PUBLIC HEARING

before

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

A Review of National Policy Directions
in Long-Term Health Care

August 31, 1987
Room 341
State House Annex
Trenton, New Jersey

MEMBERS OF TASK FORCE PRESENT:

Assemblywoman Marion Crecco, Chairperson
Paul Langevin
Marian Bass
Jeanne Sims
Theresa Dietrich

ALSO PRESENT:

Eleanor H. Seel
Office of Legislative Services
Aide, Task Force on Catastrophic and Long-Term Health Care

* * * * * * * * *

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

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

CHUCK HARDWICK
SPEAKER

BRADLEY S. BREWSTER
EXECUTIVE DIRECTOR

August 10, 1987

NOTICE OF A PUBLIC HEARING

THE NEW JERSEY TASK FORCE ON CATASTROPHIC AND LONG-TERM HEALTH CARE ANNOUNCES A PUBLIC HEARING TO REVIEW NATIONAL POLICY DIRECTIONS IN LONG-TERM HEALTH CARE:

Monday, August 31, 1987
Beginning at 10:00 A.M.
Room 341, State House Annex
Trenton, New Jersey

The New Jersey Task Force on Catastrophic and Long-Term Health Care, established pursuant to Assembly Resolution No. 151 of 1987, will hold a public hearing on Monday, August 31, 1987, beginning at 10:00 A.M., in Room 341 of the State House Annex, Trenton, New Jersey, for the purpose of receiving testimony from invited witnesses on the subject of national policy initiatives and directions in regard to long-term health care.

The task force, which is chaired by Assemblywoman Marion Crecco (District 30), will hold a series of public hearings during the next few months with a primary focus on long-term health care issues. Subsequent hearings will examine programs in other states and consider policy directions for New Jersey.

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

TABLE OF CONTENTS

APPENDIX:

* * * * * * * * *

akv: 1-71

ASSEMBLYWOMAN MARION CRECCO (Chairperson): We're going to call this meeting to order. As you know the Assembly Resolution No. 151 created the New Jersey Task Force on Catastrophic and Long-Term Health Care. I want to thank all of you for attending and going out of your way to be here to testify.

While people are living longer, this problem grows. So we're going to seek answers to several questions: One, in light of the Federal government and what they're doing, how much, if anything, should the State do in this area? And, who should pay the bill, and should participation in any plan be mandatory? We're going to listen to testimony this morning.

First I'd like to mention who the members are of our Committee. Assemblyman William Schuber cannot be with us this morning, but he is on the Committee and will be with us for the other meetings. Assemblyman Deverin also could not be here this morning, and Assemblyman Otlowski. We also have -- representing the Commissioner of Human Service, Dr. Molly Coye -- Mr. Paul Langevin. He is representing the Commissioner of Health. Marian Bass is representing the Commissioner of Human Services, Mr. Altman. Jeanne Sims is representing the Commissioner of Insurance, Mr. Ken Merin. And Theresa Dietrich is representing the Commissioner of Community Affairs.

This morning, as our first witness we will have Mr. Mark Meiners, who is the Senior Research Manager, National Center for Health Services in Rockville, Maryland. Mr. Meiners? Oh, I'm sorry. It's Dr. Meiners. Excuse me, please. Next stop is the optometrist.

D R. M A R K R. M E I N E R S: Madam Chairman, and members of the Task Force. My name is Mark Meiners. I'm with the National Center for Health Services Research, which is part of the Public Health Service. My background is in economics. I am a Senior Research Manager for long-term care projects with our organization. I specialize in health care financing, and health care of the elderly.

I'm going to be testifying about the issue with which your Task Force is dealing. I want to provide what I see as a problem definition, and then also some general ideas for possible public roles. Since I know we're going to be somewhat tight on time -- you have a lot of people you want to hear from today, you want to get started, get some background -- I'm going to work from a prepared text.

The need for long-term care is the leading cause for catastrophic health expenditures for the elderly citizens. Medicare was not designed to cover long-term care, and our private insurance options offering protection against such expenditures are extremely limited. As a result, elderly persons with resources who need long-term care usually pay for such services out-of-pocket. Since such care is quite expensive -- particularly if it is at a level that requires a nursing home stay -- people who need it, often end up spending down their income and assets until they qualify for Medicaid. Through the spend-down process, Medicaid has become the long-term care insurance program for many middle class elderly persons needing long-term care; a situation that is generally unsatisfactory for all parties concerned. The elderly, who become eligible for Medicaid through spend-down must first exhaust most of their assets. The resource limits are quite restrictive, essentially requiring that the person becomes impoverished. Even then, some people have difficulty qualifying because of seemingly arbitrary nuances of the Medicaid eligibility criteria that favor institutional care, and set all or nothing income limits sometimes more favorable to those already poor, than to those who become poor because of Medicaid needs.

The almost inevitable dependence on Medicaid when long-term care is needed, has in turn prompted consumer interest in strategies for protecting resources from Medicaid's claim. The establishment of special trusts, and the shifting

of assets to relatives are options that are being considered. When such transfers occur, however, the strain on the Medicaid program increases, because the divested resources are no longer available to the State for spend out. To reduce the incentives to divest resources, Federal regulations regarding the placement of liens on the home, and transfer of assets for protecting them in special trusts, have been strengthened to make it more difficult to qualify for SSI, and therefore for Medicaid. These policies are often viewed as too difficult, costly, and unpopular to administer, and many states seek to avoid them whenever possible.

In essence, the State and its citizens are faced with what amounts to a "Catch-22" situation. Without long-term care insurance options, consumers do not have a reasonable vehicle for financial planning -- their protection against the risks of catastrophic long-term care needs. Consumers with personal resources for a normal retirement, will nonetheless find it difficult -- if not impossible -- to save enough to pay for long-term care directly should it become necessary. Without insurance to help pay the bills, many private patients quickly exhaust their resources paying for long-term care.

This puts pressure on Medicaid, a program which already has gaps and inconsistencies in the protection it offers, and is the subject of continual cost containment attention from states. It also encourages consumers to divest rather than spend down, putting further strain on the Medicaid budget. The result is that Medicaid is subject to restrictions and limitations which make it less able to serve its intended role of assisting the poor. To the extent that states resist the pressure to cut back benefits, or eliminate eligibility, Medicaid risks being viewed as an alternative to private market insurance. This possibility has been mentioned as one of the key barriers to the development of a market for private financing options, such as long-term care insurance. This

problem description highlights the all or nothing situation that currently exists with Medicaid.

Long-term care insurance is an option that is beginning to emerge as one of those that seem to have the most promise of a whole menu of options that have been discussed and researched, and are still undergoing development and examination. Encouraged development of purchase of insurance options -- such as freestanding long-term care insurance, social health maintenance organizations, or continuing care retirement communities -- that provide consumers the chance to pool their risks, and potentially relieve some of the burden on both consumers and government.

Now, one of the most intriguing aspects of the development of long-term care insurance is the potential it holds for relieving some of the pressure on Medicaid. Government payers will benefit if private insurance can reduce the role of Medicaid as a source of payment for middle income elderly, by delaying or avoiding the need to spend down their resources. It also may be viewed as an alternative to the current incentive to transfer assets to gain eligibility. The possibility that there could be savings to public budgets as well as benefits to consumers, suggests that there is a public role in encouraging such a market.

A variety of public policy interventions to support the emerging market, are possible. A relatively inexpensive, yet extremely important role, is that of consumer education. Further efforts are needed at both the Federal and State level to inform consumers that Medicare and most private insurance policies do not provide extended benefits for chronic illness and disability. As products become available, consumers also need information and guidance to make informed choices. States in particular can play a significant educational role in the office of the Commissioner of Insurance. They can also encourage insurance regulators to assist the development and

marketing of such benefits by removing regulatory restrictions that inhibit reasonable product development. And experimentation is very important to this area. Significant additional support for market development may be achieved by coordinating the cost and care management techniques of public long-term care programs with those that the private market views as important to its success. What I have in mind-- There are things like case management, pre-admission screening -- programs that the State may already have in place to deal with the cost pressures of the Medicaid system. These are equally important to the private market development.

The significant roles states have in financing long-term care, along with having been delegated much of the responsibility for the structure and administration of long-term care programs, also provides incentive for more direct support of the emerging long-term care insurance options. In particular, the Task Force should carefully evaluate the State's current role in financing long-term care. The rules governing eligibility for Medicaid through the spend-down process should encourage the use of an individual's own resources for their long-term care needs.

Medicaid simply cannot afford to act as inheritance insurance for families, and a private long-term care insurance market cannot fully develop if Medicaid indeed plays this role. At the same time, it is important to recognize that there are situations where Medicaid rules may stand in the way of sensible support. Spousal impoverishment brought about by the deeming rules in some states is an example of this. In structuring interventions to deal with such problems, consideration should be given to incentives that encourage private initiative and responsibility.

More aggressive strategies involve direct market subsidies. There are strong reasons for encouraging such interventions in the market. Long-term care insurance is still

in its infancy. While there has been considerable interest in product development, the market is still small and quite underdeveloped. Until there is more experience with insuring long-term care we can expect progress to be slow and conservative. The limited market size and conservative pricing in turn tends to restrict the market to relatively high income persons. It is in this context that strategies to subsidize the market may make some sense. By targeting subsidies to persons otherwise unable to afford the insurance, the market size is increased and greater numbers of those most likely to spend-down to Medicaid are included.

Market subsidies could take several different forms. One approach would be to guarantee full protection from further asset spend-down for anyone paying through insurance or out-of-pocket for a set number of years.

Asset waiver strategies are based on the assumption that a major barrier to market development is the desire for asset protection. While this may be important, it is also likely that the current market may face affordability constraints which loom at least as large as a barrier to further development.

Premium or deductible subsidies in the form of, say, tax credits, or deductions if a person buys a state certified level of insurance protection, is another way to support market development. This type of subsidy could increase the affordability of current products. Both asset waiver and premium subsidy strategies are targeted to the consumer and both could be varied on the basis of income.

Other strategies could be in the form of premium tax breaks or public reinsurance programs targeted to help insurers overcome their hesitancy to enter or expand the market. Carefully crafted, a state reinsurance program could serve as the basis for a data collection initiative that could help overcome insurers' hesitancy to share information on

utilization and cost patterns under their programs. The lack of such data has been perceived as one of the barriers to more rapid market expansion. And I think it will be important to put in a solid data collection, data management system, both to develop the initiative that you're going to be considering, as well as monitoring its success as it goes forward.

Assistance to market development might also be accomplished by paying the insurance premium for persons eligible for Medicaid on the basis of low income. This would serve to broaden the risk pool and help spread administrative costs.

There is no one approach to supporting the market that is obviously the best at this stage in the development of the market. Depending on specific market characteristics, and its particular objective, your Task Force might choose to focus on one, or indeed, several of these strategies to encourage development of this type of insurance.

The need for long-term care is the single most important cause of catastrophic health expenses for the elderly. I think that's where you need to start, and really recognize that right up-front. Although this fact was noted nearly 10 years ago in a report by the Congressional Budget Office, it is only recently that it is receiving much attention. Perhaps the reason for this lack of recognition was that there was no alternative, short of the national program and that repeatedly has been avoided as too costly. I think the current debate on revisions to Medicare is following that same pattern.

There may be a few things that are included that may seem a little like long-term care benefits, but for the most part the long-term care program is not being addressed by the current legislation being considered on Capitol Hill. It made little sense in the past to alert the public to the significant financial risk associated with the need for long-term care, if

indeed there was no workable solution. I think a break in the stalemate has occurred with the recognition of long-term care as an insurable risk. The new private financing initiatives have begun to show how the risk can be shared in a way that encourages individuals with resources to participate in risk pooling, and in the process, help clarify those areas where there will be a need for more public involvement on behalf of individuals without resources.

I think what you're embarking on with this Task Force is really an exciting opportunity. In essence, you have the chance to create a new public/private partnership in New Jersey. Right now there is clearly still a public/private partnership. When you look at the numbers you see that in most states private out-of-pocket dollars tend to pay about half of the bill, Medicaid pays the other half. It's clearly a public/private partnership, but it's very unsatisfactory to everybody concerned. So I encourage you to really think in terms of trying to create a better environment, look to some of these long-term care insurance options. They are still under development. They're still very subject to improvement, but I do think they provide a useful opportunity to develop risk pooling mechanisms that can be appealing to consumers, and provide them with a better way to financially plan for these risks.

With that, I'll be happy to answer any questions that you might have.

ASSEMBLYWOMAN CRECCO: Thank you. Do any members have questions? (no response)

Dr. Meiners, are there examples of model consumer education programs in other states that we should consider emulating here, in order to develop widespread awareness of the need for long-term health care insurance programs?

DR. MEINERS: Yes. The one that comes most readily to mind is the SHBA Program -- SHBA, I won't try to remember, Senior Health Benefits Advisory Program -- in Washington State. What it is is, it's run out of the Insurance Commissioner's office and uses trained volunteers -- senior volunteers -- who help advise fellow seniors about the availability and features in various Medigap insurance policies, as well as in long-term care insurance policies; a very innovative program, and quite effective in terms of both spreading the word, and helping people avoid costly mistakes in their decision making.

A number of other states are starting to follow, North Carolina being one that at least tests their own program to see if they can have the same kind of impact in educating consumers.

ASSEMBLYWOMAN CRECCO: Thank you very much. We appreciate the fact that you're here, Dr. Meiners.

MS. DIETRICH: Madam Chairwoman, may I add that New Jersey has begun such a program.

ASSEMBLYWOMAN CRECCO: They have?

MS. DIETRICH: We have a Senior Health Insurance Program in five counties now, and we're expanding it this fall -- through the Division on Aging.

ASSEMBLYWOMAN CRECCO: Which counties are they?

MS. DIETRICH: We're now in Camden, Monmouth, Union, Mercer, and Somerset. In fact, we have the coordinator from Monmouth County here this morning in the audience.

ASSEMBLYWOMAN CRECCO: Thank you very much.

DR. MEINERS: It is a very important thing. It keeps coming up in the discussion of this issue. Consumer education seems like a simple thing, but the fact is that you do need an educated consumer out there to both make the right decision, and to help create a reasonable demand for the products and for this type of protection. So it can't be emphasized enough, and it really fits in the spectrum of-- There are less aggressive

to more aggressive. Consumer education is something that can be done certainly without huge dollars of expenditure. Subsidies, of course, can involve more expenditure on the part of the State.

ASSEMBLYWOMAN CRECCO: Thank you very much.

DR. MEINERS: You're welcome.

ASSEMBLYWOMAN CRECCO: All right, the next person testifying is Linda Schofield, who is the Assistant Director of Government Affairs, The Traveler's Insurance Company, Hartford, Connecticut; former Senior Consultant to the Connecticut Commission on Long-Term Care.

L I N D A S C H O F I E L D: Good morning, thank you. I'm Linda Schofield. I'm pleased to have been invited to report on the findings of our Commission's study. We had a similar Commission to your Task Force. Governor O'Neil appointed the Commission on Financing Long-Term Care, in June 1986.

After a year of research and public hearings we issued a report identifying the impediments to private financing and suggesting strategies to overcome those impediments. I've given copies of the report and the Governor's Action Plan to your staff, and they'll distribute that.

My following remarks are highlights of the findings and conclusions and recommendations of our report. I've also given Deb a copy of the testimony, which is a little long so I'm going to run through and summarize quickly.

There are a number of social and economic trends coming together to make long-term care one of the most serious challenges facing this country. The most significant factor -- which I'm sure you're all familiar with -- is the greying of our population; particularly increases in the population over the age of 85, who are most likely to require long-term care services.

Other factors contributing to the growing urgency of the long-term care problem include changing family structures. Both members of a couple are usually working these days, so there is less availability of family care. Members of the family live far apart. There are divorces, which inhibit people's ability to provide family care. In addition, other factor include: the limited range of options for financing long-term care, a public policy bias towards institutional care, and a lack of financial preparedness of most individuals -- largely because, as Dr. Meiners pointed out, they don't understand the issue. They're not prepared. They're not educated. They don't save money for the potential need. Adding to the problem is this misconception that everyone has that Medicare covers them, when in fact it doesn't.

The long-term care problem is a delivery problem, as well as a financing issue. In Connecticut, we projected that by the year 2000 -- which is only 13 years away -- there would be a 44% increase in the number of physician visits by the State's elderly, a 31% increase in the number of acute hospital days consumed by the State's elderly, a 42% increase in the number of elderly residing in skilled or intermediate nursing care facilities, and a 53% increase in the number of elderly receiving skilled health care, personal care, and homemaker services at home. That's a pretty significant growth in service demands over a fairly short period of time. We also have projected that given that current rate of growth, our formal delivery system will not be adequate by the year 2000 to meet those needs.

In view of these projections it's clear that informal care -- which comprises, it's estimated, about 80% of all the services that elderly receive -- is really a crucial and primary source of care. Older persons prefer to be cared for at home by loved ones. Informal care is provided without expense to the State. And informal care often precludes -- or

at least delays -- the need for formal services, thus relieving demands on the public sector and on the formal delivery system. Therefore, it's essential to bolster that system of informal care.

Just as the delivery system will not have the capacity to meet the future needs, current financing systems will likewise not be adequate to meet the challenge, if indeed they are even adequate today. As you know, individuals and families pay for long-term care from savings and available income until their resources are exhausted. At that point, the state Medicaid program begins paying the bills for nursing homes and, in some states, some limited community care services.

In Connecticut, approximately 54% -- or $318 million -- of our state Medicaid budget is earmarked for health care of the elderly. Of that $318 million spent on the elderly, $274 million goes for long-term care in nursing homes. This nursing home bill represents 5.6% of our entire state budget, and is projected to grow to over 7% in the next 13 years if things don't change. That's a pretty big chunk of the whole state budget.

The challenge to the state -- to our state and to your state -- is to design a comprehensive, coordinated system, which will moderate the growth in State expenditures for long-term care, assist families to meet their long-term care needs -- both financial and service needs. The complexity of the long-term care financing issue requires a multifaceted response. No single element of society -- neither the individual, the family, the employer, the State, the Federal government, or service providers -- can meet all of the long-term care needs that have been projected. All of these parties must collaborate in addressing the long-term care needs of today's elderly, and tomorrow's elderly.

My Commission concluded that there are better methods of public and private financing that can be found; that the delivery system, particularly community-based services, must grow to accommodate our demographic shifts. And that long-range preventive measures must be taken to improve the well-being of future generations of elderly, and therefore to contain the costs of caring for them. As well as, obviously, to improve their quality of life. We made recommendations in five broad categories:

1) The variety and availability of new methods of private financing for long-term care should be increased to meet the needs and demands of several diverse market segments and to moderate the increase in pressures on public treasuries at the state and Federal level. Let me just make a side note that very often in looking at older Americans there is a tendency to want to lump them all together, and they're not at all a homogeneous group. There really truly are very diverse segments. So there's no single silver bullet solution. You need several different approaches, several different products, in order to meet the diverse market segments of the entire older population. These different products might include home equity conversion, insurance, health maintenance organizations, continuing care retirement communities, and other innovative alternatives.

Our second recommendation pertains to the availability of financing for home and community-based alternatives, which we felt must be expanded. These home and community-based services, complement and sustain family care giving efforts. And, as an alternative to institutional care, represent savings to the individual, the family, and potentially the public sector; again, to say nothing of the fact that it's a much preferred and better quality system of providing care in the eyes of most elderly.

The third recommendation: Long-range strategies must be developed and supported to enhance the personnel resources available to meet the long-term care needs, and to moderate the increase in demand. We need long-range strategies to moderate the increase in demand for long-term care services. These positive long-range strategies should include extended employment of older adults, disease prevention and health promotion, an expanded support of research into the diseases of old age, and expanded support for the training of health care professionals. I don't know what the setup is in this State. We have a real shortage of nurses and physicians, particularly in the area of geriatrics. As competition between nursing homes and hospitals for staff grows, the nursing homes are the quickest ones to lose their staff. It's a real problem.

The next recommendation pertains to consumer education. We feel that programs regarding long-term care financing should be expanded at both the state and Federal level. A more educated populace will understand the need for timely personal financial planning efforts. Furthermore, consumer education, together with an effective program of consumer protection, will enable individuals to make selective, informed choices. As a consequence, traumas -- such as spousal impoverishment -- may be reduced and pressures for public support moderated.

The fifth recommendation, data collection efforts and public dissemination of information regarding long-term care service utilization must be improved. The lack of data -- particularly longitudinal data which describes long-term care service utilization over time -- presents design and product pricing difficulties for government, service providers, and the private sector insurers alike. We happen to have a rich data system in our state that's never really been tapped and meshed in order to yield some information that would be very useful. We've been fortunate in getting a Robert Wood Johnson

Foundation grant just recently, to work on developing some alternative financing methods; and as a part of that to begin developing our data resources. But it's surprising how much data states really do have that they don't even know of, particularly one department that may not talk to another department. If you can get those guys talking to each other it's very helpful.

Information is really the key to managing risk, and its availability will therefore expedite the entry into the market of more products, and more product sponsors. And of course will also assist the State in developing new programs.

In addition, we recommended that Governor O'Neil work with the Connecticut congressional delegation, with other members of Congress, and with the National Governors' Association, to strive for an appropriate and expanded Federal response. Tax incentives are the most obvious means by which the Federal government can encourage private financing of long-term care. Tax reforms may include removing tax barriers to new, as well as existing, private methods of financing long-term care. And creating incentives for employers, individuals, insurers, and other financial institutions, to expand their roles in long-term care.

In view of the essential role that families play in providing informal long-term care services to their elders, the Federal government should expand incentives and support these family efforts. The Federal role should also include an expansion of Federal funding in the field of geriatric research, and in the training of health professionals in the field of aging. Finally, the Federal government must begin to look more favorably on applications for Medicare and Medicaid waivers from those states -- such as your own, and my own -- interested in testing new models of long-term care delivery and financing.

The opportunity and necessity for State leadership exists in the area of long-term care financing. I'm personally very encouraged to see the number of states taking action on this issue, and I feel that the sharing of information and coordination of efforts between states, can only expedite progress. To that end, I'd be more than happy to work with your staff, serve as a resource for you, and direct you to persons in other states who are also working on this topic. If I can answer any questions, I'd be more than happy to.

ASSEMBLYWOMAN CRECCO: Any questions from the Committee?

MR. LANGEVIN: I do have one question. Is there any state that has even a year's experience with something that seems to be working, because what I hear you saying today paints a fairly bleak picture for changes in societal norms, and also for the delivery system, even if we would be able to pay for it in the State of New Jersey?

MS. SCHOFIELD: Did I sound that bleak? (laughter) There are several state initiatives. Wisconsin, for example, has begun expanding its programs for community-based services and bolstering family care efforts by providing cash assistance and respite care services to families that are caring for their elders at home. California also has a program like that. There are several states that are beginning educational programs. My state has taken some actions. The Governor immediately put together an action plan, included certain things like expanding our home equity conversion program, changing some of our Medicaid eligibility rules so that it makes home equity conversion a more favorable and economically wise choice to make. There are lots of state actions. In fact, we did a report on all of the different activities in the states around the country, and I'll be happy to send you copies of that. There are more than 20 states that have commissions or task forces or study groups like your own, and you're right

in saying that we're all sort of at the beginning. Nobody has had lots of experience, but there's a lot of activity going on out there and that's certainly the precursor -- if nothing else -- of some change.

It was very encouraging in my state to see the level of consumer awareness. If you don't mind some extemporaneous remarks here, I'd like to give you a couple of tips from experience of the last year. We really spent a lot of effort in an aggressive press strategy, which got the issue into the newspaper and on television a lot -- not just because we wanted our picture in the paper, but because it really did go a long way to increasing consumer awareness. The older community got very interested in the issue; the younger community as well. Employers, financial institutions, banks began looking at the home equity conversion as an option. That's a real important strategy. Once you get that kind of momentum going, that just carries you forth. We really tried to encourage a lot of open hearings so that people became very invested in the process, including individuals who came and told heartrending stories of their own family experiences, as well as we invited everybody from every state agency that was related to long-term care. So by the time our recommendations came out, people were very invested in the process, and interested in adopting and implementing the recommendations that we had.

And just my last comment, that I think it's real important to get the private sector involved. We did a lot of fund raising from the private sector, and put together some subcommittees of people from insurance companies and HMOs and banks and the like, to get their input and to get them, again, invested in the process. And I think that was a real useful strategy.

MS. SIMS: I have a question. I have a question about HMOs' response to this issue. Can you talk a little bit about that?

MS. SCHOFIELD: Sure. To date, the primary response of HMOs has been through a national waivered project called the Social HMO Project. There are four sites around the country. And what they provide is a capitated HMO type of program, with case manager services. They don't have extensive institutional benefits, for the most part -- usually four to six months of institutional care -- but they have focused on community-based and home-based services in an attempt to keep people out of institutions. The results of that demonstration are preliminary, at best. They've only been up and running for a couple of years, and they had difficulty marketing the program -- in part because it was a demonstration, and I think a lot of people didn't want to sign up for something that maybe wouldn't be there in three years. They've applied for an extension to do another three years so that they can really analyze the results, and I think that they will probably get that, if they haven't already. But they are finding that -- in preliminary terms -- that they are making some savings, and successfully diverting people from institutional to community-based care. We have a waivered program also in our state that also provides case, that also provides case management community-based services. That's a tremendous source of savings.

Other HMOs that I know of have not developed products to date, although the HMO Kaiser in our state, was very interested in being involved and gave an indication that in the long run they do want to develop that kind of service.

MS. DIETRICH: I have a question. I noticed that you mentioned the awareness of your group of the shortage of physicians and nurses. Did you also look at the issue of the supply of homemakers, and home health aides?

MS. SCHOFIELD: Oh yes. The whole spectrum.

MS. DIETRICH: Are there any plans or recommendations-- I noticed that you recommended that the State get involved in addressing the shortage. Is there any move in Connecticut to look at that?

MS. SCHOFIELD: We've talked about calling together people from the Labor Department and Higher Education in order to begin addressing the issue. It's actually just a tremendous national problem. I have my own personal opinions on it, but I can't say that they are really Commission endorsed opinions. I'm not sure what actions the Governor is planning to take on that one, other than to maybe work with the university system in trying to find more funding. We do have a recently endowed Chair and a couple of positions at the University of Connecticut to expand programs and coordinate programs of education in the allied health fields, focusing on geriatric medicine. I think that will begin to make some inroads to the problem.

But to be quite frank with you, a lot of it has to do just with plain old economics. If you pay people poorly, they're not going to want to take the job. And those jobs -- particularly working in nursing homes, but even working in people's homes -- are very difficult jobs. It's emotionally and physically stressful. It takes a lot of endurance, and it takes a person with a certain kind of warmth and heart to do it. Those people -- particularly women -- are finding that they now have other job opportunities that can pay them a little better. So until there's better pay equity, I'm not sure that that will ameliorate tremendously. But education will help.

MS. DIETRICH: Thank you.

MS. BASS: Madam Chair, a question. What kind of response are you getting from the insurance industry? Are they devising products?

MS. SCHOFIELD: In the state?

MS. BASS: Yes.

MS. SCHOFIELD: Yes. We had some barriers to insurance development in our state in that the Department of Insurance has still not promulgated regulations to allow

insurance in the state. Surprisingly, they've gone ahead and approved five policies without regulations, which is a bit unusual.

MS. BASS: I'm not sure it is unusual.

MS. SCHOFIELD: Well, in our state it is. They are in the process of promulgating regulations. Until a year ago when we had legislation passed, long-term care insurance was not legal. So, even though we are the heart of the, you know, the capital of the insurance industry, there were no long-term care products being sold in the state. Several of the companies are now developing, or already have products available -- domestic companies, Aetna, Travelers-- Signa is developing policies. The Hartford, I believe, has policies. So we have several companies that are domestic carriers that are interested.

There's been a tremendous growth in insurance policies available. The Health and Human Services Task Force recently did a comprehensive survey of all of the policies out there, and they found in excess of 70 companies selling long-term care insurance, with about 450,000 policies in force nationwide. When you compare that to studies that the GAO did just two or three years ago -- where they found maybe 15 companies and 100,000 policies -- that's a significant amount of growth in a short period of time. It's still very small numbers. I mean, that represents less than two percent of the elderly nationwide.

ASSEMBLYWOMAN CRECCO: Let me ask you a question. You mentioned that you've had some aggressive press, but are there any other specific steps that the state has taken to stimulate the development of private long-term care insurance, while at the same type you ensure the quality of these productions?

MS. SCHOFIELD: Steps that our state is taking?

ASSEMBLYWOMAN CRECCO: Yes, or that our's can take.

MS. SCHOFIELD: Yes. Our Governor is calling together a round table of employers. I believe he'll probably use the existing Connecticut Business and Industry Association as one

entree to that. But he's calling together all of the major CEOs of major companies in the state to call their attention to the issue, and encourage them to begin looking at programs that employers can provide, both insurance programs as well as non-insurance programs. My company, for example, The Travelers, and also the Southern New England Telephone Company in Connecticut, have taken some steps to provide services to their employees who are providing care at home for family members.

We did a survey at Travelers that showed that something like 30% of our employees over the age of 30 were engaged in some kind of family care giving efforts for an older family member, with a fairly substantial percentage of them providing care for anywhere from 10 to 40 hours a week, in addition to their full-time jobs. It's such a strain on them that it really shows in their productivity, in the number of phone calls they're making during work hours, in just their emotional stress and their own health -- days that they have to take off.

So we've developed programs of information. We had a fair where we had all of the services in the community come and provide information on what they could do for families to help. We put together support groups so that employees could -- during work hours or after work hours -- meet in the company and exchange ideas and coping strategies. Southern New England Telephone Company has done similar things with developing care giving initiatives, and referral services. We've instituted "flex time" so people would have more flexibility of when they come in and could arrange their schedules around that. And also a flexible spending account, which allows you to put pre-tax money into an account that you can later withdraw from on a tax-free basis for delivering care to your older dependent relatives. There are a lot of tax limitations that require that the person really truly be a financially dependent

person. But there are lots of things employers can do, even short of just providing insurance.

Our state is also planning to provide long-term care insurance to their own state employees to set a precedent for other employers in the state. And again, lots of educational efforts will be going forth. The Governor's Action Plan outlines all of the steps that the Governor is immediately planning to take.

ASSEMBLYWOMAN CRECCO: How far should the state go in regulating these policies, would you say?

MS. SCHOFIELD: I think that the regulation of insurance is a state responsibility. I would not look to the Federal government to do that. I would discourage that strongly. I think if you talk with your Insurance Commission people they probably would also prefer to keep regulation and consumer protection in their own purview, and not let that go to the Federal sector.

I think that what you do have to keep in mind is that it's an emerging product, and you really don't want to stifle innovation in the long run. You certainly need to provide consumer protection, especially through stringent disclosure, preventing agent abuse, and elusiory benefits. You have to be very careful that you don't prevent future developments, because it really is a rapidly developing field, particularly as case management is going to get built into long-term care insurance policies eventually, and other kinds of benefits. You might have a life insurance policy that converts into a long-term care insurance policy, or a health policy that has a rider. I mean, there are so many permutations of what could develop that you really want to be a little careful about not clamping down and assuming that what's out there now is what you're going to get in the future, and regulating just based on that, so that everybody looks like what's out there now.

ASSEMBLYWOMAN CRECCO: Thank you very much. I can appreciate this. Our family has been in that situation for several years, so it's good to have all this input. Thank you very much.

MS. SCHOFIELD: You're welcome.

ASSEMBLYWOMAN CRECCO: Our next witness will be Dr. Steven Crystal, Director, Division of Aging, and Associate Research Professor with the Institute of Health, Health Care Policy and Aging Research, Rutgers University in New Brunswick.

D R. S T E V E N C R Y S T A L: Thank you. I'm not sure what the particular creative genius was behind the sequencing of witnesses, but I felt as I listened to the presentations by Mark and Linda that this led in very well to some of the things that I wanted to say. I wanted to start taking at least one small step past the sort of descriptive basics about the long-term care problem and the need for private financing mechanisms, and so on, and try to start talking a little more specifically about some of the public policy choices that will be facing a State like New Jersey, and some of the kinds of planning and analysis that will need to be done to deal -- not just in terms of taking initiatives that ought to be taken, but also in terms of responding to some things that are going to happen whether the State takes action or not. I'm talking about the emergence of a whole variety of insurance based mechanisms which are starting to move very quickly, and will rapidly start creating demands on the regulatory processes, and raise a great many public policy issues for the State.

The issues that we're talking about revolve around meeting the long-term care crisis, and most recently, the widespread national interest in private financing -- particularly crucial in New Jersey because of the large and increasing elderly population. This is one of the oldest "States" in the nation. New Jersey has been a laboratory for a lot of ideas. Many creative things are being done in State

government, in the University sector. People like Ann Summers (phonetic spelling) -- who is here in the audience today -- have been working on these issues for years. One of the important documents in this area is the recent article by Ann in the "New England Journal of Medicine," which is starting to bring the issues of private financing of long-term care to the national health care audience.

And at Rutgers, the concern that a great deal of planning, research, and analysis needs to be done on the issues of aging -- and particularly around long-term care policy -- has led to the recent creation of the Division of Aging in the Institute for Health Care Policy, where we're starting to get a group of people together who are looking systematically at these issues. We've gotten a great deal of support and encouragement from the Department of Community Affairs, which, as you probably know, has introduced legislation to create a New Jersey Policy Research Center on Aging based at Rutgers, which would have as one of its principal foci looking at these long-term care issues.

So these are crucial issues. Quite a bit has been happening, and the things that I'll say -- and I'll try to say them quickly, so if there are logical or factual steps that you'd like me to fill in, I'll be happy to -- but I'm going to try to go quickly through a rather complex argument, and through a series of really very intellectually challenging processes that we've gone through during the last six to eight months in a study for the State of California, which was done pursuant to a bill very similar to the study bill that this hearing is convened around. As Linda mentioned, there are about 20 such bills, and many states have been looking at the public policy options for their state.

During the last year, several major reports have been done. The one that I've been working on for the State of California is in process. It hasn't been completed yet, but

it's the result not only of consultant work by two or three of us, but also an advisory committee of people that was formed of people from the insurance industry, people from state government, consumer representatives, provider representatives, other constituencies -- which put in a great deal of work -- had six full day sessions. I think there was really a lot of growth and the emergence of some consensus in areas that I think would have surprised some of the participants at the beginning, about what some of the real issues were. And I think we found that the critical issues were a little bit different than had been visualized by the legislators, and little bit different than how the issue has been framed during the last year; because there's a way in which this issue about private financing of long-term care has been framed that you'll hear repeatedly.

Perhaps it's most clearly expressed in two of the major recent reports on this issue that have been done; one by the Insurance Advisory Committee of the National Association of Insurance Commissioners, and the other by the Health Insurance Industry Association. As you'll undoubtedly notice, members of the industry have been among the leaders so far in sort of framing the public policy issues surrounding this. The consumer oriented organizations haven't yet been heard to the same extent, but I think as these issues emerge you will start seeing the major consumer issues better involved.

The argument -- sort of what's become, let's say, the conventional wisdom during the last year or so, goes something like this:

1) It's very crucial that we have the quick emergence of a fairly substantial private financing industry -- private financing alternative. This is crucial because our public costs and programs like Medicaid are going out of control, because people don't have access to a payment source. And if we have a great deal of private insurance coverage on the acute

care side, shouldn't we have it in long-term care? It is in fact an important public policy goal to find ways to stimulate this as quickly as possible.

2) The long-term care insurance market has developed very slowly. One of the reasons for that has been the lack of experience, the fact that these products are experimental, the concern that costs may get out of control, and in particular, concern about what the impact of regulation may be.

3) That we know very little about this area and, again, therefore, we're in a very experimental phase.

4) That regulation of the kind that has been imposed in other areas of health insurance for the elderly -- classically, for example, in the Medigap area, that deals with such areas as loss ratios -- would be a major obstacle to the growth of this industry. And since it's a given that the high priority is the growth of the industry, that we need to be extremely cautious and tentative about any such regulatory steps. We need to try a great many models, and therefore, again regulation should be very limited, and therefore the emphasis should be on avoiding, and removing regulatory barriers.

That, as I said, has been the conventional wisdom. And certainly, there are important, very real concerns in that, that need to be borne in mind as we address the public policy questions. We do want to avoid stifling innovation in this area. We do want to avoid stifling the market.

However, there's another series of concerns that emerged really very sharply during the course of this California study, and to give you a very quick capsule of it-- There's a statement right up near the beginning of this draft report which hasn't been released, which represents something of a consensus among people from very different backgrounds, on this task force. In fact, to my knowledge none of the members of the task force really objected to this wording, which kind

of surprised me, which goes something like, "There was a consensus that emerged that consumer protection was perhaps the most important issue at this time." And that is not the point of view that this advisory group started with. It's not the emphasis that is central in the legislation, but we repeatedly found concerns about potential consumer problems in this area as we looked at how the market has evolved. Let me summarize very quickly for you. It could obviously take much longer because there's a lot of detail to all this, but some of the things that we found that were not quite what we had expected to find:

1) We found that the industry has grown quite a bit faster than was expected, even as recently as a year ago or so, when that study bill was passed; to the point where it's hardly appropriate to talk about this as a tiny tiny industry any more. Linda mentioned that the earlier estimates -- which were the estimates that the President's Task Force on Long-Term Care were working with. As recently as six or nine months ago if you asked any of the experts how many people -- and given that there are no hard data -- what's the estimate of the number of people actually covered nationally by long-term care insurance policies, the estimates were around 150,000. Current estimates coming out of the President's Task Force are more like 450,000. There are new policies coming on the market every day.

In California, during our first advisory group meeting, some of the most knowledgeable people -- and in fact, the representatives of the Insurance Department who were the prime sponsors of the study -- figured that there were 10 to 12 policies on the market. We asked the Insurance Department to canvass all the insurers and ask for copies of the policies, which we analyzed. We found there were 46 policies, the majority of which had been issued only within the previous several months, and some of which were being marketed fairly actively. So notwithstanding some of the earlier notions, in

fact the industry does not seem to be stifled, but is moving along at quite a rapid clip.

3) The notion that the growth of private insurance coverage will lead to major savings in the public programs, such as Medicaid, which was one of the principal starting concerns, comes under considerable doubt as you look more carefully at this. Probably the most notable way that this has been quantified recently, has been a study done by the Brookings Institution, and ICF Inc., in Washington on behalf of the President's Task Force -- the Federal Task Force on Long-Term Care Insurance, which has been operating in parallel to the Task Force on Catastrophic. They used a very sophisticated econometric model which has been used and tested in other areas for looking at projections of pension income and other issues of the economics of aging. They did a simulation experiment. There are a lot of fine points about the methodology and whether the methodology was right, but actually as I looked at it, some of their assumptions were actually fairly conservative, and the results might even have been more striking if they used other assumptions.

One of their major conclusions was the following: If you assume that there was a policy out there that all the elderly would buy if they could afford it -- afford it being defined as "that the cost would be less than 5% of their income, and that they had more than $10,000 in assets to protect," because if you have very little assets to protect, you have little benefit in buying the policy -- under those assumptions in their model, 26% of the elderly would have coverage by the year 2020. However, the impact on Medicaid costs was only 1% of what would otherwise have been spent. The reasons for that have to do with who incurs Medicaid costs. Many middle and higher income people spend down but when they spend down, the ultimate Medicaid contribution is still partial. So for that reason, and many other reasons, those are basically the things that go into that model.

I'm not going to get too buried in the model, but the point is that even if you assume a considerable range of uncertainty for those estimates, it casts considerable doubt on the notion that fostering the private market is going to necessarily engender major savings in the public programs. And it certainly casts questions on the notion that by subsidizing that market, the cost of the subsidy would be recovered, or recovered manyfold as sometimes has been argued, or even that very much of it would be recovered.

We also found increasingly that this is not an easy area for the private market -- for the conventional private insurance companies operating more or less as they have operated in the past, with indemnity kind of models -- to insure. The reasons did not seem to us to have as much to do with regulatory barriers as with other factors, such as the problem of better selection in a typical individually marketed insurance kind of setup.

More and more as you look at the long-term care insurance area, the models that seem to make a great deal of programmatic sense are managed-care models. They use disability-base screening. They're involved with a flexible provision of the kind of service that the person needs. They include a variety of home care kinds of alternatives, as well as a nursing home benefit. That starts to become a product that is difficult -- certainly an untraditional kind of way for the private industry to operate. There are many examples of the industry wrestling with this problem, and I think some of the most constructive and promising ones of those, involve partnerships between the insurance industry and other kinds of health care providers -- HMOs, and the like. For example, there's a very innovative kind of program that's been developed by Group Health of Puget Sound in partnership with the Metropolitan Life Insurance Company, but because there's the health care delivery organization involved in it and not just a

financing mechanism, they are unable to have some of the flexibility, the more cost-effective provision of benefits as opposed to what's been happening.

What we saw happening in California in the conventional insurance market was, basically nursing home insurance, and nursing home insurance that models itself in many ways -- which is ironic -- on the Medicare model. Ironic, because the Medicare model was designed to not provide coverage for long-term care, but in a sense to separate that which is short-term and convalescent, and related to an episode of acute illness, from that which is truly long-term care. And yet, most of the policies are using screens that are essentially borrowed from Medicare practice. There's a three-day hospitalization prior to the utilization of benefits.

For the same condition for which the need for long-term care exists, there is a need for skilled nursing care. Now, as you get into this, that's a term you have to look at very carefully, because it's a term of art. Skilled nursing care, for example, is not the same as care in a skilled nursing facility. It may have little to do with the extensivity of the care, the degree of impairment, and the activities of daily living for which the person needs assistance; but it's a term of art. It's a term that's been used in Medicare practice as a way of cost containment, and it doesn't necessarily have much to do with the need for long-term care. One can be very extensively impaired, very dependent in basic activities of daily living, and not meet that term of art. It's particularly problematic since there's an issue as to how it's interpreted by individual companies, and how they interpret it in the first few years -- during which time they are marketing a lot of policies -- may be different and important in subtle ways from how they find themselves interpreting it 10 to 15 years from now when those policies start to mature, and people want to claim benefits from them.

The consumer knowing exactly under what conditions they would be able to draw benefits, and under what conditions they would not be able to draw benefits under these policies, is one of the major problem areas. Now those kinds of screens are justified by the industry as ways in which it becomes financially feasible for them to offer these policies and not be afraid of being wiped out by very high rates of utilization. But they accomplish that by -- in the potential, and very likely in the reality -- screening out many individuals who will have a bona fide long-term care need. So there are those kinds of problems. They've been difficult so far to handle in the private market. What we saw happening in the private market does not resemble what one would design if one would design rational long-term care policy that avoids some of the problems of the past -- the over-institutionalization -- that provides services flexibly to people in accordance with their real needs.

Now there are many kinds of policy implications that come from that, and trying to be brief, I'll just try to summarize them more in the form of a way of looking at issues and a set of things to be concerned about, more than the current recommendations -- which are complex and have to be based on very careful analysis -- but just to quickly summarize what this kind of point of view suggests: The concern for stimulating the private market is not the only concern, and needs to be balanced against concerns of consumer protection; that private financing is not a panacea for the long-term care system, or for the problems of finding public financing that's needed for long-term care; that a great deal of study and analysis is needed in this area. The developments are out-stripping the public agencies that are responsible for setting policy and for regulating. We saw that clearly with one of the most sophisticated insurance companies in the country. They were quite overwhelmed by these developments.

Insurance regulation is a fairly conservative business. Most of the products that they deal with have been around for a long time, and they divide things into categories. They say if something is a "widget" it's regulated as a "widget." If it's a "framus" you regulate it as a "framus." When they are presented with these kinds of products, they don't know what to make of it. They're not traditional products. They have some of the characteristics of health insurance, some of the characteristics of disability insurance, of life insurance. They involve a much longer time frame -- in terms of the tail, the term of the coverage. They're going to be paying much further downstream than is typically true of health insurance -- which makes it very difficult. Some of the concepts in terms of loss ratios, for example, that they deal with are difficult to adapt to this. So there is a tremendous regulatory challenge.

And we would argue that it is not appropriate to say, "Well, we'll worry about that in five or ten years, and we'll have laissez faire for the time being, and see what emerges," because there could be a great deal of damage to consumers. We found policies -- by reading these policies carefully -- that once we had looked at them carefully, studied their provisions and looked at how provisions in the policies interacted -- policies that had recently been approved by the insurance department -- that when we brought these to the attention of higher level policy makers in the insurance department and looked carefully at how the policy worked, they said, "Well this is a policy designed never to pay off anybody." These are the kinds of issues that have to be addressed, and will start catching up with consumers, whether the State takes action or not.

In terms of a general approach I would argue that just as the development of the health maintenance organization as an alternative way of financing health care did not just happen,

but required a great deal of institution building -- there were grants and loans that were important in the early emergence of HMOs -- that a positive affirmative kind of approach by the State to encourage experimentation with capitated payment for long-term care in areas like State employee benefits, is important. Developing data bases is important. Conducting ongoing analyses is important. Finding appropriate and sophisticated ways to regulate these products that avoid consumer misrepresentation and consumer disappointment, is important. Consumer education, obviously is important. Incidentally, California has a program called the "High-Cap Program," which is a consumer education program -- which initially evolved with the Medigap, the supplemental Medicare area, and now has become very involved in this. They are reporting a tremendous amount of consumer concerns, consumer confusion. And the existence of programs like that and like New Jersey's program, are going to be very important as these kinds of products emerge.

So, overall I would say that this is a complex area, because long-term care is complex, and insurance regulations are complex. It's going to be very important for the State to get out in front of it, and not just to be reactive, but to be proactive, to think about the kinds of models -- managed care models that are appropriate, to encourage them to try to avoid some of the sins of the past -- the overemphasis on institutional care for example -- and not to let some of the other long-term care agendas be set aside in the quest to privatize long-term care; that some of the initiatives in terms, particularly, of the increased funding for home care for individuals -- both the Medicaid eligible individuals, and those individuals who in most states are in particular need, who have too much income for the poverty level programs like Medicaid, and too little to pay for the home care that they need. All these agendas need to continue, and not be simply

distracted by the notion of the panacea of private financing of long-term care.

So I think with that I will stop, and answer any questions that you have.

ASSEMBLYWOMAN CRECCO: Anyone have any questions? (no response) I have one question. What provisions would a model long-term care insurance policy have, with respect to benefits provided and coverage limitations?

DR. CRYSTAL: I would argue that a model policy is not just a policy, it's a program. It's a delivery structure that has the capability to meet a person's need -- whatever that need is. Now, that entails some form of case management, entails some form of assessment, entails using screens that are valid -- that really relate to an individual's need for long-term care, as opposed to the three-day hospitalization, the skilled nursing requirement. The models that I've seen that seem to make programatic sense are, for example, the four social health care maintenance organizations -- the so called, "SHMOs." A program somewhat similar to that called MSSP in California, the Group Health of Puget Sound kind of appoach. All of these are programs which have an element of case management, which have the capability to bring in the particular service that the individual needs whether that be placement in a nursing home, whether it be home care, and to modify those service plans as individuals' needs change over time--

ASSEMBLYWOMAN CRECCO: Thank you. No questions? (no response) Thank you very much. Our next witness will be Dr. William P. Brandon. Dr. Brandon, Associate Professor of Political Science, Seton Hall University in South Orange. Could we have some order here? Yes, Dr. Brandon?

D R. W I L L I A M P. B R A N D O N: I want to congratulate you, Madam Chairwoman, the members of this Task Force, the Assembly, and the State of New Jersey, for undertaking this important and timely investigation.

The subject is important because justice dictates that we consider the problems of the current cohort of elderly citizens, and prudence requires us to prepare our society and government for the increased demands that will be generated in about 25 years when the baby boomers begin to turn 60 or 65. The study is timely because State action must be developed in conjunction with developments at the Federal level, such as the consideration of expanding Medicare to include social insurance against catastrophic illness. Reexamination of domestic social policy is also opportune in light of the relative health of the economy after the stagflation of the 1970s.

I want to begin today by explaining how my colleagues at Seton Hall's newly inaugurated Center for Public Service and I can contribute to your deliberations. The institutional culture at Seton Hall and the personal convictions of our faculty, lead us to emphasize the value questions involved in public policy issues. Of course, any useful consideration of values must be based on accurate empirical knowledge.

Along with graduate teaching in the Master's Program in Public Administration, we at the Center for Public Service are charged with the twin duties of community service and academic research.

An example of the compatibility of our service and research is the conference we held on paying for uncompensated care under New Jersey's DRG system for reimbursing hospitals. The papers and discussions at this conference were published as a symposium entitled "The All-Payers DRG System: Has New Jersey Found an Efficient and Ethical Way to Provide Indigent Care?" It was published in the prestigious "Bulletin of the New York Academy of Medicine." Subsequently, a generous grant from the Fund for New Jersey permitted us to distribute copies of the "Bulletin" to decision makers and opinion leaders in New Jersey and throughout the nation. Legislation embodying some of the principal recommendations of the conference is now being

implemented and researchers are following some of the leads suggested at the conference.

Our interest in issues relating to the finance and delivery of health care in New Jersey has become even greater since last May, when Seton Hall became a Graduate School of Medical Education. We at the Center for Public Service expect to play an important role in the State's second graduate medical school.

Since you're at the beginning of your deliberations and have asked that today's hearings consider national long-term care policy, I want to devote my statement to general principles -- or options of the broadest sort. Such fundamental consideration is often neglected, because policy analysts are busy grappling with the important details of particular policies, or this consideration is foreclosed because the policy community takes some unarticulated assumptions for granted. Thus, I'm going to try to draw us back out to take a broader look at these issues. This is in a position that's consonant with this sort of value orientation that I described a few seconds ago.

I want to start off by talking about the context for this consideration, that is security for retired workers. We may be at an important turning point in developing health and social policy for the U.S. population. The period from 1935 through the Nixon administration essentially accomplished the task of securing income maintenance and basic health coverage for retired workers. It also saw the protection of workers against periods of unemployment, sickness, and disability. The period began with the inauguration of Social Security and ended with the large increases in the value of the benefit, indexing the increased benefit to rises in consumer prices, and legislation to ensure the payment of promised private pension benefits through the ERISA legislation. Participation in the World War and the Korean War -- which interrupted the

development of these economic rights -- will also give millions of ex-servicemen additional retirement benefits, just as many of them enjoyed significant educational support when they were younger, and tax reductions as homeowners in their middle years.

Now that the basic needs of most elderly are met, new problems have become apparent. We've seen, obviously, perhaps the most evident is the rising concern about the cost of long-term care. But perhaps one of the early marks of this change was the crisis that led to the Greenspan Commission's examination of Social Security finances, and the historic compromise of 1983. The crisis in the Social Security Trust Fund was partly due to the maturing of Social Security as a system, partly it was due to particularly bad economic luck in the 1970s, and partly it was due to the aging of America. The favorable resolution of this crisis secured retirement benefits at least until the baby boom begins to draw heavily on the Social Security Trust Funds. Although some adjustment will almost certainly be needed in the next century, the imbalances are unlikely to be so great as to be unfixable. The state of the Medicare Trust Fund, however, is another story. It is important for attention to be paid to the underlying imbalance in the basic hospital and physicians' benefits promised under Medicare, before these deficits become a crisis.

Okay. This is the context of 40 years of progress in assuring adult workers of relative economic security, in both employment and retirement. It helps to explain why the issues of catastrophic illness and long-term health care have risen to the top of the national social policy agenda. It is natural to wish to complete the basic security system for the elderly by providing Medicare coverage for the entire expenses of catastrophic illness -- those which require hospitalization -- and by developing some coverage for institutional long-term care. The problems of a relatively small number of Medicare beneficiaries -- those who experience catastrophic expenses in

a year -- has led Secretary Bowen to propose his plan to cover catastrophic illness under Medicare. Yet -- as you've heard before, today -- there can be no real catastrophic protection without covering the catastrophe of extended stays in nursing homes.

It is typical of the pluralist, interest-group politics practiced in the U.S. to focus on these genuine gaps in a system that, if not complete, are at least largely in place in its general outlines, and to try to do something about these very real shortcomings. Our political system is often said to eschew comprehensive rational efforts to totally solve new problems. Instead, change generally comes "incrementally," in little steps that build on the last change. The slow accretion of social insurance programs benefiting the elderly is a good example of this incrementalism. Whereas other industrial countries began their government health insurance programs with workers, private health insurance obtained as a fringe benefit through employment has supplied U.S. workers with basic health benefits. As a consequence, social insurance for health was added to measures already in place to provide retirement income. We consequently have a fairly complete, if slightly jerry-built, social insurance structure to protect retirees and the disabled. Workers are fairly well-protected as long as they maintain employment. Large numbers of people falling outside these groups, however, have no meaningful coverage for basic health care, or for long-term care.

Thus, reflection on the great progress that has been made in providing security to retired citizens leads to the question whether social and governmental energies ought to be devoted to adding another crucial increment to reduce the remaining gaps, or whether the needs of other groups or age cohorts in society ought to receive attention. Young families faced with the problem of day-care and housing, and the striking evidence of the need for programs to enhance the health of infants and pregnant women, are frequently mentioned.

Even in forums where questions of relative need are foreclosed, an appreciation of advances in the security and financial status of the elderly is important for policy making. The fact that the economic status of the elderly as a class has improved radically since the passage of Medicare in the 1960s, lies behind the move to force more affluent beneficiaries to bear some of the costs of programs for all of the elderly. Taxation of Social Security benefits began with the historic Social Security compromise of 1983. Congressman Stark's original proposal for catastrophic insurance in the current session of Congress would have taxed affluent beneficiaries to pay for a generous benefit that all beneficiaries of Social Security or Medicare would have been entitled to. The bill actually was passed by the House in July, and involved a slightly disguised form of income related beneficiary cost sharing.

Okay. So much for the, sort of, background information in context. I want to talk about three broad options -- general directions that can be followed in providing long-term care. The first of these is, of course, to maintain the current system, perhaps ameliorating it somewhat with government support for home care and other programs that will stabilize the number of elderly who need expensive institutional long-term care. The second option is to establish a compulsory program of social health insurance that will cover all long-term care, or at least long stay institutional care. The third possibility -- that you've heard discussed in some detail this morning -- is to foster the development of private insurance for long-term care, including catastrophic long-stay institutional care.

Option one -- that is to maintain the current system -- really involves-- First, we need to understand the current system, and you've heard it explained today. The current system can be understood as being focused around Medicaid,

which is a perverse, public, catastrophic insurance for long-term institutional care. Medicaid functions as an insurance program with a gigantic deductible -- all of a person's life savings. Once one reaches that, then one has this safety net, which is a kind of a funny, sort of strange, social insurance. Although this system does provide for those needing institutional care, ultimately it has very serious drawbacks.

The first of these drawbacks is that often the focus of the State and of government on institutional care -- because that's what's absorbing the dollars -- means that the state of home care programs is relatively underdeveloped. That means there's no alternative to institutional care, and costs rise. Another drawback is that the development of Medicaid as a catastrophic insurance for people needing institutional long-term care has really distorted the original purpose of Medicaid, which was designed to provide benefits for the categorically indigent who are on welfare programs, the largest group of whom are the women and children receiving Aid to Families with Dependent Children.

Another drawback of the current system is -- that we haven't really talked about today -- is that it has tended across the country to produce a two-class system of long-term care. To a much greater extent than acute hospital care, nursing homes separate themselves into those who are essentially looking for people who at least are not on Medicaid when they are admitted to the nursing home, and some of them even try to make selections on the basis of those who won't ultimately need Medicaid; and the other kinds of homes which accept Medicaid patients. It's often been remarked that in many of these homes there's a difference in the quality of care in what goes on. New Jersey in its hospital care has avoided this two class care by ensuring that those who don't have compensation for hospital care, that the hospitals -- the

institutions -- are reimbursed fully for their care under the State rate setting system of DRGs. My understanding is that in the long-term care field, similarly the State has taken action to try to stop this two class system of care, but really across the country it's quite evident.

But finally, and perhaps the most significant drawback of using Medicaid as a system of supporting long-term care, is its effects on the individuals. The mental distress calls for someone who has essentially lived an independent life, been prudent, been self-sufficient, to in their final years be pauperized. That kind of mental distress simply cannot be calculated. Physical effects of this pauperization on the spouse who remains in the community are significant and devastating. So, from a concern simply for the individuals, the current system does not work. And it seems very strange that we have a kind of pauperization for a social net by exactly those people who, in other aspects of their lives, are the largest beneficiaries of social health insurance.

Okay. An alternative to the current system is social insurance. Social insurance involves a non voluntary pooling of large groups based on a pay as you go philosophy. It could remedy the current situation because a relatively small number of elderly, at any one particular time, are faced with the expense of long-term care. That number can be predicted, and one can develop payments from the others to pay for it. So long-term care is something which can be covered under an insurance mechanism.

Perhaps the chief reasons social insurance is not considered in the current ideological climate is because social insurance programs -- or almost all of them -- are redistributive; meaning taking from some to support others. As sort of an aside perhaps, as a citizen of New Jersey, I might remark that in our regulation of insurance -- for example automobile insurance -- the State doesn't hesitate to be

redistributive, for example in taking some kinds of surtaxes on people buying auto liability insurance to support the premiums paid by bad drivers, and that at least social insurance mechanisms, when they are straightforwardly addressed, having the advantage of doing it openly, rather than in this disguised form. But one needs to recognize reality, that currently social insurance is not in favor, and this I'm sure will weigh heavily in the considerations of this Task Force.

There are several advantages, however, of a social insurance mechanism, and that is that everyone is treated equally. Because everyone is treated equally -- has an equal right to benefits -- there's no stigma attached to using those benefits, whereas we know that Medicaid still carries for many people a kind of stigma.

Another consideration that perhaps isn't so well-known is that, contrary to popular opinion, social insurance can be cost-effective. For one thing, there are no large reserves needed since it's possible with a government guarantee to operate on a pay as you go basis. Moreover, many of the expenses of private insurance -- marketing, profits, much of the overhead costs -- really aren't necessary with a social insurance program.

A third consideration is that the concentration of buying power into the hands of one body -- for example, the government -- gives it great power to control costs. We've seen that outside of New Jersey with Medicare, which is now making rapid strides in controlling costs because they have buying power and can force providers to control costs.

However, as I indicated previously, the disadvantages of social insurance are probably decisive, especially for a State body. In the first place, any social insurance mechanism involves turning private dollars into public dollars, and in this economic climate no one wants to see government budgets appear to become larger.

The second problem is that any social insurance mechanism is liable to increase demand, what insurance companies like to call a "moral hazard," that is, if something is insured against, there will be more demand for that service, and that of course runs up costs.

The third consideration is that social insurance mechanisms probably have to be developed on a national or Federal basis. It's really hard to see in these days how states could develop their own, pretty comprehensive, social insurance mechanism; even for something like long-term care.

The third option then is private long-term care insurance, which has been explained in some detail by previous speakers. What I think hasn't been addressed here is the straightforward question of, why hasn't private long-term care insurance developed previously? One of the chief problems with long-term care insurance is that the premiums are probably prohibitive. If a policy is purchased when the individual is really faced with a significant likelihood of needing long-term care. The costs of long-term care are so astronomical that unless you get relatively young and health people buying policies that will then go into some kind of trust fund to save for them, the costs become so expensive that they are unlikely to be appealing to people faced with this choice.

Another problem, of course, in keeping the cost is -- or the assumption in saying they are expensive, is that you're going to have adequate policies that will actually deal with the problem. So the cost of purchasing long-term care insurance really has to be pushed back to people -- to middle-aged workers who do have more disposable income. Yet it's very hard to sell insurance for potential institutionalization that may or may not come about many years after purchase.

Perhaps part of the problem is this lack of information -- even by many retirees -- that Medicare does not cover long-term care. Yet, it seems to me that if government and insurance companies do succeed in correcting the failure of information so that the general population becomes aware that long-term care is not covered, the typical American male -- who is the one making the decision on insurance matters -- seems to me unlikely to subscribe to long-term care insurance until there's a real chance that he or someone in his family may face this possibility.

Another problem with our experience with depending on private insurance to supply long-term care needs, is that we have learned with health insurance to essentially function in this realm on a pay as you go basis. We have annual policies that have to break even. We don't have the habit of dealing with large trust funds which are built up over the years. We do have this experience with life insurance. Moreover, health insurance has taught us to expect, and to trust, service benefits rather than indemnity. This leaves a problem for the insurance companies, which have to engineer benefits far into the future so that these benefits will be adequate. They also have to predict costs in the future, and that is a really sticky problem -- a technical problem with insurance, but a broader problem for all of us because we don't know what is going to happen to inflation and to savings. So there are some real problems -- almost commonsensical problems -- with long-term care insurance that I think helps to explain why I think it hasn't developed, and probably which government really can't do that much about.

There is, however, a positive side, and that is the possibility of a partnership between private insurance companies and government. Government could easily do more to foster home care programs, and these would cut the costs of the really expensive part of long-term care, that is institutional

care. On the other hand, enhanced private insurance held by a large segment of the population would buffer Medicaid costs that government bears, because there would be private insurance mechanisms absorbing long-term care costs.

There's another aspect that might suggest or explain the interest and perhaps the growth -- even small as it has been -- in long-term care insurance. One of the aspects -- it hasn't been commented on very much -- on all of the new catastrophic proposals that the last Congress considered is that they are going to squeeze the supplemental or Medigap insurance policies. As Medicare becomes more comprehensive for hospital coverage, it may not appear worthwhile for individuals to purchase additional supplemental policies. This loss of the Medigap market may motivate insurance companies to develop new business in the long-term care process. So one of the reasons we may be seeing an explosion of long-term care policies is because insurance companies need to find new markets in this sort of general area to replace lost Medigap coverage.

Well, how does one evaluate the growth of -- or the value in development of private health insurance for long-term care? It clearly is a partial solution. Many people who don't have the means, aren't going to be able to afford the policies even when they're working, and before they face the risk of being subject to long-term care. But a partial solution is no doubt better than no solution at all. However, we need to be careful of three dangers that may accompany any growth in long-term care insurance in the private market.

First of course is the problem of moral hazard. That is the insurance effect in which more people will seek care if they're covered. A second is a growth in the segregation of patients by payment class, that's creating a worse problem with this two class system of care. And the third possibility is that if we have private long-term care health insurance which covers care delivered in the homes, it would be very sad to see

the care that's now given on a voluntary non-monetized -- that is a not paid for basis by family, friends, and neighbors-- It would be terrible to see that in a way become something exchanged for which we now pay money. Not only will it raise costs, but it would probably reduce the quality of that care. Other countries which depend less on payment and more on, sort of, philanthropy and volunteerism than the United States has, reports that the care is not only cheaper, but the quality and the spirit in which that care is offered is much higher. There is also a history in the American health care system of the replacement of philanthropy and volunteerism with reimbursement of various kinds of charges, with effects on the health care system.

Regulation can at least take care -- or do something to inhibit -- the growth of the two class health care system, and it seems clear that we're going to need regulation to make sure that long-term care policies actually are adequate to the problem, and that they actually do pay off in claims that they've been collecting for over the years. Hence we must really abandon the policy of buying for one year and then dropping it. Any long-term care policy must be continued over a long number of years.

Okay. I want to stop at this point and say I'd be happy to answer any questions, and in closing thank you for inviting me to come up and talk to you, and to wish you well in your important endeavors. It's a challenging task that you face.

ASSEMBLYWOMAN CRECCO: Thank you. Any questions?

MS. BASS: I just have one question.

ASSEMBLYWOMAN CRECCO: Do you? Go ahead.

MS. BASS: Something you alluded to -- and something which we in the Department of Human Services are concerned about -- should there be a significant growth in coverage for long-term care, whether that might not create a squeeze on

Medicaid patients, who already face some difficulty in finding placement into nursing homes? Can you address that a little bit?

DR. BRANDON: I think it's a serious problem -- if I understand your question right. In other words, that there would be a diversion from current Medicaid patients to support long-term care programs in the home, and therefore that the nursing home industry would in a way stagnate and there wouldn't be more beds; or that Medicaid would be paying both at home and in the nursing homes.

MS. BASS: I think my concern is more that -- as you suggested -- there might be even increased demand for nursing home beds among people who now have long-term care coverage, over and above what already exists, and that would decrease what willingness exists today among nursing home operators to accept Medicaid patients, and that we might have even more difficulty finding placements for people who really have the fewest options of anyone.

DR. BRANDON: Yes. I think that's a great possibility, unless of course Medicaid begins to pay more generously. If it's attractive to have a Medicaid patient, then I think that reluctance is going to fall very rapidly. From the point of view of social justice, that's clearly what the State of New Jersey has done with its hospital payment system; and that is to assure essentially the same payment no matter what one's payment source is. I would hope that in the long run we could move towards a long-term care program that would aim at an adequate rate of reimbursement for nursing homes just as we have for hospitals. Then of course you have the cost problems, and a different kind of squeeze, and that is that State and the Federal money that goes into Medicaid would more and more be siphoned into care for long-term care -- either in nursing homes or in home programs -- and that we wouldn't be providing that care which was the original purpose

of Medicaid, essentially for children and others on categorical welfare programs.

ASSEMBLYWOMAN CRECCO: Thank you very much. I just want to ask you one question. Of the three options you mentioned, what do you feel the prospects will be for the next five years?

DR. BRANDON: I think there's virtually no chance that we'll see social insurance for long-term care. In a way it's a non-starter, but I think it's important to continue talking about it because there's a history of finding the inadequacies of private insurance, finding large scale uncompensated care -- for example in the hospital system -- so that in the long-term, that may be the option that will emerge, but certainly not within the next five years.

The growth of private long-term care insurance: Everyone seems to talk about it as just around the corner. I'm a little skeptical. I think there's some real problems, both in informing people about the lack of current coverage, but beyond that of motivating individuals -- perhaps their unions, certainly their employers -- to provide this as a fringe benefit, or for people to pay out-of-pocket for individual policies. This climate is not conducive to increased fringe benefits, given the problems of competitiveness of American industry. Moreover, employers are particularly loath to expand benefits for retirees. In fact, there have been attempts to cut it back. It's retirees who are going to need the long-term care benefits. So that it seems to me it's unlikely you're going to have those kinds of institutional supports for the private health insurance that's discussed as the answer. So frankly, yes, I think some people will have this kind of protection. Probably it's more likely to come about through the retirement communities that provide nursing homes, with sort of large up-front deductibles -- buy-in provision, that kind of arrangement, and perhaps social HMOs, which are an interesting idea, but I think as yet unproved.

Sadly, that leaves the first option -- which is a continuation of the current program -- maybe with more efforts at home care so that people aren't forced into nursing homes, and with a commensurate decrease on pressure of Medicaid budgets. I wish there was something more positive.

ASSEMBLYWOMAN CRECCO: Thank you.

DR. BRANDON: Thank you.

ASSEMBLYWOMAN CRECCO: We're running a little late. We're going to try to conclude by 1:00, and perhaps we'll call witnesses and not ask any questions, and take testimony. That might be helpful.

The next person to come up would be Kim Bellard, or James O'Conner. (Committee Aide informs the Chairwoman that Mr. O'Conner will be testifying) Mr. O'Conner, from the Prudential Insurance Company.

J A M E S O ' C O N N E R: Madam Chairman, and Task Force members, thank you for inviting us to speak at this initial hearing of the Task Force on Catastrophic and Long-Term Health Care. My name is Jim O'Conner. I'm a Vice President and Assistant Actuary of the Prudential, located in our Group Insurance Complex in Roseland, New Jersey. I am a member of our Long-Term Care Task Force, and in the spirit of keeping things on schedule -- or back to schedule -- I will be as brief as I can; describing Prudential's activities in the area of long-term care.

Two years ago, in conjunction with the American Association of Retired Persons, we conducted a test marketing of a long-term care plan. The main benefits of the plan were a $40 per day benefit for care in a nursing home, a $25 per day benefit for home health visits of nurses and therapists, and $20 per visit for home health aides. There was a three-day hospitalization requirement, and a 20-day deductible. Nursing home benefits were payable for a maximum of three years, and home health benefits for a maximum of 365 visits. We mailed

enrollment packages to 215,000 households in six states, including New Jersey, and approximately 1200 members of the association became insured.

In the fall of 1986, we conducted another test mailing to 300,000 households in eight states, and allowed members in those states to call us requesting an enrollment package. We eliminated the three-day hospital stay requirement, but lengthened the deductible to 90 days. We added approximately 8000 insureds as a result of that test.

This year we prepared and executed a national campaign to solicit AARP members for long-term care insurance plan. The offering was advertised in AARP publications, with a toll free number for inquiries and orders of enrollment material. The plan is much the same as that from the 1986 test, with a daily nursing home benefit maximum raised to $50 per day. As today is the deadline for inquiry, I don't have any final numbers in terms of enrollments. But the response has been even better than anticipated.

We are currently planning a next generation of these insurance products, based on the feedback from our 1985 and 1986 tests, and ultimately information we gain from our current offering. Among the features we will explore adding are, an adult day-care benefit, and case management to control benefit costs.

We are also working on a number of products for the employer market that offer asset accumulation to allow individuals to accumulate funds for the purchase of long-term care insurance, and are considering policies that combine acute and long-term care in a managed care environment. We are currently negotiating with a major employer to install and manage their plant.

We plan to aggressively pursue this market, but there are many hurdles left to overcome. First is consumer awareness. As everyone has been saying this morning, most

people think Medicare and employer group coverages protect them from these risks. Of course they do not. This lessens the demand for the product.

Secondly, on the pricing front there is limited data. The sources and amounts of data are increasing, but the only published material is from experience under non insured populations that may of little use in predicting insured experience.

Third, the shifting of informal care: Care that was formerly provided by family members may be shifted to formal care givers.

Fourth, an uncertain Federal regulatory environment: The tax status of these plans is either unclear, or unfavorable. The treatment of reserves for these policies is detrimental to providing this protection. The interest on these reserves may be taxed currently, and not afforded the favorable treatment of life insurance reserves. Of course, this also increases the price of coverage. In addition, employers are discouraged from prefunding for their retirees health benefits. This discouragement extends to the long-term health care arena.

Finally, an uncertain state regulatory environment: A number of states fail to recognize the new and experimental nature of this coverage, and so, do not allow the flexibility needed to develop this market. The goal of state regulation should be a combination of consumer protection, and encouragement for product innovation.

What can we do to address these concerns? Clearly consumer education is a first priority. The public must be made aware to realize their need for long-term care services, and their need to financially prepare for these services. The Health Insurance Association of America has recently published a consumer's guide to long-term care insurance. Other groups are in the forefront of this effort. All sectors of our

society, the insurance industry, employers, and the government must play a role.

On the regulatory front: Support for proposals that clarify the treatment of reserves for long-term care insurance, proposals that allow the prefunding of retiree medical costs, proposals that in general foster the private development of long-term care, must be supported.

On the state front: The NAIC has carefully reviewed long-term health care issues, and has proposed a model law and regulation. We support these model laws, and encourage the states to adopt them.

Federal government or the individual states must realize the development of private long-term care programs will take many years before the effect is felt. On the employers' side, there is a great deal of interest in offering their employees the ability to sign up for some form of long-term care coverage. But since the expected entry of most people into a nursing home is well beyond retirement age, even the effect of adding all employees of every company to some form of coverage, would not be felt for more than 15 years. The market for those currently retired is large, and the need is much more imminent, but the cost of such coverage ranges from the merely expensive for the newly retired, to the astronomical for older retirees. This is an area where private industry and government must work together to provide appropriate and affordable coverages.

We have in other testimony in front of some House committees had some proposals that may be helpful there, and I can provide the Committee with some data that we provided there if you'd care. Cooperation will be essential to our success, and this is the only way that this problem can be solved. Thank you for letting me address you. I hope that was short enough.

ASSEMBLYWOMAN CRECCO: Thank you. Do we have just one or two questions, very quickly?

MS. DIETRICH: May I ask a question?

ASSEMBLYWOMAN CRECCO: Yes.

MS. DIETRICH: What is the cost for, say, a 65-year old for this long-term care policy, presently?

MR. O'CONNER: Okay. For a 65-year old, under our current offering, the cost is $48.75 a month.

MS. DIETRICH: Does that change as the person ages, or is the person locked into that premium?

MR. O'CONNER: The premium is intended to remain level for the person's lifetime, and could only be changed on a class basis -- in other words, all insureds of that same age with that same plan. But that would be the only way the premiums could be raised or lowered.

MS. DIETRICH: Thank you.

ASSEMBLYWOMAN CRECCO: No questions. Thank you very much. We have Suzy Chichester, who is the aide to Assemblyman John Rooney.

A L W U R F: (from audience) Madam Chairman?

ASSEMBLYWOMAN CRECCO: Yes?

MR. WURF: I'm next on the list here. I feel that I should have an opportunity to speak.

ASSEMBLYWOMAN CRECCO: We're just trying to rearrange it for the time for some other--

MR. WURF: Yes, but with great deference to the political personage, I'm still the next speaker here.

S U Z Y C H I C H E S T E R: (from audience) Whatever is your pleasure.

ASSEMBLYWOMAN CRECCO: I had another reason for putting you last -- at the end -- because I though you would be best there.

MR. WURF: Madame Chairman--

ASSEMBLYWOMAN CRECCO: All right, if you'd like to, we'll just put you up. Do you mind?

MS. CHICHESTER: You want him to come up? Fine.

ASSEMBLYWOMAN CRECCO: We'll have Mr. Wurf. Okay, this is Mr. Wurf.

MR. WURF: I apologize, Madam Chairperson.

ASSEMBLYWOMAN CRECCO: That's all right.

MR. WURF: I don't apologize for what I said.

ASSEMBLYWOMAN CRECCO: I'm just trying to know the reason for the schedule as such, but--

MR. WURF: Okay. My name is Al Wurf, and I represent AFSCME. I'm also on the Legislative Task Force on the 21st Century, which is also partially addressing this question of nursing homes, the aged of New Jersey, etc. etc. I have some material which may be of moment to the Committee -- although I'm not going to read anything -- and at some point I'll pass this on. Not today. I don't have duplications of the material.

I want to start out by saying that to really address long-term health care, you have to address the nursing home situation in New Jersey as well as America. Right now, as I understand it, in order to get into a nursing home you have pay $33,000 for a private patient, and who has $33,000? Those that do have $33,000 would last there three or four years, and go on to Medicaid or impoverish themselves.

I don't think long-term health care has a chance of succeeding unless there's a move to make nursing homes competitive. It's interesting to observe that in New Jersey you have hospitals competing with each other, yet you have a franchise, a monopoly of nursing homes, and they seem all to go at the same rate in terms of their charges.

Further, for a number of years I, as a trade unionist, have attempted to get long-term health care as a fringe benefit. About 35 or 40 years ago when I first started working, we had to convince workers that pensions made sense, and there was great resistance to pensions, and there was great resistance to plans like Blue Cross/Blue Shield, and on and on. A number of years ago I established a committee of

citizens and trade unionists and we sought to get a fringe benefit of long-term health care into the pension system.

I might tell you that an actuary study has been done by the State of New Jersey. That actuary study -- covering 250,000 workers who are in the Public Employee Retirement System -- is in the hands of the Director of Pensions -- who happens to be a nice guy, but he won't give me the results of that for fear that we and others would jump on it to try to get a fringe benefit -- or get to get a benefit negotiated in our contract. I call upon you to get that finding.

Contrary to one or two past speakers, State government can easily run long-term health insurance. Just the previous speaker, incidentally, talked about $48 for long-term health insurance. He didn't say in effect what the benefit would be per day. But let me show you how we can do it.

First, let's establish a level premium plan. I'm now talking about just the public employees, the common public employees. Offer it to the employees. There are thousands of contracts with public employers in the State. Unions will start negotiating. It's the kind of thing that we want. I think we can get it over the bargaining table, but until we do get it over the bargaining table, we may have employees on a voluntary basis pay for it -- and/or getting it over the bargaining table the employer will pay for it. Incidentally, if the State of New Jersey has that level premium plan, it ought to make it public.

Further, for those who are retired, there is a wherewithal to pay that $48 -- if in fact you get money per day from Prudential. Incidentally, I might tell you, Prudential, Blue Cross, others -- particularly Prudential -- in meeting with us a year ago said they won't put out a plan because they're unsure of the future. And I understand what they said then, and it's good to hear someone say today that they have a plan. But, when a public employee retires in this State, that

employee becomes eligible for 3/16s of a salary as a life insurance. In short, a public employee retiring in this State can get anywhere from $5000 to $12,000 as a death benefit. What if that public employee says in effect, "I have the wherewithal to be buried, but I'd like that money to be used--" that 3/16s of their salary -- "be used for long-term health care." I can't figure out that quickly what-- Okay, what is it, $50 a month? That's $600 a year premium. Six hundred dollars a year premium, if he gets $5000 he has, what, five years? Don't I make sense arithmetic-wise? So a public employee then retiring could either choose to have the death benefit, or else choose to go to Prudential or someone else's plan and be covered for long-term health care. Incidentally, I am now a senior citizen. And I tell you now that when you reach the 60s, you start worrying about going into a nursing home. You don't worry about being buried.

Further, we have to do something about those who are already retired. Some of my friends here -- who I met, incidentally when we were talking about day-care centers and senior citizens being part of day-care centers -- and our Committee, and some of the members here, have a suggestion. That suggestion is, that if there's legislation passed in the State allowing banks to set up living trusts for those who want to use their life insurance for long-term health care, they can do so. Let me show you how that works.

When you get old, you start meeting old people. Most of them seem to overly concern themselves with kids, and they're leaving insurance for their kids. Their kids in turn are scared they're going to go into a nursing home, and either they take their wealth away two year priors to that, or else they have to pay for that nursing home. I'm suggesting -- and I feel sure those who are the beneficiaries of life insurance policies would be receptive to it -- is that if I have to go into a nursing home, or if he has to go into a nursing home--

Not him, he's too young. (laughter) If anyone has to go into a nursing home, and they have a life insurance policy, they can take that life insurance-- All right, let me give you an illustration. I have a kid who loves me very much. I have a policy of $50,000 on her -- term insurance. If I had to go into a nursing home, I could go to my daughter and ask her -- tell her or ask her -- if she minds if I go to a bank and work out an arrangement in terms of a living trust -- and the lawyers understand that -- and that money would be used for nursing home for me. She would jump through the hoop to do that for me, and even if she didn't want to do it she will-- But even if she didn't want to do it, I would make that judgment. In short, there's a vast reservoir of insurance out there, and people could turn that insurance into usage for nursing homes.

One or two other items. Someone here said, government should not run this type of program; it should not be insurer of last resort. I want to tell you a little about Dukakis -- is that how you pronounce his name? The fellow that's running for President. No one's helping me here. Okay, I have a draft of a Special Commission for the Elderly of Health Care, and I read, "One, the State could design a long-term care health care insurance plan that would be available to elders at a reasonable cost. The insurance plan would have a level premium, and will utilize capital appreciation." What's happening in Massachusetts, is a benchmark for all senior citizen elderly people. First they pass laws saying in effect that if you had Medicare, a doctor must charge you the assignment rate. Now the Governor is moving -- and it's a draft, I admit it's a draft -- in a direction of covering the citizens under a state plan -- citizens like us -- under a state plan. I'm prepared to give that draft to you when you're done.

I think that's the essence, and I just want to recapitulate. First, I think the State of New Jersey can set up a plan covering 250,000 workers -- either an optional plan, a mandatory plan, a negotiated plan. Second, with the type of rate Prudential and Blue Cross/Blue Shield has, an employee retiring at the age of 65 could opt to take his -- if I may use the word -- death monies, or death plan, and convert them into insurance to cover long-term health care. Third, those who are not public employees, or retired public employees, can in an emergency of having to go into a nursing home, use their life insurance plans as a means of paying for nursing home care. Thank you.

ASSEMBLYWOMAN CRECCO: Thank you, Mr. Wurf.

MR. WURF: I apologize to you -- I don't remember the legislator. (referring to Ms. Chichester)

ASSEMBLYWOMAN CRECCO: We're not going to ask you any questions because of the time factor.

MR. WURF: I shun questions. (laughter)

ASSEMBLYWOMAN CRECCO: Okay. Thank you. We have Suzy-- Would you like to come up? Assemblyman Rooney is the Chairman of the Senior Citizens Committee.

MS. CHICHESTER: Thank you. Assemblyman John E. Rooney asked me to convey his sincere thanks to the Task Force for the opportunity to make his concerns known. The press of other legislative matters has kept the Assemblyman from attending this session today, but he has sent me with his statement. My name is Suzy Chichester, and I serve on the Assemblyman's staff. As Chairman of the Senior Citizens Committee, Assemblyman Rooney is most concerned with the issue of catastrophic and long-term health care.

"Senior citizens are the fastest growing segment of our population, expanding at a rate some five times faster than the general population. Currently, New Jersey counts almost 1 million of its citizens in the senior category. This segment

of our population accounts for almost one third of health care expenditures, over one third of hospital patients, and a whopping 90% of the nursing home residents. Disproportionately, senior citizens bear the burden of health care costs.

"Obviously, the pressures of this rapidly expanding number of older people with the frailties and serious illnesses indigenous to the elderly, make them the chief beneficiaries of any catastrophic and long-term health care legislation that may be adopted at any level of government. The mere fact that this Task Force has been created is a tribute to the legislative leadership of our General Assembly in recognizing the social implications of future population shifts, and the challenge it presents to public policy in this area.

"Providing our nation's elderly with some sort of protection against the potentially ruinous costs of a devastating illness is necessary now, and mandatory for the future. The bill, H.R. 2470, as recently approved by the U.S. House of Representatives, is a good start toward the process of providing Americans with that needed protection. The legislation, however, is far from perfect. It presents some problems while it resolves others.

"In any plan that is ultimately adopted, one concern should be adequately addressed; that of spousal impoverishment. So many programs designed for our elderly now require a spend down of assets before the individual can qualify for help. Realistically, this means that the surviving partner -- or the couple, if recovery from the illness was obtained -- has no home to live in, no car to travel in, no bank account, and not even enough money to provide for burial costs, and little or no hope of replenishing assets. The very system that has given longer lifespans, proposed for many, living those extra years in poverty and deprivation.

"I hope you'll take a look at my legislation, A-4282, that creates a Victims of Cancer and Long-Term Illness Fund, providing help in the form of grants or low-interest loans without regard to income eligibility standards imposed for other programs, or requiring asset spend down. The revenues to support the fund come from an increase in the tax on cigarettes and a new tax on all other tobacco products not currently taxed -- such as cigars, pipe tobacco, chewing tobacco, and snuff. Some of the additional monies generated would be diverted to the already existing Cancer Research Fund.

"We must help our growing elderly population by not dooming a large portion of that population to a precarious existence. We must protect them and allow them to live a safe and rewarding life. A sensible and successful catastrophic health care plan would show our vulnerable aged that they are an important part of our family of Americans, and that they are loved, and that they will be cared for, now and through the uncertainties of the future."

ASSEMBLYWOMAN CRECCO: Thank you very much. Okay, Assemblyman Bocchini will be speaking next. After which we will have Esther Abrams and Mr. Hubschmitt. Thank you

A S S E M B L Y M A N J O S E P H L. B O C C H I N I, JR.: Thank you Assemblywoman. I just noticed, we have a Task Force here on Catastrophic and Long-Term Health Care, and we probably could use a few more people that might be a little older on it. Fortunately for everyone here, it appears that we're all in good health and have a lot of years ahead of us.

But not withstanding that, you know, Madam Chairman, and members of the Task Force, I'm completing my third term in the Legislature. I'm not seeking reelection, so there's not a big push on this from the standpoint of looking to go back to the Assembly. But I must tell you one of the things -- and Marion, I don't know if you've experienced it, but I'm willing to venture that you have; I'm willing to venture that

Assemblyman Rooney has, as well as all the other Assemblypersons and Senators in this State. The one call that you get in your legislative office that you can't do anything about is, "Where do I send my mother? Where do I send my father? How do I help them get into a nursing care facility? They're sick." And you look around and you make phone calls, and it's probably one of the most frustrating experiences I've had in the six years in the Legislature.

At the same time I get people that come into my law office, and they'll say, "Joe, I've got to have my parents sign the house over to me. I've got to hold off for two years." So they in effect bankrupt their parents. They're despondent about it themselves. They're scared to death, "This is my mother. This is my father. I love them. I want to provide for them, but I still have a wife and two children," or "a husband and two children, and I need to take care of them." It's a vicious circle. It's something that as time progresses, and as our citizens continue to live longer years -- God bless them -- we're going to have to concern ourselves with.

I personally believe the prospects for change lie with the Legislature. I know there are those who might say that government should not become involved in this type of insurance activity, as far as long-term health care is concerned.

I had the opportunity to meet approximately two weeks ago with Mr. Wurf, and much of what he shared with you this morning he shared with me at that time. I believe much of what he says is very very accurate and on point. I believe that there is a need for most certificates of need, as far as nursing homes are concerned. Last week my office, as a result of my meeting with Mr. Wurf, I wrote to Doug Forrester and asked him for the actuary study that took place in relation to the Division of Pensions on this particular issue. I think it's something that this Task Force, Marion, should very seriously look for and see what benefit we could get from it.

The facts very simply are, you know, the money is not there for Mr. and Mrs. John Q. Public who are in that vast middle income bracket. They're stuck. And what makes it even more terrifying, I look at my mother and father now -- my dad being 67, my mother being 63, and knock on wood they enjoy good health. I had a very traditional Italian mother, "I work for all this for you and your brother." Well I say, "Don't worry about that, Mom. I'm doing fine, and, God forbid, I'm doing well enough that if Bob ever needs anything I'll be able to take care of him. What you have is yours." But there aren't necessarily people in the same position that I'm in. Not everybody has been fortunate enough to have the type of successes -- as mild as they might be, or as great as they might be, according to the beholder of it is -- that there are far more people my age who are concerned. You start to become concerned.

I had to chuckle, Al, when you said, "You know, you don't worry about what happens when you die if you've got the money to bury yourself." You're right. I hear people tell me constantly when they come in to do wills in my office, "I don't care what happens when I'm gone. I don't care where they take me." Some do, but a lot of them chuckle and say, "Hey, when I'm out, I'm out." But when happens when you're here? Right? What happens when you're here? What happens when you're here and you need somebody, and you need a place to go?

Long-term care insurance is intended to cover long-term medical costs, and I think the State of New Jersey-- I think it's something that we can put ourselves in the forefront as far as making that fringe benefit available to the public employees, in a bargaining fashion, as a fringe benefit. It's something that the employee who is now 30, I think will see the wisdom in it. It may be more difficult for that employee who is 50/55, but we're going to have to start somewhere. We can have all the Task Force meetings that we

want, unless we begin some type of progressive movement on it we could be in big trouble.

Many of the insurance companies that offered long-term insurance policies are very costly. They have pre-hospitalization requirements, or a 60 to 90 day deductible in which the patient bears the cost. With diseases such as Alzheimer's and Parkinson's, hospitalization is usually not necessary. But in order to receive assistance most policies require some type of pre-hospitalization. There are only eight insurance companies in New Jersey that have been approved by the Department of Insurance in meeting the minimum standards for long-term care coverage. A major problem with offering long-term care policies is cost. Congress has been looking into public/private partnerships as a way to advance this type of coverage and keep costs down, while the President -- President Reagan -- has signed into law a catastrophic health care bill. This plan to protect older Americans from catastrophic health care costs does not cover nursing home care for those people under 65 who have no health insurance.

In looking at things, and putting things in perspective, if I had my choice, New Jersey does not need $180 million bond issue for a baseball stadium when you have a population of seniors and older Americans, New Jerseyans, who are wondering what is going to happen to them in the year 2000.

As far as I'm concerned, we need to get our priorities in order. I think one of those priorities -- because I might be 43 right now, I hope I'm still around at 63, but I just want to be certain when I'm 63 and the people who graduated in the class of '62 from Trenton High with me, they have a place that they're going to be able to be taken care of; and that their families, their children, and grandchildren, aren't going to be looking and saying, "What am I going to so with my parents or grandparents?" Thank you.

ASSEMBLYWOMAN CRECCO: Thank you very much, Assemblyman. Is Dr. Crystal still here? I wanted to ask him one question. Is he? (affirmative response) Dr. Crystal, I'd just would like to ask you one question. Can you come here, Dr. Crystal?

DR. CRYSTAL: Yes?

ASSEMBLYWOMAN CRECCO: I just want to ask you one question, if I may. Do any other states, besides Alaska, have state workers' long-term insurance?

DR. CRYSTAL: (from audience) A number of states are looking at it. California is starting to look at it. And of course, probably one of the most important examples is the Federal example. I don't know if you're familiar with the plan that's being put forth by the Office of Personnel Management. The response is similar to what Mr. Wurf was talking about where there is voluntary conversion of articulated life insurance values, on a one-time basis at age 55. According to the Office of Personnel Management Plan-- (inaudible) There are many states that are looking at state employee long-term care benefits. I think that's very important because it's a way to put something in place and test it, without having to deal with the adverse selection problem that is so difficult for all the plans that have to recruit people on a one by one basis, to deal with. So there's a good argument that the way to test this and get it into place is to define populations on an across-the-board basis, then you have a realistic way of looking at actuarial experiences. So I would encourage you to look seriously at the option of the state employee plan -- not only as a way of helping state employees, but as a way of testing some concepts that can then be expanded to other markets.

ASSEMBLYWOMAN CRECCO: Thank you. We're going to look into that also. Our next witness would be Esther Abrams, Chairperson of the State Legislative Committee for the New Jersey AARP. Oh here you are.

E S T H E R A B R A M S: Chairperson Crecco, members of the Task Force on Catastrophic and Long-Term Health Care, my name is Esther Abrams. I live in Princeton, and I'm the Chairperson of the New Jersey State Legislative Committee of the American Association of Retired Persons.

I would like to digress for just a little bit. I appreciate the gentleman from Prudential, and I know that the AARP does work with the Prudential for long-term health care policy; but we represent in New Jersey over 900,000 members, and of course they start at age 50. Nationally we have 26 million members. So there are people I'm sure that can take advantage of that, but my husband and I-- We live in Princeton. We're relatively comfortable. But we did decide that the risk of getting long-term care insurance certainly was overcome by the cost for people our age because I'm late 60s and he's in the 70s already. So this is a factor. The cost is tremendous for older people.

I'm doubly grateful for the opportunity to speak to you today because I'm also a spokesperson for the Women's Initiative, which is a new program that has been started by AARP. I have not only become fully aware of how overwhelming the long-term care problems are for the elderly, but also how much more severe these problems are for older women.

Among the elderly, men and women have significantly distinct health histories which affect their chance of being poor and alone. Older men have higher rates of fatal diseases, while older women are more prone to long-term chronic diseases. Women aged 65 and over have more days of restricted activity, longer average stays in the hospital, and are more likely to be transferred from the hospital to the nursing home than men aged 65 and over. In effect, women have a greater likelihood of surviving their spouses and of being impoverished through out-of-pocket health expenses related to long-term chronic illness.

Medicare's emphasis on acute care hospitalization and physician services penalizes older women. Because many of their chronic health care needs are not covered, older women must pay a greater percentage of their income on Medicare expenses. It is estimated that in 1986 Medicare paid for 49% of the total health care expenditures of unmarried men over age 65, 44% of the total health expenditures of married couples over 65, but only 33% of the total health care expenditures of unmarried older women. Unmarried women age 65 and over, spent a greater percentage of their incomes on health care -- 16.3% -- than did either unmarried older men -- 12.2% -- or older couples -- who spent 8.9%. This is due both to women's lower median incomes and to their greater likelihood of having health needs that Medicare does not pay for.

Women are the primary users of long-term care because they have more chronic health problems and they live longer than men. Long-term care includes in-home services, adult day-care, and care in resident facilities, convalescent homes, intermediate care, and skilled nursing facilities.

The majority of the elderly are not in nursing homes. And this is -- from my standpoint -- the risk that we were taking into account, whether we would end up in a nursing home. Most older people will never be a resident of a nursing home. Contrary to popular belief, only 5% of the elderly are institutionalized at any given time; 20% may require nursing home care sometime during their lifetime. The chance of institutionalization increases with age. Only 2% of persons between 65 and 74 are nursing home residents, compared with 22% of those over age 85. Yet in 1985 about $35 billion, or 8% of the national health care expenditures was spent for nursing home care. This is three times the amount spent a decade ago, and 16 times what was spent in 1965 when Medicare and Medicaid were established.

At the same time, current public and private expenditures for home health care and other community-based long-term care are only a small fraction of the amount now spent on nursing homes. Medicare does not pay for long-term chronic care. Unfortunately, millions of elderly persons and their younger family members incorrectly believe that it does. One of the duties of AARP volunteers is to dissuade our members of this belief, and to help them to understand that Medicare will only pay for a limited number of days of skilled nursing care after the patient is discharged from the hospital.

On the other hand, while the average cost of one year in a nursing home -- and this is nationwide -- is approximately $22,000, about half of the country's total nursing home bill is paid by residents and their families. But personal savings are quickly expended. Consequently, Medicaid, a program designed to fund health care for the poor, has become the predominant public payer of long-term care. And women, who have worked and saved along with their husbands throughout their lives face the humiliation and financial nightmare of spousal impoverishment in the later years of their lives. Once a spouse becomes eligible for Medicaid, much of the couple's monthly income may be considered available to pay the nursing home bill. The spouse living in the community may then keep only a small spousal maintenance allowance for living expenses. Women are more likely than men to be pauperized in this way, both because they are less likely to have income in their own name, and because they tend to outlive their husbands.

Millions of elderly need home-based care. A critical need and a heartfelt desire of most older people is to remain in their own home despite infirmities; the need to live out their lives independently, not in a nursing home. In order to do so, many need some help with maintenance care such as bathing, dressing, or eating; or with daily activities such as meal preparation or shopping. Coverage of home care is

extremely limited under both Medicare and Medicaid. Most home-based care is provided by unpaid care givers, primarily female relatives. They receive no pay, no benefits, and little relief from this demanding work. The average age of care givers of the elderly is 57, but more than one in three is over 65, indicating that the informal care system is composed in large part of the young-old caring for the old-old. Since these care givers receive little relief from a 24 hour day, 7 days a week, many develop health problems of their own. New Jersey has taken some positive steps with a Respite Relief for Care Givers program, but the problem remains a large one.

AARP's concern about Medicare beneficiaries' access to home health service they are presently entitled to, as well as the quality of the care they do receive, arises from many sources. We are concerned about data showing rising denials of home health claims. Despite evidence of increased need for this service, expenditures for this benefit have not kept up with need.

The increasing need for home health care is due in part to changing patterns in health care delivery and reimbursement. While the Department of Health and Human Services has yet to document the extent to which earlier hospital discharge has increased the need for post-acute care, there is every reason to believe this is the case. We know that the average length of hospitalization has shortened for every diagnostic related group, and for patients of every age. It is a fact that hospitals are discharging elderly patients quicker and sicker. However, since the implementation of prospective payment for hospital service, the rate of growth in Medicare outlays for home health care has dropped sharply.

We are also alarmed by the government's ineffective monitoring and control of providers; lack of national minimum qualifications for home health aides; and the virtual absence of consumer information with which to select a high quality

provider. With this in mind, the New Jersey State Legislative Committee of AARP is planning to work with State agencies in support of Senate Bill 3151 to achieve mandatory licensure of home care agencies.

Finally, I want to express my thanks and that of the New Jersey State Legislative Committee of AARP, as well as AARP members living throughout our State, to you, Chairperson Crecco, as well as the entire New Jersey Assembly, for your willingness to examine and develop recommendations relating to the financing of catastrophic and long-term health care. And I would like to add at this point after listening here all morning, that I appreciate so much having the opportunity as a consumer to talk to you, because I feel that there was a tremendous representation of all types of groups, but I think the consumers really have to add their piece. They're the people that are really concerned about this issues. And by making New Jersey a leader in the development of a more equitable and accessible health care system, you will also bring hope to all elderly citizens of New Jersey. Thank you.

ASSEMBLYWOMAN CRECCO: Thank you very much. Any questions from the Committee? (no response) I suppose it's time now, and I'll hold my questions.

MS. ABRAMS: Thank you.

ASSEMBLYWOMAN CRECCO: Our last person to speak is Edward Hubschmitt, Advisory Council, Passaic Office on Aging.

E D W A R D H U B S C H M I T T: Yes. I'll only take four minutes. I've got the shortest and the most different, would it be? Wait until I give it to you. My name is Ed Hubschmitt. I'm Legislative Chairman of the Advisory Council to the Passaic County Office on Aging. I represent 77,000 Passaic County senior citizens.

We have to erase the word "catastrophic" from illness. Illness is a human condition, and it is natural to get old, and get sick, and die. For us humans to have allowed

long-term health care to become one of the most lucrative businesses in our society, needs correcting now.

As far as funding options go, the House of Representatives has just passed a bill to alleviate catastrophic illness, paid for by us senior citizens. I think we should be left out in the State of New Jersey for any more payments. Also, the Brookings Institute -- who is quite well-known -- in a study just published says, "Until insurers attempt to improve coverage and reduce premiums, private long-term care insurance cannot be expected to be a major option for financing long-term care for the elderly." Brookings predicts change may come slowly; we can't afford it -- senior citizens. We don't have the time. We've got to reform existing programs and develop some more realistic ones.

To attempt to eliminate catastrophic illness without additional sources of income, and regulating the health providers would be extremely impossible. It would just be a joke I think. For additional income we already have legislation introduced into the Assembly by Assemblyman D. Bennett Mazur A-3786, which is to increase the casino revenue fund from 8% to 12%. The casinos give away $500 million a year in complimentary services to high stake rollers. They surely could give 4% more for the people who voted them in in 1976. This 4% could be used to finance health care for the elderly. It no longer would be catastrophic.

But without regulation of health care providers, all would be lost. We have legislation introduced there also by Senators Garibaldi and Orechio, stating that these bills would keep doctors' fees within the guidelines arrived at by the United States Secretary of Health and Human Services. These guidelines would be just as binding on doctors as they are on the senior citizens.

We, the senior citizens of Passaic County, are asking the Task Force to consider our recommendations. Our great amount of experience on this earth has shown us that many great problems have simple answers. Thank you.

ASSEMBLYWOMAN CRECCO: Thank you very much. Any questions? (no response) Thank you all for being here. The meeting is adjourned.

(HEARING CONCLUDED)

APPENDIX

Statement

By

Mark R. Meiners, Ph.D.

National Center for Health Services Research
and Health Care Technology Assessment
(NCHSR)

Department of Health and Human Services

BEFORE THE NEW JERSEY TASK FORCE

ON CATASTROPHIC AND LONG-TERM HEALTH CARE

August 31, 1987

Mdm. Chairperson and Members of the Task Force

It is an honor to appear before you today.

I am here as a researcher. I work for the National Center for Health Services Research and Health Care Technology Assessment (NCHSR) which is part of the Public Health Service. I will be presenting information on long-term care insurance based on my involvement with research on this topic over the past 8 years.

Background

Private options for enhancing the resources of the elderly and mobilizing them to help pay for long-term care had, until recently, been largely unexplored. Insurance, the major vehicle for financing health care privately, was generally perceived as not applicable to long-term care. As a result private financing mechanisms for long term care did not receive much serious attention.

This situation is beginning to change. In 1979 the National Center for Health Services Research undertook a multifaceted study to determine whether and under what circumstances a market for long-term care could exist. This study has produced research results which have shown that a reasonable case can be made for long-term care insurance, that data are available to begin to examine alternative prototype benefits, that a few insurers were actively involved in selling such coverage, and that there was more consumer interest in such insurance than was first thought.

2x

Through various publications and presentations the NCHSR research has served as the catalyst to further research and development. We believe our findings have helped the insurance industry to adopt its current, more positive attitude about the potential of risk pooling mechanisms to insure long-term care and stimulated further inquiry into ways to finance those options.

No One Model

Three basic models of LTC insurance are currently being marketed -- free-standing LTC insurance, Social-HMOs, and continuing care retirement communities (CCRCs). The approaches differ along a variety of dimensions including the comprehensiveness of the benefit package, the management of risk, and the organizational structure. Free-standing LTC insurance is the most generic of these models in that it focuses on the long-term care risks alone. The Social-HMO model expands the concept by integrating chronic care benefits with acute care benefits in a managed care environment. The CCRC model (in its broadest configuration) expands the concept further by providing sheltered housing as well as a comprehensive health care guarantee. No one model may be best for everyone. Each is undergoing testing, revisions, and further development. However, it is the free-standing type of product that has captured much of the initial interest in the insurability of long-term care and it is on this approach that I will focus my discussion today.

Free-standing LTC Insurance

Medicare and Medigap insurance policies are intended to

cover only acute illness or post-acute recover. In contrast, free-standing LTC insurance is an insurance policy that provides for the payment of care in an institution, the community, or an individual's residence when such care goes beyond the Medicare definitions of care and when the policy holder is not locked into a particular provider system. Implicit in this definition are two very important distinguishing features. As noted, chronic illness rather than acute illness or post-acute recovery is the focus of the insurance so the benefits are designed to address the need for personal assistance with basic activities of daily living (often termed intermediate or custodial care) in addition to skilled nursing and therapeutic sevices. Also, the benefits are designed to pay for an extended spell of illness. These are the key features that distinguish long-term care insurance from the acute care related nursing home and home care benefits of Medicare and Medigap insurance.

There are several reasons why the free-standing type of product has captured much of the initial interest in dealing with the problem of financing long-term care. By focusing on the long-term care risk alone it is easier to define what constitutes the insurable risk. Under this approach one can specify the features of the policy and provide a clearer description of the benefits to potential buyers. It also makes it possible to market the insurance as a new product rather than a modified supplementary Medicare policy that then must compete against the cheaper Medigap policies which are widely available and which have been purchased by about two-thirds of the elderly.

The market for free-standing LTC insurance is still new and not well developed. About 25 products are now being sold and many have only become available within the last year. Information on the number of policies sold is difficult to obtain but estimates are in the range of 200,000. Most of the policies have been sold on an individual basis although some are marketed through groups.

Until recently most of the insurers involved in selling this kind of protection were small companies. This has begun to change, however, and some of the largest insurance companies are in the process of developing and marketing their own products.

The specific features of the policies available now differ but they have a number of things in common. Most cover nursing home care at the skilled and intermediate levels. A few also offer custodial and home health care benefits but typically these benefits are limited and sometimes only available under an optional rider. Benefits are structured as fixed amounts per day with waiting period as long as 100 days before benefits begin and there are limits on the coverage period of anywhere from 2-6 years. In addition to emphasizing institutional care and carving out a segment of the long-term risk, a variety of techniques (see TABLE 1) are used to manage the risk.

The premiums are age rated, with the rate fixed at the time of purchase in most cases. The actual premium rates vary widely among products depending on the age at time of purchase, the features of the policy, and the expense-loading charged by the insurer. One recent review of several of the available products, published in Money Magazine, indicated a 65 year old purchaser

should expect to pay $174 to $1,451 a year for policies that cover skilled and custodial care.

In assessing the free-standing products currently available it is easy to find fault. Most tend to perpetuate the institutional bias that prevails in our public programs, they use restrictive risk management techniques, and the better ones, while not exhorbitant are also not cheap. All these factors serve to limit the market for such protection.

Nonetheless, free-standing products are available that deserve serious consideration by those that can afford them. By focusing on the nursing home risk, they address the major cause of catastrophic health care expenses among the elderly. For the elderly, out-of-pocket payments on nursing home care are about equal to out-of-pocket payments on all other health care expenses combined.

The limits and restrictions are a function of a conservative industry entering into a new and unexplored product line with little hard information to guide them. As more insurers enter the market, competition should encourage better benefit packages and more affordable premiums. I believe we can also expect to see creative linkages with other risk pooling vehicles to achieve more comprehensive coverages that take advantage of managed care and offsetting risks.

Further Development Necessary

Further research and development will be necessary to achieve the full potential of private market LTC insurance.

Comprehensive products sold to groups before retirement that use some form of managed care environment are good candidates for overcoming the major barriers to such a market. Insurers should be encouraged to offer Medicare supplemental options that include long-term care benefits. The interest on the part of some Medicare-HMOs in offering LTC insurance to their members is a move in this direction worthy of note.

Further opportunities to expand the market for LTC insurance include reinsuring retirement communities for their chronic care guarantee and developing similar risk pools among community members prefering to stay in their own homes. Both these strategies are appealing because they involve group sales where all parties to the agreement work together to control the risk in a managed care environment that includes the home setting.

Strategies for market expansion might also involve links with other financing vehicles such as home equity conversion or life insurance to take advantage of offsetting risks while promoting recognition of the need for long-term care protection. Other strategies involve tax preferences for individual savings accounts dedicated to the purchase of LTC insurance or for encouraging employers to offer such protection as a retirement option. Although the current fiscal environment is not encouraging for tax incentives, the need for protection against the catastrophic expenses associated with long-term care may lead people to conclude that these strategies may warrant special consideration.

Possible Public Policy Roles

One of the most intriguing aspects of LTC insurance is the potential it holds for relieving some of the pressure on Medicaid. Government payors will benefit if private insurance can reduce the role of Medicaid as a source of payment for middle income elderly by delaying or avoiding the need to spend-down their resources. It also may be viewed as an alternative to the current incentive to transfer assets to gain eligibility. The possibility that there could be savings to public budgets as well as benefits to consumers suggests that there is a public role in encouraging the market.

A variety of public policy interventions to support the emerging market are possible. A relativly inexpensive yet extremely important role is that of consumer education. Further efforts are needed at both the Federal and state level to inform consumers that Medicare and most private insurance policies do not provide extended care benefits for chronic illness and disability. As products become available consumers will also need information and guidance to make informed choices. States in particular can play a significant educational role through the office of the commissioner of insurance. They can also encourage insurance regulators to assist the development and marketing of such benefits by removing regulatory restrictions that inhibit reasonable product experimentation. Significant additional support for market development may be achieved by coordinating the cost and care management mechanisms of public long-term care programs with those that the private market views as important to its success.

The significant role states have in financing long-term care, along with having been delegated much of the responsibility for the structure and administration of long-term care programs also provides the incentive for more direct support of the emerging insurance options. In particular, states should carefully evaluate their current role in financing long-term care. The rules governing eligibilty for Medicaid through the spend-down process should encourage the use of an indiviual's resources for their own long-term care.

Medicaid cannot afford to act as inheritance insurance for heirs and a private LTC insurance market cannot fully develop if Medicaid plays this role. At the same time it is important to recognize that there are situations where Medicaid rules may stand in the way of sensible support. Spousal impoverishment brought about by the deeming rules in some states is an example of this. In structuring interventions to deal with such problems consideration should be given to incentives that encourage private initiative and responsibility.

More aggressive strategies involve direct market subsidies. There are strong reasons for considering such interventions in the market. Long-term care insurance is in its infancy. While there has been considerable interest in product development the market is small and underdeveloped. Until there is more experience with insuring long-term care we can expect progress to be slow and conservative. The limited market size and conservative pricing in turn tends to restrict the market to relatively high income persons. It is in this context that

strategies to subsidize the market may make sence. By targeting subsidies to persons otherwise unable to afford the insurance the market size is increased and greater numbers of those most likely to spend-down to Medicaid are included.

Market subsidies could take several different forms. One approach would be to guarantee full protection from further asset spend down for anyone paying through insurance or out-of-pocket for a set number of years. This would address the concern that current policies do not offer complete catastrophic protection; the maximum coverage being about 6 years. A disadvantage of this approach is the potential of public dollars being spent on relatively well-off individuals.

Asset waiver strategies are based on the assumption that a major barrier to market development is the desire for asset protection. While this may be important, it is also likely that the current market faces affordability constraints which loom at least as large as a barrier to further development.

Premium subsidies in the form of tax credits or deductions if a person buys a State certified level of insurance protection is another way to support market development. This type of subsidy could increase the affordability of current products. Both asset waiver and premium subsidy strategies are targeted to the consumer and could be varied on the basis of income.

Other subsidy strategies could be in the form of premium tax breaks or public reinsurance programs targeted to help insurers overcome their hesitancy to enter or expand the market. Carefully crafted, a state reinsurance program could serve as the basis for a data collection initiative that could help overcome

insurers hesitancy to share information on utlization and cost patterns under their programs. The lack of such data has been perceived as one of the barriers to more rapid market expansion.

Assistance to market development might also be accomplished by paying the insurance premium for persons eligible for Medicaid on the basis of low income. This would serve to broaden the risk pool and help spread administrative costs.

There is no one approach to supporting the market that is obviously the best at this stage in the development of the market. Depending on specific market characteristics and its particular objectives a State might choose to use one or several of these strategies to encourage developent of this type of insurance. The uniqueness of a state's Medicaid eligibility criteria in addition to its regulatory approach to long-term care insurance will drive state initiated efforts to conform with the constraints they impose in other areas. In addition, a state's own fiscal outlook and political climate will play a role in determining whether strict budget neutrality will be the measure of feasibility and success or whether the benefits of a more workable method of paying for long-term care will be viewed as worthy of more resources.

Conclusion

The need for long-term care is the single most important cause of catastrohphic health expenses for the elderly. Although this fact was noted nearly 10 years ago in a report by the Congressional Budget Office, it is only recently that it is

receiving much attention. Perhaps the reason for the previous lack of recognition was that there was no alternative short of a National program and that has repeatedly been avoided as too costly. It made little sense to alert the public to the significant financial risk associated wtih the need for long-term care if there was no workable solution. A break in this stalemate has occured with the recognition of long-term care as an insurable risk. The new private financing initiatives have begun to show how the risk can be shared in a way that encourages individuals with resources to participate in risk pooling and in the process help clarify those areas where there will be a need for public involvement on behalf of individuals without adequate resources.

The development of LTC insurance is in its infancy and there is a need for improved data on virtually all aspects of that development including information on utilization, costs, risk management, marketing, and the impact of such coverage. At the current time it seems that supporting this development is a wise first step. There is sufficient uncertainty about long-term care needs now and especially in the future that a pluralistic approach makes considerable sense; particularily when the possibility of continued stalemate is likely. As we learn more about how to insure long-term care other, bolder, strategies may suggest themselves.

Table 1. FREE-STANDING LTC INSURANCE RISK MANAGEMENT TECHNIQUES.

- PRIOR HOSPITALIZATION REQUIRED - USUALLY 3 DAYS
- NURSING HOME OCCUPANCY MUST BEGIN IN 14-90 DAYS - 30 DAYS MOST TYPICAL
- MUST BE SAME ILLNESS OR INJURY THAT CAUSED THE HOSPITAL STAY
- PHYSICIAN RECOMMENDATION AND REVIEW OF CARE REQUIRED
- SCREEN SALES FOR PRE-EXISTING HEALTH CONDITIONS AND PRIOR HOSPITAL OR NURSING HOME STAYS - TIME PERIODS VARY
- EXCEPTION TO COVERAGE, E.G., CARE OUTSIDE U.S., EXPENSES DUE TO WAR, SELF-INFLICTED INJURY, MENTAL DISORDERS
- PREMIUM ADJUSTMENTS POSSIBLE
- RENEWABILITY MAY NOT BE GUARANTEED
- SERVICE DEFINITION IMPORTANT ESPECIALLY IF THEY DETERMINE LENGTH OF COVERAGE AND BENEFIT LEVELS

STATEMENT

of

THE CONNECTICUT GOVERNOR'S COMMISSION

ON THE

PRIVATE & PUBLIC RESPONSIBILITIES

FOR

FINANCING LONG TERM CARE FOR THE ELDERLY

Before the

NEW JERSEY TASK FORCE

on

CATASTROPHIC

and

LONG-TERM HEALTH CARE

"FINANCING OF LONG TERM HEALTH CARE"

August 31, 1987
Trenton, N.J.

Presented by
Linda Schofield

Good morning. I am Linda Schofield, Senior Consultant and Research Director of the Connecticut Governor's Commission on Private and Public Responsibilities for Financing Long Term Care for the Elderly. I am also Assistant Director for Government Affairs at The Travelers Companies.

I am pleased to have been invited to report on the findings of the Commission's study as well as on the Governor's Action Plan designed to implement the Commission's final recommendations.

In anticipation of the potential crisis in long term care, Governor William A. O'Neill appointed the Commission on Financing Long Term Care in June, 1986. The Governor charged the Commission to assess the long term care financing needs in Connecticut, to evaluate our current system of financing long term care for the elderly, and to propose new financing methods. He especially sought to identify ways the State could work with the private sector to increase private sector support in financing long term care for the elderly.

After a year of research and a series of public hearings we have issued a report identifying the impediments to private financing and suggesting strategies to minimize or overcome them. Our recommendations focused on State leadership to stimulate action at the state and federal levels, in the private sector, and in the community. My following remarks highlight the findings, conclusions, and recommendations of our report.

The financing of long term care is rapidly emerging as one of the most serious challenges facing this country. This issue's sudden ascent in importance has occurred because a number of social and economic trends are coming together to create the potential for a silent social disaster. These factors are creating significant

pressures on state and federal government, on business and community institutions, and on our individual citizens and families.

The most significant factor is the "greying" of our population, particularly the increases in numbers of those 85 years of age and older who are most likely to require long term care. The demographic projections in Connecticut roughly parallel those for the nation. From 1980 to the year 2000, the number of Connecticut residents age 65 and older will grow by 41 percent, while the state's population as a whole will grow by only 9 percent. By 2000, nearly one-half of those age 65 and older, will have reached age 75 (48 percent).

Between 1980 and 2000, the number of elderly in Connecticut age 75 to 84 is projected to increase by 70 percent, from 3.5 percent of the total population to 5.5 percent of the total population. Those aged 85 years of age and older will increase by 67 percent, from 1.2 percent of the total population to 1.8 percent of the total population. By the year 2000, those age 75 and older will constitute 7.3 percent of our population.

Other factors contributing to the growing urgency of the long term care problem include changing family structures, such as the increased prevalence of family members living far apart, divorces and two-worker families, the current limited range of options for financing long term care, a public policy bias toward care provided in institutional settings, and the lack of financial preparedness of individuals and families to meet long term care needs. Adding to the problem is the enormous misconception that there already exists a system for financing long term care through Medicare, when no such system exists.

The greying of Connecticut's population will result in an unprecedented increased need for both acute and long term care services

over the next 13 years. In Connecticut, by the year 2000, we project a 44 percent increase in the number of physician visits by the state's elderly, a 31 percent increase in the number of acute hospital days consumed by the state's elderly, a 42 percent increase in the number of Connecticut elderly residing in skilled and intermediate care nursing homes, and a 53 percent increase in the number of elderly receiving skilled health care, personal care, and homemaker services at home.

These projections for long term care require us to address the adequacy of our resources both to deliver and to finance future long term care services.

Currently, it is estimated that over 80 percent of all long term care services are provided by families and friends. This resource is crucial for three reasons: Older persons prefer to be cared for at home by loved ones; informal care is provided without expense to the public sector; and informal care often delays or precludes the use of formal services thus relieving demands on the long term care delivery system. In fact, the primary determinant of institutionalization versus care in the community is the availability of assistance from others, not the severity of illnesses or functional impairments.

Formal long term care services are provided through a loosely-organized, partially-integrated system of service providers, including long term care facilities, home care agencies, adult day care centers and other community-based support services. However, the current rate of growth in formal service capacity is not adequate to meet projections of future needs.

Just as the delivery system will not have the capacity to meet future needs, the financing systems will likewise not be adequate to the challenge. The stark reality is that individuals and families pay

for long term care from savings and available income until their resources are exhausted. At that point, the State Medicaid program begins paying the bills for nursing home care and some community-based services.

In fact, approximately 54 percent of $318 million of the State's 1987 Medicaid budget, which is $585.1 million, is earmarked for health care of the elderly. Of the $318 million, $274 million will go for long term care in nursing homes. This nursing home bill represents 5.6 percent of the total state budget. If patterns of care and financing are not modified by the year 2000, these costs for nursing home care will rise from $274 million to $1.4 billion, or 7.9 percent of the state budget.

Individuals and families pay most of the remaining bill for long term care, with other public programs and private insurance contributing little. This causes tremendous hardship for those unfortunate people in need of services. In 1984, of the $30.2 billion of out-of-pocket health care expenditures incurred by the elderly, 42 percent, or $12.7 billion, went for nursing home care. That amount represents the impoverishment not only of thousands of individuals, but sometimes their spouses as well.

When a married nursing home resident is Medicaid eligible, the community-residing spouse is allowed a monthly income of only approximately $350 from their joint resources. This is not an adequate income upon which to survive.

The current long term care financing system, which leads people either to impoverishment or to gaming the system by transferring assets, and which results in inappropriate institutionalization, is

irrational, inequitable, and inadequate. This system came about by default not by design.

The challenge to the State is to design a comprehensive, coordinated system which will moderate the growth in State expenditures for long term care, assist families to meet their long term care financial needs, and assist families to find the care services needed by the elderly and their families. The complexity of the long term care financing issue requires a multifacted response.

No single element of society -- neither the individual, the family, employers, insurers, service providers, state government, nor the federal government -- can meet our overall long term care financing needs alone. They must all participate collaboratively in addressing the long term care needs of today's and tomorrow's elders.

In addition, a combination of strategies is essential if we are to provide the array of services necessary to meet the needs of the elderly in an efficient and cost-effective manner. The problem of financing long term care is not just a financing problem. It is a financing problem, a service delivery problem, a health promotion and research problem, a data collection and a consumer education problem.

The Commission concluded that better methods of public and private financing of long term care are needed, that the delivery system -- particularly community-based services -- must grow to accommodate our demographic shifts, and that long-range preventive measures must be taken to improve the well-being of future generations of elders and to contain the costs of caring for them.

We made recommendations in five broad categories:

1. <u>The variety and availability of new methods of private long term care financing should be increased</u> to meet the demands of

diverse market segments and to moderate the increase in pressures on public treasuries at the state and federal level. These methods include home equity conversion, insurance, health maintenance organizations, continuing care retirement communities, and other innovative alternatives. The more private financing options which are available, the greater will be the opportunity to avoid the negative consequences of the present system -- spousal impoverishment, asset transfer, and growing public liability.

Similar to action being considered at the federal level by the Office of Personnel Management, the Governor plans specifically to offer long term care insurance to State employees to set an example for other employers. In addition, he plans to convene Connecticut business and labor leaders to focus attention on employer sponsorship of long term care benefits and other business implications of a growing elderly population.

The Governor has directed appropriate State agencies to expand the flexibility of current State-sponsored home equity conversion programs and to remove current barriers to the use of home equity conversion now inherent in our Medicaid eligibility standards.

In addition, the Office of Policy and Management responded to an invitation from the Robert Wood Johnson Foundation to submit a grant proposal for the exploration of public and private partnerships in financing long term care. The proposal was acted on in July and will be funded beginning in September, at which time data collection and analysis efforts will begin, with simulations of various proposals to follow.

2. The availability of and financing for home and community-based alternatives must be expanded. These home and community-based services complement and sustain family caregiving efforts and, as an alternative to institutional care, represent savings to the individual, the family and potentially the public sector.

As financing options are created, available services with appropriate cost controls must also be expanded. The Governor plans to begin encouraging the development of community-based alternatives by expanding Medicaid coverage of adult day care.

In addition, new techniques for controlling costs, and for managing the appropriateness and quality of long term care services are being expanded. In Fairfield County, Connecticut, pre-admission screening of Medicaid-eligible hospital patients awaiting nursing home placement has led to the successful diversion of 24.4 percent of them to community-based care. With case-management these individuals have been cared for in the community at a monthly savings of $778 compared to expected costs for institutional care. Pre-screening and case-management for Medicaid-eligible nursing home candidates will be expanded statewide this year.

3. Long-range strategies must be developed and supported to enhance the personnel resources available to meet long term care needs and to moderate the increase in demand for long term care services. These positive long range strategies should include the extended employment of older adults, disease prevention and health promotion, expanded support of research into the diseases of old

age, and expanded support for the training of health care professionals.

Increased financing options and expanded service delivery systems will not be sufficient if we do not simultaneously work to reduce the numbers of elderly who will be in need of long term care in the future.

4. Consumer education programs regarding long term care financing should be expanded. A more educated populace will understand the need for timely personal financial planning efforts. Furthermore, consumer education, together with an effective program of consumer protection, will enable individuals to make selective, informed choices. As a consequence, traumas such as spousal impoverishment may be reduced and pressure for public support moderated.

The Governor has directed the State Department on Aging to enhance its current educational efforts and to collaborate with other State departments in establishing public education outreach programs. Similarly, the Departments of Insurance and Consumer Protection have been instructed to intensify public education and consumer protection programs.

5. Data collection efforts and public dissemination of information regarding long term care service utilization must be improved. The lack of data, particularly longitudinal data which describes long term care service utilization over time, presents design and product-pricing difficulties for government, providers, insurers and other entities which may provide long term care risk-sharing, e.g. health maintenance organizations and continuing care retirement communities.

Information is the key to managing risk, and its availability will therefore expedite the entry into the market of both more products and more product sponsors.

The State has already undertaken projects to coordinate access to the data collected by 13 State health and social service agencies and to analyze its existing long term care data base.

The Commission also recommended to the Governor that federal action in support of state and private initiatives be enlisted.

The federal government has played and continues to play an important role in providing health care for the elderly. Among other things, the federal government supports nursing home care through the Medicaid program at a cost of approximately $15 billion per year, thereby meeting one-half of the public sector's share of the nation's nursing home bill for the elderly. Given the projected increase in demand for health care services, however, this level of funding not only must continue, but it must increase and it must be supplemented by additional federally-funded health care strategies.

While the current political climate and the realities of decades of federal deficit spending impinge upon the ability and the inclination of the federal government to play a leadership role in responding to the impending crisis in long term care financing, a federal role is integral to the ultimate resolution of the problem. A response by Connecticut alone or by a collection of states cannot be sustained without complementary national initiatives.

Consequently, Governor O'Neill will work with the Connecticut congressional delegation, other members of Congress and the National Governor's Association to strive for an appropriate and expended federal response.

Tax incentives are the most obvious means by which the federal government can encourage private financing of long term care. There are currently very limited financial incentives for the private financing of long term care through savings, insurance, pension or family contributions.

By creating tax incentives and removing tax barriers to new, as well as existing, private methods of financing long term care, employers, individuals, insurers and other financial institutions will be encouraged to expand their roles in long term care.

In view of the essential role families play in providing informal long term care services to their elders, the federal government should expand incentives and support for these family efforts. Current tax incentives for family caregiving are very difficult to qualify for because of the restrictive definitions and tests of "dependency." Modifications to the tax code should be made to facilitate the use of tax advantage programs, thereby creating incentives for, or in some cases, financially enabling, family members to care for their elders.

The federal role also should include an expansion, rather than the retrenchment we have experienced in the past few years, of federal funding in the field of geriatric research and the training of health professionals in the field of aging. The federal government also must expand its activities in the areas of health promotion and disease prevention, which will help the elderly retain their well-being later in life and will help to contain the costs of their care. Finally, the federal government must look more favorably on applications for Medicare and Medicaid waivers from those states interested in testing new models of long term care delivery and financing.

Connecticut, for example, because of its size and the depth of its financial, business, and intellectual resources, would be an ideal site for demonstrating alternative financing and delivery models. And the State is interested in playing a leadership role in this capacity.

Without establishing any new entitlement requiring major new outlays in federal revenue, the federal government can continue and enhance its essential role in shaping a more humane, cost-effective, rational system of providing and paying for long term care.

25x

STATE OF CONNECTICUT

Governor's Plan of Action on Private and Public Responsibilities for Financing Long Term Care for the Elderly

WILLIAM A. O'NEILL
Governor

June 8, 1987

26X

GOVERNOR O'NEILL'S RESPONSE TO THE GOVERNOR'S COMMISSION ON PRIVATE AND PUBLIC RESPONSIBILITIES FOR FINANCING LONG TERM CARE FOR THE ELDERLY

AN ACTION PLAN FOR THE ELDERLY

Connecticut's older population, like the nation's, is growing. While the majority of our older citizens will enjoy good health, social well-being and will remain productive, increased numbers of them reaching their seventh and eighth decades will suffer some of the serious diseases and disabilities associated with old age and will require long term chronic care. The need for this type of care will place significant demands on families, on those who deliver health care and on those -- including the State of Connecticut -- who finance long term care.

A review of our changing population, its needs and the growing impact of those changes on families and the State budget compelled me to appoint a special Commission to assess the State's continued ability to finance long term care and to seek ways to better meet the long term care challenge before us in a rational and compassionate manner.

The Governor's Commission on Private and Public Responsibilities for Financing Long Term Care for the Elderly ably addressed its charge and involved the widest spectrum of opinions in studying the issues. I have carefully reviewed the Commission's findings and support the conclusions it has reached and recommendations it has made.

The projected need for long term care and the expenditures associated with meeting that need will add to the current burden on individual and family resources. In addition, it will strain State resources. Unless steps are taken to moderate the growth in expenditures for long term care, individuals and families can expect to spend $1.2 billion by the year 2000 for long term care, primarily in nursing homes, and the State can expect to pay $1.4 billion. This

latter figure represents a staggering increase over our 1986-1987 budgeted expenditure of $274 million.

The challenge to the State is to take the steps needed to moderate those projected expenditures and to provide quality care for our older citizens. The Commission has outlined a number of constructive recommendations that can and should be acted upon. As they so appropriately point out, there is no single solution, nor is there any one sector that can assume sole responsibility for meeting the future long term care needs of Connecticut's older population. That responsibility must be shared among the State government, the federal government, the private sector and families and individuals. Connecticut, however, can and will take the lead by assuming its share of the responsibility and stimulating action within the other sectors.

Specifically, we need to create new options for financing long term care, to increase our efforts to expand cost effective ways to deliver long term care and to develop long range strategies to contain the rate of growth in the numbers of elderly who will need long term care in the future.

In Connecticut we have to begin this process immediately. Our consciences and our debt to our older citizens will not allow us to wait for others to take the first necessary steps. Simultaneously, however, we also will begin the process of enlisting the private sector's and the federal government's support as we strive for a solution to the truly national problem of providing for our older citizens.

To begin our response, I am taking the following steps to implement the recommendations put forth by the Governor's Commission on the Private and Public Reponsibilities for Financing Long Term Care for the Elderly.

STATE ACTION

I am designating Anthony V. Milano, Secretary of the Office of Policy and Management, to oversee the implementation of Commission recommendations.

The Office of Policy and Management coordinates the implementation of executive policy by all agencies of State government. Consistent with the importance of the issues raised by the Commission's Report and the necessity for coordinated involvement by a variety of State agencies in response, I am vesting overall responsibility for overseeing the implementation of State policy regarding the Commission's findings in Anthony V. Milano, Secretary of the Office of Policy and Management. He will coordinate the activities of the Long Term Care Commission; the Departments of Health Services, Income Maintenance, Aging, Insurance, Administrative Services and Consumer Protection; and the Connecticut Housing Finance Authority. As necessary, he also will employ the resources of the Center on Aging at the University of Connecticut to anticipate and plan for Connecticut's long term care needs.

Commissioner Negri of the Department of Administrative Services will begin to develop a plan to make appropriate long term care insurance products available to State employees who wish to purchase them.

We must lead by example. By making long term care products available to our own employees, Connecticut can, as an employer, exert a market-place influence which will aid in the development of private long term care financing products.

Executive Director Dubno of the Connecticut Housing Finance Authority will begin to explore suitable means for introducing greater flexibility into his authority's home equity conversion programs.

Connecticut has been a leader in the development of home equity conversion financing options. We must remain a leader. The Commission's report has provided useful insights into the actual market place reaction to our home equity conversion programs. The report also has identified long term care as an under-utilized purpose for obtaining home equity conversion loans.

With the specific need for long term care financing in mind, Executive Director Dubno can tailor the current program for home equity conversion loans so as to make the proceeds of these loans easily available to people who would use them to finance their long term care needs.

Commissioner Heintz of the Department of Income Maintenance has changed the Department's policy of treating home equity conversion proceeds as income and will begin to identify individuals who may be newly eligible for State Supplemental Assistance as a result of the change.

I am grateful to the Commission for having identified the regulatory anomaly of treating loan proceeds as income. As pointed out in its report, this practice frustrated the use of home equity conversion proceeds for legitimate health needs by, in some cases, disallowing borrowers from participation in other entitlement programs. Commissioner Heintz has changed the policy and will work with the Department on Aging to identify persons who might now be eligible for State Supplemental Assistance.

Commissioner Gillies of the Insurance Department will begin to review Insurance Department regulations and the legislation under which they are promulgated. The Department will assess the suitability of our existing regulatory framework to the development of new and innovative long term care insurance products.

.30X

Commissioner Heintz will take the steps necessary to make adult day-care expenses reimbursable under the Medicaid program.

Since 1983, the Medicaid program has been reimbursing adult day care services for the elderly under the home and community-based service waiver in Fairfield County. On the basis of that experience, and in light of the Commission's Report, the State of Connecticut secured federal approval to offer adult day care throughout the state under a new and expanded community-based service waiver. I am pleased that this waiver expansion, together with pre-admission screening, will be implemented statewide in the near future.

In addition, I have asked Commissioner Heintz to initiate the steps necessary at the state and federal levels to add Adult Day Care to the regular Medicaid State Plan in order to make these valuable services available to a wider population.

I also am asking Commissioner Heintz to determine whether other services, such as respite care, should be added as Medicaid reimbursable expenses under the State plan.

Commissioner Klinck of the Department on Aging will begin to take lead responsibilities for alerting our citizens to their long term care needs.

It is unacceptable that as many as four out of five of our citizens may be laboring under the erroneous belief that they have insurance coverage which will protect them from the expenses attendant upon long term care. What they do not know can very seriously hurt them and their families.

Nursing home care can quickly drain a family's financial resources, leaving a spouse impoverished and burdening subsequent generations both financially and emotionally. Therefore, the

Department on Aging will begin to intensify its long term care public education effort. Where constituencies other than that of the Department on Aging should be included in the public education outreach program, Secretary Milano will direct the assignment of public education responsibilities to other State agencies.

Commissioner Heslin of the Department of Consumer Protection and Commissioner Gillies of the Insurance Department will begin to intensify public education and consumer protection programs regarding long term care insurance products.

As new insurance products become available, the consumer education and consumer protection functions of the Department of Insurance and the Department of Consumer Protection must rise to the needs of our citizens.

Our people must understand more completely their long term care needs. They must understand the benefits and services provided by long term care products. And they must be able to assess the relative costs and values of the benefits and services offered to them.

Connecticut's people also must be protected from falsely advertised products and unscrupulous sales practices.

The Office of Policy and Management under Secretary Milano, on behalf of the people of Connecticut, will pursue foundation and federal funding for demonstration projects for long term care services and financing.

The search for solutions to the impending crisis in long term care must begin immediately. As one of his first responsibilities as executive branch coordinator of this action plan, Secretary Milano will oversee the preparation and submission of applications for federal and national foundation funding for demonstration projects

to explore innovative ways of providing and financing long term care.

The Office of Policy and Management under Secretary Milano will begin to develop the reliable data base we need in order to make informed judgments about our future long term care needs.

In the course of the Commission's research, one point has become startlingly clear. We do not have the specific information necessary to respond in a cost-effective manner to our population's long term care needs.

The Office of Policy and Management already has begun to coordinate the Departments of Health and Income Maintenance to make certain that our information on service utilization and needs is gathered appropriately and assembled into useful formats. That office will continue to do what is necessary to achieve a comprehensive and useful data base.

To emphasize further the need for a coherent and informed long term care financing strategy, long term care will be a principal focus at this October's Governor's Day on Aging.

I will submit legislative proposals appropriate to achieving the goals and objectives set forth in the Commission's report.

As our response to our people's long term care financing and service needs evolves, I will be working with the legislative leadership to develop such legislation as may be necessary to effect meaningful and lasting solutions. To prepare the legislature for these proposals, I am transmitting the Commission's Report to the legislative leadership and to the chairs and ranking members of legislative committees of cognizance, and I have asked the Commission to make itself available for legislative briefings.

In the fall, I will convene a Governor's Round Table consisting of Connecticut business and labor leaders to bring the private sector's focus to bear on long term care financing.

As we in the government of the State of Connecticut learn more about the need for long term care financing alternatives and as we develop experience in terms of the relative merits of the alternatives we explore, we must share our knowledge with the private sector.

The private sector should appreciate the long term care crisis from a number of perspectives. Private businesses pay public taxes and have a vested interest in our efforts to moderate the increase in pressure on public treasuries to pay for long term care. A private business also should become involved in long term care issues out of a concern for productivity. Businesses should appreciate the number of working Connecticut residents who are also providing care for loved ones. Businesses should appreciate the strains inherent in the care giving function and the subsequent effect of these strains on workplace productivity. As a consequence, businesses will appreciate the need to counsel employees about financial planning for future care needs and the availability of risk-pooling products which can diminish the individual impact of long term care needs.

To deliver these messages, I will convene business and labor leaders from throughout Connecticut to a meeting in the fall at which time we will present the Commission's report together with any new data which we have developed as a result of the other activities which are beginning today.

At that meeting, I hope not only to share data with the private sector, but to forge an ongoing program of shared experience which will result in a coordinated response by the public and private sectors to the needs of our state's and our nation's elderly.

STRIVING FOR AN APPROPRIATE FEDERAL RESPONSE

I will bring the issues raised in the Commission's report before the National Governors' Association at its meeting in July of 1987 and urge that body to develop a proposal for sharing responsibility for the care of our elderly between the state and federal governments.

The National Governor's Association provides an appropriate vehicle for the development of a balanced state government/federal government reaction to the long term care financing and service crisis. Obviously, public funding for service, training, research and demonstration projects must be shared by the state and federal governments. To what extent these responsibilities are allocated between the federal and state governments is a question which must be dealt with in a reasoned manner.

I therefore will ask the National Governors' Association to assess the appropriate roles which the state and federal governments should play in providing for our population's long term care financing and service needs.

I will urge the Connecticut Congressional Delegation to sponsor legislation which will broaden the options for long term care financing and address on a comprehensive basis our society's need for and ability to provide long term care.

The development of a federal role in providing for our nation's long term care needs requires congressional leadership. I therefore will meet with appropriate members of Connecticut's congressional delegation to share with them the Commission's findings and to urge upon them serious study of the degree to which the federal government must bear responsibility for meeting increased long term care financing and service needs. Specifically, I will ask them to consider the tax incentives

described in the Commission's Report and to reconsider recent reductions in federal spending on preventive health strategies, gerontological research and training of health care employees.

I will transmit the Commission's finding to Health and Human Services Secretary Otis R. Bowen so as to initiate a dialogue directly between Connecticut and the federal government.

I intend to transmit the Commission's Report directly to Secretary Bowen so that he may assess the relationship of our information to an appropriate executive-branch national strategy.

The tasks set forth above are imposing ones but so is the problem confronting us. As we complete these first efforts, we must at the same time develop the next stage in our response to the problem of long term care. We must all work together now to carry out this 16 point plan if we are to avoid a $2.6 billion problem in the year 2000.

William A. O'Neill
Governor

36x

TESTIMONY

at a Public Hearing of

THE NEW JERSEY TASK FORCE ON CATASTROPHIC

AND LONG-TERM HEALTH CARE

AUGUST 31, 1987

TRENTON, NJ

by William P. Brandon, Ph.D., M.P.H.
Associate Professor of Political Science
Center for Public Service
Seton Hall University

I want to congratulate you, Madam Chairwoman, the Members of this Task Force, the Assembly, and the State of New Jersey for undertaking this important and timely investigation.

The subject is important, because justice dictates that we consider the problems of the current cohort of elderly citizens and prudence requires us to prepare our society and government for the increased demands that will be generated in about twenty-five years, when the baby boomers begin to turn 60 or 65. The study is timely, because state action must be developed in conjunction with developments at the federal level, such as consideration of an expansion of Medicare to include social insurance against catastrophic illness. Reexamination of domestic social policy is also opportune in light of the relative health of the economy after the stagflation of the 1970s.

Let me begin by explaining how my colleagues at Seton Hall's newly inaugurated Center for Public Service and I can contribute to your deliberations. The institutional culture at Seton Hall and the personal convictions of our faculty lead us to emphasize the value-questions involved in public policy issues. Of course, any useful consideration of values must be based on accurate empirical knowledge.

Along with graduate teaching in the Master's program in Public Administration, we at the Center for Public Service are charged with the twin duties of community service and academic research.

An example of the compatibility of our service and research

is the conference that we held on paying for uncompensated care under New Jersey's DRG system for reimbursing hospitals. The papers and discussions at this conference were published as a symposium entitled "The All-Payers DRG System: Has New Jersey Found an Efficient and Ethical Way to Provide Indigent Care?" in the prestigious Bulletin of the New York Academy of Medicine. Subsequently, a generous grant from the Fund for New Jersey permitted us to distribute copies of the Bulletin to decision-makers and opinion-leaders in New Jersey and throughout the nation. Legislation embodying some of the principal recommendations of the conference is now being implemented and researchers are following some of the leads suggested at the conference.

Our interest in issues relating to the finance and delivery of health care in New Jersey has become even greater since last May, when Seton Hall became a Graduate School of Medical Education. We at the Center for Public Service expect to play an important role in the State's second graduate medical school.

Since you are at the beginning of your deliberations and have asked that today's hearings consider national long-term care policy, I want to devote my statement to general principles--or options of the broadest sort. Such fundamental consideration is often neglected, because analysts are busy grappling with the important details of particular policies, or foreclosed, because the "policy community" takes some unarticulated assumptions for granted.

The Context: Security for Retired Workers

We may be at an important turning point in developing health and social policy for the U.S. population. The period from 1935 through the Nixon administration accomplished the task of securing income maintenance and basic health coverage for retired workers. It also saw the protection of workers against periods of unemployment, sickness and disability. The period began with

the inauguration of Social Security and ended with large increases in the value of the benefit, indexing the increased benefit to rises in consumer prices and legislation to insure the payment of promised private pension benefits (i.e., the Employee Retirement Income Security Act of 1974 or PL 93-406). Participation in the World War and the Korean War, which interrupted the development of these economic rights, will also give millions of ex-servicemen additional retirement benefits, just as many of them enjoyed significant educational support when they were younger and tax-reductions as homeowners in their middle years.

Now that the basic needs of most seniors are met, new problems have become apparent. The first mark of this change was the crisis that led to the Greenspan Commission's examination of Social Security finances and the historic compromise of 1983 (1). The crisis was partly due to the maturing of the Social Security system, partly due to the unusual economic bad luck of the 1970s, and partly due to the aging of America. The favorable resolution of this crisis secured retirement benefit at least until the baby boom draws heavily on the Social Security Trust Funds (2). Although some adjustment will almost certainly be needed in the next century, the imbalances are unlikely to be so great as to be unfixable. The state of the Medicare Trust Fund is another story, however. It is important for attention to be paid to the underlying imbalance in Medicare before deficits create a crisis mentality (3).

---

1. U.S. National Commission on Social Security Reform, Final Report (Washington, DC: Government Printing Office, January 1983).

2. See, for example, Paul Light, Artful Work: The Politics of Social Security Reform (New York: Random House, 1985) and Barthe Derthick, Policymaking for Social Security (Washington, DC: The Brookings Institution, 1979).

3. See, for example, the report developed by "representatives from 172 different health, health-related, business government and consumer groups" published as The Health Policy Agenda for the American People (n.p.: Health Policy Agenda, 1987), pp. 139-145.

Among the most pressing of the new problems is the need for non-acute health care and social supports for those who encounter difficulties in living independently. Demographics, better health services, greater wealth and the other improvements worked together to increase the proportion of elderly from less than 6.9 percent of the U.S. population in 1940 to 11.3 percent in 1980. Those living to older ages increased even more rapidly (4). These factors made a new long-term care industry possible. Medicare and Medicaid are usually credited with spawning the nursing homes, although the most recent scholarship suggests that the Kerr-Mills Act of 1960 (PL 86-778) is actually responsible for the scope and structure of the industry (5).

This context of forty years of progress in assuring adult workers of relative economic security in both employment and retirement helps to explain why the issues of catastrophic illness and long-term health care have risen to the top of the national social policy agenda. It is natural to wish to complete the basic security system for the elderly by providing Medicare coverage for the entire expenses of catastrophic illnesses that require hospitalization and by developing some coverage for institutional long-term care. The problems of a relatively small number of Medicare beneficiaries who experience catastrophic expenses in a year led Secretary Bowen to propose his plan to cover catastrophic illness care under Medicare. Yet there can be

---

4. U.S. Department of Commerce, Bureau of the Census, Statistical Abstract of the United States 1943 (Washington, DC: Government Printing Office, 1944), p. 24; U.S. Department of Health and Human Services, Public Health Service, Health United States 1983: and Prevention Profile, Prepublication Copy, DHHS Pub. No. (PHS) 84-1232 (Hyattsville, MD: Nation Center for Health Statistics, December 1983), p. 171; Dorothy P. Rice and Jacob J. Feldman, "Living Longer in the United States: Demographic Changes and Health Needs of the Elderly," Milbank Memorial Fund Quarterly/Health and Society 61 (1983): 363.

5. James M. Brasfield, "The Management of Invisible Policies: Medicaid and Long Term Care," paper presented at the meeting of the Southwestern Social Science Association, Dallas TX, March 18-21, 1987.

40x

no real catastrophic coverage without covering the catastrophe of extended stays in nursing homes.

It is typical of the pluralist, interest-group politics practiced in the U.S. to focus on these genuine gaps and to try to do something about them. Our political system is often said to eschew comprehensive rational efforts to totally solve new problems; instead, change generally comes "incrementally," in little steps that build on the last change. The slow accretion of social insurance programs benefitting the elderly is a good example of this incrementalism. Whereas other industrial countries began their government health insurance programs with workers, private health insurance obtained as fringe benefits of employment supplied U.S. workers with basic health benefits. Social insurance for health was added to measures already in place to provide retirement income. Consequently, we have a fairly complete, if slightly jerrybuilt, social insurance structure to protect retirees and the disabled. Most workers, of course, are fairly well protected so long as they maintain employment. Large numbers of people falling outside these groups, however, have no meaningful coverage.

Thus, reflection on the great progress that has been made in providing security to retired citizens leads to the question whether social and governmental energies ought to be devoted to adding another crucial increment to reduce the remaining gaps or whether the needs of other groups or age-cohorts in society ought to receive attention. Young families faced with problems of day-care and housing and the striking evidence of need for programs to enhance the health of infants and pregnant women are frequently mentioned.

Even in forums where questions of relative need are foreclosed, an appreciation of advances in the security and financial status of the elderly is important for policy-making. The fact that the economic status of the elderly as a class has

improved radically since the passage of Medicare in the 1960s lies behind the movement to force more affluent beneficiaries to bear some of the costs of programs for all the elderly. Taxation of Social Security benefits began with the historic Social Security compromise of 1983; Congressman Stark's original proposals for catastrophic insurance in the current session of Congress taxed affluent beneficiaries to pay for a generous benefit package. The bill that was passed by the House in July involves a slightly disguised form of income-related beneficiary cost-sharing.

Three Broad Options

Three general directions can be followed in providing long-term care (6).

- Maintain the current system, perhaps ameliorating it somewhat with government support for home care and other programs that will stabilize the number of elderly who need expensive institutional long-term care.
- Establish a compulsory program of social insurance that will cover all long-term care or long-stay institutional care.
- Foster the development of private insurance for long-term care, including catastrophic long-stay institutional care.

The current system provides a perverse public catastrophic insurance for long-term institutional care. Medicaid, America's federal-state program of welfare medicine, functions as an insurance program with a gigantic and variable deductible: a beneficiary's entire savings.

Although this arrangement does provide a safety net for those needing institutional care, it has serious drawbacks. Too often, there are no home care alternatives to expensive institutionalization that Medicaid will have to support. The

---

6. This section draws on William P. Brandon, "Paying for Long-Term Institutional Care: Social Insurance versus Means-Tested Welfare," paper presented at the annual meeting of the American Political Science Association, New Orleans LA, August 29-September 1, 1985.

large proportion of Medicaid funds feeding the nursing home industry is a distortion of the original intention of Medicaid, which was designed to provide health care to those eligible for categorical welfare programs of income support. The largest group of poor people needing such care are the women and children receiving Aid to Families with Dependent Children (AFDC).

Moreover, the intrusion of Medicaid into long term care financing has resulted in a particularly egregious two-class system of medical care. Long-term care institutions are notorious for separating into those that will accept new patients on Medicaid and those that select private payers or sometimes only those patients who are thought likely to remain self-paying. In the area of acute hospital care New Jersey has eliminated such discrimination by payment source by fully reimbursing hospitals for otherwise uncompensated care. The State has accomplished this goal at little cost to itself through its unique DRG system (Diagnosis Related Groups), which sets the reimbursement rates that hospitals can charge (7). My understanding is that the State has also made serious efforts to control such discrimination in nursing homes. Throughout the country, however, nursing homes practice the kind of discrimination that hospitals and other institutional providers would not attempt.

Finally, policy makers need to be sensitive to the harsh consequences for individuals of Medicaid financing for nursing home care. Most of us have become aware of individuals or couples who are faced with the Hobson's choice of either allowing the expenses of long-term care to make them destitute or divesting themselves of assets and income in order to achieve Medicaid eligibility. Pauperizing self-reliant individuals after

---

7. See the Seton Hall DRG Conference "The All-Payers DRG System: Has New Jersey Found an Efficient and Ethical Way to Provide Indigent Care?" in the Bulletin of the New York Academy of Medicine 62 (July-August 1986): 627-701.

a lifetime of prudence and financial responsibility produces unmeasurable mental stress. The physical difficulties attendant upon impoverishment are especially severe for the spouse who is not institutionalized. Something is clearly wrong when significant numbers of the only major group that is covered by social insurance (Social Security and Medicare) are forced to rely on means-tested welfare for extended medical care.

Social insurance, non-voluntary programs covering all persons in a broad and therefore heterogeneous group by virtue of their group membership, can remedy this situation. Because the need for long-term care is relatively rare in the elderly population, but financially catastrophic when it occurs, extended stays in long-term care facilities are precisely the sort of contingency against which insurance can be effective.

In the current ideological milieu social insurance programs are unpopular. A major reason why they are dismissed is that almost all are redistributive. Because all beneficiaries or potential beneficiaries do not have the means to contribute their "actuarially fair" premium, those who are more affluent must pay premiums or taxes that will keep the social insurance pool in balance.

As a somewhat disgruntled citizen of New Jersey, I cannot resist reminding the Task Force that New Jersey uses its regulatory control over supposedly private insurance to redistribute premiums from good drivers to bad drivers. (I gather that some similar redistribution now occurs in the case of homeowners insurance.) The redistributive aspects of straightforward social insurance seem to me to be much less objectionable than these hidden regulatory surtaxes, which are not based on the ability to pay.

The strength of broad social insurance programs is that everyone in some clearly definable group is entitled to the benefit if it is needed. Since the program is widely used, it

does not carry the stigma that usually accompanies means-tested welfare programs.

Contrary to popular perceptions, social insurance can also be cost-effective. Although prudent governments attend to major demographic changes, social insurance schemes are organized on a pay-as-you-go basis. Thus large reserves are unnecessary. The size of social insurance programs produce very large economies of scale. Moreover, profits, marketing expenses and much of the administrative overhead of private insurance companies are unnecessary in a government operation. The concentration of so much buying power also permits government to impose cost control.

The disadvantages, which are probably decisive for the current era, are twofold. Social insurance converts private dollars for a social service into government dollars. The current aversion to increased public expenditures and the unwillingness to increase taxes makes forthright social insurance for long-term care an unlikely prospect. The other major problem is that our government has always had difficulty in controlling the increase in demand that usually follows new social insurance coverage. Private insurance may also entail such "moral hazard," but private carriers can always raise the rates for classes of high-users (or hold indemnity benefits constant in the face of increasing costs of care). Nowadays private companies are also better able to impose cost controls on providers than formerly.

This Task Force will also probably conclude that any expansion in social insurance, like the current proposals for catastrophic health insurance, must be developed and implemented at the federal level.

Private insurance for long-term catastrophic care has not developed. It is important to ask why a principal feature of the health care system serving middle-class families is not widely available in the long-term care field.

Perhaps the chief problem is that the actuarially fair cost

of adequate, effective long-term care insurance is prohibitive if purchased at retirement or even later, when potential insureds recognize that current levels of personal risk for long-term care justify the purchase of insurance. Although middle-aged workers tend to have more disposable income, it is hard to sell insurance for potential institutionalization that may or may not come about years after the initial purchase. The problem is undoubtedly due in part to the well-documented fact that most people (including a large percentage of retirees) believe that Medicare supplemented by private "Medigap" insurance policies covers nursing home care. Yet even if government and insurance companies succeed in correcting this information failure, it seems unlikely that the typical American male (who makes decisions on such matters) will subscribe to long-term care insurance until institutionalization in a nursing home is a real possibility.

Another part of the problem is that our experience with private health insurance, unlike life insurance, involves essentially "pay-as-you-go" annual policies rather than building large trust funds. Health insurance has taught us to expect and to trust service benefits. This expectation leaves insurance companies with the difficult problem of engineering benefits far into the future and developing reserves that will enable them to pay possibly inflated costs incurred many years after the policy was initiated.

There is a more positive side to the possibility of private insurance for long-term care. It is possible to envision a partnership between government and the private insurance industry in which government fosters the growth of home care programs to reduce the demand for long-term institutional care. In return, increased private coverage against the risks of catastrophic long-term care will buffer Medicaid from some of the demand that will come in the twenty-first century when the baby boom becomes elderly.

A little-discussed aspect of all the catastrophic proposals during this past year may result in increased interest by private insurance companies in developing and marketing long-term care insurance. It is quite possible that the addition of catastrophic hospital insurance to Medicare will make supplemental "Medigap" insurance policies unattractive. The loss of this market niche may motivate insurance companies to compensate by pioneering new insurance policies for long-term care.

Although private insurance can only be a solution for that part of the population which is relatively affluent, a partial solution may be better than no solution at all. Aside from the obvious problem of insurance-generated demand, there are two dangers. The most likely is that a partial solution that further separates the elderly population into affluent, insurance-protected senior-citizens and unprotected, potentially indigent retirees will lead to greater segregation into classes of long-term care institutions. Thus, effective regulation may be necessary to dampen the likely effects of economic inequalities.

The other danger is that the availability of insurance reimbursement may monetize much of the care that is now delivered without charge in homes by family, friends and neighbors. There is a long history in American health care of voluntary service and philanthropy being replaced by charges and other forms of reimbursement. Such substitution not only increases the dollar costs of services, but risks discouraging and devaluing the personal commitment of family, friends and neighbors. Countries that encourage volunteerism in this area are said to save money and improve the quality of services.

If the general public ever begins to understand that Medicare does not cover long-term care, and if this understanding generates a boom in long-term care insurance, it will be important to make sure that private policies actually provide

adequate coverage for the money charged. It would be extraordinarily sad to see the abuses by some of the Medigap insurers who seemed to promise a lot and deliver very little repeated in insurance for long-term care.

Conclusion: Prospects and Predictions

It is very reasonable to ask in conclusion about the chances that each option will become our future reality.

The Task Force has already heard positive reports about the future prospects for private insurance and it will undoubtedly hear a great deal more on this subject. Despite the strides that have received so much attention in the last couple of years, I am skeptical that a significant proportion of America's elderly will ever be covered by private long-term care insurance. If private insurance does become a major payer of long-term care bills, it is unlikely to be important until well into the next century.

We must be clear about what constitutes "significant coverage." A modest criterion for judging the success of the private insurance option would be for 20 percent of those over 70 to have adequate private long-term care coverage. Undoubtedly we will hear many reports of rapid growth in the number of long-term care policies before the criterion is approached; increases of more than 100 percent are not unlikely. Very high growth rates, which are relatively meaningless, can be expected when the original base is low. In this respect, long-term care insurance may resemble the record of the Health Maintenance Organization (HMO) program (which, almost a decade and a half after the first federal HMO legislation, only enrolls slightly more than ten percent of the US population) (8).

Part of the problem, of course, is that voluntary private insurance cannot grow until Americans learn that they need to

---

8. InterSudy reported that HMOs enrolled 27.7 million members in the first quarter of 1987, according to Medicine and Health 41 (17 August 1987): 3. See generally, Lawrence D. Brown, Politics and Health Care Organization: HMOs as Federal Policy (Washington, DC: The Brookings Institution, 1983).

purchase protection against long-term care costs. Education always takes a great deal of time. Fortunately, there is quite a long time for thorough education, because the public problem really becomes severe only in the twenty-first century.

In the meantime we must continue to cope with the problems that stem from the current system. Although no one would choose such a system, it may be unavoidable in the short term. There are ways of ameliorating its worst problems--e.g., by trying to humanize spend-down provisions, liberalizing the most niggardly state Medicaid payments to nursing homes, providing more home care, and improving the quality of nursing home care. Until the baby boom generation retires, however, the elderly may not be numerous enough to create the perception of a real crisis in the long-term care system as it currently operates. In the first quarter of the next century the sudden increase in the number of elderly will make long-ignored problems in long-term care seem overwhelming. By then the political power of seniors is likely to be irresistible.

Although social insurance for long-term care has no prospects within the next five years, it may have better chances in the intermediate to long term. If private insurance is an obvious failure, a compulsory government program of long-term care insurance may be recognized as the only alternative to the inequities and inefficiencies of the current system. Other nations often developed comprehensive health insurance schemes out of a patchwork of private and government programs that failed to provide financial security, justice or cost-containment. It is always possible that conditions in the long-term care field will become intolerable. For example, a combination of growing inequities between those with private insurance or the means to pay for extended care and those without, escalating nursing home costs, and increasing disparities between states in regard to both the services and payments provided for indigent care might

make social insurance for long-term care look attractive.

If conditions ever become favorable for the adoption of social insurance, a sizable cadre of public health professionals who are committed to social responsibility for health care are certain to advocate it vigorously. They just might be successful, for a long series of polls show that public opinion continues to be favorably disposed to the idea of national health insurance. Consensus typically breaks down only at the political stage when government institutions grapple with the tough questions necessary to produce a particular program.

It only remains, Madam Chairwoman, to thank you for asking me to talk with you. I want to wish you and the other members of the Task Force well in your important endeavors. You are embarked on an exceedingly challenging enterprise.

50X