PUBLIC HEARING

before

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

To consider issues and options relating to the financing of long-term health care

November 24, 1987
Room 334
State House Annex
Trenton, New Jersey

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Assemblyman William "Pat" Schuber
Paul Langevin
Marian E. Bass
Jeanne Sims
Theresa Dietrich

ALSO PRESENT:

David Price
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Long-Term Health Care

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NOTICE OF A PUBLIC HEARING

THE NEW JERSEY TASK FORCE ON CATASTROPHIC AND LONG-TERM HEALTH CARE ANNOUNCES ITS FOURTH AND FINAL PUBLIC HEARING TO CONSIDER ISSUES AND OPTIONS RELATING TO THE FINANCING OF LONG-TERM HEALTH CARE

Tuesday, November 24, 1987
Beginning at 9:30 A.M.
Room 334, 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 its fourth and final public hearing on Tuesday, November 24, 1987, beginning at 9:30 A.M., in Room 334 of the State House Annex, Trenton, New Jersey, for the purpose of receiving testimony about policy directions and options for New Jersey, and related issues, in regard to catastrophic and long-term health care. The task force will receive testimony from the relevant departments of State government and from private insurance companies and other persons interested in submitting testimony.

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 a primary focus on the financing of long-term health care. The task force has been examining national policy directions, state initiatives, the scope of existing public 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): Good morning ladies and gentlemen. This is the final hearing on the Catastrophic and Long-Term Health Care Committee. Each of the departments that is represented here at the table who have been permanent members of this Committee, will submit their testimony this morning.

In addition, various Task Force members have requested to receive more input from insurance companies concerning the long-term care policies currently being offered, and future prospects. In that regard, several health insurance industry representatives will report to the Task Force from their perspective. Some maintain that few companies will be willing to assure the risk of long-term care financing unless allowed to reap higher than market rewards for such risk. The number of long-term care policies have increased, but the percentage of companies currently offering long-term care coverage with 422,000 policies in force, only reach a very small portion of the eligible people. However, designing the proper regulatory environment and utilizing other targeted strategies can encourage more private market development. As more insurers enter the market, competition should encourage better benefit packages and more affordable premiums.

We look forward to this morning's exchange of ideas and learning about what specific courses of action the State government can take to ensure that quality programs are affordable, in order to reach those persons now spending down to qualify for Medicaid.

I wish to thank, on behalf of myself and Assemblywoman Crecco, all of the department representatives for their diligent attendance and questions raised, which occurred at our various hearings over the last several months. I'm also appreciative to all of the professional experts, groups, and citizens, who have testified before this Committee over the last several months, and to those who are prepared to testify

today. You certainly have helped us put things in their proper perspective, which will invaluably contribute to this Task Force's report and recommendations. I wish to thank all of you again.

Without further ado, I think we'll take testimony from our first witness who is Anne Somers, Adjunct Professor of Environmental and Community Medicine, UMDNJ, Robert Wood Johnson Medical School. Welcome.

D R. A N N E S O M E R S: Thank you, Mr. Chairman. I appreciate very much the opportunity of appearing before the New Jersey Task Force on Catastrophic and Long-Term Health Care. I congratulate Assemblywoman Crecco, and other members of this Task Force, for helping to publicize these very important issues; and to dramatize the urgent need for State leadership in seeking solutions.

I also want to compliment the four departments represented here for your contributions over the years to better health and health care for the elderly and disabled of New Jersey. Just a few days ago, the Division on Aging celebrated its 30th birthday -- not a day over 30, Theresa. (laughter) New Jersey was the first state in the Union -- as most of you perhaps do or no not know -- to establish such a division. Its statewide, county-based, aging network has not only contributed to innumerable useful program, but just as important, it has provided a vehicle for the elderly themselves to become active and responsible participants in the policy making process; thus contributing to our mental as well as physical health.

I can't even begin to name all the contributions of the Department of Health in this respect. Almost by definition, this Department is our first line of defense against the ravages of chronic illness, which of course is the primary cause of long-term disability and its often catastrophic financial consequences. I mention just one

example, your role in the creation and maintenance of the Alzheimer's Disease Institute and Resource Center at UMDNJ in Piscataway.

Human Resources has also played an indispensable role. Through its administration of Medicaid -- the ultimate, albeit imperfect, safety net for those unfortunate elders and younger disabled on whom Medicare, private insurance, and sometimes even their own families have turned their backs -- through the CCPED and other imaginative Federal/State waiver programs, and your leadership in the in the State Long-Term Care Planning Committee from 1980 to 1983, Human Resources long ago earned the right to, as well as responsibility for, continued leadership.

Up to now, the Insurance Department has played a less obvious role in long-term care. But if you believe, as I do, that long-term care financing cannot be segregated from mainstream health care any more than chronic disease and disability in a given patient can be segregated from his or her acute care needs, then you will welcome with open arms the Insurance Department's new commitment to this field.

However, there is another side to this coin. If things are going so well, why am I here today? Indeed, why was this Task Force created? The answer, of course, is that there remains a major omission in New Jersey's health care policy, a gaping hole in that presumed safety net. I refer, of course, to the tragedy of discrimination against patients with long-term chronic conditions. This is why -- despite my admiration for the programs I have mentioned, and many others that could have been mentioned if time permitted -- that is why I appear today to plead the case for these neglected orphans of our remarkable, and remarkably expensive, health care system.

So I come to you today not only as a member of the UMDNJ faculty for over 16 years, but as a student of health care policy for 35 years, and even more to the point,

unfortunately, a consumer of U.S. health care for over twice that time. Of special relevance to your Task Force, I come as the wife of a long-term care patient, who has personally lived through all of the problems and frustrations that you have heard about in your three previous hearings.

My husband, Herman Somers, a professor at Princeton University, a former member of the board of UMDNJ, and my long time collaborator on health policy studies and books, suffered a severe stoke in August 1979. After several weeks in a coma and several months of acute care and rehabilitation, he was still aphasic and hemiplegic, unable to speak, dress himself, or walk alone. He has remained in this condition for over eight years. For 7-1/2 of these years, I have cared for him at home with the help of a dedicated staff of nurses, aides, and students. So I am sure you will understand why, with this amount of on the job training, long-term care and its financing have become for me a virtual crusade.

I don't need to tell you that my husband's case is not unique. Probably everybody in this room knows of someone -- a grandparent, the mother of a friend or colleague, perhaps a client -- with some similar experience. In Princeton, a number of stroke victims, their families, friends, and professionals helping to care for them, have organized with the help of the American Heart Association, the Mercer County Stroke Club. This club provides not only important social and emotional support for stroke patients, but also an outlet for their frustrations. Recently it published a remarkable little book of firsthand experiences called, "A Stroke is Not the End." This is it right here. (holds up book) In addition to the courage and determination of these wonderful people, what comes through is their increasing frustration, even despair, over societal neglect. Just one example, Mr. D., a retired C.P.A. who has cared for his disabled wife -- also a stroke patient -- at home for over seven years, writes of those -- and I quote

his exact words -- "ruthless antagonists" who run Medicare, and to whom -- and I still quote -- "the patient is the enemy who is trying to bilk the government out of its assets. None of them keeps in mind where the government money came from."

Now I can't agree with his broadside against all government, but I sympathize deeply with his frustrations. To have to undergo the physical and mental suffering, the indignities, the gradual abandonment and the financial catastrophes that too often come with prolonged disability, especially in this most affluent of all societies, is not only heartbreaking, I find it a cause for embarrassment and indignation. I find it especially embarrassing that two close friends, both associated with Princeton University -- in one case the wife had Alzheimer's, and the other the wife had, and subsequently died of, amyotrophic lateral sclerosis, Lou Gehrig's Disease -- both felt they had to leave New Jersey, with its second highest per capita income in the nation, to go to die in Vermont, one of the poorest states, in order to receive tolerable long-term care.

How common are these cases? Well, here we need a sense of proportion. Fortunately most elderly are not disabled. We often hear the statistic that some 80% have some form of chronic disability, but that is meaningless for our purposes here today. Practically everyone over 40 has some disability -- nearsighted, mild arthritis, etc. We learn to live with such impairment. What we are talking about in long-term care are the severely disabled -- not even every stroke patient, not even every Alzheimer's patient. We are talking about people who are functionally impaired. Those who cannot get out of bed alone, dress themselves, toilet themselves; even with the help of computers of other mechanical aids.

Now, how many such individuals are there in New Jersey? Well, nobody know for sure. Some have suggested as

many as 18% of our elderly fall in this category. This is far too high. Of course it depends on how you define severe disability, and of course how you define it will depend on how many people you will find. There are very precise ways of measuring disability or functional impairment today. People have developed scales called ADL Scales -- Activities of Daily Living -- and so forth; and depending on where you want the cut-off point will depend on how many disabled you will find.

Taking some of the more common measures, starting with nursing home patients -- that's one measure of people who are presumed to be considerably disabled. Shall I pause for a moment, Madam Chairman? (Assemblywoman Crecco arrives)

ASSEMBLYWOMAN MARION CRECCO (Chairwoman): Good morning. You'll have to please excuse me.

DR. SOMERS: Delighted to have you here.

ASSEMBLYWOMAN CRECCO: Thank you.

DR. SOMERS: And congratulations on your reelection.

ASSEMBLYWOMAN CRECCO: Thank you very much.

DR. SOMERS: I was just trying to talk a little about some ways of getting at the number of disabled in the State, a difficult problem itself.

Starting with nursing home patients, if you want to consider that one approach, the last national figure for 1985 is 4.6% of the elderly, which somewhat surprisingly is down slightly from the 1977 figure. And a plausible estimate is that perhaps another 5% of the non institutionalized elderly are equally disabled.

If these ratios were applied to New Jersey, what would the numbers look like? How many patients are currently in New Jersey nursing homes? How many on long-term home health care? How many of both groups are on Medicaid? How many already have some form of private insurance? How many live in a continuing care retirement community? I assume your Task Force has been gathering this type of information to help you project future

needs and demand for long-term care insurance and other benefits, and I certainly look forward to your report.

But as important as such projections are, let me emphasize that that is only part of the picture. Most of the projections of future need for long-term care -- projections that have scared off many policy makers and insurance carriers -- have simply assumed past patterns of disability and of health care utilization. This is a serious error, I think, because just as the past quarter century has witnessed dramatic reductions in death rates for many chronic diseases -- especially stroke and heart disease -- so I believe we are on the verge of similar dramatic reductions in the incidence or onset of such diseases. Indeed this is already beginning.

To cite just one single example: A 26-year study of changes in heart attack rates among male employees of the duPont Company from 1957 to '83 -- that's a pretty long, good, longitudinal study -- found a 28% drop in the age adjusted incidence rate, compared to a 20% drop in 30-day fatality rates. In other words, even those people who have heart attacks today are having them later in life, and while the death rate continues to fall, the age of incidence or onset is falling even faster. This is terribly important, not just to the patients involved who have future years of disability, but to insurance carriers, to the government, or anybody else interested in providing financial protection against the costs of long-term care.

Because, if, as some pessimists have predicted, the rate of disability among the elderly is going to rise in the future with every improvement in acute care, to the point where some people say that perhaps 25% of the over 65 population and 5% of the total population could be disabled and in need of such benefits, then indeed the burden on the nation, and on the State could become intolerable, and almost certainly un insurable. If, on the other hand, we can look forward to

continued reduction in the incidence of chronic disease greater than improvement in life expectancy, then the period of disability is shortened or compressed, and the burden becomes manageable and insurable.

Now please understand me. I present this not as a prediction, but as an option; but a very important option. And as we move to design our long-term care financing policies, I submit we can go in one of three directions:

1) Do nothing and just hope the problem will go away. I submit this is not a serious option. The costs of Medicare and Medicaid will continue to rise, despite continuing and perhaps even Draconian efforts to contain them. There will be increasing inter-generational conflicts over who should bear the burden, and government will be caught in the middle -- a very uncomfortable place to be.

2) Assume current or worsening rates of disability among the elderly, and try to design the cheapest possible way of meeting their needs; even if it means creating a separate system of care for the victims, a system which I am sure can be "separate and unequal."

3) Aim for sufficient reduction in the rates of disability to permit us to provide adequate, high quality, mainstream health care to the remaining victims. Needless to say, this is the option I think we should pursue. In practice, option 3 calls for equal attention to prevention of chronic illness, and to financial protection of the victims. If you prefer insurance language, you can call prevention "Risk-Management." That's a very respectable word.

Ladies and gentlemen, time is the enemy for all of us. My own time is clearly running out. Your patience is running out. Your time as a Task Force is running out. You have a report to prepare in just over a month. The time for this Administration is limited. Governor Kean will leave us in a little over two years. Most important of all, the time for

the people of New Jersey to choose between these three options is not unlimited. And I believe this is probably true for the nation as a whole. For good or for ill, New Jersey has become a pace-setter for national health care policy. Consider that we had -- as I mentioned earlier -- the first Division on Aging. We were one of the first to adopt the Certificate of Need, the first to require institutional ethics committees -- following the Quinlan decision -- and of course, DRGs.

Whether we focus on State or nation, we have before us today a window of opportunity that will not last too long. Because while the number and proportion of elderly in the population will not rise dramatically during the next decade, if we do not prepare ourselves in advance before the Baby Boomers begin to turn 65 around 2010, the results will be disastrous. Other pressures, not just budgetary but from competing legitimate needs -- in education, jobs, environmental controls, housing, even in the health fields, AIDS and so forth-- These pressures will increasingly impinge on our freedom of movement to close this disgraceful and tragic gap in our health care system. We must act promptly and on both fronts: prevention of chronic disease and disability, and protection of its victims.

Elsewhere, I have drawn up a list of 10 guiding principles for a national policy on long-term care. You will be pleased to know I am not going to impose this on you, but I have already given David a copy, and it's here for anybody who cares to look at it. It starts with emphasis on prevention and it goes on to talk more about some of the financing aspects.

And as some of you know, I have also long advocated the creation of a senior level, Blue Ribbon New Jersey State Commission on Long-Term Care Financing, committed to public/private solutions; and to both long run and short run approaches. Other states have already acted. This time we cannot claim to be the first. I just brought along one copy--

The State of Connecticut got out, and in one year's time they produced this. This is the report, and this is what the Governor accompanied it with, the Governor's Plan of Action on Private and Public Responsibilities for Financing Long-Term Care for the Elderly. It's very impressive I think.

In recent months this proposal has been brought to the attention of the Governor's Office on Policy and Planning, as well as the four departments represented here today, and various provider and consumer interest groups. There has been, I'm happy to say, considerable support, and I understand some skepticism -- possibly from unfounded fears that it might interfere with some existing departmental initiatives. And if you want more information on this particular initiative of the proposal for a State commission, Mrs. Livingood is the person to talk to.

I've already made clear my support for all such promising initiatives, and I'm sure we're going to hear more about this later on this morning. But long-term care is too complex, too multifaceted a problem for any one individual, any one group, any one government agency to claim a monopoly of wisdom, resources, or approaches. We need all of your departmental initiatives. We need a good report from your Task Force. And, we need a broad, Blue Ribbon Commission to take up where you leave off. For once, it seems to me, the timing is exquisite. Let's get together and make the most of our window of opportunity. Thank you all very very much.

ASSEMBLYWOMAN CRECCO: Thank you. Any questions? (no response) I don't have any myself. Thank you very much.

Richard Lloyd, Director of Public Relations for Blue Cross and Blue Shield of New Jersey, Inc.? Good morning.

R I C H A R D W. L L O Y D: Assemblywoman Crecco, Assemblyman Schuber, members of the Task Force, As you said, my name is Richard Lloyd. I'm the Director of Public Relations for Blue Cross and Blue Shield of New Jersey. I want to thank

you for the opportunity to testify today on the way Blue Cross and Blue Shield of New Jersey perceives the potential for marketing long-term care health care coverage.

For several years, Blue Cross and Blue Shield of New Jersey has been surveying this field, and we're of the opinion that there is a major unmet need for policies providing coverage for long-term care. At present, we project marketing a long-term care product in New Jersey by the latter half of 1988.

At Blue Cross and Blue Shield of New Jersey we believe that a long-term care product can be marketed which will provide long-term care coverage at an affordable price, and still remain actuarially sound. A major concern of our company has been to design a long-term care policy that appeals to individuals between the ages of 40 and 65. For it is among this group of New Jerseyans that the greatest opportunity exists to market a long-term care product that is reasonably priced. While this is our goal, we anticipate during the inception of this policy that purchasers will be over the age of 65.

While the long-term care product that we anticipate marketing has not yet been finalized, it is possible to give a fairly specific outline as to the direction that we intend to take. Please recognize, however, that there may be certain changes based on market testing of the product, and revisions in actuarial estimates as to adequate premium level and benefit design.

Blue Cross and Blue Shield of New Jersey proposes to market an indemnity insurance product, which provides nursing home and home health care benefits on a long-term care basis. Under the policy, individuals would be eligible for long-term care benefits if they were received in an approved skilled nursing facility or an intermediate care facility. Home care provided by registered nurses, licensed practical nurses,

physical therapists, speech therapists, or certified home health aids, would also be eligible for reimbursement. Importantly, this policy would cover custodial care, which is defined for the purposes of the policy as care which assists an individual in performing the activities of daily living.

As presently designed, the policy would pay up to $75 a day for care at a skilled nursing facility, $60 a day at an intermediate care facility, and $30 a day for home health care. The policy would have benefits maximums equivalent to the cost of four years of care at a skilled nursing facility. Policyholders would be eligible to receive benefits after either a 30-day stay in a long-term care facility, or a combination of 30 nursing home days and home health visits. This day deductible will put the focus on true long-term care. The policy, however, will not require that an individual be hospitalized prior to being eligible for benefits. At the same time, pre-utilization review will be required before benefits can be received. All payments will be directed to the policyholder, unless the individual requests the payment be forwarded to a provider.

Our direct market for this policy are people age 40 to 65. However, any New Jersey resident up to age 75 who meets health underwriting criteria, may purchase the product. For one year after the initial purchase of this policy, there will be no provision of benefits for any illnesses which were in existence in the year prior to purchase of coverage. This pre-existing clause is something currently in place in our standard non group policies.

Applicants for this coverage who are eligible for Medicare, must be enrolled in Medicare's programs. The policy will also be a secondary payer if benefits are available to the individual under Medicare, no fault insurance, or other Blue Cross contracts.

Several points should be made about the policy's premium structure. It will be defined as a level premium in that the premium will stay the same throughout the life of the policy, with the possibility of adjustment after five years if it is determined that the actuarial trends need to be recalculated. The principle of a level premium is that it will be increasing only be predetermined adjustments for inflation indexing.

Many potential purchasers of long-term care policies will be concerned about the future value of their policies. This is why our proposed plan will provide indexing in both premiums and benefits over the course of the policy's life. The daily benefit amount and benefit maximum will increase by a predetermined percentage each year in order to keep pace with inflation.

One potential refinement in the above outline policy includes making a cash surrender feature available to policyholders.

In addition to the policy I've just discussed, we're also in the process of researching two other long-term care policies, and we are doing this in conjunction with other Blue Cross and Blue Shield plans in the country. One potential product would involve a life insurance annuity, which can be purchased at an early age, and at a later date converted to long-term health care coverage. The other plan would provide benefits via continuing care retirement communities. These communities would provide seniors with the opportunity to live in a private residence in a senior community, while having access to a nursing care facility capable of taking care of all health needs. At Blue Cross we're actively pursuing both of the abovementioned options, and are determining how viable they are as products for New Jerseyans.

The challenge of meeting the long-term care needs of our citizens is an area which will require the cooperation of both the public and private sector. At Blue Cross and Blue Shield of New Jersey, we believe the private sector is up to the challenge of providing affordable long-term care coverage. We applaud the effort of this Task Force in conducting these hearings, and stand ready to work in a cooperative manner with both State and Federal officials to successfully address this crucial health care issue.

Thank you, and I'd be happy to try to answer any questions if I can.

ASSEMBLYWOMAN CRECCO: Thank you. What would you consider affordable?

MR. LLOYD: I would say the estimates on the premiums -- and these are just estimates right now -- is that on an annual basis we would be anticipating for an individual at the age of 40 it would be approximately $400 a year. Then it would go up, obviously, in increments to where we're talking about a policy for a 70-year-old of over $1500, but not substantially over that. That's under the current estimates that we have. These may change. In all probability they will be adjusted slightly upward in the future, but that is where we see the policy falling at least at this moment. The object is, there's no point in marketing a product which is unaffordable because no one will purchase it, and the idea would be to get people to purchase the policy prior to their going to use it -- meaning that, not purchasing it with the idea that they're going to use the benefits within the next year or two.

ASSEMBLYWOMAN CRECCO: Would this also be considered with an employer/employee group plan?

MR. LLOYD: While we are initially talking of marketing it on a non group basis -- and I have not heard that there has been a great deal of interest expressed by employers in selling it as a group benefit -- I think that is clearly a

direction that our company would like to go in, and I think most insurers would. The question that we do have now is that most employers are very concerned about their health premiums as it is, and that includes the benefits of retirees. So you see more of a, I would say, contraction of benefits as opposed to an expansion. But I can assure that if there is a market demand for that, we would be responding to it.

ASSEMBLYWOMAN CRECCO: This also would be separate from other health insurance that they would have from you?

MR. LLOYD: Yes. This would be a separate policy.

ASSEMBLYWOMAN CRECCO: So then they would have two policies?

MR. LLOYD: Yes. We would be selling it in addition. We sell a Medicare supplemental policy right now, which as you're no doubt aware, does not pay for long-term care.

ASSEMBLYWOMAN CRECCO: Well, thank you very much. Any questions?

MS. BASS: Yes. I have two questions. The first is, what, if any, kinds of consumer education did you envision putting in place to prepare the way for, or accompany the marketing of the plan?

MR. LLOYD: Well, I do know that in researching the product they used focus groups, used some consultants, to try to determine what is the perception that people have of the long-term care market. In general, there is a perception among many people that the benefit is covered under Medicare, a situation which may become slightly aggravated if the, let's say, the so-called Medicare Part C, or the new Medicare, comes in. People may then say, "Well now I have my nursing home coverage." So it will be clearly be-- And one of the reasons why it has been so difficult to get involved in the program is to determine how can you get people to buy it, except right when they're about to use it, at which point it becomes actuarial and feasible, and the premiums would be too high.

So, I do not know all the ins and outs of how it will be marketed, but I'm assuming that we'll make a concentrated attempt to make people aware that they need to protect themselves far in advance of when or if they may ever need a long-term care policy. I think there will also be certain marketing aimed at the children of senior citizens, to say you may wish to purchase this policy for your parents in order to protect them.

MS. BASS: My other question has to do with case management. Do you know whether the company envisions having any kind of managed access to the use of the benefits?

MR. LLOYD: Well there will be utilization review prior to admission, in the sense that the case will be reviewed to determine whether or not in fact, let's say custodial care or what degree of care may be necessary. I would assume that as in most utilization review functions it might be determined based on, let's say, the preliminary report of a physician, that a spell of 60 days, 90 days in a facility might be sufficient. In which case the case might be re-examined.

MS. BASS: But there would be some form of--

MR. LLOYD: Yes, there would be.

MS. BASS: --managed access?

MR. LLOYD: Obviously we do not want people receiving benefits going into a facility, when possibly they don't really need the benefits. Obviously since there will be some limits, the benefits for home care will also be encouraged -- for people to use home care, as opposed to necessarily always going into a long-term care facility. Their benefits will last for a longer duration with use of a home care policy.

MS. BASS: Thank you.

MS. DIETRICH: I have a question. I was interested in your feature that permits people to have benefits paid if they have first received home care, rather than having been in a skilled nursing facility for a certain number of days. This

home care feature, would that be a particular level of care? What I'm getting at is, could someone receive home care for a dementing illness and then be covered by your policy if they went into a nursing home following that care?

MR. LLOYD: I would really have to get back to you on that. I am not the-- Actually, what I was initially hoping was, we have several people who have done a great deal of research on this subject and I was hoping that one of them would be available. However they are up in Connecticut meeting with representatives of the Connecticut plan on long-term care issues. So I am pinch-hitting since I am used to speaking in front of microphones. But I will get back to you on that.

MS. DIETRICH: Fine.

MR. LLOYD: Okay?

MS. DIETRICH: Okay. Thank you.

ASSEMBLYWOMAN CRECCO: Thank you very much.

MR. LLOYD: Okay. Thank you.

ASSEMBLYWOMAN CRECCO: Next we have Chris Petersen, Assistant Counsel, Health Insurance Association of America? Mr. Petersen, I know you have a tape to show us, but we thought that perhaps we'd wait until the end and -- depending on time constraints -- see if we have enough time for that. All right?

C H R I S P E T E R S E N, E S Q.: Okay. That sounds fine.

ASSEMBLYWOMAN CRECCO: Thank you.

MR. PETERSEN: I'm Chris Petersen. I'm Assistant Counsel at the Health Insurance Association of America. The HIAA is comprised of approximately 340 member insurance companies that write over 85% of the private health insurance available from commercial insurance companies in this country. A large number of our member companies conduct business in New Jersey, and therefore we are very interested in assisting this Task Force and the New Jersey State Legislature as they address the issue of long-term care financing.

Before I begin my presentation, I would like to say how pleased I am to be here. As I will discuss later in my comments, the biggest obstacle facing the development of adequate long-term care financing is the lack of information and understanding surrounding the problem. Hearings such as these provide for the exchange of ideas and information, and I believe that legislators, insurers, and the public will all learn and benefit from the efforts of this Task Force.

Long-term care is the major source of catastrophic illness expense paid for directly by the elderly today. On average, for those elderly with out-of-pocket health care expenses over $2000 a year, 80% of those expenses are for nursing home care. With nursing home costs estimated at an average of $22,000 to $25,000 per year, such expenses are a financial drain.

Nearly half of all nursing home costs are paid out-of-pocket, and the other half is financed by Medicaid. This generates great insecurity for the elderly. However, not everyone will need nursing home care. Somewhere between 25% and 40% of the elderly are likely to require nursing home care at some point in their lives. Of these, only about half will be institutionalized for more than 90 days. Because of these factors, long-term care expenses are well-suited to insurance. It is potentially very expensive; it is difficult to predict for a given individual; and the frequency is low enough that the cost per person, spread across a large group, is modest. Each person pays a periodic budgetable amount. And, when the need arises, no one person is forced to bear the enormous financial burden alone.

Although the costs of long-term care seem to be a natural focus for the insurance mechanism and progress is being made, the market has been slower to develop than we would wish. A major past inhibitor to long-term care insurance purchase was that elderly concerned primarily with adequacy of

their retirement income, and with coverage for the cost of acute medical care. There are other factors, however, which continue to inhibit the development of long-term care insurance. The most important of which are:

- A low level of consumer awareness about the risks and costs of long-term care, coupled with widespread belief that Medicare and supplemental Medigap policies cover long-term care costs; and

- An uncertain regulatory environment for companies developing long-term care insurance.

It is obviously difficult to sell a product or service to individuals who are either unaware that they need it, or are convinced that their need will be met in some other way. Yet, this is the situation we find with respect to long-term care.

A survey conducted by the American Association of Retired Persons revealed that 79% of those who thought they might need nursing home care believed that Medicare would cover these expenses. These misconceptions are echoed in popular and erroneous beliefs that private Medigap insurance plans provide this kind of protection.

The need for better consumer education is the responsibility of both the private and public sectors.

The HIAA has undertaken a number of initiatives to address the consumer awareness problem. We have a toll free hot line for consumers to inquire about the availability of long-term care insurance coverage in their state. In addition, we have recently published a "Consumer's Guide to Long-Term Care Insurance." I have enclosed a copy of the Guide for the record. We have also conducted educational press seminars on long-term care, and given numerous public presentations on the subject. Our objective has been simple: an educated public can best understand the issues and make informed decisions about their needs.

I might also add that consumer education is the first line of defense against potential problems and abuses in the long-term care insurance market. This Task Force must develop a public education campaign that will bring this issue to the forefront. This is the first step the Task Force must take.

It is also important that flexibility is available in the State regulatory environment. The HIAA has worked with the National Association of Insurance Commissioners for the past several years to develop a Long-Term Care Insurance Act. In December 1986, the NAIC adopted a model act that was amended in June 1987. The HIAA supports the model act, and strongly recommends that the State of New Jersey adopt the act with three changes that I will be discussing shortly.

We believe the Long-Term Insurance Model Act protects consumers, while at the same time providing insurers the necessary flexibility to develop products and to enter the marketplace. The following are some of the consumer protections contained in the model act:

1) Long-term care policies may not be canceled on the grounds of the age or health of the insured;

2) It prohibits new waiting periods in the event existing coverage is converted or replaced within the same company;

3) It establishes a six month preexisting condition time period;

4) It contains a right to return free look provision; and;

5) Also requires outlines of coverages.

The HIAA believes the rights and interests of the consumer are fully protected by the model act.

The HIAA, however, recommends that certain changes be incorporated into the model. We feel the definition of preexisting conditions should contain a reasonably prudent person standard. The reasonably prudent person standard states

that there is a preexisting condition if there is the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care, or treatment. This language is taken from the NAIC model accident and health insurance language, and was originally included in the December draft of the model act.

However, in June the preexisting condition definition was amended to apply the Medicare supplement standard. Long-term care insurance is designed to provide coverage for chronic care versus acute care, and we believe should have a different standard from that of Medicare supplement. The existing standard could conceivably create a situation where an applicant is denied coverage because they received treatment from a provider within the past six months. Upon learning the basis of the denial, the applicant could cease treatments for a period of six months and then qualify for coverage without preexisting conditions. This could occur even though the applicant had symptoms during the entire six months that would cause the ordinarily prudent person to seek medical treatment. The HIAA does not believe that this situation is in the best interest of anyone, and thus we recommend that the reasonably prudent person standard be adopted.

The model act also exempts employer group policies or certificates, as defined in Section 4E, from the preexisting condition limitations. HIAA believe that all group policies would be similarly treated and, therefore, we recommend the exemption also apply to Section 4E(1) labor organization, to Section 4E(2) professional associations, and to Section 4E(3) associations.

Finally we believe the model act should be amended to grant Insurance Commissioners discretionary authority to approve specific limiting or exclusionary waivers or riders. Flexibility is needed in this product, and we are finding particularly in community care retirement communities quite often they have exclusions or limitations, and they would like

to purchase insurance policies which are similar to their contractual relationships with their patients. HIAA recommends that the following language be added to the last sentence in Section 6C(4), "unless such waiver or rider has been specifically approved by the Commissioner," in order to provide some degree of discretion for the Commissioner to approve waivers and riders.

At its June meeting, the National Association of Insurance Commissioners exposed a draft Long-Term Care Insurance Model Regulation. We offer the following comments on the model regulation.

HIAA is opposed to the prohibition in Section 6A on the sale of conditionally renewable policies to individuals. The HIAA has considered at length the concept of conditionally renewable policies, and we believe that the ability to write a conditionally renewable product is important to encourage market entry, innovation, and experimentation by insurance companies. There is substantial competition in the market today, providing choice to consumers who want to buy guaranteed renewable products rather than conditionally renewable products. Disclosure allows consumers to make an informed choice as to which product renewability feature they desire.

Insurance companies do not enter a market with the intention to non renew business. The decision to nonrenew is never taken lightly by the company. It adversely affects relations with the public, with regulators, and with the company's agency force. Insurers are concerned with guaranteed renewability because, when coupled with rating errors, it can result in severe financial consequences for the insurer, or force premiums up to a level where fewer people can purchase the product. HIAA believes that insurance companies should have the opportunity to decide for themselves whether they wish to sell an individual product that is guaranteed or conditionally renewable. Likewise, we believe consumers should have that same option.

HIAA does not oppose inclusion of an optional loss ratio provision in the model regulation. However, we oppose any specific loss ratio in excess of 55%. The development of long-term care policies is still in the experimental stages and the industry is still not certain what should be an appropriate loss ratio for such a product. However, we believe that a loss ratio of 55% or less is a valid starting point.

The slow development of claims experience, the expense of sales, and the cost of claims investigation, is similar in long-term care insurance to that seen in long-term disability insurance. With respect to the effect of coverage on provider availability, long-term care and long-term disability have substantial conceptual similarities. The greater risk being assumed by insurers, and the higher marketing costs that will be experienced to sell this product, validate the need for a greater margin than is typically assumed for most acute care health insurance products. It is our recommendation that the appropriate starting point for the individual long-term care loss ratio guideline is the long-term care disability guideline, and not the loss ratio guideline applicable to Medicare supplement insurance.

We also oppose the requirement in Section 8 to include the telephone number of the Insurance Department in replacement notices. It would add an additional step to the sales process, also add cost to companies to maintain additional replacement notices, and will create substantial work for the Insurance Department.

The HIAA supports the model act and regulations with the exception noted above. The model and regulations are important first steps to take to ensure that long-term care financing is available to the residents of New Jersey.

Another step that needs to be undertaken is a review of all existing and proposed State statutes and regulations to determine their impact on the development of long-term care.

New Jersey should repeal those statutes and regulations that will hinder the development of this product.

For example, proposed regulatory amendments N.J.A.C. 11:4-18.3. et al., requires that if there is an individual insurance policy where premiums are rated by age and the attained age of the insured is 65 years or more, the loss ratio must be at least 65%. Thus, a long-term care policy sold to a 64-year-old will require a loss ratio of 65%, once that individual attained the age of 65. A 65% loss ratio for long-term care coverage would discourage, and possibly prevent, companies from marketing a product in New Jersey. Not a single state requires a loss ratio of 65% on long-term care policies. This proposed amendment, if adopted, will discourage the development of long-term care products in New Jersey, and we recommend that the change not be allowed to become final. This is just one example. The Task Force should review all existing proposed statutes and regulations for other possible barriers to development of this product.

The Task Force should also consider new and innovative means to encourage development of long-term care insurance. Colorado grants a 1% reduction in premium taxes for insurers on qualified long-term care policies. This incentive appears to be working. The State has witnessed an increase in the number of insurers seeking approval to issue long-term care policies in Colorado. In effect, as new policies are sold, additional tax revenues are generated. So it's not really a tax losing proposition. New Jersey may also want to consider such an approach.

That's all I have on the subject. If you want to view the tape at a later point, just let me know. Thank you.

ASSEMBLYWOMAN CRECCO: Thank you very much. Do you have any questions?

MS. BASS: Yes. At the beginning of your remarks you mentioned some of the difficulties to insurers in devising

policies because of the absence of useful data. Could you talk a little bit more about the kinds of data that you feel would be helpful?

MR. PETERSEN: Some of it is not actually available at this point. We don't know what increase in utilization of long-term care facilities would result after we have insurers. So some of it is not available. There is almost no data to establish the rate at which private paid patients exhaust their resources to become Medicaid eligible. Information on the lifetime use of nursing homes is also very limited.

The Department of Health and Human Services, however, we view as starting to make some of this information available. Several national data bases will hopefully be available shortly. So, hopefully some of this data will start becoming available and can be utilized by insurance companies.

MS. BASS: Those are the two primary areas?

MR. PETERSEN: Yes.

MS. BASS: Thank you.

ASSEMBLYWOMAN CRECCO: I'm just wondering, what are some of the factors that will determine the conditional renewals?

MR. PETERSEN: Well that would be up to the individual insurer. The product has not been very much developed at this stage. It won't be age and health under the model act, if you adopt it. I guess insurers want to develop the product to keep costs down, and to develop -- just as a marketing tool to develop. I can't specifically say what individual insurance companies will do with conditional renewal.

ASSEMBLYWOMAN CRECCO: Thank you. Anyone else? Yes?

MR. LANGEVIN: If you could-- You enumerated several reasons why we're not experiencing a great participation of private insurance in this State so far. Could you characterize what you think is the overriding reason? I heard you reference a lot of the regulatory changes that you would like to see both

in the model act and perhaps in existing administrative part of the State, but I also get the sense that there's some question actuarily what can be done, whether the premiums can be reasonable in comparison to the types of benefits being offered. But you seem to be probably the single representative from private insurance that we've heard from that's enumerated as much as you have regarding the reasons why an insurance company shouldn't come to New Jersey. (laughter)

MR. PETERSEN: Well, insurance companies, because of the lack of data and just the lack of understanding as to what will be the potential financial consequences of offering the product, need a regulatory environment where they can have some degree of flexibility. They have to be able to market the product, we believe at a 55% loss ratio. In New Jersey presently you have a 65% loss ratio, particularly if the proposed regulation comes into effect, of anyone that's over 65. So that would discourage insurers from selling to individuals, I believe, that are close to reaching age 65, because they will not have sufficient historical data in five years to justify a 65% loss ratio. But yet a 60-year-old in five years will have -- so anyone that's over 65, and those are the people that are typically buying the product today, also in New Jersey presently have a 65% loss ratio. So the types of problems, I guess.

MR. LANGEVIN: As I've listened to you talk, and the representative from Blue Cross, I don't hear a short-term five-year solution coming to the front anytime early. I do think given Dr. Somer's testimony earlier that, certainly if you base your premiums on existing actuarial data, that in essence insurance companies could make out fairly well -- assuming they could market the product in some sort of number. But I guess I'll take at face value the statement that it's the -- your perception anyway -- that it's the regulatory environment from the insurance company's standpoint is the single most important--

MR. PETERSEN: Well, I would say possibly the lack of consumer education is the need. You know, this would be a great product to market for 40-year-old individuals. And you're very correct, it's a real problem--

MR. LANGEVIN: Well, that would be helpful in 25 years.

MR. PETERSEN: Yes.

MR. LANGEVIN: But it won't help us in the next 10 or 15.

MR. PETERSEN: Yes, and that's a real difficulty. What are we going to do for the next five years, because financially the products -- and it's already been discussed before -- the individuals that this product would be well-suited for are not the people that are going to need it in the next five years? You're quite correct. That might be a whole other subject area that this Task Force will have to look into, is what do we for the short-term? The long-term solutions I think are much easier. The short-term solutions are much more difficult.

MR. LANGEVIN: But for the Task Force charge, I think perhaps maybe in the next five to ten years, perhaps giving a free regulatory environment in this State would not probably bring in insurance companies to the front where we would be able to solve the kinds of problems that we face today. Is that fairly accurate?

MR. PETERSEN: Just because of--

MR. LANGEVIN: Your personal estimate.

MR. PETERSEN: The policies are difficult to sell to the people that are going to need them in the next five years. I don't think the regulatory environment-- I don't know what you could do regulatorily to encourage people to sell.

MR. LANGEVIN: Hypothetically speaking, if we didn't have it, it still wouldn't make any difference in the next five to ten years?

MR. PETERSEN: If you're going to sell products to someone who needs it in two years, you're going to have to sell it basically with everything but two years worth of interest on it, because you have to be able to make a payment in two years and you're going to have central costs in two years, so the premium would have to be very high. So it will be very difficult to market the product in anticipating that someone's going to use it in two years, no matter what the regulatory environment, and no matter how well-informed the consumers -- which I think are the two biggest problems.

ASSEMBLYWOMAN CRECCO: How would you reach the consumer to educate them, and what method can we possibly use to reach the particular age group that needs to be reached?

MR. PETERSEN: Various approaches have been tried. I believe the State of Washington has a group of senior citizens that they have put together to address the problem. I think it would have to come from sources other than the insurance industry, because we do have in a sense a credibility problem. We can't go out and say, "You have this problem, and here, buy this insurance." I think it's better if it comes from the State or other private organizations, because people would be a little suspicious. We do put out programs, and we are doing as much as we can. I think just a public education campaign would be most appropriate for this State, whether it be print media, the broadcast media, or any other source. But it's a difficult problem because people don't really seem to understand it.

ASSEMBLYWOMAN CRECCO: That's true. Thank you. Thank you very much.

MR. PETERSEN: Thank you. I plan to stay for the entire hearing, so if you want to leave the tape for the end--

ASSEMBLYWOMAN CRECCO: Mr. John Tergis, Task Force on Legislative Concerns, with the New Jersey State Commission on Aging? (no response) Not here? All right. Ms. Eleanor Stone, Director of Government Relations for the Association of Jewish Federations of New Jersey?

E L E A N O R B. S T O N E: I thank you very much for hearing me today. I represent the New Jersey Federations, which are similar to the United Ways in raising funds for beneficiary agencies. We have become interested in long-term insurance because we run both nursing homes, Jewish Family Services home health care agencies, and we have a large percentage of people who are utilizers of services.

I'm going to apologize for not having full written remarks today. We've had a fire at our office, and we're working under adverse situations. But I bring to you today, I think, some information that's important.

At the national convention for Jewish Federation Agencies, which just met this past week, long-term health insurance has become a number one priority for the Jewish community. That means, nationally we are interested in doing this. We have a demonstration project -- and I'm going to leave these with you here (refers to printed material) -- which we are beginning to sell insurance in Boston to meet this concern. This is the proposal that we have put out in Boston for different insurance carriers to answer to and to bid on. We now have two successful bidders who will meet most of these criteria, and I can't give you the names at the moment because we're in the process of negotiating with both of them. We're in this double bind. I've delayed giving this testimony thinking we would finish this double bind, and we've never quite reached that point. It's taking a little longer than we expected.

I must tell you that the insurance covers case management, which is one of our major criteria. It covers home health care, has to have no hospitalization for implementation, it needs three years minimum for coverage of nursing home payments or home health care payments, and it includes -- I mean, if you read through it you will see. I'm just giving you a quick summation. It needs -- what do you call it? -- a wider base of participation.

We have received one local grant and one national grant to do the education on why you should purchase this insurance. One was from the Federal government, which we will now begin implementation in January, in educating and using our newspapers -- which are 300 newspapers across the country -- to educate the general public on what current policies include and what they don't; why they need to think about long-term care; and what the age groups and interest are. We have received one local grant, which will be dealing with just the Boston area, and doing the education. We have now published three pamphlets and run two articles in two national Jewish newspapers, which explains what's available and what isn't.

So I offer this as information of what is currently going on, what is happening on a very small scale, because obviously we are a very small community in relation to the rest of the State. And yet we are looking toward the State, and towards New Jersey, to begin either a Task Force -- through the Blue Ribbon Task Force -- to expand your information, to begin the development of model legislation here, to make it applicable to New Jersey. At this point we have no vehicle to come into New Jersey and put forth a similar proposal to what we have in Boston.

I'm going to take questions, I think, at this point. I see a few.

MS. SIMS: I have a question.

MS. STONE: Sure.

MS. SIMS: This is an RFP to insurance companies?

MS. STONE: Right.

MS. SIMS: In return for an insurance company bidding on this business, what do you offer to the insurance company?

MS. STONE: A captive market, basically.

MS. SIMS: How big?

MS. STONE: In New Jersey, we have 400,000 Jewish people, which means it translates into about 200,000 some odd thousand, about 185,000 families. One of our bases for selling all of this would be estate protection. In other words, we're going to sell to children to protect their family's estate. The other is a well recognized need that Medicaid is not for the lower middle class or the middle class. It's for the poor. And we are going to try to educate people to that fact so that-- And you must understand, our nursing homes run between 80% and 90% Medicaid. So this is not another way of getting out of the Medicaid business. This is a way of supplying those services which fall between the cracks, and which we are called upon at all times to try to provide. Raising the volunteer dollar is just too much to try to do at this current time, and do it on a donation basis.

MS. SIMS: I may have misunderstood. Have you gotten any bites from insurance companies?

MS. STONE: Two insurance companies are in final negotiations in the Boston area to sell this policy.

MS. SIMS: Are they reacting to any of the things that Mr. Petersen--

MS. STONE: I think they're reacting to everything that's happening.

MS. SIMS: Positively or negatively?

MS. STONE: Positively. One of the reasons they're looking at the Jewish community is, we have newspapers and we have our own educational vehicles. Okay? We also have an organized community. We also provide all service, from the home health care, to the nursing home, to the burial societies. So we are involved currently in all of this. We would not accept any policy that doesn't include case management. What is being discussed now is, who does the case management, and how do we bid on it? Do we do it through the Jewish Family Services, or do we do it through an outside

provider? And how many representatives does the insurance company have sitting on these case management -- and how do they build those criteria? Those are thing that are still out for negotiation at the moment, and they're not resolved.

One of the reasons the policies aren't being announced on who the bidders are is the resolution of those differences. The risk factor for the Federation has been that part of prestige. If we go out and try to sell it and we can't, you know, what do we look like? We've put a lot of money into this, because we've assigned three staff people full-time who do nothing but health and planning for the last two years, to develop these policies and to get to this point. We've now gotten two major grants, one from a private foundation and one from the Federal government, to try to sell it. I mean, we've put a lot of our national and local prestige on the line. We've put our own money into it in a demonstration in Boston. We chose Boston because it's a self-contained community, as opposed to New Jersey where the Jewish community lives everywhere all over the State. In the Boston area it's much more confined to where they live, and it is not as big as New York which makes it terribly unmanageable in numbers alone; and as opposed to California, which is also so spread out in three or four major geographic areas, making it much more difficult to market. So, the marketing of it is beginning in Boston because of that.

ASSEMBLYWOMAN CRECCO: Any other questions?

MS. BASS: Since the Federation or the combined Jewish philanthropies in Boston is not a membership organization, would the--

MS. STONE: It will be membership only.

MS. BASS: I'm sorry?

MS. STONE: It will be sold to members only.

MS. BASS: How? Members--

MS. STONE: Of the Federation only. It's $10 a year to be a member. Okay?

MS. BASS: How many members do you have?

MS. STONE: In Boston, 85,000. I mean it's a nominal-- To get the newspaper you have to pay $10, and that automatically gives you a membership.

MS. BASS: Membership, okay. That's the vehicle.

MS. STONE: And if you belong to a synagogue it's an automatic membership. I mean, it's not to exclude. It's always been that way.

MS. BASS: Will this be marketed as a group policy?

MS. STONE: Yes. I just wanted to keep you apprised of this, and if you want more additional information as we go along, if you want the first formats, we'll be glad to keep supplying them to you. We'd also like to be included in your deliberations as you go along.

ASSEMBLYWOMAN CRECCO: We'll look forward to hearing from you upon the conclusion of your negotiations also. That would be good. Yes?

MR. LANGEVIN: Yes. I suspect that your evaluatory period will come long after this Committee makes its recommendation, but could you advise us how long of a period you're going to have this period for? Obviously sales would be one piece of the evaluation, but also the kinds of coverage and any problems that you encounter in delivering the care through the policy. I'd like to personally be able to get that kind of information back at the Department.

MS. STONE: Sure. We're working with the Brandeis health community, and Brandeis is doing the research and evaluation on this. It's a five-year research and evaluation. It's being done under the highest professional standards. It's not being left just to being done ad hoc. The material to be accumulated will be evaluated and published by Brandeis Health and Policy.

MS. BASS: One last question. Since you will be marketing to a self-contained community but presumably a lot of

these people have friends and acquaintances who are not Jewish and might talk about this-- If someone were to learn about this who is not a member of the Federation--

MS. STONE: It costs $10 to be a member of the Federation.

MS. BASS: And so, Jewish or not Jewish--

MS. STONE: You don't have to be Jewish.

MS. BASS: If they put up the $10 they can buy the policy.

MS. STONE: At this point we are not hoping to make that a wide--

MS. BASS: Right, but someone wouldn't be foreclosed from purchase if they were interested?

MS. STONE: At this point no. I guess we would have to look at that if the volume overwhelmed us. I mean, we're doing a demonstration, and we're beginning, and we're trying, and we felt we couldn't wait any longer.

MS. BASS: And presumably the insurers would like to have some limitation on their outstanding risk as well.

MS. STONE: Everything, but that doesn't preclude it if we moved to another state and had data that could support a wider environment and wider involvement. Thank you very much. Unless there's other questions?

MS. BASS: Thank you.

ASSEMBLYWOMAN CRECCO: Thank you very much, Ms. Stone. It was very informative.

Our next person giving testimony will be Mr. Paul Langevin. Is he here?

MR. LANGEVIN: I'm right here.

ASSEMBLYWOMAN CRECCO: Oh I'm sorry. (laughter) I'm looking all over there. It's okay. I just got out of the hospital. I'm not really with it yet.

MR. LANGEVIN: I think I'm on my way in. Thank you, Madam Chairman.

Chairwoman Crecco and members of the Task Force. Thanks for the opportunity to discuss the problem of financing long-term health care, and to relate to you the concerns of the State Health Department on this issue.

We have heard several speakers during the course of the past three hearings advise us that the number of elderly who may require long-term care is continually and rapidly expanding. Furthermore, we have heard that the cost of long-term care is to a large extent borne by government programs or out-of-pocket. While the Health Department is not responsible for administering any of the payment programs per se, we have great concern about the rising cost of long-term care services, and the need for adequate funding mechanisms to ensure the maintenance of quality in New Jersey's nursing homes, and continued access to these programs by those persons needing skilled nursing care.

The Department of Health has just completed a revision of the long-term care regulations governing the operation of nursing homes, which by the way will be introduced to the Health Care Administration Board in January of 1988. Based on the recommendations of over 2000 health care experts in industry, academe, and the government, the improvements to our existing long-term care system necessary to elevate and maintain the quality of care in New Jersey nursing homes will cost an additional $20 million in State funds alone over the course of the next three years.

Additionally, the number of licensed long-term care beds in New Jersey is expected to reach over 46,000 by the early to mid 1990s. The number of licensed nursing home beds has risen by over 10,000 in the last decade alone. We're right now hovering in the neighborhood of 37,000 licensed beds in the State. Considering the fact that the State's Medicaid program is currently spending in excess of $400 million annually to finance long-term care for about 57% of New Jerseyans residing

in nursing homes, a stable financial system capable of addressing the future needs of the State's elderly is essential.

Over the last three years, the Department of Health has attempted to assist the State's citizens by producing the New Jersey Consumer Guide to Selecting a Nursing Home, and I've made copies available to the Committee and to the public as well. This guide walks one through the process of selection, highlights the key areas to consider when evaluating a home, and offers a layman a simplified explanation of the regulatory process for quality assurance. And I must apologize, but the guide is very wanting in explaining the financing of long-term care. Certainly an oversight on our part, which I'll have to take the blame for.

We've also recently developed a new patient's rights guide, and we currently provide survey information on over 350 facilities to local health departments and county offices on aging. It has been our experience -- as previous testimony has pointed out -- that the more the consumers participate in the system and are aware of the way it functions, the more responsive the system will be to their needs.

Nursing homes have been the traditional setting for the provision of long-term care services for patients with continuous nursing requirements. However, the widespread development of home care services provides us with a health care delivery alternative which is less expensive and would dovetail with some of the financial schemes such as the home equity conversions that we've heard about; and allow the elderly to receive care at home and to delay institutionalization. The Department of Health would strongly support any plan which facilitates home care, as this approach provides more affordable care to a large number of people, while simultaneously containing costs. Currently legislation is pending which would bring all home care agencies under the regulatory purview of the Health Department, thus allowing for

a less fragmented approach to accessing and planning home care services. Hopefully, the Department will be able to work with the providers in this area, to develop home care services.

We look forward to the recommendations of the Task Force as a source of innovative methods for dealing with this difficult problem. Thank you.

ASSEMBLYWOMAN CRECCO: Thank you very much. Do you have any questions? (no response) I don't have any either. Thanks so much.

Marion Bass, Director of the Office of Program Evaluation, Analysis and Strategic Planning, Department of Human Services?

MS. BASS: Thank you, Madam Chairman, members of the Task Force. And thank you for the opportunity to discuss the role and concerns of the Department of Human Services.

The Department of Human Services manages the joint Federal/State Medicaid program. In fiscal year '87, the Department's Medicaid program spent $452 million on nursing home care, which represented a 107% increase over the 1981 level of $218 million. If this pattern holds -- an average 18% annual rate of increase -- the Department will see its expenditures for nursing home care rise to the billion dollar mark by 1992, only five years from now. I should add that we might expect that that will happen even sooner, because the rate of increase for just the last fiscal year was 25%, up from last year's level of $360 million.

These numbers are even more frightening when considered together with a number of additional facts:

- Institutional care for the elderly is the single largest share of the State Medicaid budget.

- Our expenditures for institutional care represent 32% of the Medicaid budget, but provide care for only 14% of Medicaid recipients.

- Medicaid expenditures for long-term care are only half of the total spent on nursing home care; virtually all of the remainder comes from institutionalized individuals or their families. What this means is that by 1992, the combined total spent by private citizens and the State's Medicaid program will be over $2 billion a year for institutional long-term care.

- A sizable portion of Medicaid expenditures are on behalf of persons other than the traditional poor -- either those who have transferred their assets in advance of the two year look back that Medicaid requires, or those who have spent down to Medicaid eligibility after entering the nursing home.

Over the next 20 to 30 years, these numbers will increase dramatically. The baby boom generation is entering middle age. In 25 years it will start to retire. As this cohort begins to require long-term care, the rate of expenditure, both public and private, can be expected to increase astronomically.

What is the alternative to costly institutional care? The preference of most elderly and disabled citizens is to remain at home, in their communities, for as long as possible. Much home care is either privately financed or provided at no cost by friends and family. Public expenditures for home health care have been relatively small, and are currently in the range of $50 million annually for the Department of Human services -- up from $5 million a year in 1980, a tenfold increase.

Recognizing this imbalance, the Department has begun several programs to provide community-based alternatives to institutional care:

The first of these is the Community Care Program for the Elderly and Disabled. Operated by the Division of Medical Assistance and Health Services, CCPED offers home and community-based services for persons over the age of 65, or who are disabled and would be eligible for nursing home placement

under the Medicaid program. CCPED was started in October, 1983. In the last four years, over 4000 individuals have been served. Expenditures under this program totaled $11 million during fiscal year 1987.

Next is the model waiver programs, there are three of them. These three programs, like CCPED, provide home and community-based services for disabled and blind children and adults who would be eligible for Medicaid supported institutional care. Each program is capable of serving 50 individuals at any given time. Since the inception of the model waiver programs, 206 individuals have received service at total cost of $3,800,000.

The AIDS Community Care Alternatives Program -- or ACCAP. This program provides home care services for persons having a diagnosis of Acquired Immune Deficiency Syndrome, or AIDS related complex, who meet the guidelines for disability established by the Social Security Administration. ACCAP program began on March 1 of this year, and is the first such program operated under Federal waiver in the United States. To date, 100 clients have been served, and expenditures have been $35,400. We expect this program to grow dramatically in the next ten years. The program has just begun, and has to date served only a very small segment of the affected population.

The next program is Respite Care Services. Since May of 1984, the Department of Human Services has provided respite care to relieve the regular caretakers of elderly and disabled persons. Initially a demonstration program in 5 sites, respite care is now being converted to statewide availability. This new broader program will serve 1200 to 1500 persons annually, at a cost of approximately $4 million to be shared equally by the State and Federal governments. Based on the success of the small scale demonstration, Senator Bradley amended the Catastrophic Health Care Bill -- now in Congress -- to provide up to $2 million a year for three years to New Jersey to support the statewide respite care program.

Personal Attendant Services: In April of 1986, the Department began a pilot program to provide personal attendant care services to physically disabled adults who are employed, preparing for employment, or trying to avoid institutionalization. The demonstration phase of the program will conclude in November. Legislation is pending to establish an ongoing statewide program. It is estimated that 600 to 650 persons would be served each year, at a cost of just over $4 million.

Last is our Legal Assistance to Medicare Patients, or LAMP. Beyond the provision of direct services, the Department has also begun a program to help Medicare patients receive the full benefits to which they are entitled. Federal rule changes of the last few years have limited the availability of Medicare home health services. The LAMP program -- which will begin next year -- will provide Medicare beneficiaries with legal representation to appeal denials of Medicare home health benefits. LAMP is funded at $235,000 a year in State funds.

All of these programs -- some demonstrations, some permanent -- are good starts, but cannot help to prevent the impoverishment of many who must spend their life savings before qualifying for Medicaid support for nursing home care. In an effort to determine whether these individuals can be helped and whether the rate of growth in the Medicaid budget can be slowed, the Department of Human Services has plans to pursue a demonstration program in long-term care insurance.

We have been invited to submit a proposal to the Robert Wood Johnson Foundation -- in cooperation with the other agencies represented on this Task Force -- for funding of the design of a demonstration program. We plan to submit a proposal by the beginning of December -- early next week -- and have been working with staff and the other agencies represented around this table, about the possible design of such a demonstration.

Although it is very preliminary, we expect the study to focus on some of the following elements:

- How to design policies which would protect an individual or couple from having to spend down to meet Medicaid's maximum asset requirement;

- Consumer education, since so many people believe they are already covered for nursing home care;

- Coverage of home care as well as institutional care, with special emphasis on providing supportive services to sustain family-based in-home care.

Furthermore, we have entered this initiative as one of our budget priorities for Fiscal Year '89, which has just been approve by the OMB at the level of $300,000 for consideration during the appropriations process early next year. Would we be able to secure the foundation grant, 12 to 18 months from now we could be prepared to launch a demonstration program in this area.

I'd be happy to answer any questions.

ASSEMBLYWOMAN CRECCO: On the respite care, are you currently taking care of 600 people--

MS. BASS: I'm not sure.

ASSEMBLYWOMAN CRECCO: --or is it a projection for this year?

MS. BASS: Well the projection is that under the full program, a possible maximum number of 1500 would be served. And, depending on the exact amount of the Federal appropriation should that come through, we might either be able to raise that number somewhat or to provide more extensive services. I think a decision is pending on that by the people who are designing the program.

ASSEMBLYWOMAN CRECCO: What would be the determining factor insofar-- I would imagine there are more than 1500 people who would qualify?

MS. BASS: Part of it is income eligibility.

ASSEMBLYWOMAN CRECCO: All right. Thank you. Anyone else? (no response) Thank you very much.

Jeanne Sims, Special Deputy Commissioner, Department of Insurance?

MS. SIMS: Thank you. The Department of Insurance is keenly aware of the need for adequate, carefully planned financing mechanisms for long-term health care. The market for such private insurance plans is in its infancy, but we expect rapid growth soon. The Department wants to encourage this growth, with safeguards for both consumer protection and the companies' solvency.

Meaningful long-term care policies are basically non-existent in New Jersey, especially those that are home health care oriented. So the only insurance data that I'm going to be providing here today is going to involved Medicare supplemental policies and nursing homes policies.

I'd like to talk about Medicare supplement policies first. There are 17 companies licensed to sell Medicare supplement policies to individual consumers, with premiums ranging from $24 to $95 per month, depending upon the extent of benefits. As of December 1986, 10,357 such policies were in force in this State. Three companies also sell group Medicare supplement policies. Seven HMOs provide similar services under contract with Medicare. The number of people covered by groups for HMOs is unknown.

Medicare supplemental policies cover primarily acute hospital and a portion of doctor's bills. They provide only minimal funding for home health care, nursing homes, or other non acute costs.

Nursing home policies: Six companies are selling policies, but that's primarily for patients who are institutionalized. Generally long-term home health care benefits if provided are done so only at a minimum. Annual premiums range from as little as $21 to as much as $5670, with

obviously a major difference in benefits and higher premiums for older clients. As of December of '86, there were 4670 individual policies in force, and one group -- through AARP -- covering 678 lives.

The Department of Insurance believes that there is a need for widely available long-term health insurance, but we are still investigating and analyzing the marketplace. Policy is still being developed. One of our primary goals is to assure that policies are affordable so that consumers will in fact buy coverage, but also underwritten properly to assure financial stability of the companies.

The Department of Insurance is not only willing to cooperate with other agencies, but in fact must rely on the expertise of other agencies.

For instance, insurance is only a financing mechanism. This Department has the responsibility and authority to assure that companies receive adequate but not excessive revenues to pay for benefits. But this Department does not necessarily have the expertise to say that benefits pledged under a certain policy is enough to meet the client's anticipated health needs

We rely on the Department of Health for such information, and Human Services and Community Affairs for information about costs paid by governmental agencies.

Insurance regulations can do a lot to make sure that companies will sell policies which not only deliver benefits which are promised, but also promise enough. To draft these regulations, we need expertise provided by other departments. We currently have in place a program that coordinates with the Department of Community Affairs called the SHIP Program -- the Senior Health Insurance Program -- where we have one staff person that has virtually gone around the State and trained many many volunteers. There are 13 SHIP programs that will be certified by the end of this year. We also put out a brochure

that talks about the various Medigap policies that are being sold in the State, as well as nursing home policies, and that is available through the Department of Insurance.

One of our goals for '87 will be to adopt long-term health care model legislation as well as regulations. Thank you.

ASSEMBLYWOMAN CRECCO: Anyone have questions? (no response) Well, I just have one question. Is the Department of Insurance doing anything with the NAIC model guidelines?

MS. SIMS: Yes. That is what we're looking to.

ASSEMBLYWOMAN CRECCO: All right. You don't have any specific--

MS. SIMS: No. As Chris Petersen from HIAA pointed out, there are some areas that we want to pay particular attention to, and we're looking at those areas. We should have something out during 1988.

ASSEMBLYWOMAN CRECCO: Okay. Thank you.

MS. SIMS: Thank you.

ASSEMBLYWOMAN CRECCO: Okay Theresa Dietrich, Program Development Specialist, Division on Aging, Department of Community Affairs.

MS. DIETRICH: Thank you, Chairperson Crecco. On behalf of the Department of Community Affairs also I thank you for the opportunity of presenting the Task Force on Catastrophic and Long-Term Care a picture of those of our activities that are relevant to the issue.

The Division on Aging of the Department of Community Affairs is the central agency responsible for the planning and coordination of New Jersey's programs and services for older persons. The Division also serves as a State Agency on Aging to carry out activities mandated under the Federal Older Americans Act.

Each county in New Jersey has an area agency on aging, usually referred to as the county office on aging. These

agencies provide a wide variety of services to help the elderly in their communities. Those most relevant to the charge of this Task Force include homemaking, visiting nurses, home health aides, information and referral, legal assistance, outreach, friendly visitor, telephone reassurance, respite care, hospice care, local ombudsman program, protective service, advocacy assistance, and home delivered meals. Not all of those services are in every county. Some of them are mandated services and others are options, according to the needs as determined in the individual counties.

The current activities of the Division as a whole can be grouped into those which involve planning and coordination, direct services, and advocacy. I will just summarize briefly what some of those are.

We are the agency that coordinates the Interdepartmental Task Force on the Elderly, which is a sub-cabinet committee appointed by the Governor to provide a forum for discussion of programs and policies affecting the health and well-being of the elderly. There are 13 State departments and agencies that meet on a quarterly basis as part of that Interdepartmental Task Force.

The Hospital Initiatives in Long-Term Care for the Elderly was a survey published by the Division on Aging in cooperation with the New Jersey Hospital Association, which surveyed the long-term care services available both by acute care hospitals in the communities, and county offices on aging. So that's available as a resource.

Also, in conjunction with the Academy of Medicine in New Jersey and the Home Care Council of New Jersey, the Division -- through a grant with the Brookdale Foundation -- conducted training in Alzheimer's disease for medical personnel. There were about 1700 physicians and related medical personnel, mostly nursing staff or home care providers. Also the directory "Alzheimer's Disease: A New

Jersey Directory of Service for Family Care Givers and Health and Human Service Providers" was reprinted as a joint venture of the Departments of Health and Community Affairs. Three thousand copies of that were distributed. In addition, the Division purchased and distributed about 100 copies of a publication from another state called "Understanding and Caring for the Person with Alzheimer's Disease." Those are being distributed upon request through the Division and the county offices on aging.

Also, another activity was the Gatekeeper Program. Hundreds of utility company employees are being trained to identify vulnerable older persons who might be in need of assistance, and to report that need as they observe it to the county offices on aging. Public Service Electric and Gas, Jersey Central Power and Light, and Atlantic Electric, have implemented this Gatekeeper Program after training which was developed with the assistance of our Division.

There are several studies that we will soon have available. One entitled, "Home Care in New Jersey: Current Access and Strategies for Potential Program Development." This report found that approximately 100,000 older persons are estimated to be in need of formal home care -- that is, home care assistance by the part of agencies -- because of chronic long-term medical or social problems.

Another study that will soon be available after the first of the year, is "Family and Community-Based Care for 75 and Older Citizens of New Jersey." This study profiles the 75 plus population, since it's this group which is most vulnerable to health problems requiring long-term medical and social services. The report will describe the general characteristics of this cohort, their living arrangements, and economic situation.

In terms of direct service, the New Jersey Senior Citizens Information and Referral Service is a statewide

program that is accessed through an 800 number, and it receives a consistently growing number of calls daily. The resource specialists manning that system have access to a computerized data retrieval and follow-up system ranging from current requirements for participation in entitlement programs, to more general information on program services and senior organizations.

The Division on Aging administers the Congregate Housing Services Program. That's a supportive services program which provides personal care, housekeeping, and congregate meals, to low income frail elderly. These services are provided through casino revenue funds, and there's also a cost sharing arrangement -- fees by the elderly recipients. There is now an average of 650 participants each month in this program, and the average State subsidy for each participant each month is about $126, with the participant contributing about $76 toward the total cost of services provided.

Another program was already alluded to by my colleague, the Senior Health Insurance Program, which we administer, and, as already been mentioned, we recruit and train volunteers. The Department of Insurance coordinates the training, and the Department of Insurance personnel provides the training for the private sector portion of that training venture, with the Health Care Financing Administration of the Federal government providing the training in the Medicare program for that. By the end of the year more that 300 volunteers will have been trained, and they will then be available for one on one counseling with older citizens. Part of the training now includes the nursing home policies that are available in the State, so that in 13 counties at least by the end of the year, citizens will have available sources in their counties for learning about these programs and being able to evaluate them in contrast with their own perceived needs.

In terms of our advocacy, the Task Force on Housing Options for Senior Citizens was convened in November of last year. Its initial purpose was to analyze and evaluate home equity conversion mechanisms, and possible State intervention. So, they worked collectively and in subcommittees and they closely examined the existing reverse mortgage programs and other equity conversion mechanisms available in the State, and they also made recommendations.

New Jersey has two home equity conversion plans through private lending institutions, with approximately 350 homeowners participating. There was widespread agreement among the Task Force members that home equity conversion transactions can be of tremendous benefit to older homeowners. In concert with this finding was a conviction that consumer education and protection are needed, and the recommendations of the Task Force reflect these sentiments.

So in conclusion, these activites represent the commitment of the Division on Aging not only to the senior population as a whole, but particularly to those persons who are most vulnerable due to functional impairment. We are sensitive to the growing need of our senior population for solutions to the difficult problem that this Task Force is addressing, and we're eager to participate in efforts to address the problem of financing long-term health care.

However, a solution requires policy decisions that we see as beyond the power of departments of the State government individually. We lack the actuarial data, there are no hard figures concerning the total cost of a system for providing adequate care for all those in need.

The issue requires the attention of the Governor and the Legislature. Also, the private sector -- both the insurance and the health care provider industries -- must participate in developing viable strategies. Only after a public/private coalition including all of these sectors reaches a consensus, can the necessary policy decisions be made.

If anybody has any questions I'll be happy to answer them.

ASSEMBLYWOMAN CRECCO: I don't have any.

MS. DIETRICH: Thank you.

ASSEMBLYWOMAN CRECCO: Thank you. You know, I just wanted to ask you, those information pamphlets that you have, are they available at no cost if the constituents would like to have them?

MS. DIETRICH: Yes. We provide many publications, and the Department of Insurance also provides a publication, "Bridging the Medigaps." That's no cost.

ASSEMBLYWOMAN CRECCO: You just call for them?

MS. DIETRICH: Yes.

ASSEMBLYWOMAN CRECCO: Because sometimes we get calls for information at our office, and I just realized that you have so much.

MS. DIETRICH: Yes. And they're accessible through the county offices on aging, as well as directly through our Division and the Department of Insurance, and also the Health Department.

ASSEMBLYWOMAN CRECCO: Thank you. We appreciate it very much.

We have two other people who would like to give testimony. Ed Davies, is he here? (affirmative response)

E D D A V I E S: I'd like to thank you, ladies and gentlemen, for allowing me to testify as a concerned citizen. I would like to think that I represent the 6 million -- give or take odd -- citizens of the State of New Jersey, in regards to long-term care, and also catastrophic illness.

As Assemblywoman Crecco knows very well, the Assembly Bill 188 was introduced into the 1984 session entitled "Catastrophic Illness and Children Relief Fund," which was then reintroduced at the 1986 session as Assembly Bill 2315. Am I correct?

ASSEMBLYWOMAN CRECCO: (affirmative response)

MR. DAVIES: This bill basically covers children up to the age of 18 in case of catastrophic illnesses. It is laying in the pigeonhole in Trenton for over four and a half years gathering dust, while it could have been passed and amended to take care of the citizens -- both adult and children -- in the State of New Jersey in case of catastrophic illness or long-term care. As seven other states, according to President Reagan -- whom I talked with four and a half years ago in regards to it, and he suggested to me at the time that I talked with him and asked him why doesn't the Federal government have a catastrophic illness fund, at say a dollar per week out of each employed person's salary; and the monies collected from each particular state going into that state fund for a catastrophes illness fund to take care of the particular people in said state. He mentioned that the laws of our states were drawn up in such a way that each state's legislature had to pass this.

So therefore, after having run into this particular situation through the fact that I was blessed with the opportunity to help a 13-year-old in 1983 continue living a beautiful life, who had lost two kidneys and a spleen. They were from a very poor family. They couldn't afford having the mother continue working and having someone come in and take care of the child at 13. They had to go three times a week to a dialysis center in Newton, New Jersey; five hours a day. When I saw that 13-year-old go into that dialysis center, and pick up the spirits of adults who were down and depressed -- because being on a dialysis machine is no joke ladies and gentlemen. It's very nasty. When I saw this I said, "I have a purpose in my life."

I went out and raised funds for this young child. I got him a kidney through President Reagan's intercession. And I also had Governor Kean proclaim -- through my efforts --

Organ Donor Month, which is September if you ladies and gentlemen know that. I also have an Organ Donors Pace each September at Meadowlands Race Track, so that the captive audience may be enlightened to the fact that the organ donor card is a necessary evil in our society today. I feel that if by listening to what they say on the loud speaker that particular evening, when a person who is need of a transplant or had a transplant makes the presentation of the silverware to the winning horse's owner, maybe 40 people will go home and sign an organ donor's card. Then I feel I've accomplished something.

But, when I see the legislators sitting on this bill for four and a half years, and getting highly paid for it -- and if I make enemies by saying that, because most of you are highly insured, when 480,000 people in the State of New Jersey do not have any sort of medical coverage at all-- Well for 50 cents a week -- now, let's assume there's 6 million people in the State of New Jersey, 2 million work. You take two dollars a month out of every one of their salaries, times that by 12, you have $48 million that you can put into a catastrophic illness interest bearing fund. More than enough to take care of many of your problems as far as long-term care and catastrophic illness is concerned.

But yet, we sit here, we talk, we do nothing. Basically, I don't care if you hate me. I'm not married to you. I'm here to speak my piece. There are 6 million people in the State of New Jersey that need not talk, they need action.

There are people out there -- and I have a letter right here. I'll read it to you. This is from a Russell Slater -- Salter, whichever -- from Phillipsburg, New Jersey. He is 80 years old:

"Dear Mr. Davies, I am writing this letter in regards to Assembly Bill 188, that is long overdue. I have a very sad condition in my family. My wife was taken very sick to the

point that I had to hire two people at two eight hour shifts, at $50 for one a day; or enter her in a nursing home at $80 a day. Being 80 years old I can only do so much. At $2400 a month my life savings will not last long. If we old people could only get some help after we leave the hospital, what a blessing that would be." And that's Russell Slater, RD 2, Phillipsburg, New Jersey. And these are many many more of them.

I'll read you another one from a 38-year-old couple.

"Dear Mr. Davies, I've been meaning to write to you since I saw your letter to the editor in the Easton Express. The article about Danny Titus in today's Express pushed me to do it. My husband was diagnosed with renal failure in April of 1986. Until he went into the hospital we had no idea that he had only one kidney, let alone that it was failing. Fortunately for us he is from a fairly large family, and three of his four brothers and sister came up good matches. They were all very anxious to give, and finally his older brother, Jim, was chosen as the donor. We were scheduled for transplant surgery on August 14. The pre-transplant test on the donor revealed that he also only had one kidney as well. But his was functioning fine. The transplant was then rescheduled for January 20, 1987, a particularly significant date in light of the article in the 'Parade Magazine' the following weekend, which you so nicely brought to everyone's attention. His surgery went well, and he's doing fine.

"We were very fortunate to have had things move as surely as they did for my husband. We were fortunate to be part of two very loving and supportive families during all this time. My husband didn't have to endure the painful and expensive course of dialysis for any length of time. He did do proportional dialysis from diagnosis to transplant, as do many others. We are now in our first year of post transplant, and although Medicare does cover quite a bit of the expense for now, the drug costs for my husband are about $400 a month.

cyclosporin is a very valuable drug, but also very costly. However, we will find some way to cover it at 38. Right now, our medical insurance is very good, and hopefully he will be able to continue to work.

"Also in 1986 we had our second son. He was born with a congenital heart defect, and was operated on when he was two days old. He will need more surgery as time goes on. Right now, he is a delightful one-year-old, who is almost completely normal.

"I didn't give you this narrative of my life for the last year to make you feel sorry for me. All things are going very well for us now. I only did it to illustrate the part of your Catastrophic Illness Expense Fund. We were not sickly people. My husband is 38 years old. He had no idea he had only one kidney. My son didn't ask to have his heart problems. That doesn't alter the fact that it happened to us, and it could happen to anyone. You're never prepared. Knowing that there was some kind of financial help available somewhere certainly would ease the burden for those of us who find ourselves in a bad spot. We are not destitute, and are fairly well-insured as I said, but a lot of things are just not covered.

"Again, I deviated from the point. The 50 cents a week you asked for in your editorial letter is less than half the cost of a pack of cigarettes. It is hardly a painful tariff for anyone, but can mean so much to many. Please count on us to do whatever we can to help you in your efforts. Thanks so much for caring."

Now, ladies and gentlemen, that's just two of many letters. I have a petition in Warren County going around to have Assembly Bill 188 amended to cover every adult and citizen in the State of New Jersey. Now, if the 50 cents a week at this point does not cover the cost, then you can raise it to a dollar. That would bring you in $96 million a year; $96

million a year at no cost to the State, which is a heck of a lot better than the fiasco the Assembly passed last year -- the Medically Needy bill -- which spent $10 million on administrative costs to give less than 800 people in the State of New Jersey, who qualified for this Medically Needy bill, under the assumption that they had to make $418 or less-- And less than $1 million went out to help these people. Now, that is a fiasco. And if you don't believe me, I have it in writing from the Department of Human Services that their bill is a fiasco. So I don't talk and suck wind out of my thumb.

I've seen a 13-year-old boy in 1983, who needed a kidney -- which I got for him, and I was very happy to do it --I saw him on September 22 in the winner's circle at the Meadowlands a robust healthy 17-year-old, who went to the United States 1986 Transplant Olympic Games in Texas, and came back with a Gold Medal. At 13 he walked a thin white line. At 17 he is a good student.

Now, you talk about talking, you talk about money. Get the heck out of this room and do something about it. There are people out there getting inferior care and you people are talking. All this paperwork and all this talk isn't going to do a darn thing. You have a bill, Assemblywoman Crecco. All you have to do is introduce it, and not leave it lay in the pigeonhole. Introduce it and amend it to cover every darn citizen in the State of New Jersey. So, if they have to pay a dollar a week, who is going to object? No one. Not one of us would object. And why should we have to go hat in hand like many people in the State of New Jersey, and I'll read to you a few of them,

The family of Marlene Hartung (phonetic spelling) was told that travel and living expenses would run approximately $12,000, and like other families in their place, they raised money from their friends and neighbors to cover the extraordinary expenses that their insurance will not. In

August of that year, a Sussex County resident -- 41-year-old Judy Skarky (phonetic spelling) -- in dire need of a liver transplant, left for a Pittsburgh hospital to await a liver donation that she needed to stay alive. And we have to worry about money? This woman and her friends raised $70,000 because they couldn't afford to pay for it.

Now, it's a shame that in this country, in this State, that we have to go hat in hand and beg and borrow to pay for our extraordinary expenses. Insurance companies behind me talk about whether we can afford-- The heck with affording it. The State can afford it. The people, the citizens themselves will pay for it at a dollar or so a week, and they will not object. And it will be more than enough to take care of every darn one of us. You folks may be covered with extraordinary insurance, but there are citizens out-- Well, I don't know that, but I say if the shoe fits wear it.

ASSEMBLYWOMAN CRECCO: But Mr. Davies--

MR. DAVIES: But there are thousands out there, madam, that do need your help.

ASSEMBLYWOMAN CRECCO: That's why we're having this Task Force, Mr. Davies.

MR. DAVIES: Yes, but cut the talk out.

ASSEMBLYWOMAN CRECCO: Yes, well, we're concluding today--

MR. DAVIES: See, as I say, I'm not married to you and I don't care if you get mad at me. Governor Kean has already thrown me out of his office on another issue, see.

ASSEMBLYWOMAN CRECCO: Well, Mr. Davies, I would never get angry at you because it's nothing personal. But this is why we have this Task Force. We're concluding it today, and then we will have our meetings and we'll make our recommendations. So what you have given us, your information, is certainly-- We need this. I empathize with everything you say. That's why I am here, as opposed to being out--

MR. DAVIES: Do. Do. Do. Do.

ASSEMBLYWOMAN CRECCO: --and earning a living. I'm here. I-- (inaudible)

MR. DAVIES: I ask you to do on behalf of all the citizens of the State of New Jersey. I'm going to read you one little article that someone wrote in.

ASSEMBLYWOMAN CRECCO: All right. One more, because we have two other people testifying.

MR. DAVIES: Okay. I'll make it short. We all want to go to lunch I know. It's been a boring session, so to speak, in a way.

ASSEMBLYWOMAN CRECCO: No. We have other people who would like to--

MR DAVIES: "Medical care shouldn't depend on ability to pay." Now, this is in regards to an Easton, Pennsylvania hospital, but it's apropos to any state, any citizen, anywhere. "I read with kean interest a letter from Kathy Dogerty (phonetic spelling) about here ordeal at Easton Hospital, and a response from Donna Mulholland, Vice President of Administration at the Hospital on October 26. I join Dogerty's outrage. My family and I were clinic patients who are on Medicaid for a few years. We no longer receive this benefit, as per our choice. We were often treated in much the same manner as Dogerty was when her son was mistakenly believed to be a clinic patient. Long waits while others with insurance cards were taken before us, was the rule rather than the exception. These people and their condition were not more urgent. I or a family member waited in pain and very ill for as long as five hours. When we did get to a doctor, many times our questions were ignored, our comments disallowed, and we were treated patronizingly. Our statements to the doctor in attempts to participate in our own care fell on deaf ears and were brushed off.

"One time I went to the emergency room at night because of a bladder infection, which was a chronic condition. I told the doctor this but he ignored me. He ordered a urine test and let me sit in severe pain for two hours until the results came in. I was offered nothing to drink, which is very important for bladder infections, nor was I offered anything for pain.

"Another problem is the routine excessive use of tests and procedures through both the hospital clinic, and the hospital itself. On several occasions my husband underwent repeated blood work and repeated x-rays in a short period, for upper respiratory infections. The doctors, the nurses, the clerical help, were more interested in those who bore insurance cards than the less fortunate who were not covered."

This is any state, anywhere, U.S.A. And it stinks.

MR. LANGEVIN: I would hesitate to jump into this, but I think New Jersey is a very unique state. Patients have access to acute care services, without regard for their ability to pay. I believe that is one thing that sets New Jersey apart from several other states including the one across the river. For the record, it should reflect that New Jersey did get off its duff several years and also provides uncompensated care coverage to patients.

MR. DAVIES: Sir, I'd like to take you by the hand, and go through emergency wards, at my discretion, and take you where I want you to go, and show you the care some hospitals give.

MR. LANGEVIN: I've been a patient in E.R.s and I've been less than impressed with some of the care that's been delivered to me personally, and I take action as a citizen through the avenues that are available, and if you bring those complaints--

MR. DAVIES: You take actions?

MR. LANGEVIN: Yes, as a citizen.

MR. DAVIES: But how about the many people who do not take available -- because they are afraid to talk up, and they're afraid to come forward because they are poor and needy, and they are afraid of the system because they have that old cliche "You can't fight city hall"?

MR. LANGEVIN: We try and help those people.

ASSEMBLYWOMAN CRECCO: Excuse me, Mr. Davies. You have been very clear, and this is truly why we are here. All this will be taken--

MR. DAVIES: Well, all I ask you, on behalf of all the citizens, do, not talk, do. And then you'll--

ASSEMBLYWOMAN CRECCO: We will. We are, actually.

MR. DAVIES: Hopefully.

ASSEMBLYWOMAN CRECCO: I'm very optimistic.

MR. DAVIES: And why don't you take Assembly Bill A-2315 out of it, and amend it; instead of leaving it sit there for four and a half years.

ASSEMBLYWOMAN CRECCO: Well, you know it was up before the Assembly on Monday.

MR. DAVIES: Well, you have the power to do, so do.

ASSEMBLYWOMAN CRECCO: Thank you very much. We have Kathy Myer who would like to speak.

MR. DAVIES: Kathy Myers couldn't come. She was the one -- the 38-year-old -- who I read the letter about. She was afraid that is was bucking the system, and that she would not be heard -- were her words to me last night.

ASSEMBLYWOMAN CRECCO: Well, did you assure her that--

MS. SMARTH (Assembly Majority Staff): Well, actually I spoke to her yesterday afternoon, I assured her that we would be here until at least 12 or 12:30, and that she was welcome to come even though she had only called yesterday. So, I wanted to make that clear.

MR. DAVIES: Yeah, well she spoke to me last night. That was what she said.

ASSEMBLYWOMAN CRECCO: If we can, I think-- Mr. Petersen, how long is the tape about?

MR. PETERSEN: Fourteen minutes.

ASSEMBLYWOMAN CRECCO: Fourteen minutes? I think we can spare 14 minutes if it's important, and then we will adjourn.

(Mr. Petersen shows video tape on long-term health care insurance, prepared by the Health Insurance Association of America)

ASSEMBLYWOMAN CRECCO: Thank you, Mr. Petersen.

MR. PETERSEN: You're welcome.

ASSEMBLYWOMAN CRECCO: With the rising cost of health care, and the financial and emotional strains on the chronically ill and the elderly and their families, I am very heartened to know that insurance companies are planning for the future. But time is not on our side. One of the themes repeated by various speakers over and over again, focuses on initiating a public education campaign. I think in this area where we have a good opportunity to foster public/private sector partnerships to not only eliminate these false perceptions of individuals, but also to entice and provide incentives for the development and formulation of group plan policies. This means not only educating individuals, but also reaching out to employers, corporations, small- and medium-sized businesses, and pooling our resources. This can lower premiums and improve the affordability factor.

I look forward to drafting our report, and I want you all to know that the points raised through out the course of our hearings will be considered, and properly reflected in our final report. These recommendations will lay the groundwork for legislation to be introduced early next session. For those on the Committee, the first draft will be available next week. Thank you all.

(HEARING CONCLUDED)

APPENDIX

Testimony presented to New Jersey Task Force on Catastrophic and Long-Term Health Care, Public Hearing, Trenton, New Jersey, November 24, 1987.

My name is Anne Somers. I live in Princeton. I am an Adjunct Professor, Department of Environmental and Community Medicine, University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School. I appreciate the opportunity of appearing before the New Jersey Task Force on Catastrophic and Long-Term Health Care. I congratulate Assemblywoman Crecco and other members for helping to publicize these important issues and to dramatize the urgent need for State leadership in seeking solutions.

I also want to compliment the four departments represented here for your contributions over the years to better health and health care for the elderly and disabled. Just a few days ago, the Division on Aging celebrated its 30th birthday. New Jersey was the first state in the Union to establish such a division. Its state-wide, county-based "Aging Network" has not only contributed to innumerable useful programs but, equally important, has provided a vehicle for the elderly themselves to become active and responsible participants in the policy-making process, thus contributing to our mental as well as physical health.

I cannot even begin to name all the contributions of the Department of Health in this respect. Almost by definition, this Department is our first line of defense against the ravages of chronic illness, the primary cause of long-term disability and its often catastrophic financial consequences. I mention only one example - its role in the creation and maintenance of the Alzheimers Disease Institute and Resource Center at UMDNJ in Piscataway.

Human Resources has also played an indispensable role. Through its administration of Medicaid - the ultimate, albeit imperfect, "safety-net" for those unfortunate elders and younger disabled on whom Medicare, private insurance, and sometimes even their own families have turned their backs, through the CCPED and other federal-state "waiver" programs, and its leadership in the interdepartmental State Long-Term Care Planning Committee, 1980-1983, Human Resources has earned the right to, as well as responsibility for, continued leadership.

Up to now, the Insurance Department has played a less obvious role in long-term care. But if you believe, as I do, that long-term care financing cannot be segregated from mainstream health insurance any more than chronic disease and disability in a given patient can be segregated from his/her acute care needs, then you will welcome, with open arms, the Insurance Department's new commitment to this field.

However, there is another side to this coin. If things are going so well, why am I here today? Indeed, why was this Task Force created? The answer, of course, is that there remains a major omission in New Jersey's health care policy, a gaping hole in that presumed "safety net." I refer,

of course, to the tragedy of discrimination against patients with long-term chronic conditions. This is why - despite my admiration for the programs I have mentioned and many others I could have mentioned if time permitted - I appear today to plead the case for these neglected orphans of our remarkable, and remarkably expensive, health care system.

I come to you today not only as a member of the UMDNJ faculty for over 16 years but as a student of health care policy for 35 years, and - even more to the point - a consumer of U.S. health care for over twice that time. Of special relevance to your Task Force, I come as the wife of a long-term care patient who has personally lived through all the problems and frustrations that you have heard about in the three previous hearings.

My husband, Herman Somers, a professor at Princeton University and my long-time collaborator on health policy studies and books, suffered a severe stroke in August 1979. After several weeks in a coma and several months of acute care and rehabilitation, he was still aphasic and hemiplegic, unable to speak, dress himself or walk alone. He has remained in this condition for over 8 years. For 7-1/2 years, I have cared for him at home with the help of a dedicated staff of nurses, aides, and students. I am sure you will understand why, with this amount of on-the-job training, long-term care and its financing have become, for me, a virtual crusade.

I don't need to tell you that my husband's case is not unique. Probably everyone in this room knows of someone - a grandparent, the mother of a friend or colleague, perhaps a client (many of you are professionals) - with some similar experience. In Princeton, a number of stroke victims, their families, friends, and professionals helping to care for them have organized, with the help of the American Heart Association, the Mercer County Stroke Club. The Club provides not only important social and emotional support for stroke patients but also an outlet for their frustrations. Recently, it published a remarkable little book of first-hand experiences, A Stroke is Not the End. In addition to the courage and determination of these wonderful people, what comes through is their increasing frustration and despair over societal neglect. For example, Mr. D., a retired CPA who has cared for his disabled wife at home for over 7 years, writes of those "ruthless antagonists" who run Medicare and to whom "the patient is the enemy who is trying to bilk the Government out of its assets. . . . None of them keeps in mind where the Government money came from." I do not agree with his broadside against "Government" but I sympathize deeply with his frustrations. To have to undergo the physical and mental suffering, the indignities, the gradual abandonment and the financial catastrophes that too often come with prolonged disability - especially in this most affluent of all societies - is not only heartbreaking, it is cause for embarrassment and indignation as Americans and as New Jerseyans. I find it especially embarrassing that two close friends - both associated with Princeton University (in one case, the wife had Alzheimers; in the other case, she had, and subsequently died of, amyotrophic lateral sclerosis, Lou Gehrig's Disease) - felt they had to leave New Jersey - with its second highest per capita income in the nation - for Vermont - one of the poorer states - in order to receive tolerable long-term care.

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How common are these cases? Here we need a sense of proportion. Fortunately, most elderly are not disabled. We often hear the statistic that some 80 percent have some form of chronic disability. But that is meaningless. Practically everyone over 40 has some disability - nearsighted, impaired hearing, mild arthritis, mild hypertension, etc. We learn to live with such impairment. What we are talking about in long-term care are the severely disabled, those who cannot get out of bed alone, dress themselves, toilet themselves - even with the help of computers or other mechanical aids.

How many such individuals are there in New Jersey? I don't think anyone knows for sure. Some experts have suggested that 18 percent of our elderly fall in this category. I am sure this is much too high. It depends, of course, on how you define "severe disability." Starting with nursing home patients, the latest national figure (1985) is 4.6 percent of the elderly - down slightly from the 1977 figure - and a plausible estimate is that perhaps another 5 percent of the noninstitutionalized elderly are equally disabled.

If these ratios were applied to New Jersey, what would the numbers look like? How many patients are currently in New Jersey nursing homes? How many on long-term home health care? How many of both groups are on Medicaid? How many already have some form of private insurance? Or live in a continuing care retirement community? I assume your Task Force has been gathering this type of information to help you to project future needs and demand for long-term care insurance and other benefits.

But, important as such projections are, they are only part of the picture. Most of the projections of future needs for long-term care - projections that have scared off many policy makers and insurance carriers - have simply assumed past patterns of disability and health care utilization. This is a serious error. Just as the past quarter-century has witnessed dramatic reductions in death rates from many chronic diseases, especially stroke and heart disease, so I believe we are on the verge of similar dramatic reductions in the incidence, or onset, of such diseases. Indeed, this is already beginning. To cite just one example: A 26-year study of changes in myocardial infarction rates among male employees of the Dupont Company, 1957-83, found a 28 percent drop in the age-adjusted incidence rate compared to a 20 percent drop in 30-day fatality rates.* In other words, even those people who have heart attacks

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*S. Pell and W. E. Fayerweather, "Trends in the Incidence of Myocardial Infarction and in Associated Mortality and Morbidity in a Large Employed Population, 1957-1983." New England Journal of Medicine, Vol. 312 (April 18, 1985), pp. 1005-1011.

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are having them later in life and, while the death rate continues to fall, the age of incidence is falling even faster. This is terribly important - not just to the patients involved, who have fewer years of disability, but to insurance carriers, government, or anyone else interested in providing financial protection against the costs of long-term care.

If, as some pessimists have predicted, the rate of disability among the elderly will rise in the future with every improvement in acute care, to the point that perhaps 25 percent of the over-65 population and 5 percent of the total population would be disabled and in need of such benefits, the burden on the nation could indeed become intolerable - and probably uninsurable. If, on the other hand, we can look forward to a continued reduction in the incidence of chronic disease greater than improvement in life expectancy, then the burden is manageable and insurable.

Please understand me. I present this not as a prediction - but as an option, a very important option. As we move to design our long-term care financing policies, I submit we can go in one of three directions:

(1) Do nothing and hope the problem will go away. I do not consider this a serious option. The costs of Medicare and Medicaid will continue to rise - despite continuing and perhaps even Draconian efforts to contain them. There will be increasing intergenerational conflicts over who should bear the burden - and government will be caught in the middle, a very uncomfortable place to be.

(2) Assume current or worsening rates of disability among the elderly and try to design the cheapest possible way of meeting their needs, even if it means creating a separate system of care for the victims, a system which I am sure can only be "separate and unequal."

(3) Aim for sufficient reduction in the rates of disability to permit us to provide adequate, good-quality, mainstream health care to the remaining victims. Needless to say, this is the option I think we should pursue. In practice, Option 3 calls for equal attention to Prevention and to Financial Protection. If you prefer insurance language, you can call Prevention "Risk-Management."

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Time is the enemy - for all of us! My own time is running out. Your time as a Task Force is running out. You have a report to prepare in just over a month. The time for this Administration is limited. Governor Kean will leave us in just over two years. Most important of all, the time for the people of New Jersey to choose between these three options is not unlimited. And I believe this is probably true for the nation as a whole. For good or for ill, New Jersey has become - if not a pace-setter - at least a barometer - for national health care policy. Consider the first Division on Aging, one of the first to adopt the Certificate of Need, Karen

Quinlan and institutional ethics committees, and, of course, DRGs.

Whether we focus on State or Nation, we have before us today a "window of opportunity" that will not last too long. While the number and proportion of elderly in the population will not rise dramatically during the next decade, if we do not prepare ourselves in advance before the "Baby Boomers" begin to turn 65 around 2010, the results will be disastrous. Other pressures - not just budgetary but from competing legitimate needs - in education, environmental controls, housing, job creation, AIDS, etc. - will increasingly impinge on our freedom of movement to close this disgraceful and tragic gap in our health care system. We must act - promptly and on both fronts: prevention of chronic disease and disability and protection of its victims.

As some of you know I have long advocated the creation of a senior-level, Blue Ribbon New Jersey State Commission on Long-Term Care Financing, committed to public/private solutions. In recent months this proposal has been brought to the attention of the Governor's Office of Policy and Planning as well as the four departments represented here today and various provider and consumer interest groups. There has been considerable support for this proposal and, I understand, some opposition, possibly from unfounded fears that it might interfere with some existing departmental initiatives.

I have already made clear my support for all such promising initiatives. Long-term care is too complex, too multi-faceted a problem for any one individual, any one group, any one government agency to claim a monopoly of wisdom, resources, or approaches. We need these departmental initiatives. We need a good report from your Task Force. And we need a broad, Blue Ribbon Commission to take up where you leave off. For once, the timing is exquisite! Let's get together and make the most of our "window of opportunity."

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Statement

of the

Health Insurance Association of America

On

PRIVATE INSURANCE FOR FINANCING LONG TERM CARE

Presented by

Chris Petersen

Assistant Counsel

November 24, 1987

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Hello, my name is Chris Petersen. I am an assistant counsel at the Health Insurance Association of America. The HIAA is comprised of approximately 340 member insurance companies that write over 85 percent of the private health insurance available from commercial insurance companies in this country. A large number of our member companies conduct business in New Jersey and, therefore, we are very interested in assisting this Task Force and the New Jersey State Legislature as they address the issue of long-term care financing.

Before I begin my presentation, I would like to say how please I am to be here today. As I will discuss later in my comments, the biggest obstacle facing the development of adequate long-term care financing is the lack of information and understanding surrounding the problem. Hearings such as these provide for the exchange of ideas and information. Legislators, insurers, and the public will all learn and benefit from the efforts of this Task Force.

HIAA appreciates the opportunity to talk to you about the developing long-term care insurance industry. We believe that the private sector is responding to this new market in thoughtful and creative ways. We firmly believe that a successful financing solution to long-term care must involve the private sector. Government cannot afford to take on this entire burden alone. Individual resources must continue to be tapped, but in a more equitable and affordable manner. Private insurance can accomplish these goals.

The advances in both medical technology and general health that are increasing the lifespan of the elderly are also increasing the number of people who will

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require treatment for chronic illness. Simultaneously, rising income, particularly among the elderly, makes insurance against the costs of long-term care both more desirable and affordable. The time has come to begin folding long-term care into this country's extensive private insurance system.

Nature of the Problem

When we speak of "long-term care," we are describing a wide range of medical and support services provided to individuals who have lost some or all capacity to function on their own due to a chronic illness or condition and who are expected to require these services for an extended period of time.

Long-term care is the major source of catastrophic illness expense paid for directly by the elderly today. On average, for those elderly with out-of-pocket health care expenses over $2,000 a year, 80 percent of these expenses are for nursing home care. With nursing home costs estimated to average $22,000 - 25,000 per year, such expenses can indeed represent a catastrophic financial drain.

Nearly half of all nursing home costs is paid for out-of-pocket and the other half is financed by Medicaid. This generates great insecurity for the elderly. The burden of these costs forces middle income people to impoverish themselves, "spending down" virtually all of their resources to become Medicaid eligible. And it also encourages people to divest themselves of assets in order to qualify for Medicaid benefits. As a result, Medicaid, a program designed for the poor, is spending almost half of its dollars for nursing home care.

Not everyone will need nursing home care, however. Somewhere between 25 and 40 percent of the elderly are likely to require nursing home care at some point in their lives. Of these, only about half will be institutionalized for more than 90 days. Because of these factors, long-term care expenses are well suited to insurance. It is a potentially very expensive event; it is difficult to predict for a given individual, and the frequency is low enough that the cost per person, spread across a large group, is modest. Each person pays a periodic budgetable amount. And, when the need arises, no one person is forced to bear the enormous financial burden alone.

New Developments in Long-Term Care Insurance

There has been a small private market for long-term care insurance in this country for some time. Widespread misunderstanding among the elderly about the extent of Medicare coverage, coupled with other, higher priority uses for their funds are two of the primary reasons why spending for private long-term care coverage has had little appeal.

Recently, that has changed dramatically, as evidenced by the number of companies developing long-term care insurance products, the number of individuals covered and the variety of products being developed. A recently completed survey by the Department of Health and Human Services (DHHS) Task Force on Long-Term Health Care Policies found that, as of April 1987, about 70 insurance companies offered long-term care policies and approximately 423,000 were policies in force. Three years ago, only 16 companies were identified by DHHS as selling long-term care policies.

Although long-term care is an insurable event, much about the nature and extent of the risk will only become known as we gain experience. Accordingly, the initial insurance industry response was a conservative one. Initial products tended to focus on institutionalization, covering only nursing home care following hospital confinement. But, products are already considerably more flexible and creative. Home care is now common place in most new policies. In some policies, benefits are triggered by the level of functional disability using limitations in Activities of Daily Living, rather than prior institutionalization. We will see a continued trend toward more comprehensive and liberal benefit provisions as insurers and the consuming public become more sophisticated. It is important that the regulatory environment allow and encourage this development.

Within the last year, employer-sponsored long-term care policies have been marketed for the first time. A number of carriers now offer a variety of group coverages; several others have announced plans to begin marketing group products. And a privately insured long-term care plan for federal employees is in the planning stages.

Private long term care insurance offers people a new opportunity for funding their care which was not available until recently. It is not the solution for everyone. However, it is the goal of the insurance industry to make the product affordable to as many people as possible. Clearly, group coverage through the workplace, offered when people are younger and healthier, can reach a much wider segment of the population.

Challenges to the Long-Term Care Insurance Market

Although the costs of long-term care seem to be a natural focus for the insurance mechanism and progress is being made, the market has been slower to develop than we would wish. A major past inhibitor to long-term care insurance purchase was that elderly people were concerned primarily with the adequacy of their retirement income and with coverage for the costs of acute medical care. Recent studies show we have the first generation of elderly going into retirement with both Medicare and supplemental Medigap protection, private pension benefits plus, incidentally, substantial capital appreciation in their homes. There are other factors, however, which continue to inhibit the development of long-term care insurance. The most important of which are:

- A low level of consumer awareness about the risks and costs of long-term care, coupled with a widespread belief that Medicare and supplemental Medigap policies cover long-term care costs.

- A lack of usable data regarding the use and costs of long-term care services, particularly in an insured environment, which makes actuarially sound pricing of products very difficult.

- An uncertain regulatory environment for companies developing long-term care insurance.

Consumer Awareness

It is obviously difficult to sell a product or service to individuals who are either unaware that they need it or are convinced that their need will be met in some other way. Yet, this is the situation we find with respect to long-term care.

A survey of the elderly conducted by the American Association of Retired Persons revealed that 79 percent of those who thought they might need nursing home care believed that Medicare would cover these expenses. These misconceptions are echoed in popular and erroneous beliefs that private Medigap insurance plans provide this kind of protection.

The need for better consumer education is the responsibility of both the private and public sectors. Passage of any legislation for catastrophic Medicare coverage must be accompanied by a full and complete disclosure of coverage gaps, including long-term care. Also, education must begin early, so that people can purchase insurance when they are younger and premiums are more affordable.

The HIAA has undertaken a number of initiatives to address the consumer awareness problem. We have a toll-free hotline for consumers to inquire about the availability of long-term care insurance coverage in their state. In addition, we have recently published a Consumer Guide to Long-Term Care Insurance. Secretary Bowen wrote the Forward to the Guide and it received the support of the AARP. This was truly a cooperative effort between the public

and private sectors. Since its publication in June, thousands of copies have been requested. I have enclosed a copy of the Guide for the record. We have also conducted educational press seminars on long-term care and given numerous public presentations on the topic. Our objective has been simple -- an educated public can best understand the issues and make informed decisions about their needs.

I might also add that consumer education is the first line of defense against potential problems and abuses in the long-term care insurance market. I believe that the future direction of long-term care insurance -- coverage in the workplace -- offers an additional advantage to individuals seeking such benefits. Besides offering lower premiums, employers play the important role of a sophisticated consumer in selecting the plan and educating their employees about the benefits. These circumstances provide working age consumers more opportunities to gain information and understand their potential long-term care needs.

Lack of Data

It has been particularly difficult for insurers to design and price policies when essential information has been unavailable. Past data have been fragmented and very limited. For example, there are almost no data on the rate at which private pay patients exhaust their resources to become Medicaid eligible. Information on the lifetime use of nursing home care is also limited. In this early stage of development, timely access to federal and state data, in a readily usable form, would be most helpful.

We already have progress in this direction. Several national data bases on long-term care will become available to the private sector this year, and this should help product design. Moreover, encouraged by members of the insurance community, the Department of Health and Human Services sponsored a technical conference in the spring of 1987 to communicate the contents of these data bases and ways that they can best be used. This activity is a small example of the kind of cooperation that is required between private and public sectors if we are to deal with the long-term care problem.

State Regulatory Environment

The HIAA has worked with the National Association of Insurance Commissioners for the past several years to develop a Long-Term Care Insurance Act. In December 1986, the NAIC adopted a Model Act that was amended in June, 1987. The HIAA supports the Model Act and strongly recommends that the State of New Jersey adopt the Act with three changes that I will be discussing shortly.

The Long-Term Care Insurance Model Act protects consumers, while at the same time providing insurers the necessary flexibility to develop products and to enter the marketplace. The following are some of the consumer protections contained in the Model Act:

a) long-term care policies may not be cancelled on the grounds of the age or health of the insured;

b) it prohibits new waiting periods in the event existing coverage is converted or replaced within the same company;

c) a six month preexisting condition time period is established;

d) a right to return-free look provision is included; and

e) outlines of coverages are required.

The HIAA believes the rights and interests of the consumer are fully protected by the Model Act.

The HIAA, however, recommends that certain changes be incorporated into the Model. We feel the definition of preexisting conditions should contain a reasonably prudent person standard. The reasonably prudent person standard states that there is a preexisting condition if there is the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment. The language is taken from the NAIC model accident and health insurance language and was included in the December draft of the Model Act.

In June, the preexisting condition definition was amended to apply the Medicare supplement standard. Long-term care insurance is designed to provide coverage for chronic care, versus acute care, and should have a different standard from that of Medicare supplement. The existing standard could conceivably create a situation where an applicant is denied coverage because they received treatment from a provider within the past six months. Upon learning the basis of denial, the applicant could cease treatments for a period of six months and then qualify for coverage without preexisting conditions. This could occur even though the applicant had symptoms during

the entire six month period that would cause the ordinarily prudent person to seek medical treatment. The HIAA does not believe that this situation is in the best interest of anyone and thus we recommend that the reasonably prudent person standard be adopted.

The Model Act exempts employer group policies or certificates, as defined in Section 4E(1), from the preexisting condition limitations. HIAA believes that all group policies should be similarly treated and, therefore, we recommend that the exemption also apply to Section 4E(1) labor organizations, to Section 4E(2) professional associations, and to Section 4E(3) associations.

Finally, we believe the Model Act should be amended to grant Insurance Commissioners discretionary authority to approve specific limiting or exclusionary waivers or riders. Certain waivers and riders are in the interests of consumers, such as those for specific injuries. Continuing care retirement communities sometimes restrict entry by excluding coverage for specified preexisting conditions or by requiring an additional fee. These facilities have approached insurance carriers seeking underwriting of the long-term care insurance component of the retirement community benefit package. Flexibility is necessary to allow insurance policies to contain provisions consistent with the contract between the facility and the prospective member. HIAA recommends that the following language be added to the last sentence in Section 6C(4) ," unless such waiver or rider has been specifically approved by the Commissioner.", in order to provide some degree of discretion for the Commissioner to approve waivers and riders in certain long-term care insurance policies.

At its June meeting, the National Association of Insurance Commissioners exposed a draft Long-Term Care Insurance Model Regulation, dated June 22, 1987. We offer the following comments on the Model Regulation.

HIAA is opposed to the prohibition in Section 6A on the sale of conditionally renewable policies to individuals. The HIAA has considered at length the concept of conditionally renewable policies, and we believe that the ability to write a conditionally renewable product is important to encourage market entry, innovation, and experimentation by insurance companies. There is substantial competition in the market today providing choice to consumers who want to buy guaranteed renewable products rather than conditionally renewable products. Disclosure allows consumers to make an informed choice as to which product renewability feature they want.

Insurance companies do not enter a market with the intention to nonrenew business. The decision to nonrenew is never taken lightly by the company. It adversely affects relations with the public, with regulators, and with the company's agency force. Insurers are concerned with guaranteed renewability because, when coupled with rating errors, it can result in severe financial consequences for the insurer or force premiums up to a level where fewer people can purchase the product. HIAA believes that insurance companies should have the opportunity to decide for themselves whether they wish to sell an individual product that is guaranteed or conditionally renewable.

HIAA does not oppose inclusion of an optional loss ratio provisional; however, we oppose any specific loss ratios in excess of 55%. The

development of long-term care policies is still in the experimental stages and the industry is not certain what should be an appropriate loss ratio for such a product. However, we believe that a loss ratio of 55 percent or less is a valid starting point.

The slow development of claims experience, the expense of sales, and the cost of claims investigation is similar in long-term care insurance to that seen in long-term disability insurance. With respect to the effect of coverage on provider availability, long-term care and long-term disability have substantial conceptual similarities. The greater risk being assumed by insurers, and the higher marketing costs that will be experienced to sell this product validate the need for a greater margin than is typically assumed for most acute care health insurance products. It is our recommendation that the appropriate starting point for the individual long-term care loss ratio guideline is the long-term care disability guideline and not the loss ratio guideline applicable to Medicare supplement insurance.

We oppose the requirement in Section 8 to include the telephone number of the Insurance Department in replacement notices. This requirement would result in a substantial number of inquiries directed toward the Department. The analysis and comparison of policies, and recommendations as to what consumers should do, might expose the Insurance Department to legal liability. It will add an additional step to the sales process, will also add costs to companies to maintain additional replacement notices, and will create substantial additional work for the Insurance Department.

We support inclusion of a provision authorizing the Commissioner to suspend or modify certain provisions of the Regulation, upon making a finding that such suspension or modification would facilitate flexibility and innovation in developing a particular long-term care insurance policy. We also oppose the lack of an aviation exclusion in the list of permitted exclusions found in Section 6B. This is a standard exclusion utilized in accident and health insurance policies to exclude coverage for illness or injuries sustained while flying a private aircraft. It is not intended to exclude passengers in a commercial aircraft. The exclusion should be permitted.

The HIAA supports the Model Act and Regulations with the execption noted above. The Model and Regulations are important first steps to take to ensure that long-term care financing is available to the residents of New Jersey.

It is also important to begin the process of educating the public as to the importance and necessity of preparing for the financing of their potential long-term care. As I noted earlier, the public's knowledge of the problem is wholly inadequate. The HIAA and the insurance industry have taken steps to rectify the problem; however, the insurance industry cannot be expected to correct the situation on its own. The State of New Jersey must also play an active role in educating its citizens on this issue. This Task Force must develop a public education campaign that will bring the issue to the forefront.

The Task Force must also review all existing and proposed state statutes and regulations to determine their impact on the development of long-term care

financing systems. New Jersey should repeal those statutes and regulations that will hinder development of long-term care insurance. In order to develop this product, insurance companies need a regulatory environment that permits flexibility. If the regulatory environment is too rigid, insurers will not enter into the market place. However, without a thorough review of existing or proposed regulations it might not be apparent what impact certain measures will have on long-term care financing.

For example, proposed regulatory amendments N.J.A.C. 11;4-18.3, 18.5 and 18.10 (19 N.J.R. 1620 (b)) require that if there is an individual insurance policy where premiums are rated by age and the attained age of the insured is 65 years or more, the loss ratio must be at least 65 percent. Thus, a long-term care policy sold to a 64 year old would require a loss ratio of 65 percent once that individual attained the age of 65. A 65 percent loss ratio for long-term care coverage would discourage, and possibly prevent, companies from marketing a product in New Jersey. As discussed earlier, there are a number of uncertainties involving this coverage and companies will be hesitant to develop the product if loss ratios are too high. Not a single state requires a loss ratio of 65 percent on long-term care policies. This proposed amendment, if adopted, will discourage the development of long-term care products and HIAA recommends that the changes are not allowed to become final. This is just one example, the Task Force should review all existing and proposed statutes and regulations for other possible barriers to the development of this product.

This Task Force should also consider new and innovative means to encourage

development of long-term care insurance. Colorado grants a 1 percent reduction in premium taxes for insurers on qualified long-term care policies. This incentive appears to be working; the state has witnessed an increase in the number of insurers seeking approval to issue long-term care policies in Colorado. New Jersey may also want to consider such an approach.

Medicaid Reform

To provide an adequate safety net for those unable to purchase private insurance, changes in Medicaid are also necessary. For example, eligibility standards need to be set uniformly across the states to cover all elderly under the poverty level. Eligibility criteria must also consider the resource needs of the noninstitutionalized spouse who must continue to maintain an adequate standard of living. Medicaid reimbursement, especially for nursing home care, must be adequate to permit the provision of good care in well-maintained facilities. Adequate reimbursement will also minimize the current cross-subsidy private pay patients now contribute to Medicaid. Lastly, certification and survey requirements need to be adequate and aggressively enforced to guarantee the delivery of quality care.

Summary and Conclusion

We all agree that solving the long term care financing problem is vitally important. Solutions must continue to come from both the public and the private sectors. There will always be those who cannot purchase insurance. For this group, federal and state safety net programs will continue to be

necessary. However, given the current federal budget deficit, we believe public policy would be better directed toward those areas that will support and nourish the growth of the variety of private initiatives that are gaining momentum.

The private insurance industry is rapidly deploying its resources to address this issue. It is important to recognize that long term care coverage is part of the natural evolution of a system of financial security. We believe that private long term care insurance will continue to evolve in the coming years and offer widespread protection to the majority of the elderly. Government policy should provide appropriate encouragement to the private market through consumer education, data sharing and flexible regulation.

COMBINED JEWISH PHILANTHROPIES OF GREATER BOSTON

REQUEST FOR PROPOSAL

FOR A

LONG-TERM CARE INSURANCE PLAN

APRIL 1987

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INTRODUCTION

The Combined Jewish Philanthropies of Greater Boston ("CJP") is the primary planning, problem-solving, and allocating body of Boston's Jewish community. CJP's planning umbrella in the area of services to the elderly has included a major acute care hospital, two chronic care hospitals, a home care/home health agency, a housing agency, several strategically sited community centers, and an agency providing vocational services to employable older workers.

As the Jewish federation of the Greater Boston community, our mission includes fundraising and community-building. CJP therefore has strong linkages to the synagogue community, and to other "special interest" Jewish organizations. Our file includes approximately 50,000 households throughout the Greater Boston area. We are linked locally to the general community as a major beneficiary and planning partner of the United Way, and to the national Jewish community thru our active participation in the Council of Jewish Federations.

Our mission, the service and management capacity of our agency-based delivery system, our planning and communication linkages and our recent extensive research and planning with regard to the elderly have led us to identify long-term care insurance as our major near-term research and development effort.

Having reviewed existing LTC insurance offerings and viewing them as inadequate to meet our policy objectives, as specified in the text of this document, and the projected needs of approximately 40,000 Jewish persons aged 50 and above, CJP is requesting proposals from insurance carriers to

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develop jointly with us one or more group LTC insurance plans, and for the carrier to underwrite, market, and administer the plan.*

Although CJP has formulated a preliminary outline of the general features of a plan, we are seeking detailed recommendations from carriers with respect to specific features of the plan as well as an evaluation of likely premium costs.

This request for proposal is organized into the following parts:

I Statement of Objectives and Guidelines

II Questions for the Insurance Carriers

III Appendices

A. CJP Annual Report 1985-86

B. CJP Dateline January/February 1987 (see inside pages for discussion of long-term care insurance)

C. Memorandum on findings of CJP's 1985 demographic study of the Boston Jewish community, with regard to the elderly

D. Report of the CJP Task Force on Services to the Elderly

We would appreciate receiving responses by May 29, 1987 if possible, and we ask you to send your proposal to our consultant:

Jay N. Greenberg
Director of the Long-Term Care Group
Health Policy Center
Heller Graduate School
Brandeis University
Waltham, MA 02254
(617)736-3900

* This request for proposal reflects explicit and enthusiastic support by CJP's Executive Board and Board of Trustees for a research and development effort, and for the policy objectives and guidelines identified in our narrative. Recognizing, however, the uncertainties attendant on any research and development effort, and on the advice of counsel, CJP reserves the right to reject any or all proposals received in response to this request.

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I. Objectives & Guidelines

The basic objectives of the plan are to provide financial protection from the cost of LTC and to help the enrollee live as independent a life as possible should they require long-term care. CJP is of the opinion that these objectives will best be met by an insurance plan that is designed around the following guidelines:

- The plan should include a wide spectrum of support services ranging from assistance with household tasks in the enrollee's home to skilled care in a nursing home and all levels in between.
- The plan should specify the maximum dollar amount of total benefits and/or the maximum duration of benefits but it should be flexible regarding how much of the benefit can be spent on home care and how much on nursing home care. A three year benefit is considered a minimum.
- Eligibility for benefits should be determined using specific, objective criteria that are directly related to the enrollee's physical and cognitive functioning. Artificial gates to benefits such as prior hospitalization should be avoided.
- The plan should use case management to control costs and to provide needed assistance to enrollees and their informal care givers.
- The plan should be structured to encourage younger persons (50-65) to purchase the plan.
- The plan should be attractive to a wide range of age and income groups. This may suggest that more than one policy be offered.
- The plan should utilize risk sharing and financial structures that give all parties (carrier, case management organization, providers, and enrollees) incentives to be cost conscious and efficient.
- The plan's premium should be level by entry age.
- The plan should be guaranteed renewable.
- The plan should provide for protection against the erosion by inflation of the maximum daily benefit amount (at least as an optional benefit).

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II. Questions For Insurance Carriers

Plan Design

1. What methods would you use to guard against adverse selection? If risk management techniques such as health screening, prior condition exclusions, or waiting periods will be used, please be specific as to how you would use them and the criteria you would use for rejecting an application. What percentage of the population aged 60-70 currently living in the community would you estimate/guess will fail your proposed screens?

2. What criteria would you recommend be used for benefit eligibility? Please be specific. Who would certify benefit eligibility and how frequently would reassessment occur?

3. We desire a benefit package that does not have an institutional bias and provides maximum flexibility with regards to use of home care and level of nursing home care. How would you structure the benefits to achieve those objectives?

4. How would you recommend the case management function be structured and organized with respect to:

   a. Functions and responsibilities of the case management organization;

   b. Would enrollees have a choice of case management organizations? If yes, when and how would they make selection?

   c. Would the case management organization be part of or separate from the carrier?

d. The organization(s) who should perform case management;

e. The nature of the financial risk, if any, they should face and how they should be reimbursed;

f. The relationship between the carrier and the case management organization;

g. Relationship of the case management organization to providers;

h. Quality assurance.

5. What types and levels of enrollee cost-sharing would you recommend? Would it differ by type of service?

6. What methods, if any, would you recommend for guarding against inflation eroding the value of the policy to the enrollee?

7. If an enrollee moves out of the area, how would that be handled?

8. Will you guarantee renewability? If yes, please specify, as precisely as possible, the definition and terms of renewability.

9. Please explain how you propose to protect CJP against any and all liabilities and obligations that may be asserted against CJP in connection with any policy that you may underwrite, market, and administer.

Pricing

1. Using the policy you described above and level premiums at age of entry, please furnish:

a. schedule of uni-sex age related premium rates (please use 5 year intervals from age 45 to age 75) for the following two policies (assuming a 1988 start):

1. Maximum Daily Benefit: $80 in nursing home and $40 in home or community.

   Maximum Duration of Benefit: Combination of three years in any setting.

   Waiting Periods: 30 days or 100 days (please provide us with your definition of a waiting period).

2. Maximum Daily Benefit: $80 in nursing home and $40 in home or community.

   Maximum Duration of Benefit: Combination of five years in any setting.

   Waiting Periods: 30 days or 100 days.

b. For what period of time would you guarantee these rates?

c. Would you give discounts to married couples? What level of discount would you give?

Alternative Policy Designs

If you think that there are policy designs that could better meet our objectives please describe them and present pricing estimates.

Time-Table and Tasks

Please indicate what you think are the major tasks that need to be accomplished to bring the plan to market and provide your best guess as to a time-table. When discussing the tasks please include the major issues/decisions that need to be made.

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Corporate Capabilities

1. Please indicate other organizations for whom you underwrite or administer long-term care insurance plans.

2. Please indicate your experience with managed care products particularly as it relates to the elderly and long-term care.

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Testimony for the

New Jersey Task Force on Catastrophic and Long-Term Care

NJ Department of Community Affairs

Division on Aging

Theresa Dietrich

November 24, 1987

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Chairperson Crecco, thank you for giving the Department of Community Affairs Division on Aging, the opportunity of presenting to the Task Force on Catastrophic and Long-Term Care a picture of our activities that are relevant to the issue.

The Division on Aging of the Department of Community Affairs is the central agency responsible for the planning and coordination of New Jersey's programs and services for older persons. The Division also serves as the State Agency on Aging to carry out activities mandated under the federal Older Americans Act.

Each county in New Jersey has an Area Agency on Aging, sometimes referred to as the County Office on Aging. The Division allocates funds to each county through an area plan contract and monitors progress in the implementation of each area plan contract. The Area Agencies on Aging provide a variety of services and help maintain maximum independence and dignity for the elderly. Those most relevant to the charge of this Task Force on Catastrophic and Long-Term Health Care are homemaking, visiting nurses, home health aides, information and referral, legal assistance, outreach, friendly visitor, telephone reassurance, respite care, hospice care, local ombudsman program, protective services, advocacy assistance and home delivered meals.

Current activities of the Division on Aging can be grouped into those which involve planning and coordination, direct services, and advocacy.

PLANNING AND COORDINATION OF PROGRAMS AND SERVICES FOR THE ELDERLY

Interdepartmental Task Force on the Elderly

Coordination of the planning and delivery of programs and services for the elderly throughout the state is facilitated by the Governor's appointed subcabinet committee, the Interdepartmental Task Force on the Elderly, through which a variety of state agency representatives participate in a forum for discussion of programs and policies affecting the health and well-being of the elderly population. Thirteen State departments or agencies are represented on the Task Force, which meets quarterly.

Hospital Initiatives in Long-Term Care for the Elderly

This survey, published by the Division on Aging in cooperation with the New Jersey Hospital Association, details findings from a survey conducted by the Health Research and Education Trust of New Jersey of acute care hospitals and County Offices on Aging. Efforts continue to improve the level of community-based, long term care by the acute care hospitals and County Offices on Aging. Funding was provided by the Robert Wood Johnson Foundation.

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Alzheimer's Disease Training for Physicians

The Academy of Medicine of New Jersey, the Home Care Council of New Jersey and the Division on Aging, through a grant from the Brookdale Foundation, conducted training in Alzheimer's Disease for approximately 1700 physicians, related medical personnel and home care providers. "Alzheimer's Disease: A New Jersey Directory of Services for Family Care Givers and Health and Human Service Providers" was reprinted and 3000 copies distributed. In addition, the Division purchased and distributed nearly 1000 copies of "Understanding and Caring for the Person with Alzheimer's Disease," a publication of the Atlanta Area Chapter, Alzheimer's Disease and Related Disorders Association.

Gatekeeper Program

Hundreds of utility company employees are being trained to identify vulnerable older persons who may be in need of assistance and to report that need to County Offices on Aging. Public Service Electric and Gas Company, Jersey Central Power & Light Company, and Atlantic Electric implemented the Gatekeeper Program after training which was developed with the assistance of the Division on Aging.

"Home Care in New Jersey: Current Access and Strategies for Potential Program Development"

This study, which is not yet available, addresses issues faced by New Jersey residents in the 1980's as solutions are sought to the problem of providing humane home care to that portion of the elderly population which needs assistance in order to continue living in the community. The report states that approximately 100,000 older persons are estimated to be in need of formal home care because of chronic long-term medical/social problems. The report cites programs for geriatric home care services; namely, the Congregate Housing Services Program of the Division on Aging, and the Community Care Program for the Elderly and Disabled, a Medicaid waiver program administered by the N.J. Department of Human Services. Also reviewed are public programs in other States and Canada, and private programs.

"Family and Community Based Care for 75 and Older Citizens in New Jersey"

This study, which will also be available by the end of the year, profiles the 75+ population, since it is this group which is most vulnerable to health problems requiring long-term medical and social services. The report describes the general characteristics of this cohort, their living arrangements, and economic situation.

DIRECT SERVICES

N.J. Senior Citizens Information & Referral Service

One of the most direct and immediately effective ways that the Division on Aging reaches out to older persons, their families or their caregivers, is through a staff of resource specialists who respond to telephone calls through a statewide, toll-free telephone response system. These resource specialists have access to a computerized data retrieval and follow-up system ranging from current requirements for participation in entitlement programs to more general information on programs, services and senior organizations. The N.J. Senior Citizens Information & Referral Service, 1-800-792-8820, receives a consistently growing number of calls daily.

Congregate Housing Services Program

The Division on Aging administers a supportive services program which provides personal care, housekeeping, and congregate meals to low-income, frail elderly residing in subsidized housing facilities. Congregate housing services are provided through casino revenue funds and fees paid by the elderly. Twenty-four subsidized housing projects receive grants to provide services in 33 buildings throughout the state serving an average 650 participants each month. The average state subsidy for each participant each month is $126 with the average participant contributing almost $76 toward the total cost of the services provided.

Senior Health Insurance Program

The Senior Health Insurance Program (SHIP) administered by the Division on Aging recruits and trains volunteers, mostly elderly persons, to clarify health insurance matters and options on a one-to-one basis to older individuals at no cost. Volunteers are trained to assist the elderly in filling out claim forms, understanding responses from insurance carriers, and evaluating specific health insurance needs. The 15-hour training includes Medicare coverage, a brief overview of Medicaid, and all types of private coverages, including long-term care policies. The training is coordinated by staff of the N.J. Department of Insurance, and is presented by staff of the U.S. Health Care Financing Administration and the N.J. Department of Insurance. More than 300 volunteers in 13 counties will have been certified by the end of 1987.

As of September 30, approximately 1000 clients have been served.

ADVOCACY

Task Force on Housing Options for Senior Citizens

The New Jersey Task Force Study on Housing for Seniors was convened by Commissioner Leonard S. Coleman, Jr. in November 1986. Its initial purpose was to analyze and evaluate home equity conversion mechanisms and possible state interventions. Collectively and in subcommittees, the Task Force members closely examined existing reverse mortgage programs and other equity conversion. They heard presentations from experts and practitioners, and, in two public hearings, from older New Jersey residents.

New Jersey has two home equity conversion plans through private lending institutions assisting approximately 350 older homeowners.

There was widespread agreement among Task Force members that home equity conversion transactions, while relatively new and complex, can be of tremendous benefit to older homeowners. In concert with this finding was a conviction that consumer education and protection are needed. The Recommendations of the Task Force reflect these sentiments.

The Task Force recommends that the state undertake a significant education and training effort. They also recommend several legislative initiatives:

- authorizing a property tax deferral program;
- establishing disclosure requirements for sale leasebacks;
- appropriating funds for a Senior Citizen Housing Coordinator program at the county level.

These activities represent the commitment of the Division on Aging not only to the senior population as whole but particularly to those persons who are most vulnerable due to functional impairments. We are sensitive to the growing need of our senior population for solutions to the difficult problem that the Task Force is addressing. We are eager to participate in efforts to address the problem of financing long-term health care.

However, a solution requires policy decisions that are beyond the power of departments of State government. We lack actuarial data, and there are no hard figures concerning the total cost a system for providing adequate care for all those in need.

The issue requires the attention of the Governor and legislature. Also, the private sector, both the insurance and the health care provider industries, must participate in developing viable strategies. Only after this public - private coalition reaches a consensus, can the necessary policy decisions be made.

Thank you.

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