading level. My colleagues were sitting at their desks and counting syllables. They were producing letters that were so twisted with bad logic, because they couldn't use too many big words, that I felt the whole system was working

backwards. Since then, I've become aware of programs such as the Older Adult Literacy Program where I now work.

Older adult literacy programs need to be geared to the needs of older adults. This may sound obvious, but the two largest literacy organizations -- Literacy Volunteers of America, and Laubach Literacy Action -- reach more than 55,000 students a year, and only 5% of those students are 65 years of age and over.

And from the United States Department of Education, we learn that only 6.5% of the people who participate in adult education are 60 years of age and older.

What are some of the issues we are faced with? Being illiterate and over 60 puts a person in a very delicate situation. They have years of feeling embarrassment or shame to deal with. These people are reluctant to be identified. They have gotten by without literacy skills, but now at 60-plus, the lack of these skills makes life increasingly difficult as the old support systems disappear.

If a spouse or sibling who has died or a child who has moved away have always done the reading, what happens next? Illiteracy and health are linked. As a person hears and sees less TV, they have less input of information.

The literacy program that is going to be of value to the older American has to be easily accessible and convenient. The referral has to be confidential. The program should be free to the student and the tutor. The material covered should be geared to the individual student's needs and goals. And, most importantly, the literacy program should be linked, and should be able to link, the student with the aging services network. Students in my Program have gotten their driver's license; can write

to their family; fill out money orders by themselves; sign the Social Security checks; and take phone messages at work.

I hope I have pointed out the urgency in passing Senate Bill No. 342. The bill calls for three years of funding and expansion into another county, for a total appropriation of $99,000. The scope of the problem demands, in reality, that the funding should be $99,000 per year, and be expanded into all of the counties. Thank you very much.

SENATOR JACKMAN: Did everybody understand what the young lady just spoke about? (no response) (Sonia Delgado speaks to audience in Spanish)

Whoever is going to make their remarks, you do not have to read your entire statement. Try to capsulize it, so that it's shortened. We will be able to then take your remarks and discuss them in Spanish for our Hispanic friends. Is that okay with everybody?

What about the doctor? If you would, Dr. Primich, please try to capsulize your statement.

F R A N K J. P R I M I C H, M.D.: The only problem is, it's interrelated and it's rather important.

SENATOR JACKMAN: I don't want your background and how you were born, and everything else.

DR. PRIMICH: That's very important.

SENATOR JACKMAN: Rather than talk about it, let's see what you can do.

DR. PRIMICH: Senator Jackman, interested parties, and innocent bystanders: My name is Frank J. Primich. I've been a physician for over 40 years, and a practicing obstetrician-gynecologist in this town of West New York for more than 30 years.

For the past 20 years, I have been actively involved with a variety of medical organizations dedicated to the preservation of the best health care that the world has ever known, and maintenance of the traditional

doctor-patient relationship, which is such a critical component of that care.

I have repeatedly represented the Medical Society of New Jersey before legislative hearings in New Jersey, as well as Washington, D.C. Last year I refused to reaccept chairmanship of MSNJ's Council on Public Relations for reasons that I will explain later.

In view of that fact, I must ask that my testimony be viewed as that of a single individual. Having said that, let me beg your indulgence, from two rather divergent perspectives: First, as a 67-year old victim of Big Brother's benevolence. Let me quickly review my personal life. I grew up in Weehawken, New Jersey.

I attended undergraduate school at Columbia University, and studied medicine at New York Medical College. Aside from a few meaningless odd jobs, I was supported by my parents. My father, a skilled carpenter, was still paying off depression debts at the same time. Two break-even tours of military service were interspersed between five years of post-graduate training, where my pay ranged from $50 to $200 a month. This led to a sizable indebtedness by the time I started practice. Even during my most productive periods, delivering more than 250 babies a year, my income never approached the $100,000 figure we hear so often today.

My early thoughts on aging were perhaps unique. Convinced I would practice medicine until the day I died -- I was right about that -- I felt secure in the delusion that I would always be able to make a living doing what I loved, and easing off as my biological clock took its toll.

At the same time, doctors were mandated -- a word I've learned to hate -- to join the Social Security program. I didn't know then that Congress still exempted its members from that scam. Apparently, they had better ways of securing their own future.

As a dutiful taxpayer, I simply added the maximum "donation" to my annual IRS tab. After all, the post-65 payout would help ease my eventual financial burden, or would it? Born in 1921, I fell into the gap. I'll let someone else argue whether the apparent unfairness is valid.

At age 65, I was informed that I was eligible for payments of a little over $700 a month. That was almost enough to pay the mortgage on the old homestead. However, if I intended to eat there, I'd have to continue work. This was expected. The surprise came when I realized that if I had earned income, I would have to give back one dollar for every two earned. This meant that earning the needed $17,000 to attain what may soon be classified as the poverty threshold, would deprive me of my pseudo-security. That's damned unfair.

Let me now discuss my status as a Medicare beneficiary.

Years of experience and multi-thousands of dollars written off as professional courtesy had led me to carry basic Blue Cross and Blue Shield, so that I could offer token payment, instead of useless gifts, should I need services from my hospital or my colleagues. I switched to Medicare, and kept a supplemental policy. If I could swallow my pride, I'd need neither.

So here I am, unable to collect Social Security, and still paying into it at the maximum rate. Now comes the added insult that most middle-class seniors should be as angry about as I am.

The recently enacted catastrophic care legislation is aptly named. You don't have to be a lip reader to recognize this as a catastrophic tax. Our double-talking, double-dealing, giveaway artists in Washington have outdone themselves. This is not only a discriminatory tax; it is a tax upon a tax. The benefits

are dubious. The cost is outrageous. Yet AARP, for self-serving reasons, originally backed, and still supports, this boondoggle.

The advent of the birth control pill and legalized abortion cut my annual delivery numbers by almost half. Many of my patients exercised what could be called "lateral mobility." In order to escape the inner city -- Hudson County -- most moved to distant suburbia, which put my office out of reach for all but a loyal handful.

An oversupply of physicians and the introduction of closed-panel insurance programs further depleted the pool of potential patients. Government-caused inflation forced me to repeatedly raise my fees, always in a belated effort to catch up, with day-to-day financial worries clouding the prior pleasure of giving good service. That service is probably better now. I always had given ample time to my patients, and I now have even more time to give. I would often spend some of that time trying to educate my patients about the ominous future facing them, if current policies continued. Many shared my concerns, and appreciated the threat of an eventual "Day of Reckoning." To others, it probably serves as an additional turnoff. People don't like to be told that their grab for instant benefits will sooner or later return to haunt them, unfairly burden their children and future generations.

The biggest single factor in this whole economic equation has been the cost of medical liability insurance. This is a subject about which both the public and the Senators appear to be grossly uninformed.

There is such a thing as malpractice, and in my mind it exists to an alarming extent. There were plenty of laws to adequately deal with both the problems of adequate compensation and appropriate punishment. I'm tired of hearing that the medical profession has failed to police itself. As one who has tried repeatedly to weed out such

bad apples, we have no legal authority to rid the public of these perpetrators.

All we can try to do through so-called peer review is shame a few, and curtail privileges of the more flagrant violators. Too often, sincere efforts are aborted by the entry into the picture of lawyers. Legal loopholes and due process lead to prolonged litigation and threats of retaliation on the basis of restraint of trade. Since only someone in the same specialty can render the necessary judgment, it is contended that a conflict of interest exists. The Federal Attorney General is now compounding this problem.

Under such circumstances, it's a rare crusader who will volunteer for such hazardous duty. It is sad to relate that much true malpractice goes undetected. It is a rarity when actual malpractice is involved in current suits. What we are dealing with is a new concept of medical liability. This tends to blend a cost-free lottery with a social welfare system.

If the results of medical treatment are not optimum, regardless of whether it's anyone's fault, compensation seems like a desirable solution. Most of you probably see nothing wrong with this, as long as the proverbial pot of gold is being filled by those rich doctors.

The practice of medicine involves a continuous series of decisions. Rarely are those judgments cut and dried. They frequently present a 50-50 choice. It is easy, with hindsight, to later show that if a doctor zigged instead of zagged, the result might have been better. Such second guessing is all that many sympathetic jurors need to hear.

Stop and think for a moment that those rich doctors, and we poor ones, must pass those costs along to you as best we can. Moreover, you are paying for many

marginally necessary tests, which offer minimal protection to the suit-conscious physician.

If you haven't lost faith already, how long do you continue to trust your doctor when you realize that he or she no longer trusts you? Since each supposed case leads to the employment of at least two lawyers, it should be clear as to why the trial lawyers oppose any remedial change.

After 30 years without a lawsuit -- I have been hit with several non-meritorious claims -- my insurance carrier supplies me with a lawyer. He is paid on the basis of how much paperwork he generates and how much time he expends. This is hardly an incentive for quick resolution. No one, outside the profession, considers the impact upon the physician of an unwarranted claim. The immediate emotional impact and subsequent alteration and approach to patients is difficult to measure, but it is undesirable.

Since the costs of legal defense add up quickly, it becomes economically prudent to make a small settlement. This can best be characterized as legal blackmail.

My colleagues in New York, Florida, Massachusetts tell me that we are lucky in New Jersey. Their insurance rates are already far worse than ours. As the problem worsens everywhere, there's a small consolation. My current professional liability premium is $19,980 for $100,000/$300,000 coverage. When I started practice, that same policy cost $350. I'm unique in this respect: Everyone else in my specialty that I know carries $1 million/$3 million, with annual premiums of $35,000. I recently received my renewal notice. It calls for a 9% increase.

Since I'm doing about 20 deliveries a year, that prorates out to about $1000 a case. My fee for

vaginal delivery, exclusive of office visits, is $1000. Do you think I can make it up in volume?

I'm surviving by working at my hospital as a private contractor. As such, I do not receive any benefits, am paid straight rates for overtime, and then actually pay higher tax rates on that additional income. My wife has returned to work as a nurse. This welcome help turned sour in April, when our joint IRS return penalized us in still another way.

Those outrageous liability premiums vary from state to state. In each state, rates vary only according to specialty. Premiums are the same, regardless of practice volume or income. This unfairly burdens the young, the old, and the isolated physicians. This is leading to massive dislocation of medical resources, with growing pockets of areas that lack critical medical services.

There is a parallel international problem. Highly touted, but hardly successful, socialized medicine schemes have led to what is referred to as the brain drain. The best and the brightest, if permitted, left for greener pastures.

The classic example is British doctors who emigrated to Canada and the U. S. Most of those who chose Canada, along with many Canadian M.D.s, have since moved here.

Don't believe the recent poll propaganda that doctors in these countries are happy and satisfied. Meanwhile, patient complaints are steadily rising over rationing and deteriorating quality of care.

With nowhere else to go, the final round of musical chairs is being played among our 50 states, with their varied degrees of regulation and liability costs. Massachusetts, classified by its state's Medical Society as an unfavorable place to practice, leads the list in loss of physicians. It is infuriating to read unquestioned quotes

from Al Evanoff and other organized senior leaders claiming that everyone is happy in Massachusetts. They started with the highest concentration of doctors in the country, so early losses weren't significant. Now, the rate of loss is accelerating, and replacements are few and far between. Shortages in certain specialties and particular areas are approaching crisis proportions.

As the Massachusetts miracle of Dukakis campaign hype proves to be an illusion, budgetary restraints will worsen the problem.

If individual states and the Federal government will simply allow time for full evaluation of the fall-out from this lunacy, we could spare ourselves the chaotic end results.

Last year I attended the Assembly Committee on Health and Human Services meeting addressing the mandatory Medicare assignment. I never got to testify, because of a behind-the-scenes decision that my overkill would not be necessary. They were half right. The bipartisan committee voted the bill down unanimously. But it ain't dead yet. Senator Orechio is offering CPR with S-1649.

Under pressure to do something, MSNJ has recommended that its county societies set up voluntary means-tested programs to insure care of needy seniors. I objected to the program for several reasons.

First, the word "voluntary" has been too often converted to "mandatory" and the ceiling threshold raised to cover all.

More importantly, it wasn't necessary. The Medicare law, since its inception, gave physicians discretion to accept assignment when they saw fit. You must understand the discrepancy between customary fees and Medicare's allowances.

About five years ago, at the behest of the AMA, most physicians voluntarily froze their fees for Medicare patients. Two years later, a mandatory freeze was lifted to permit a 1% increase.

The old $30 fee for the most common type office visit, which had risen to $50 or $60 for other patients, would now be allowed $30.30. Is it reasonable to charge a retired millionaire $30.30, and some poor working stiff $50 for the same service? Of course not. If the government had stayed out of the picture, they would both probably be seeing bills of $30, or less.

My contentions and advice regarding Medicare assignment were embodied in an ad that I prepared for MSNJ which was widely circulated.

I refer to it as "the 20 cents solution" -- the price of a local phone call. Most seniors have someone whom they consider as "their doctor." If having even moderate financial hardship, all they have to do is ask, and most doctors, out of simple compassion, will accommodate even to the point of no charge. Those few who lack concern in the current competitive market will settle for assignment. In those cases, that may well represent overpayment.

The main argument of the mandatory revivalists is that the functioning means-tested programs have attracted few seniors. If anything, this confirms my contention that most of these folks are already being cared for. Their position is one of a categorical rejection of means-testing. Note that this objection does not arise from those who would qualify, but, self-servingly, from those who would not.

In conclusion, let me plead for two actions from the Senate: First, oppose S-1649 for the aforementioned reasons. My other request is that you break the strangle hold of the trial lawyers.

I hope that I've made it clear as to how liability-associated costs affect fees and availability, and are ultimately paid, in large part, by the patients.

If you could give immunity to bartenders, little league coaches, and municipalities, why leave health care providers to feed the avaricious appetites of the legal piranhas?

For the past several years, Speaker Chuck Hardwick and the Assembly have proposed a package of tort reform bills which would have helped a lot. Nothing has come of them, because the appropriate Senate Committee is dominated by, guess who -- the trial lawyers.

That same roadblock is responsible for our shameful auto insurance mess. There, public awareness is growing, and open rebellion of voters may bring some relief. For professional liability, the road appears longer and less promising.

My suggestion is a per-procedure insurance charge, comparable to flight insurance. That would at least fairly distribute the cost, until the fundamental misconceptions could be rectified.

To the senior citizens in the audience, let me leave with a parting thought: Try thinking as I do, despite my sad recitation, that I'm glad to be alive. I promise you that I, and most of my colleagues, will gladly continue to help the truly needy among you.

However, don't ask us to reward your survival, particularly when that survival, in many cases, is largely due to our efforts, and often in spite of your own self-destructive tendencies.

Thank you for this opportunity, and I would be glad to answer any questions.

SENATOR JACKMAN: Thank you, Doctor. Ladies and gentlemen, sitting up here with me today is

Commissioner James Langon, representing the Board of Commissioners.

Commissioner Langon, would you like to say a few words? With your permission, we're going to ask everybody else who is going to speak to be very brief. What's going to happen, at 11:30 a lot of people have to leave to go to lunch. So, let's do that. I know your speeches are prepared, but try to capsulize it, so everybody will get a general idea, and she can give it in Spanish. (referring to Ms. Delgado) A lot of people are going to be leaving at 11:30.

J A M E S F. L A N G O N: The Mayor has asked me to read this letter which he has sent to the New Jersey State Legislature, the Senate Committee on Aging, "To Whom It May Concern: It has been said that senior citizens, having contributed much to our State, and having been the foundation of our nation, and having earned our respect, and being deserving of same, that they ought to be able to enjoy their lives without undue concern in stretching their fixed incomes.

"This is the shame of our time, especially from the time of John F. Kennedy, President of the United States, who dedicated the wherewithal of this nation for the benefit of seniors.

"Many of our senior citizens do not have enough to eat. They fear daily the loss of their freedom by being placed in inadequate nursing homes. They are not made to feel as though they are part of our society. They are lonely and need companionship of the young. The stories are replete with situations that make one shudder at the thought of becoming old.

"We have here in West New York, and have long prided ourselves with affording our seniors programs to make them feel as though they are part of life. We wish we had more funds to give even more to those who have paved the way for the benefits we now enjoy.' Sometimes we forget too easily those who labored to make our streets and

buildings, those who fought to make our unions strong to guarantee a living wage, those who fought on foreign shores to protect this country, those who opposed individuals and groups in this country who would deny individual freedom. Those persons do not only deserve respect. They should demand it.

"Without further comment, I suggest that the Governor and the State Legislature take immediate action to ease the burdens on senior citizens, especially those living on fixed or modest incomes by the following means. One, establish a commission, bipartisan, to provide the Governor and State Legislature with recommendations on the following:

"A. Reduction of property taxes for elderly homeowners.

"B. Assist senior citizens on fixed or moderate income to maintain a reasonable standard of living.

"C. Increase the power and role of the New Jersey Commission on Aging.

"D. Create a cabinet post called 'Department of Aging.'

"E. Contact all local government as to the issues affecting their seniors, thereby gaining direct knowledge of needs and problems of seniors throughout the State of New Jersey.

"Finally, establish meaningful programs in which our seniors can participate, as they feel they are important members of society. To all those who have not reached the age of seniority, I give this admonition: Time waits for no man, and time moves rather rapidly.

"What you do today for our seniors, you are most likely doing for yourselves. Very truly yours, Anthony M. DeFino, Mayor of the Town of West New York."

SENATOR JACKMAN: Thank you. Next, Bert Bristol.

B E R T B R I S T O L: Ladies and gentlemen, I represent the Senior Health Insurance Program of Essex County Health Care Advocacy Program. We want to comment on the serious shortcomings of the Catastrophic Health Care bill.

Primarily, it fails to deal with the needs of the elderly in the area of its highest priority: Long-term custodial health care. This bill, which was backed by the AARP initially, had the loftiest intentions and hopes that the legislation they sponsored would truly address long-term care. Yet, when the bill was whittled down to a bare nothing, rather than withdrawing its support with strong protest, they opted to accept a bird in the hand which turned out to be all feathers and no meat.

The cost of insurance that this bill provides is unreasonably high, and is charged to a specific segment of the population in a most discriminatory manner.

Congress, in turn, saddled with deep debt, following the lead of this most prestigious and influential organization of 32 million, failed to recognize that the bill they were ending up with was, in truth, an effort to provide for 1.5 million elderly who were underinsured, uninsured, and yet did not qualify for medical assistance under the present welfare program and, therefore, had no access to medical care. This calls for reform of the welfare program. It is not a Medicare problem.

The strongest part of this whole debate, is that here Congress passes a law which affects 32 million people, and months afterward few of them know much of anything about the new law. Suddenly, eight months after the passage of this catastrophic bill, a storm is gathering clear across the country in an effort to reopen discussions and rectify the inequities and inanities which become apparent in study of this bill.

In order to truly understand the problem, one must be aware of what Medicare provided prior to the implementation of the catastrophic bill.

Medicare comes in two parts: Part "A" addresses hospital care, skilled nursing facilities, and hospices.

First, in 1988, Medicare provided 60 free days in the hospital subject to $540 deductible payable by the patient. Thereafter, from 61 to 90 days, the patient made a co-payment of $135 per day; from 91 to 150 lifetime days, there was a co-payment of $270 per day. These deductibles and co-payments could have been covered fully with a Medicare supplement policy with further coverage up to 365 days. The cost of this policy in 1988 was $25.95 a month.

Under the new law, Medicare covers 365 days with one deductible of $560. You will notice that this was all covered by the supplement previously.

Furthermore, under the existing Medicare regulations, the DRG -- Diagnostic Related Groups -- there are almost 500 groups-- A specific number of hospital days are prescribed and permitted for the particular disease.

For example, a stay for a myocardial infarction would be 11.3 days; for a hip replacement, 13.9 days. Then you are discharged. Thereafter, you cannot stay unless you pay personally, barring very strong medical necessity. Of what use is 365 free days?

In my six years of experience as a health care advocate, I saw one case where a patient exceeded 150 days of hospitalization in a benefit period.

This provision is without merit and benefits only the insurance company, which is relieved of paying the co-payments of $135 per day and $270 per day and balance of 356 days.

Second, skilled nursing home stays; Medicare allowed 20 free days, 80 days with a co-payment of $67.50 per day, paid by the patient or supplemental insurance, for a total of 100 days.

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Under the new bill, care is extended to 150 days, with a co-payment of $25.50 for the first eight days, and the balance of 142 days free. The additional 50 days are not meaningful, since only 5% of all nursing home residents require skilled care at any given time.

Skilled care is being attended by a registered nurse to dress wounds, monitor medication, give injections, receiving physical therapy, speech therapy, occupational therapy, and then only so long as the patient responds to the treatment and improves. Everything else is custodial care: Bathing, dressing, feeding, walking, the everyday aspects of living, which an infirm person cannot do for himself or herself. This was not covered by Medicare and is not covered by the new bill.

Three, home health care in 1988 on the books: Home health care was unlimited skilled care. In reality, what was provided was two hours a day, three days a week. Under the new bill, you have 38 consecutive days of skilled home care. What about a patient home from the hospital who can't get out of bed to prepare a meal, take a bath, get dressed? There is no provision for this.

Four, hospice care in 1988 was a total of 201 days. Under the new bill, days are extended to meet needs. Much of this service is available free through volunteers from cancer care organizations.

Part "B" of Medicare covers doctors, x-ray, pathology, therapy, and home health care. In 1988, unlimited medical care, after a deductible of $75 per a calendar year; then Medicare pays 80% of the approved rate. The approved rate is what Medicare determines to be the usual, customary, and reasonable rate in a given area, based on average fees charged for different procedures in that area over a given period of time -- generally 9 to 12 months.

Generally, Medicare pays about 60% of a doctor's fee. The patient then pays the 20%, plus any charges over and beyond the approved rate to meet non-participating fees. Here, too, the supplement picks up the 20%. Some supplements will also pick up the 75% deductible. This insurance now typically costs $40 to $60 per month per person.

Under the new bill, the deductible still is $75, but after one has paid out of pocket $1370 -- which is made up of $75 deductible and the 20% which Medicare does not pay -- then, Medicare will pay 100% of the approved rate. This means that the approved cost for medical care must be more than $6500, and the doctor's fee could be $10,000 or more. How many people incur medical expenses of this magnitude, over and above hospital charges?

Additional provisions of the new bill include, one, respite care. If, as, and when one has met the $1370 gap of Part B, a care-giver, one who cares for a patient -- a family member, etc. -- without charge, is entitled to 80 hours during a calendar year or free time to leave the patient in the care of one provided by Medicare.

Here in New Jersey respite care is provided by staff social services at a sum of $1000 a month, without the need to qualify for the $1370 gap in Medicare. Besides, all too often, a patient not needing extensive medical care is in such a predicament where the caretaker needs respite; for example, Alzheimer's patients. This provision is not only inadequate, but is not well-thought-out.

Two, under the new bill, effective in 1990, prescription drugs will be paid for by Medicare after a deductible of $600 at 50% -- to be increased annually as per experience to 80% of cost. In New Jersey, and in about 13 other states, there exists a pharmaceutical aid program which provides prescription drugs at $2 each for elderly and disabled who qualify for the income gap.

According to the New Jersey fiscal report for 1987, in this program, which provides for 247,000 elderly and disabled, the average payout per beneficiary was $402.76. What merit is there in a $600 deductible?

There are other provisions in this bill for those who qualify for Medicaid. One provides safeguards against spousal impoverishment, when a spouse is in the nursing home for custodial care, and the other is still in the community.

There is also a clause which allows for Medicaid to buy into Medicare. Now, the cost of this bill, estimated at $30 billion over five years, is to be borne by Medicare recipients.

Part B, which was provided to Medicare recipients at a cost of $27.90 per month for 1988, goes to $31.90 for 1989, and will increase annually. Furthermore, they must pay an additional surcharge of 15% of their income tax liability. If your tax is $300, you will pay $45. If your tax is $3000, you pay $450. If your tax is $5000, you pay $750 -- no more than $800 for a single person, and no more than $1600 for a couple.

Congress has stated that this bill was meant to help 1.5 million in various degrees who were uninsured because they could not afford the cost of insurance, and yet were not eligible for welfare or any other social program which could help pay for medical care.

Clearly, this is a welfare problem and should be addressed as such. Everyone should be entitled to medical care, regardless. Funds are provided by taxes. If needs exist, they must be met by all the population. Giving these taxes new names and charging special groups for its cost is a fraud. Aren't we all going to pay for the bailout of the savings and loans -- $29 billion? You don't see the banking industry footing the bill, do you?

School taxes are paid by all, whether people have children or not. Comments, such as those by Senator Lloyd Bentsen of Texas, that seniors are "fat cats," and "wealthy," are a gross inaccuracy. Most seniors have a difficult time equating today's dollar with the 1950 to 1960 dollar. They are paying tax on their Social Security, income from investments, and many are still working for low wages.

They are deeply angry, and a ground swell of protest is rising because this bill gives so little and costs so much. However, they recognize the need for welfare reform and are willing to pay for it, equitably, along with everyone else.

We respectfully request the Senate of the State of New Jersey to make known to Washington its displeasure with this inadequate, inequitable Catastrophic Health Care bill. Your help and assistance is needed to rectify this situation. Thank you.

SENATOR JACKMAN: Ruth Boer.

R U T H B O E R: I'm Ruth Boer. I represent the Home Health Care Agency Assembly of New Jersey, an organization of over 70 home care providers, whose mission is to provide leadership in planning for the future, and providing quality home health care services in the present.

I'm also the administrator of a home health agency that provides services to residents in Hudson and Bergen Counties. I am personally committed to assuring the availability of humane, cost-effective, high quality home care services to all who need them.

I appreciate this opportunity to address the issues and concerns of senior citizens, because the majority of patients that the home care community serves are the frail elderly who are most at risk when vital services are not available, or are cut back because of lack of adequate reimbursement.

A fundamental health care need of senior citizens is coverage of long-term illness.

Thousands of New Jersey seniors are victims of illnesses of long-term duration, such as Alzheimer's disease, cardiac disease, stroke, cancer, and Parkinson's disease. The bulk of the care required is custodial and can be provided in the home. But these senior citizens require regular assistance to stay in their home. They need help in performing functions such as eating, dressing, preparing meals, getting in and out of bed, and going to the bathroom. These personal care tasks and activities of daily living are performed by home health aides.

The Department of Human Services, through various Medicaid programs, is committed to home care. But the reimbursement for the home health aide visit is inadequate, and the reimbursement method is inequitable. Home health agencies are incurring losses that they cannot afford, and which are entirely unfair.

In 1987, the last year for which there is documentation, home health agencies throughout New Jersey were underpaid by $800,000 for their Medicaid home health aide visits. The unfair method of determining the rate of reimbursement remains unchanged, and agencies continue to experience losses. At least one of these agencies is going bankrupt, and they are not in a position to continue to provide services at a loss.

They will be forced to curtail care, and patients may suffer. Providers cannot be expected to shoulder the State's obligation without sufficient reimbursement. Patients will not receive adequate visits, even though home care may be needed to prevent a patient from entering a nursing home. It's inappropriate to use the Medicare cap on homemaker/home health aide visits which are based on Medicare.

The same home health agencies certified by the Health Care Finance Agency to provide care for Medicare patients serve Medicaid patients as well.

Medicaid in New Jersey does not pay more for a home health aide visit to a Medicaid patient than the Medicare cost cap calculated for a visit to a Medicare patient.

It is inappropriate to use the Medicare cap on homemaker/home health aide visits for the more time-consuming Medicaid population. The typical Medicare patient, e.g., an elderly woman released from the hospital with a broken hip, has a greater need for professional nursing hours, and somewhat fewer home health aide hours than required by the average Medicaid patient.

Medicaid patients are poorer, with multiple chronic illnesses, whose total circumstances require longer visits by the aides. They may be bedbound, and they do not have the family support network of the Medicare patients.

Documentation proves that the average Medicaid home health aide visit is 25% longer than the average home health aide visit.

The reason that New Jersey home health care agencies lose money when delivering home health aide visits is directly related to these longer visit's time.

When the Health Care Finance Agency of the Federal government calculates the allowable cost cap of a visit, it combines an agency's Medicare and Medicaid home health aide visits, and averages them together. The additional time needed for providing adequate care to the Medicaid patients pushes agencies' costs over the cap allowed by Medicare, and although the agencies' time and costs for their Medicaid cases are more, they do not get paid sufficiently to cover their expenses.

Commissioner Altman, of the Department of Human Services agrees that it is inequitable not to pay the

agencies for their costs. The Commissioner agreed to apply an adjustment factor to the Medicaid rate to reflect a longer time required per visit, which would be disbursed. He would have then disbursed $800,000 to agencies that experienced deficits, and to recommend that similar adjustments be reviewed during the fiscal year of 1990, but this was rejected by the New Jersey Office of Management and Budget.

The only fair recourse for fair reimbursement for agency costs is through legislation intervention. There must be a resolution to include the $800,000 documented overrun from 1987 in the 1989-90 New Jersey budget, so that the Department of Human Services can adjust reimbursement rates for Medicaid home health aide visits to reflect actual costs.

I urge your commitment to support legislation to fund fair reimbursement for Medicaid homemaker/home health aide services. Long-term home care improves the quality of life, since a patient is surrounded by his familiar environment and support systems. The homemaker/home health aide is an essential element of this service, but without adequate reimbursement, the availability of this service will be decreased. Thank you.

SENATOR JACKMAN: Is there any pending legislation, to your knowledge?

MS. BOER: It's a resolution. A Senator has introduced a resolution.

SENATOR JACKMAN: Who introduced it?

MS. BOER: I have to look.

SENATOR JACKMAN: Now, I'm going to ask the people from Weehawken to give me five minutes. There's one more gentleman who wants to speak. I'm going to limit you,

because the bill you're going to talk about is already law, okay?

G E O R G E H O L D E R E I D: We heard the talk about the catastrophic illness and the dimwits in Washington. We go that one better in New Jersey. It seems like a few years ago, the hospitals were going into the red. They couldn't survive. So, we had to do something about it.

But, what the legislators did, was say, "We're going to pass a surtax" -- that's a horrible word again -- "of 10.9%" -- two years ago -- and the limitations ran out this year. So, before the limitations ran out, they decided to put a 5% increase on hospital bills overall. And the legislators came along and passed a bill that said, "We're going to increase your bill 13%."

Now, this adds up to be an 18.5% increase on anybody that can afford to pay the bill. This is for people who cannot afford to pay the bill. They will be paid for by the surtax.

Now, for two years, it hasn't hit people very hard, because for people that were on Medicare, the money came out of Medicare funds. And Medicare says, this year they are not going to supply the funding for it. I left my paper over here that tells how many millions of dollars the State has taken away from Medicare funds, which were funds to people of 65 and over. It wasn't supposed to be used to save a hospital. But, of course, this just happens to be what it was used for. But, this year, Medicare will not pick up the bill. That means whatever insurance carrier you might have -- whether it be by AARP insurance, or one of the HMOs, or Blue Cross-Blue Shield -- will have to increase their bill to you by at least 25%.

So, this is what you have to look forward to now. There are other ways to pay this bill. It isn't up to a person who is sick, and most of the sick people that are in hospitals are 60 years old or over. So, this means

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a bigger portion of paying a hospital bill for what you deserved, plus 18.5% more that they did for you, just to save a hospital. That's outrageous. The dimwits' thinking at its best.

Now, I think it's up to society as a whole in this State to see that a hospital is there if you need it. And what better way to do it, than to take it from the people who are wage earners, not people who are retired, not people that are on a fixed income, who are forced to pay. What the bill goes on to state, too, that I thought was a real kick, was, you have two weeks in order to come up with the money. If you didn't come up with the money in that time, they were going to notify the Taxation Bureau. If you had any money coming to you for rebates, this money is supposed to be given to the hospital until all your bill is paid up; not the bill that you should have paid, but the 18.5% above that, that they shouldn't have even charged you.

But, if the State would say, for example, "We have a lot of wage earners in this State-- You have a lot of young people, and if they need a hospital, what's going to happen to them? If the old people-- If they say to the old people, "Look, we're going to take the burden off your back," if they would say, "Okay, every pay day we'll charge anybody who's working a dollar, and this will go in a fund, or two dollars every pay day--" With that, I guess, if they insist that a person has to go to the hospital for a week and pay $600 a day, that maybe they could cut it down, if they wanted to, to 1% or 2% on a surtax, or maybe they shouldn't even include the old people at all and say, "Look, we've taken enough from you." But when you look at what the State subsidizes -- and they will not subsidize the hospitals -- and when they subsidize, for example, school guards or welfare, the whole bit, whatever subsidy there is in this State, transportation, $210 billion just for transportation alone, because somebody doesn't want to pay

the transportation for the price it costs-- They don't say that to the old guy that's in the hospital when he gets out. They say, "Hey, you're going to pay 18.5% more, period. If you can't pay it, you're not going to get your rebate." So there are ways of doing this, and it's very easy if they include all of society to say, "Now, we're going to include all of society, so we can have a hospital, not just to tax the old guy who's coming out of the hospital on medical care, or steal money from Medicare, because when you realize how much Medicare has paid into it, and they are not going to pay it this year, you either have to pay the extra, or if you don't have insurance, you're stuck.

But the guy who bills you for your supplemental insurance is going to say, "We're going to charge you 25% or more. Either that, or we're not going to carry you."

SENATOR JACKMAN: Thank you, George. Thank you very much.

I just wanted to say thank you, and she'll give you in Spanish some of the brief remarks that were made before.

I'm going to say something to you that I think is very important: I appreciate the fact that you came here. You must put a value on what we're going to try to do. However, I think that somewhere along the line we're missing the boat. We should make sure that everybody in this room doesn't have to go around begging to get something done. To me, I think this country owes it to the people that are sitting in this room today.

Now, what can we do? Why are we spending millions and millions and millions of dollars giving to the Japanese? And they own this country. They are buying this country right from underneath us, and we're not taking care of our own people in this room who need to have health care. That's what gets me mad. We spend hundreds of

billions of dollars in defense, because they don't have a Navy. They don't have an Army. That's because we won the war and they won the money.

We better wake up and make sure that, as the doctor has said before-- Here's a man that I've known many years, a gynecologist, and there's a lot of people in this room who don't need him any more. You know that, because he takes care of babies. Not too many people are going to have babies in this room today. I'm 73 years old, so, I'm an old-timer. I know what's happening today. I think maybe we better let the Congressmen know and the legislators know what you need.

This gentleman who just got up and spoke before-- For his edification, I went over to tell them, what he spoke on is already law. The bill was passed, and signed by the Governor. Nobody went down there and objected to this bill to any degree, and consequently the majority of the people in the Senate and the Assembly voted in favor of the bill. Lady, don't put your hand up when I'm talking. And the Governor signed it into law.

So, now, the only way you can change that is by making a new law or amending this law. That's what I told the gentleman before.

Now, I think what we've got to do here in this room, Hispanic-- Forget about the nationality, or what culture you come from. We're all Americans. We have to worry about one another, and we have to make sure that the money is available. If we can send money all over the world, then we better start taking care of the people who have to eat here. We've got too many people sleeping in the streets. Too many people are homeless, and we have to take care of them.

Now, I'm in the Legislature. This is my 24th year that you've sent me down there. I'm the oldest Democrat today in the Legislature. That's because I got

elected by all of the people here in Hudson County. Now, we have a job ahead of us. I'm getting older. Some younger people will be coming up taking my place, shortly. But, in the meantime, let's take care of one another, and I want to thank you all for being here today, because it was important. Thank you for coming from Weehawken and Union City and other sections. And I can assure you that we'll do everything-- And West New York, of course. That's my hometown.

UNIDENTIFIED MEMBER FROM AUDIENCE: How do we find out about these bills?

SENATOR JACKMAN: Where do you come from?

UNIDENTIFIED MEMBER FROM AUDIENCE: Fanwood.

SENATOR JACKMAN: Do you know who your Assemblyman and Senator are? You have to contact them, like my people here contact me. I get called every day in the week. I hope you don't think I'm being facetious. Unfortunately, you belong to the AARP. Is that right? And where were they when the bill was being passed? Where was the organization?

MR. HOLDEREID: The interesting thing about this is, I went to a meeting in Bordentown, and I asked them down there if they were going to take any action. They said, "We don't know anything about a surtax. And I said, "Gosh, it's already passed the Senate, and it's going to come up before the Assembly." "We don't know about it."

SENATOR JACKMAN: It not only passed in the Assembly. It was amended and passed in the Senate again.

MR. HOLDEREID: It had to go back to the Assembly for the last vote.

SENATOR JACKMAN: There's a time element. I'm going to lose some of the people. It's unfortunate that people don't pay attention in the districts where they come from when a bill is being passed. I can tell you, there's a lot of people in this room to let me know, and I make

sure I get the thing. Incidentally, this bill was drawn up by this young lady. Is that right? She worked on the bill and put it together. So, I wanted you to know about it.

MR. HOLDEREID: Half of it is tremendous. The other half is, who's going to pay for it?

SENATOR JACKMAN: In this room, when you leave here today, if there's anything you think that you should take care of, contact your local people here. This gentleman who's been with us: How old are you now, Junior? I'll be 73 on July 2. All right, so, I'm no baby any more.

R A L P H D A M I A N O: I would like to say a few words. You have to get to the youth, because it's they who are making our rules today. It's not us. We cannot get up and go to you down in Trenton and fight for what we want. It's an impossibility. We are too old to do that today. You've got to get to your youth and let them know what is going on today. They don't give a darn today, because they are making good money. They are happy. They will not realize until they reach our age what it is.

SENATOR JACKMAN: I hope they reach our age.

MR. DAMIANO: And then let the public know what is going on down in Trenton. Don't come out with a law, and then a week later tell us, "This is what was passed." And we didn't know a thing about it so we could fight for it. That's what is happening today. You should let the public know what is going on down there every day of the week. There are many things going on down there. We never know about them until it's too late.

SENATOR JACKMAN: I agree with you. Let me try to say this to you, and I think it's important: I don't think we should blame any one group of people, whether it be young, or what have you. I've been down there 24 years, and everything that I do, I try to do in the best interest of my communities.

I don't think anybody can ever point a finger. I still live in this town. I lived here all my life, and I was raised here; went to public schools here, and that's it. But, I can tell you this: We've got a job ahead of us. A lot of people are living longer.

As the doctor said before, and I'm not being facetious when I say this, the lawyers today-- You don't know this, but the Legislature is not made up of people like me who just work for a living. I'm not a lawyer. I'm not a doctor. There are more lawyers and doctors in the Legislature today then there are people like myself who come from your ranks. Oh, there's more lawyers. You know why? Because they get elected, okay? And there's a lot of people that don't care. You know that better than I do. There's a lot of people that don't even vote today. That's why we got some of the conditions we got in this country.

It seems to me, if we can spend money all over the world, we ought to spend money here where it's more important. Thank you, and God bless you.

(HEARING CONCLUDED)