PUBLIC HEARING

before

ASSEMBLY REVENUE, FINANCE AND APPROPRIATIONS COMMITTEE

on

Assembly Bill 608

(Allows "Medically Needy" Persons to Qualify for Medicaid)

Held:
July 12, 1984
Room 114
State House Annex
Trenton, New Jersey

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MEMBERS OF COMMITTEE PRESENT:

Assemblyman John S. Watson (Chairman)
Assemblyman Rodney P. Frelinghuysen
Assemblyman Walter J. Kavanaugh
Assemblyman Karl Weidel

ALSO PRESENT:

Assemblyman Thomas J. Deverin
Sponsor of Assembly Bill 608

Jay Hershberg, Analyst
Division of Budget and Program Review
Office of Legislative Services
Acting Aide, Assembly Revenue, Finance and Appropriatons Committee

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ASSEMBLY, No. 608

STATE OF NEW JERSEY

PRE-FILED FOR INTRODUCTION IN THE 1984 SESSION

By Assemblyman DEVERIN

AN ACT to amend the "New Jersey Medical Assistance and Health Services Act," approved January 15, 1969 (P. L. 1968, c. 413).

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. Section 3 of P. L. 1968, c. 413 (C. 30:4D-3) is amended to read as follows:

3. Definitions. As used in this act, and unless the context otherwise requires:

a. "Applicant" means any person who has made application for purposes of becoming a "qualified applicant."

b. "Commissioner" means the Commissioner of the Department of Human Services.

c. "Department" means the Department of Human Services, which is herein designated as the single State agency to administer the provisions of this act.

d. "Director" means the Director of the Division of Medical Assistance and Health Services.

e. "Division" means the Division of Medical Assistance and Health Services.

f. "Medicaid" means the New Jersey Medical Assistance and Health Services Program.

g. "Medical assistance" means payments on behalf of recipients to providers for medical care and services authorized under this act.

h. "Provider" means any person, public or private institution, agency or business concern approved by the division lawfully pro-

EXPLANATION—Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.
Matter printed in italics *thus* is new matter.

viding medical care, services, goods and supplies authorized under this act, holding, where applicable, a current valid license to provide such services or to dispense such goods or supplies.

i. "Qualified applicant" means a person who is a resident of this State and is determined to need medical care and services as provided under this act, and who:

(1) Is a recipient of aid to families with dependent children; [or]

(2) Is a recipient of supplemental security income for the aged, blind and disabled under Title XVI of the Social Security Act; [or]

(3) Is an "ineligible spouse" of a recipient of supplemental security income for the aged, blind and disabled under Title XVI of the Social Security Act, as defined by the federal Social Security Administration; [or]

(4) Would be eligible to receive public assistance under a categorical assistance program except for failure to meet an eligibility condition or requirement imposed under such State program which is prohibited under Title XIX of the federal Social Security Act such as a durational residence requirement, relative responsibility, consent to imposition of a lien; [or]

(5) Is a child between 18 and 21 years of age who would be eligible for aid to families with dependent children living in the family group except for lack of school attendance or pursuit of formalized vocational or technical training; [or]

(6) Is an individual under 21 years of age who qualifies for categorical assistance on the basis of financial eligibility, but does not qualify as a dependent child under the State's program of aid to families with dependent children (AFDC), or groups of such individuals, including but not limited to, children in foster placement under supervision of the Division of Youth and Family Services whose maintenance is being paid in whole or in part from public funds, children placed in a foster home or institution by a private adoption agency in New Jersey or children in intermediate care facilities, including institutions for the mentally retarded, or in psychiatric hospitals; [or]

(7) Meets the standard of need applicable to his circumstances under a categorical assistance program or supplemental security income program, but is not receiving such assistance and applies for medical assistance only.

A person shall not be considered a qualified applicant if, within 1 year of becoming or making application to become a qualified applicant, he has made a voluntary assignment or transfer of real or personal property, or any interest or estate in property, for less

than adequate consideration. Such voluntary assignment or transfer of property shall be deemed to have been made for the purpose of becoming a qualified applicant in the absence of evidence to the contrary supplied by the applicant. This requirement shall not be applicable to Supplemental Security Income applicants or aged, blind or disabled applicants for Medicaid only unless authorized by federal law, *or*

(8) Meets the standard of need applicable to his circumstances under a medically needy category set forth in subsection b. of section 7 of P. L. 1968, c. 413 (C. 30:4D–7).

j. "Recipient" means any qualified applicant receiving benefits under this act.

k. "Resident" means a person who is living in the State voluntarily with the intention of making his home there and not for a temporary purpose. Temporary absences from the State, with subsequent returns to the State or intent to return when the purposes of the absences have been accomplished, do not interrupt continuity of residence.

l. "State Medicaid Commission" means the Governor, the Commissioner of Human Services, the President of the Senate and the Speaker of the General Assembly, hereby constituted a commission to approve and direct the means and method for the payment of claims pursuant to this act.

m. "Third party" means any person, institution, corporation, insurance company, public, private or governmental entity who is or may be liable in contract, tort, or otherwise by law or equity to pay all or part of the medical cost of injury, disease or disability of an applicant for or recipient of medical assistance payable under this act.

2. Section 7 of P. L. 1968, c. 413 (C. 30:4D–7) is amended to read as follows:

7. Duties of commissioner. The commissioner is authorized and empowered to issue, or to cause to be issued through the Division of Medical Assistance and Health Services all necessary rules and regulations and administrative orders, and to do or cause to be done all other acts and things necessary to secure for the State of New Jersey the maximum federal participation that is available with respect to a program of medical assistance, consistent with fiscal responsibility and within the limits of funds available for any fiscal year, and to the extent authorized by the medical assistance program plan; to adopt fee schedules with regard to medical assistance benefits and otherwise to accomplish the purposes of this act, including specifically the following:

a. Subject to the limits imposed by this act, to submit a plan for medical assistance, as required by Title XIX of the Federal Social Security Act, to the federal Department of Health[, Education] and [Welfare] *Human Services* for approval pursuant to the provisions of such laws; to act for the State in making negotiations relative to the submission and approval of such plan, to make such arrangements, not inconsistent with the law, as may be required by or pursuant to federal law to obtain and retain such approval and to secure for the State the benefits of the provisions of such law;

b. Subject to the limits imposed by this act, to determine the amount and scope of services to be covered, that the amounts to be paid are reasonable, and the duration of medical assistance to be furnished; provided, however, that the department shall provide medical assistance on behalf of all recipients of categorical assistance and such other related groups as are mandatory under federal laws and rules and regulations, as they now are or as they may be hereafter amended, in order to obtain federal matching funds for such purposes and, in addition, provide medical assistance for the foster children specified in section 3. i. (7) of this act. The medical assistance provided for these groups shall not be less in scope, duration, or amount than is currently furnished such groups, and in addition, shall include at least the minimum services required under federal laws and rules and regulations to obtain federal matching funds for such purposes.

The commissioner is authorized and empowered, at such times as he may determine feasible, within the limits of appropriated funds for any fiscal year, to extend the scope, duration, and amount of medical assistance on behalf of these groups of categorical assistance recipients, related groups as are mandatory, and foster children authorized pursuant to section 3. i. (7) of this act, so as to include, in whole or in part, the optional medical services authorized under federal laws and rules and regulations, and the commissioner shall have the authority to establish and maintain the priorities given such optional medical services; provided, however, that medical assistance shall be provided to at least such groups and in such scope, duration, and amount as are required to obtain federal matching funds;

The commissioner is further authorized and empowered, at such times as he may determine feasible, within the limits of appropriated funds for any fiscal year, to issue, or cause to be issued through the Division of Medical Assistance and Health Services all necessary rules, regulations and administrative orders, and to do or cause to be done all other acts and things necessary to implement

and administer demonstration projects pursuant to Title XI, Section 1115 of the federal Social Security Act, including, but not limited to waiving compliance with specific provisions of this act, to the extent and for the period of time the commissioner deems necessary, as well as contracting with any legal entity, including but not limited to corporations organized pursuant to Title 14A, New Jersey Statutes (N. J. S. 14A:1-1 et seq.) [and], Title 15, Revised Statutes (R. S. 15:1-1 et seq.) *and Title 15A, New Jersey Statutes (N. J. S. 15A:1-1 et seq.)* as well as boards, groups, agencies, persons and other public or private entities[.];

The commissioner is further authorized and empowered, at such times as he may determine feasible, within the limits of appropriated funds for any fiscal year, to expand the medical assistance program to include medically needy groups whose income and resources equal or exceed the levels of maintenance under the plan but are insufficient to meet their medical costs and who, except for their financial circumstances, meet all of the conditions of eligibility under one of the categorical assistance or supplemental security income recipient programs. The medical assistance provided for these medically needy groups shall include at least the minimum services required under federal laws, rules or regulations to obtain federal matching funds for these purposes, and may be expanded to provide medical assistance services currently furnished other recipients.

c. To administer the provisions of this act;

d. To make reports to the federal Department of Health[, Education] and [Welfare] *Human Services* as from time to time may be required by such federal department and to the New Jersey Legislature as hereinafter provided;

e. To assure that any applicant, qualified applicant or recipient shall be afforded the opportunity for a hearing should his claim for medical assistance be denied, reduced, terminated or not acted upon within a reasonable time;

f. To assure that providers shall be afforded the opportunity for an administrative hearing within a reasonable time on any valid complaint arising out of the claims payment process;

g. To provide safeguards to restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with administration of this act;

h. To take all necessary action to recover any and all payments incorrectly made to or illegally received by a provider from such provider or his estate or from any other person, firm, corporation, partnership or entity responsible for or receiving the benefit or

possession of the incorrect or illegal payments or their estates, successors or assigns, and to assess and collect such penalties as are provided for herein;

i. To take all necessary action to recover the cost of benefits incorrectly provided to or illegally obtained by a recipient, including those made after a voluntary divestiture of real or personal property or any interest or estate in property for less than adequate consideration made for the purpose of qualifying for assistance from such recipient, legally responsible relative, representative payee, or any other party or parties whose action or inaction resulted in the incorrect or illegal payments, or from their respective estates, as the case may be and to assess and collect such penalties as are provided for herein, except that no lien may be imposed against property of the recipient prior to his death except in accordance with section 17 of P. L. 1968, c. 413 (C. 30:4D–17); provided, however, that no recovery action shall be initiated 5 years after an incorrect payment has been made to a recipient when such incorrect payment was due solely to an error on the part of the State or any agency, agent or subdivision thereof;

j. To take all necessary action to recover the cost of benefits correctly provided to a recipient from the estate of said recipient in accordance with sections 6 through 12 of this amendatory and supplementary act;

k. To take all reasonable measures to ascertain the legal or equitable liability of third parties to pay for care and services (available under the plan) arising out of injury, disease, or disability; where it is known that a third party has a liability, to treat such liability as a resource of the individual on whose behalf the care and services are made available for purposes of determining eligibility; and in any case where such a liability is found to exist after medical assistance has been made available on behalf of the individual, to seek reimbursement for such assistance to the extent of such liability;

l. To compromise, waive or settle and execute a release of any claim arising under this act including interest or other penalties, or designate another to compromise, waive or settle and execute a release of any claim arising under this act. The commissioner or his designee whose title shall be specified by regulation may compromise, settle or waive any such claim in whole or in part, either in the interest of the medicaid program or for any other reason which the commissioner by regulation shall establish;

m. To pay or credit to a provider any net amount found by final audit as defined by regulation to be owing to the provider.

Such payment, if it is not made within 45 days of the final audit, shall include interest on the amount due at the maximum legal rate in effect on the date the payment became due, except that such interest shall not be paid on any obligation for the period preceding September 15, 1976. This subsection shall not apply until federal financial participation is available for such interest payments;

n. To issue, or designate another to issue, supenas to compel the attendance of witnesses and the production of books, records, accounts, papers and documents of any party, whether or not that party is a provider, which directly or indirectly relate to goods or services provided under this act, for the purpose of assisting in any investigation, examination, or inspection, or in any suspension, debarment, disqualification, recovery, or other proceeding arising under this act;

o. To solicit, receive and review bids pursuant to the provisions of P. L. 1954, c. 48 (C. 52:34-6 et seq.) and all amendments and supplements thereto, by authorized insurance companies and non-profit hospital service corporations or medical service corporations, incorporated in New Jersey, and authorized to do business pursuant to P. L. 1938, c. 366 (C. 17:48-1 et seq.) or P. L. 1940, c. 74 (C 17:48A-1 et seq.); and to make recommendations in connection therewith to the State Medicaid Commission;

p. To contract, or otherwise provide as in this act provided, for the payment of claims in the manner approved by the State Medicaid Commission;

q. Where necessary, to advance funds to the underwriter or fiscal agent to enable such underwriter or fiscal agent, in accordance with terms of its contract, to make payments to providers;

r. To enter into contracts with federal, State, or local governmental agencies, or other appropriate parties, when necessary to carry out the provisions of this act;

s. To assure that the nature and quality of the medical assistance provided for under this act shall be uniform and equitable to all recipients.

3. This act shall take effect six months following enactment, but all arrangements necessary or appropriate to enable this act to become fully effective on this date shall be made as promptly as possible as though this act were effective immediately.

STATEMENT

This bill would expand the medicaid program to certain "medically needy" groups who 1. are ineligible for medicaid because their incomes are too high, but 2. can demonstrate that their incomes are insufficient to meet medical costs, and 3. except for financial circumstances, meet all of the conditions of eligibility under one of the categorical assistance or supplemental security income programs.

ASSEMBLYMAN JOHN S. WATSON (Chairman): Good morning. It is nice to see so many people here this morning. We would like to begin our hearing on A-608, sponsored by Assemblyman Deverin. Bill A-608 would extend New Jersey's Medicaid program to persons and households that are medically needy, such as people in households who are not entitled to either AFDC or SSI, but who would be eligible for assistance if their medical expenses were excluded when determining eligibility.

New Jersey is one of 18 states which does not have a medically-needy program. A medically-needy program must cover pregnant women during the course of their pregnancy, and all other individuals under age 21, or, at State option, under age 20, 19, or 18.

In addition, a medically-needy program may include the following group: individuals under age 21; caretaker relatives; aged; blind; and disabled. A medically-needy program would not provide Medicaid coverage to all persons. In particular, single persons and childless couples would not be eligible for this program.

A-608 is perhaps the most important piece of social and health legislation pending before the Legislature. Since October of 1981, when the Federal effort to reduce Federal expenditures began in earnest, elderly and disabled Medicare recipients have been subjected to significant increases in both deductibles and copayments, and over 70 thousand persons, terminated from public assistance, have lost their Medicaid benefits. A medically-needy program would assist elderly and disabled Medicare recipients to meet their medical needs in the face of higher Medicare deductibles and copayment requirements. It would also fill some of the medical gaps which exist in the Medicare Program in such areas as dental care.

Persons who lose their public assistance would no longer be faced with the loss of their Medicaid benefits, and they would not have to forego necessary medical care.

The purpose of this public hearing is to obtain data as to which groups are to be covered by a medically-needy program; the number of persons within each group who may qualify; the type of services to be offered; their estimated cost; and how best to administer the program. We wish to know in advance the cost associated with this

program in order to avoid the problems that surrounded the pharmaceutical program in 1978.

The experiences of other states with medically-needy programs provide some information on medically-needy programs. States with medically-needy programs show that 14 percent of their caseload is made up of medically-needy persons. The medically-needy population tends to be older than the regular Medicaid population: 30.1 years for the medically-needy population versus 19.3 years for the Medicaid population.

Average monthly cost for a medically-needy person is 2.3 times higher than for a categorically-needy person. Medically-needy expenditures range from $107 per month for those between age 0 to age 20 years, compared with $784 for those over 80 years. A greater percentage of medically-needy individuals tend to have medical insurance coverage; whereas, their categorically-needy counterparts do not.

A medically-needy program takes on added importance when viewed in light of recent indications that the Federal Health Care Financing Administration may not renew New Jersey's Hospital Rate-setting Program, which provides over $200 million in reimbursement for indigent care and bad debts, through the rates paid by Medicare and Medicaid.

The Department of Health has indicated that as many as twenty to twenty-five inner city hospitals face serious financial difficulties, and even bankruptcy if New Jersey's Rate-setting Program is terminated. A medically-needy program would pick up some portion of this $200 million in indigent care and bad debt cost, and the Committee would be interested in knowing the impact a medically-needy program would have on indigent care and bad debts.

First, I would like to thank you again for being here today regarding this important bill that is facing the Legislature. I would like to introduce to you some of the members of my Committee. To my far right, is Assemblyman Rodney Frelinghuysen. We also have with us Assemblyman Karl Weidel. And, of course, we have my staff. On my right is Mr. Jay Hershberg, and on my left is staff member, Mr. Fred Butler.

The first person to testify today is the sponsor of the bill, Assemblyman Thomas Deverin.

ASSEMBLYMAN THOMAS DEVERIN: Thank you very much, Mr. Chairman. Thank you very much for having us here. You know, the time has come in New Jersey for this type of bill. There are 38 or 39 states that have this legislation now, successfully.

New Jersey has a very brave reputation throughout this nation for being a State that really cares about its citizens. You know our PAA Program was the first in the nation, and it is well run. We run our welfare program with compassion. We have great control over our nursing homes. Our institutions are probably the best institutions in America. So, we always look after the health care needs of the people of New Jersey.

The problem at this time in New Jersey is a very serious problem. If one is eligible for welfare or Medicaid, one is pretty well taken care of when his or her health needs come up. Their children can have their teeth fixed. They can have their eyes fixed. They can be taken care of.

If one is eligible for PAA, one can get his or her prescriptions at $2.00 each. If one is eligible for SSI, one falls automatically into Medicaid and one's health care needs are taken care of.

Now, on the other hand, if one is wealthy enough, or if one is retired from a company that has medical programs that the employee can pick up upon retirement, one has no problem. One can buy his or her health care and pay for his or her health problems.

But, there is a group of people in New Jersey who fall into a special category. They are actually in limbo. They fall into a crack between being poor enough to be eligible for the entitlements and not being wealthy enough to take care of themselves. They are the people this bill addresses, and there are many of them. In New Jersey, I estimate there are between 200 and 300 thousand people who fall into this category.

I am sure you, Mr. Chairman, and the rest of the Committee, have all heard the same stories in your offices and on your telephones as I have heard. I know of a case in Elizabeth, New Jersey, of a man

who is 73 years old, completely paralyzed, and in a wheelchair. His wife is 76 years old. They are very lonely people, and I talk to them on the phone maybe once a month, hoping that something can be done. But, they are above income by some 40-some dollars for SSI and help with Medicaid. They are above the income for PAA. The prescriptions for that man alone are over $200 a month, and his wife's are $100-some dollars a month. So, that couple faces a choice of buying food or buying medicine. These are the kinds of people we are talking about in this bill.

I am sure you have also heard of the other end of this category; for instance, a young woman whose husband is disabled and who has not worked in the work force long enough to be eligible for some of the programs. I can tell you of a case in Roselle, New Jersey, of a woman with four children, the oldest is 12 and the youngest is 3, who has a husband that was crippled in an accident. There was no insurance. He finally got disability. For about three and one-half years she was eligible for welfare, and she got welfare. Her children were taken care of. Now one of the children has a very bad disease of the jaw, but when her husband got his disability pension it put them $102 over the limit. No way can they pay for food, put the kids through school, put shoes on their feet, and take care of their illnesses. No way can they do that, unless they starve. They are not eligible. This is another type of person who can fit into this program.

The time has really come for us to do something with this. I am not going to try and estimate the cost. I am not going to try to tell you exactly who fits into the category and who doesn't fit into the category. I have no concern about how we set up the program, percentagewise. I think we probably ought to start out with a 100 percent of need criteria, and maybe after one or two years' experience we could try to go to 133 percent.

I think the Commissioner -- and I am not trying to patronize that Department -- of Human Services in New Jersey is one of the smartest and brightest people we have, and between him and this Committee in the Legislature, we can set up a program in New Jersey that will work.

I heard you mention the DRG. I know, and you know, that the DRG is in trouble. As a former county Freeholder and a former local mayor, I understand what will happen if that program goes down the tubes. Many times, the county had to come up with money to keep the hospitals going, especially the inner city hospitals. And, regardless of what the Federal government does with indigent care for hospitals, this bill will be of help.

So, Mr. Chairman, all I am really asking the Committee to do is to give serious consideration to this bill. Thirty-eight million dollars seems like an awful lot of money, but we will get back $38 million in matching funds from the Federal government. The program is really and truly needed, and we are no longer a poor State. We are a State that has come a long way in the last ten years. We are a State to whom the nation now looks, one that it no longer finds anything funny about.

We have done some great things in New Jersey. This is one more step on the social ladder to help people who fall into that special category, into that crack, the ones who are in limbo and who can't get help from anybody else except the government. There is no help from the Federal government. That help is being cut back day after day. There is no help from the State government for them. This bill will do just that, Mr. Chairman. It will help the senior citizens. It will certainly help the poor young people who are struggling to take care of their children and themselves. It is something we need, Mr. Chairman, and I trust this Committee will give it serious consideration and allow us to fund it properly in order to get it started. We can, through the efforts of the Commissioner, this Committee, and the Legislature, come up with a good program. I thank you for allowing me to come here this morning, Mr. Chairman.

ASSEMBLYMAN WATSON: Thank you, Assemblyman Deverin. Assemblyman Deverin, your bill, A-608, is a very generalized and broad one. Should the bill be tightened with respect to the income level to be used?

ASSEMBLYMAN DEVERIN: Yes. You know, the bill itself covers a broad category. There is no question about that, Just as with any piece of legislation that has this kind of ramification, it has to be

modified and tightened up. Besides the level of percentages that would be involved, there ought to be some sort of means test and there ought to be an asset test, etc. There ought to be the same broad generalization that covers all the programs. That, Mr. Chairman, has to be done, and it should be done. I would appreciate it -- in fact, I look forward to this Committee making suggestions and any kind of amendment they think will make this a better bill for all of us.

ASSEMBLYMAN WATSON: Assemblyman, would you have any kind of recommendation, insofar as the asset level that should be established?

ASSEMBLYMAN DEVERIN: I am always amazed at the asset level that is established now. It is $1,000 for those on Welfare and $1500 for those on SSI. If you don't mind me being personal now, I made a trip to the SSI office in New Brunswick with a woman who had $2700 in the bank. That $2700 came about as result of a $500 policy from her husband who died in 1958 or 1959. It grew through interest. And, when she found out that she was not eligible, Mr. Chairman, because of that lousy $2700 and change -- I think it was $20 -- all she kept repeating to the lady was: "That is my burial fund. That is what they are going to bury me with." The lady just said: "I am sorry; you are only allowed to have $1500 in assets."

I think there has to be this kind of thing, but I don't think, Mr. Chairman, that the asset or the means test ought to be as bad as it is for SSI or Welfare.

ASSEMBLYMAN WATSON: I would like to ask the Committee members if they have any questions of Assemblyman Deverin. Assemblyman Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: Some time in the future.

ASSEMBLYMAN WATSON: Okay. Assemblyman Weidel?

ASSEMBLYMAN WEIDEL: I would just like to get this into focus. When we put the PAA Program in, it was going to cost about $7 or $8 million, and it now costs $68 million. Mr. Deverin, you are suggesting a program, but you are not suggesting the income level. You are not suggesting the eligibility level. You are not suggesting how much we should set it at.

ASSEMBLYMAN DEVERIN: Oh, I am. I said the entitlements ought to be 100 percent of the program now. For instance, if it is

$385 -- if a family is eligible for Medicaid at $385, or for SSI, 100 percent ought to be part of the program. There ought to be a spend-down in the program too, Mr. Weidel. If someone is way above the level and is caught with a catastrophic illness, or has to spend his money down to a certain level, he ought to be eligible for this program. I don't think that I am ready or able at the moment to tell you the exact figures or what they should be. I think that is a matter of study, in order to establish rules and regulations. But, there certainly has to be some criteria regarding who is eligible and who is not eligible.

ASSEMBLYMAN WEIDEL: I see. That is what I wanted you to state. We don't know the overall cost of the program right now.

ASSEMBLYMAN DEVERIN: If we go to the 100 percent, the estimates would be about $38 million, Mr. Chairman. If I had my druthers, the funding for the senior citizen part of it -- those estimated to be eligible from the senior citizen, 65-year-old category -- would be about $19 million. Those in the younger category -- the Aid for Dependent Children, etc. -- would be about $19 million. The total would be about $38 million.

I would have no qualms about, nor would I be concerned with, funding the senior citizen part of this from the casino funds. Those funds are intended for this type of work. They are intended for the health and welfare of the senior citizens, and this is a program for the health and welfare of the senior citizens. I have no objection to that. The rest of the fund should come from the General Revenue.

I think a $38 million fund would be more than adequate to start with. I agree with you, Mr. Weidel, that the PAA Program, when you and I were cosponsors of that legislation, started out at a very small figure, but reached $66 million. However, in this day and age, I think both of us are very proud of that program.

I think we can start this program the same way because of what we have learned from the PAA Program. We should start out with some definite guidelines and after a year or so, we should review it and see how we are doing with it.

ASSEMBLYMAN WEIDEL: Thank you.

ASSEMBLYMAN WATSON: Thank you, Assemblyman Weidel and thanks again, Assemblyman Deverin.

Our next speaker is the Commissioner of Human Services, Commissioner Albanese.

Commissioner, would you be so kind as to identify your staff?

COMMISSIONER GEORGE J. ALBANESE: To my right is Alan Wheeler, Deputy Director, Division of Medical Assistance and Health Services, and Mr. Larry Lockhart, a Deputy Commissioner. To Mr. Lockhart's right is Constance Thomas, Executive Assistant with the Division of Medical Assistance, and Ann Kohler, Chief of the Bureau of Health Statistics and Economics, with the Division of Medical Assistance.

ASSEMBLYMAN WATSON: Thank you.

COMMISSIONER ALBANESE: Mr. Chairman, we are handing out copies of testimony, and also a copy of a report that we prepared when we began our analysis of the medically-needy program. I think that will be very helpful to you.

Mr. Chairman, I would first like to commend you and the members of the Committee for taking the lead by holding public hearings on an issue as important as extending Medicaid coverage to the medically needy. I would also like to commend Assemblyman Deverin for his sensitivity to this particular matter.

We have been going back and forth with Assemblyman Deverin, and he has been very patient while we have gathered some of the facts that were necessary to put together this program. So, I would like to thank him for his patience and for caring for those in need.

There is no denying the need for such legislation. One of the most critical areas that must be addressed is the long-standing issue of the medically needy — those who fall between the cracks of eligibility for medical coverage.

Who can benefit from a medically-needy program? Our children, our elderly, our pregnant women, or working poor, our blind, and our disabled can. The Department estimates there are 100,000 children who qualify for a medically-needy program, 90,000 elderly, 12,500 disabled, and 50,000 adults. They are New Jersey citizens whose monthly income disqualifies them for Aid to Families with Dependent Children or SSI, yet whose income is insufficient to meet medical costs.

A medically-needy program would provide Medicaid benefits to those who would be eligible for a cash assistance program if their excess medical bills could be deducted from their income.

As an example, take Mary Smith. She is 58, disabled, and she lives alone. Mary has an income of $400 a month from Social Security Disability, and she has assets which meet the SSI criteria. She is not eligible for Medicaid only because her income, minus an allowable disregard, exceeds the SSI income standard of $343. However, she would be eligible under a medically-needy program because her income would be less than the program's standard.

Another example would the Jones family. Mr. Jones is underemployed. He earns $650 a month. He and his wife have two children. Because the AFDC standard is $590 per month, Mr. Jones can't qualify for Medicaid. But, Mr. Jones has one child who has asthma. The child needs regular medical care, including shots. Each month, Mr. Jones spends $60 on medical bills. Because it was determined his family must spend $58 before the family becomes eligible, he only receives a $2 benefit. However, any other medical bills for Mr. Jones or his family will be paid under the medically-needy program during the eligibility period.

There is no question that access to health care is a critical problem for pregnant women, elderly, disabled people, and children of low-income families. According to a report by the Association for Children of New Jersey: "Many hospitals and physicians reported that parents are waiting longer to bring children in for care because of a lack of funds. There has been an increase in the number of cases where the illness has worsened because of delayed medical care."

It has been documented that low-income children suffer more illness and are more at risk of dying young than other children. It has been documented that one out of every 80 infants born in the United States dies at a rate higher than in 15 other countries. It has been documented that one in 20 pregnant women in this country receives late prenatal care, or none at all. It has been documented that a minority woman is three times as likely to die in childbirth as a non-minority woman. And, it has been documented that senior citizens must pay 20 percent of their medical bills out-of-pocket, over and above what Medicare will pay.

We must reach out and protect our medically needy under a health care umbrella. By so doing, we can not only care for their immediate illness, but we can also practice preventive measures.

For instance, we know that among the causes of mental retardation are inadequate prenatal care, drugs and alcohol during pregnancy, maternal diabetes, premature birth, poor diet, and the age of the mother. We also know that there are high-risk populations whose children are more likely to be born mentally retarded. They include adolescent mothers, female diabetics prior to conception, and the low-income undereducated.

The medically-needy program would provide protection for many in the high-risk population. The program would also serve to bring in people who need early care before health problems become severe.

It has been said that the health of the people is really the foundation upon which all their happiness depends. Therefore, I support implementing a medically-needy program in New Jersey.

The Department is presently studying a list of options available, and it is focusing on areas which would include ambulatory care for children; prenatal delivery and postnatal care for pregnant women; and selected services for the aged and disabled. This kind of program, however, is not without substantial cost.

I estimate the minimum cost would be $35.4 million, while a maximum cost could be about $250.7 million. However, while I support the concept of a medically-needy program, I must caution you that this issue must be carefully studied. I have a list of concerns:

Eligibility determination: Which agency decides — the counties or the State? What is the eligibility determination?

Error rates: Exceeding mandated targets would expose the Department to Federal fiscal sanctions.

Spend-down requirements: Administration will create claim processing problems and will be difficult to monitor.

Provider relations: Questions of time lags, eligibility determinations, billing and paying procedures could all create problems for providers.

Agency resources: I estimate it will take at least one year to implement such a program. It will mean personnel recruitment and

training, systems changes, office spacing needs, and a coordinated effort of various State departments.

While the Department has reviewed several options, I want to tell you there are any number of options that could be implemented. We are not locked into any plan, and there are a lot of variations available. It is up to this Committee, through these hearings, to define the types of groups to be covered and the kinds of services to be offered.

I want to assure you that the Division of Medical Assistance and Health Services is gathering data from across the country and we will be pleased to forward that information to you to help in your deliberations.

As I noted previously, I have with me Mr. Wheeler, who is the Division's Deputy Director, to answer any technical questions on this particular program. Thank you for your attention.

ASSEMBLYMAN WATSON: Commissioner, just for the record, I would like my Committee and each and everyone here to know that we sent you a list of questions that you responded to. This will be made part of the minutes and it will be incorporated as part of the testimony.

Commissioner, A-608 is very broad and very general, leaving much discretion to the Commissioner. The concern the members of this Committee will have is that it provides too much discretion to the Commissioner. Should the legislation be tightened up as to the income standards to be used, the asset test to be used, the services that should be provided, and how the program is to be administered? Do you have any suggestions in this regard?

COMMISSIONER ALBANESE: As you may recall, Mr. Chairman, at the Joint Appropriations Committee meeting we discussed the medically-needy program. Because of these problems -- that there are so many variables in the program, and it is a complex program -- I did suggest -- and I commend you for this public hearing process -- that we all needed to get the input of the citizens of the State of New Jersey in formulating this program. So, I have no hard and fast conceptions as to what the various limitations or eligibility requirements should be.

I, like you, am eliciting, through the public hearing process, information as to the needs of the citizens of the State of New Jersey. I think this process will allow us to evolve a program within the flexibility that Assemblyman Deverin has given to us. I think that is a proper approach.

I think we all have to hear what the needs are from our citizens.

ASSEMBLYMAN WATSON: Then I gather you would rather wait before making any kind of suggestions. We have AFDC, which is county operated through Welfare, and we have other types of things administered by your office.

The only thing I would like to know, as a member of this Committee, is how you would prefer this to be administered.

COMMISSIONER ALBNESE: In our deliberations we have been researching, discussing, and trying to understand this program, because it is probably one of the most complex of programs due to its implementation and administration. We are in the deliberation stage right now, whether it is with the county welfare agencies making their determination, or whether it is with the Medicaid offices. Whether, as Assemblyman Deverin said, it is 100 percent or 133 percent, who do you help? If you reduce the eligibility, can you expand into additional services? There are a lot of variables that we really have to look at. It is very complex, and we are continuing to look at it.

As I said, we have gone out to all of the states in order to gather information on their programs. We want to find out what is working and what is not working, and how best we can structure our program. This would include eligibility periods of from one month to six months. I have not made any final determination in these areas.

In this document, for example, we use the 130 percent standard. Our figures are based on that. Assemblyman Deverin was talking about 100 percent. So, it is somewhat variable, and we are listening, as you are listening, to the comments of people coming before you.

ASSEMBLYMAN WATSON: Commissioner, do you feel that there could be a workable situation, where the counties could work the AFDC part, and Medicaid and SSI could be worked out of your Division?

COMMISSIONER ALBANESE: You know, we really haven't gotten into the logistics. We know it is going to increase the cost for our county welfare agencies. You know, we could be talking about personnel for this program of anywhere from 200 to 400. It depends on our final determinations as to who will handle the program and who will determine eligibility. All of that has to be discussed with relation to the respective components of the program.

That is the difficulty with the administration of this program. It is a complex program. It is really setting up a brand new Medicaid program for the State of New Jersey. You have to look at it that way. It is a new program with new eligibility, and different spend-down features, in terms of incurred medical bills. So, we are really in the throes of an embryonic stage of putting this program together.

ASSEMBLYMAN WATSON: Commissioner, I feel there will probably be other hearings on this. I know you spoke about gathering medical assistance data with regard to other states. Would this data be collected first and then provided to this Committee months after people go off the rolls? If this is enacted, it will probably have the effect of diminishing the cost here for the medically-needy program because those folks will stay on the regular program.

COMMISSIONER ALBANESE: That is also part of it. When they changed the disregards in Welfare, we had the working poor going off welfare. Based on reports we looked at in New Jersey, the medically-needy program would pick up a lot of that population who lost Medicaid, but who might still be called marginally poor.

ASSEMBLYMAN WATSON: Can you explain the accounting period and how that is used in determining eligibility?

COMMISSIONER ALBANESE: I would try, but I would prefer to defer to the experts.

MR. WHEELER: Assemblyman, under Federal regulations, we have the option in a medically-needy program, to establish eligibility monthly, or we can go to a maximum of semi-annually -- six months. Basically, what that means is, whichever period you select, the individual who qualifies is eligible for that period. For example, if it is monthly and if we use 133-1/3 percent, which is in the data book

we provided to you, and they are underneath that-- If they are above the categorical level and the AFDC level, for example, but within 133-1/3 and there is no spend-down, they will be eligible for a month — or if it is quarterly, for three months; or, for six months, if you use that period. If there is a spend-down, it gets to be a little bit more difficult, because you then have to determine how much they have to spend down and when, in that eligibility period, do they become eligible? For example, if you use six months and if they have a fairly hefty spend-down -- let's say several hundred dollars -- they are not eligible within that six-month period until they have incurred medical bills which are equivalent to the spend-down. Let's say it is $300. They may meet that in the second month or in the third month, or they may meet it in the first month. They then remain eligible for the balance of the period. In the next period they begin all over again and they have to incur medical expenses, etc.

We have tried to analyze what is best for the recipients, what is best for the providers, and what is best for the State and the counties, and it is difficult to call it because in some instances an extended period of eligibility is advantageous to everybody, and in some cases it penalizes the client. I think in the document we shared with you, we gave some examples of how that can either work to the advantage, or to the disadvantage, of the various principles in this program.

The other comment I would make on the eligibility period relates to the issue of quality control and error rates -- things of that nature. Basically, if an individual has a spend-down to meet, we must assure the Federal government that we do not pay for any of the services they receive that are applied to the spend-down. If we do, the client is then technically ineligible. We would then have an eligibility error, which, if it exceeds a certain Federal target, leads the State to fiscal sanctions from the Federal government.

So, the issue of extended periods really needs careful analysis. You are never going to please everybody with it. Somebody is going to be benefiting and somebody is going to be losing, and I think what we have to do is to find out what the best mix is for all parties concerned. The states we are getting data from are all over

the lot. Some are six; some are three; some are going to one because of the quality control error rate problem.

ASSEMBLYMAN WATSON: I would gather then that the one month, as opposed to the six months, would be more costly to administer, but it would be better for the client.

MR. WHEELER: Absolutely.

ASSEMBLYMAN WATSON: The six month's administration would be easier for us to handle, but worse for the client. There is a mix there that we have to talk about.

MR. WHEELER: That's correct.

ASSEMBLYMAN WATSON: Were you going to say something on that, Commissioner?

COMMISSIONER ALBANESE: No.

ASSEMBLYMAN WATSON: Your submission did not consider assets. If assets are considered, how much would your case load be reduced -- by what estimated amount?

MR. WHEELER: Pardon me, Mr. Chairman?

ASSEMBLYMAN WATSON: How much would it be reduced by? It didn't consider assets.

COMMISSIONER ALBANESE: I believe we did consider assets in the determination. I have been corrected; we did not include that. We didn't know, to be honest with you.

ASSEMBLYMAN WATSON: All right. Assemblyman Frelinghuysen, do you have a question?

ASSEMBLYMAN FRELINGHUYSEN: There is no asset test for the Pharmaceutical Program, but there would be one considered for this program, is that correct? (Whereupon there is trouble with microphone, and original thought is lost in the process of setting up a working microphone)

(Assemblyman Frelinghuysen, continuing) I would like to say for the record that I believe all the Assembly representatives at the table, including the sponsor of the bill, are former Freeholders. (Whereupon Assemblyman Deverin announces that he is a Mayor and not a Freeholder)

You are a Mayor? You have never been a Freeholder? Well, you have missed something. I know both Mr. Watson, Mr. Weidel, and I

have worked on the county level. Well, first of all, I would like to commend you for your bill and its intent. Serving on a County Welfare Board, as I know John and Karl have done -- they have experience in this field as well -- has certainly shown that a lot of people fall between the cracks. This is certainly the type of legislation that will address some of those historic concerns.

I have a basic question for the Commissioner. I know there are a lot of people who want to testify after you are through, so we don't want to keep them waiting, but since you are here -- we do not have an opportunity to question you too often -- I wanted to ask you a question concerning the asset test of $1500 or less, for eligible persons in this medically-needy program. Is that amount set by the Federal government due to its financial participation?

COMMISSIONER ALBANESE: It is a variable. They say in the Federal regulation that it has to be a reasonable asset limitation. It is not necessarily the $1500 that is in the regular Medicaid Program.

That would be another determination that we would have to make, in terms of a reasonable asset limitation for this particular program. Now, first we have to find out what the Federal government means by "reasonable." So, that is another part of the complexity of this program.

ASSEMBLYMAN FRELINGHUYSEN: I find that many constituents, represented by some of the people behind you, wonder why the Federal government set the income limits where they did, and what rationale they used when setting these limits. Would you care to take a whack at that?

COMMISSIONER ALBANESE: Well, I recently petitioned Secretary Heckler, in the Community Care Program, to change the asset limitations in that Program. We found that while the Federal government gave us the discretion to equalize the eligibility for institutional care and community care, one must realize that when one is in the community he still has other needs and costs that are not found in a nursing home. So, regarding that particular Program, we requested that we be allowed to raise the asset limitation because it was, in fact, hampering people from getting into the Program. They were afraid to give up their assets in order to get into the Program -- to get down to that level. The reason why? I have no idea.

ASSEMBLYMAN FRELINGHUYSEN: I have other questions, but one that I would like to at least end with is, from my short time here in the Legislature I have seen a tremendous amount of emphasis put on the availability of casino dollars. Frankly, a lot of people who have benefited from those dollars tell me that they worry about more and more programs dipping into that source of money. They are concerned about whether, in fact, that dependence is a healthy thing. What about that? The evidence that I have seen shows that casino revenue expenditures seem to be out-pacing casino revenue collections, and if the surplus drops, where do we stand relative to taking money for this commendable program, if, in fact, we have problems providing for our responsibilities regarding the Pharmaceutical Program, and, for that matter, the Lifeline Utility Credit Program? Is this a problem you have wrestled with?

COMMISSIONER ALBANESE: I will give you a flavor of what I have heard from many senior citizen groups, in terms of casino funds. Maybe this is a recent phenomena, but I think that in terms of priorities you can best ask the senior citizen groups who are here today. We have been giving additional increases in pay in the Lifeline Program. It keeps going up, and my sense -- and I really don't want to speak for the seniors -- is the priority they have now is the medically-needy program. We have established programs, and paid Lifeline programs, but we ought to concentrate on putting our additional resources into this program.

I think this is something for the Legislature to think about in its future budget deliberations. Instead of increasing benefits for programs, they should develop this new program, which has been my impression is one of our elderly's primary needs at this point in time -- the medically-needy program.

ASSEMBLYMAN FRELINGHUYSEN: I don't mean to hog the microphone, but the other part of the casino revenue for which there is quite a bit of legislation being considered is for the needs of the physically handicapped. There are any number of groups that I have heard from who feel they haven't gotten their fair share. My point, obviously, is there are commitments that have to be kept, as well as new ones that have to be anticipated. I am just wondering if the medically-needy program ought to be drawing from this pot of money.

COMMISSIONER ALBANESE: I would agree with you that in the last year or so the disabled population has surfaced, insofar as recognition that they are also eligible for the casino money is concerned. I think there is a growing awareness and desire on their part to get involved with the casino funds. I have heard the same thing.

ASSEMBLYMAN WATSON: Thank you, Assemblyman Frelinghuysen. Assemblyman Weidel, do you have any questions?

ASSEMBLYMAN WEIDEL: Yes, I do.

ASSEMBLYMAN WATSON: Assemblyman Weidel.

ASSEMBLYMAN WEIDEL: Commissioner, concerning this spend-down program you mentioned, you are unable to gather how many there will be, or what the cost will be, and you haven't gotten all the data yet. You will, will you not?

COMMISSIONER ALBANESE: That was regarding the assets.

ASSEMBLYMAN WEIDEL: It was on the spend-down too. In other words, do you know how many people will be involved, after they deduct their medical expenses?

COMMISSIONER ALBANESE: Let me say it is a guesstimate.

ASSEMBLYMAN WEIDEL: It is an estimate?

COMMISSIONER ALBANESE: It is a guesstimate.

ASSEMBLYMAN WEIDEL: And, you have no— What is your guess?

COMMISSIONER ALBANESE: We are talking about around 250,000 people, and that is a guesstimate.

ASSEMBLYMAN WEIDEL: That is what I wanted to ask first. The estimate of the cost of the program — does that include the spend-down clients?

COMMISSIONER ALBANESE: Yes.

ASSEMBLYMAN WEIDEL: I don't think it does.

COMMISSIONER ALBANESE: Ms. Kohler will answer that.

ASSEMBLYMAN WATSON: Would you introduce yourself, please?

ANN KOHLER: My name is Ann Kohler and I am with the Division of Medical Assistance. I prepared these estimates, and it is very hard to determine that. There is limited data on that, and there is no data on spend-down fines. What we had hoped is that they would almost wash out. We tried to get an estimate that was as realistic as possible by

using census data, which at this time is the only thing available to us in order to get a handle on the clients.

We feel that the estimates here will be sufficient to cover the spend-down people.

ASSEMBLYMAN WATSON: Does that answer your question, Assemblyman?

ASSEMBLYMAN WEIDEL: That answers that question; now I want to ask another.

ASSEMBLYMAN WATSON: I think Assemblyman Deverin would like to answer.

ASSEMBLYMAN FRELINGHUYSEN: Oh, sure. Let him answer that.

ASSEMBLYMAN DEVERIN: As far as the spend-down is concerned, if you set the category at 133 percent, I am not sure the spend-down would be a very big item to most of the people we are talking about as being eligible. I am not sure it would be that big a concern. I would have no objection, and I don't think anyone else at this table would either, to setting a cap as to where the spend-down would begin and end. For instance, if someone was making $1,000 a week, we could control it, if we make the spend-down fall into this category. So, I have no objection to setting a cap after you set the categorical aid, percentagewise, as to where the spend-down ends and begins. I think that ought to be considered, Mr. Chairman, if that is what the problem is.

COMMISSIONER ALBANESE: Assemblyman Deverin, I don't believe under the Federal regulations or legislation you can set up a cap, as long as an individual meets the categorical requirements — the assets, the disability age, or the AFDC criteria. They could be extremely wealthy, really, and if they have incurred sufficient medical expenses within a certain period of time, they could become eligible for this program during the balance of that period. That is why it is extremely difficult to make a judgment as to how many are out there.

ASSEMBLYMAN DEVERIN: I am trying to agree with you, because an extremely wealthy person would have his or her own insurance anyway, and his needs would probably be covered by his insurance. I don't think we are throwing our oranges in the wrong basket this time. I think the spend-down in itself would not— I think if you set the

category, the aid would be 133 percent and the spend-down would take care of itself.

ASSEMBLYMAN WATSON: You may continue, Assemblyman.

ASSEMBLYMAN WEIDEL: I want to tell you, Commissioner, that I support the program, but I have been a member of the Appropriations Committee for 13 years and this year was different from any other year. All of us are concerned as to whether next year is going to be the same as this year, with the surplus. I hope and pray that you come up with a program where you are able to tell the Legislature, a lot better than we were told when the PAA Program was started, what your estimates are as to the future, so that we can appropriate--

The way I understand this program, we have to appropriate the money to you. You work out the program, subject to our appropriation. I can just see you sitting there, three or four years down the road, saying, "I got $38 million the first year; now I need $69 million," or, "Now I need $169 million." I just hope that we can put some parameters on the program you come up with, in order to maintain a reasonable cost escalation.

COMMISSIONER ALBANESE: We are just as concerned with that area. I was pointing out before that one of the things we are doing is surveying the other states for information, data, and their experience, which is very important. Because in some cases, I wouldn't even call them estimates; I call them guesstimates. It is very difficult to ascertain that kind of information if, in fact, one can ascertain it at all. So, we are concerned. What we are trying to do is to learn from the experience of other states' programs. That information will be provided to you, and the growth patterns of the other stages will be provided also.

ASSEMBLYMAN WEIDEL: Yes, that is another item that is hard for me to comprehend, sitting here -- and you sitting there as the Commissioner. What state do you believe, in your interdepartmental workings and your associations with commissioners in other states, is a lead state? Is there a lead state? There is no lead state, right? You mentioned that they are all over the lot, so to speak.

COMMISSIONER ALBANESE: Thirty-some states have this type of program.

ASSEMBLYMAN WEIDEL: How long has the oldest one been in effect?

ALAN G. WHEELER: I would imagine since the beginning of Title 19, which is 1966 or 1967. I think what is new and what we are kind of in the forefront with in New Jersey is, under the Federal TEFRA legislation of 1982, states began to have the opportunity to have options in medically-needy programs. We have given some examples of that. Before that, they didn't have options; they pretty much had to cover large blocks of services — all the same same services for all the same client groups.

Lately, I have been talking with Iowa which is setting up a program now. They have the same kinds of problems we are wrestling with here. What services for what groups, etc., is a new concept. Nobody has really had to wrestle with that. That is what we are dealing with.

ASSEMBLYMAN WEIDEL: Does Florida have a program such as this, where they have a lot of aged people?

MR. WHEELER: Florida does not have a medically-needy program. I understand Florida, South Carolina, and a couple of other states are in the stage of development we are in. I think Iowa has legislation to enact one. We are all kind of trying to exchange information with one another.

COMMISSIONER ALBANESE: The variables of the program are, you can expand eligibility, or you can restrict or expand the number of services. It is very much like our Medicaid Program. In the State of New Jersey I think we have about 27 programs, and there are 32 options available. That is part of our deliberations. It is not only who we are going to cover, but what types of services are going to be provided to those who will ultimately become eligible.

So, as I said, it is extremely complex and there are extreme variables in the development of the program.

ASSEMBLYMAN WEIDEL: Excuse me, Mr. Chairman. Commissioner, do you, by regulation, expand or restrict a program, subject to the appropriation, or does the Legislature and this bill restrict the program? Are we going to have a program that, when we put it in place, will stay in place, or does the Commissioner expand it and set eligibility?

COMMISSIONER ALBANESE: I don't want to speak for Assemblyman Deverin, but I believe the bill, as structured, provides that we start with a minimum eligibility, and then we will explore the development of increased eligibility, and also the types of programs. I believe he leaves it to the Commissioner, is that correct?

ASSEMBLYMAN WATSON: I think so. I think in the legislation it leaves it to the Commissioner.

ASSEMBLYMAN WEIDEL: Thank you.

ASSEMBLYMAN WATSON: Thank you, Assemblyman Weidel. I would just like to recognize the arrival of Assemblyman Walter Kavanaugh. It is nice to have you, Assemblyman.

ASSEMBLYMAN KAVANAUGH: I am sorry I am late.

ASSEMBLYMAN WATSON: Commissioner, in getting your information from the other states, would you also assist us by gathering the assets test they use in those other states?

COMMISSIONER ALBANESE: Definitely.

ASSEMBLYMAN WATSON: We would appreciate that. Are there any other questions? Assemblyman Frelinghuysen.

ASSEMBLYMAN FRELINGHUYSEN: Has an analysis been done on what some of the counties are doing? I know our county provides a free dental program, and it also puts quite a lot of money into meeting the needs of crippled children. Has the Department done an analysis, county by county, as to what the counties are doing, so that this will also be reflected in the data you are putting together?

COMMISSIONER ALBANESE: No, we are not.

ASSEMBLYMAN FRELINGHUYSEN: I suggest that maybe you might do that. In fact, it may make this overall proposal a little less costly. We wouldn't want to duplicate some of the good things that are being done by the counties presently. Thank you.

COMMISSIONER ALBANESE: That is a good point, because we were looking at the paid program -- the interaction between the paid program and the medically-needy program. Certain determinations have to be made there, in terms of keeping people eligible for the paid program and the medically-needy program. One of the administrative nightmares is if you take someone off of the paid program and get them onto the medically-needy program, their eligibility might change on a monthly

basis, or every six months, and you would then have to put them back on the paid program. So, there is just an awful lot of research and thought that has to be done as to how this program is actually going to be implemented.

ASSEMBLYMAN WATSON: Have you completed your questioning, Assemblyman?

ASSEMBLYMAN FRELINGHUYSEN: Yes.

ASSEMBLYMAN WATSON: Assemblyman Weidel.

ASSEMBLYMAN WEIDEL: I have one more question, Commissioner, and I know that it may not be apropos to this particular bill, but I have to ask it anyway. There is an underground economy. When we have all these restrictions as to how much income people can have and how much we can subtract, are there penalties? Is it just under Medicaid that we have the penalties the Attorney General's Medicaid Fraud section uses? Are there penalties in these bills when there is a conspiracy as to what the income is -- the underground economy, the paid-in case, or the person who gets it under the table? I know this doesn't relate specifically to this bill, but it does relate to the whole situation where this economy now exists -- which you know. Cleaning women now want cash because they will be outside their limit if they get more money. A druggist knows a person isn't needy, but, yet, he fills the prescription. Doctors know this exists. Are there penalties outside of the bill or in the bill? Is there a fraud statute to cover this?

COMMISSIONER ALBANESE: I don't believe there is any penalty in the bill -- in Assemblyman Deverin's bill. We basically use the AFDC penalty for Medicaid enforcement.

A recent piece of legislation for private-pay contracts and discrimination was sponsored, which specifically provided for prosecution or for reimbursement when this type of activity is found. That is the only one I know of, where there is a bill in New Jersey. That involves the private-pay contract and the divestiture of assets. There was a provision for getting that money back from individuals who divested their assets to get into the program.

ASSEMBLYMAN WEIDEL: Thank you.

ASSEMBLYMAN WATSON: Thank you, Assemblyman.

Since there are no further questions, we want to thank Commissioner Albanese and Director Wheeler for their appearance here this morning. Thank you for your response to the questions we have asked you.

COMMISSIONER ALBANESE: Thank you, Assemblyman.

ASSEMBLYMAN WATSON: Is Ciro Scalera here, representing the Association of Children of New Jersey?

Mr. Scalera, do you have a statement?

CIRO SCALERA: Assemblyman, before I begin my comments, I would like to submit a prepared statement from the Rutgers School of Research. Their representative is not able to be here today; however, they delivered their prepared statement to our office, and I would like to submit it, on their behalf, to the Committee and hope that it would be incorporated in the record.

Mr. Chairman and members of the Committee, my name is Ciro Scalera and I am the Executive Director of the Association for Children of New Jersey. We are a statewide childrens' advocacy organization. I am here today on behalf of the organization to express our strong support for A-608, which expands New Jersey's Medicaid program to include medically-needy individuals. ACNJ, along with the Federation of Senior Citizens, is actively involved in the Medically Needy Coalition in our State, and has consistently supported this legislation and initiative.

I will not read the entire text of my statement. I want to go through and selectively read portions of it.

As a statewide citizen-based child advocacy organization, ACNJ recognizes that the lack of adequate health care is one of the most pressing problems facing children in our State today. We believe that enactment of a medically needy-program is one of the most important steps that we can take to begin to address these health care needs.

Medicaid is an important children's program. Medicaid is the largest government health care program for the poor, and children represent the largest percentage -- approximately 50 percent -- of individuals covered under Medicaid. According to the 1982 Census Bureau report, Medicaid covered approximatly 40 percent of all poor

households, and 52 percent of all poor households with children under 19 years. Clearly, poor children depend heavily on Medicaid.

I have attached the Executive Summary report commissioned by the American Academy of Pediatrics entitled Medicaid and Children: A Policy Analysis for your information. This national report and others pointed out some disturbing trends in terms of the poverty and health status of Medicaid children.

The poverty status of Medicaid children is an important issue. In the past year there have been various Census Bureau reports on the increase of poverty in America. The House Select Committee on Children, Youth, and Families recently estimataed that one out of five children and one out of two black children live in poverty. In discussing federal and state programs designed to help these children, the AAP report found that eligibility standards have not been adjusted for inflation, particularly for AFDC recipients whose famililes must be increasingly poor to qualify for Medicaid under AFDC.

The implications of the failure of eligibility standards to keep pace with inflation, it notes, can be summarized in a number of ways, and one important one is that a smaller percentage of poor children are eligible for Medicaid than had been previously. This trend will worsen unless current eligibility standards are raised.

I might comment as an aside, that we had worked very actively in supporting, before the Joint Appropriations Committee, an increase in the AFDC eligibility standards, and, in fact, that has been approved by the Governor. That will help somewhat with this problem. The Committee is to be commended for its support of that effort.

The AAP report also cites documentation of the fact that poor children have more health problems than other children. Children in low-income families were 3.5 times as likely as children in high-income families to be judged as being only in fair or poor health. Low-income children have higher infant mortality rates despite nationwide improvement in all income groups. Dental disease is another area showing disparity between children of different income groups. The report also points out growing medical problems for infants needing newborn intensive care, children with chronic conditions, and adolescents.

It concludes that because of the restrictive nature of eligibility criteria, a substantial number of poor children are not covered by Medicaid and cites the drastically growing number of children without coverage in the last five years.

The situation in New Jersey reflects many of these national trends. Two recent reports completed by our Associaton, Through the Safety Net: The Child Watch Project and a survey by ACNJ, in collaboration with the Newark Preschool Council Headstart Program, called Not Enough to Live On provided us with important data on problems in the health area. Both identified the need for a medically-needy program as a priority in New Jersey. We support A-608 and a medically-needy program in this State for several reasons. I will summarize the rest of my statement from this point on.

The first reason is that tens of thousands of New Jersey's poor children lost Medicaid eligibility and are presently without access to health benefits. When we conducted our survey, we could document about 18,500 children who were removed from Medicaid. We feel the figure is somewhat higher and there may have been as many as 40,000 children who were actually removed from that program. The Department estimates, as you heard the Commissioner say, that potentially 100,000 children could be eligible for inclusion in the program, so we know from our research that many families and children were removed from Medicaid eligibility.

When we followed that up in our most recent survey, Not Enough to Live On, we also got some evidence that of the families who lost Medicaid eligibility, about half of them told us that they are either delaying or not bringing their children to the doctor as frequently as they would have, or did, when they were eligible and had access to Medicaid. We are, on our own score, going to be doing further research to try to get a better handle on that particular issue. From the research we have done to date, there does seem to be evidence that both of those things take place.

Another reason why we are supporting this initiative is that it begins to look at the question of support for preventive efforts on behalf of these children. In the testimony, I cite a number of different research studies and data that have been documented over the

years pointing out the fact that to invest some dollars in preventive efforts, through Medicaid and through what is known as the Early Periodic Screening, Diagnosis, and Treatment Program, which is a part of Medicaid, for many of these children can prevent very serious kinds of disabilities and diseases that will later occur and are much more costly to treat.

We also are supporting this because we believe that a number of families and children who are ineligible are presently utilizing emergency rooms and other kinds of costly forms of care inappropriately, out of desperation, and because they do not know where else to turn. We would agree that there is undoubtedly pressure on the DRG system by way of the growing uncompensated care costs in the State. We feel that the medically-needy program is supportive and should be pursued as a way of perhaps dealing with part of the problem and the pressures that are on the DRG program.

We are aware of the four options that are presently being proposed. ACNJ, along with the Federation of Senior Citizens, the PTA, several dental associations, and several other organizations met with Commissioner Albanese. We are trying to work cooperatively and with a realistic sense of what kinds of problems lie ahead in this program. We feel, however, that the time is here and now to move forward with this. We can overcome, or at least it is our association's position that we can overcome some of the administrative problems and difficulties that lie ahead. Hopefully, if we all work cooperatively, the services that these families need can be put into place. Thank you, Assemblymen.

ASSEMBLYMAN WATSON: Thank you, Mr. Scalera. Would you just stay seated for a short time; we may have some questions to ask you. You heard the Commissioner's statement and comments about the complexity of a medically-needy program. Do you have any suggestions as to the income standard to be used?

MR. SCALERA: At the present time, we are supporting the 133 percent, using the figures that we have reviewed from the Department unless there is substantial evidence that those figures are unrealistic, from a fiscal point of view or otherwise. But for the present time, we are supporting the 133 percent.

ASSEMBLYMAN WATSON: What would be your recommendation as to the asset level to be used?

MR. SCALERA: I think that, as the Commissioner indicated, there is some flexibility in setting that. I would urge that we look to increasing that figure. If the $1500 is not fixed, and it is within the Department's discretion to fix a reasonable level -- I think that a number of people have brought to this Committee some concern that the $1500 is not a reasonable limit -- then we ought to look seriously at increasing it.

ASSEMBLYMAN WATSON: Do you have any idea as to how the program should be administered?

MR. SCALERA: I think that I would favor an approach that is not that dissimilar from what the Department has taken in other things: a strong State role with a fair amount of county involvement, both on the planning and the implementation level. I see a strong State role in terms of coordinating, overseeing, and operating this program. I think that we should have that for a number of reasons, but I wouldn't preclude either a county fiscal or a county programmatic involvement in one way or another in this. If there is a network out there -- and we know there is, through the CWA -- then it ought to be looked at, as to how to utilize and build upon that already existing system.

ASSEMBLYMAN WATSON: Thank you. I would now like to entertain questions from my Committee members. Assemblyman Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: Thank you, Mr. Chairman. Mr. Scalera, I have a question. There was a fair amount of lobbying for a bill that is being considered -- I forget its name -- but I was visited by a number of school nurses. The bill has to do with the ratio of school nurses to population. I forget the number of the bill, but whatever the bill number is doesn't matter. I learned through that process, and maybe you would like to comment on this, of a number of things that are being done in our school districts which fall into some of the categories that we are discussing generally here today, in terms of health care and prevention. Has your Association done an analysis of what is being done around the State in the various school

districts? I have found -- I am not sure it is a bad thing, and it is true in districts that are wealthy as well as those that are not -- that school districts are providing health services that traditionally have been provided by families. They are picking up health costs and health responsibilities that traditionally had been done through the family physician. Have you done an analysis of the types of services that are being provided by the school districts, and if so, does that analysis have any bearing on this particular proposal? If you haven't done an analysis, would you do one? Thank you.

MR. SCALERA: Our association, per se, has not done an analysis. I also serve as vice chairman of Governor Kean's Governors Committee on Children's Services Planning. As part of our responsibility on the Governor's Committee on Children, I, along with our health subcommittee, interviewed representatives from the Department of Health, and one of the areas that we explored was the issue of greater utilization of the schools in terms of providing health care services.

One of the issues that I know the Department of Health-- And, I would be glad to provide you with data. I can contact the Governor's Committee staff and have them provide you with the data they have provided to us on the issue of present efforts by local school districts, working with the Department of Health. Through their local health departments they run what are known as child health conferences. They hold these conferences every six months -- or they have them frequently.

One idea they are exploring is the idea of having a greater relationship with the school districts, having more of those types of conferences held, and perhaps having more of a formal role by the schools in the areas that presently exist.

I was surprised to find out that 20 years or so ago, the schools had a much greater role in the health area than they do today. They, in fact, performed some functions that they do not do presently. One of the issues we discussed was whether or not it would be feasible to recommend that the schools again play more of a role in this area.

The other way it relates to this medically needy issue is, under the program I mentioned, the EPSDT Program is a part of

Medicaid. That is another initiative I am aware of. One of the problems we have had in New Jersey with that program is that it has not really lived up to its potential in the sense that not all of the children who theoretically would be eligible for screening have been identified and located. One of the efforts that is going on right now is to involve -- and I know this is taking place in Newark and in one other part of our State - school districts, schools, and other day-care agencies -- other agencies that work with children -- by having them link up with Medicaid and the EPSDT Program, in order to try to identify kids who are eligible for these services, but who, for various reasons, are not being brought to the attention of the Medicaid officials. That effort could fit in well with the medically-needy program that is being considered.

So, those are two areas, and I can get information to you about that issue and what we have gotten from the Department of Health on that.

ASSEMBLYMAN FRELINGHUYSEN: Thank you for your answer. I don't mean, Mr. Chairman, by asking that question, that I am forgetting about the preschool population, which obviously is an extremely important area as well as the prenatal portion of this program. Thank you.

ASSEMBLYMAN WATSON: We understand that, Assemblyman. Are there any other Assemblymen who would like to ask further questions? (no response) Hearing no response, I would like to thank you, Mr. Scalera.

MR. SCALERA: Thank you very much.

ASSEMBLYMAN WATSON: Is there a Mrs. Edith Edelson present? (affirmative response) Ms. Edelson, is Mr. Malanga with you?

EDITH EDELSON: He is going to speak as an individual.

ASSEMBLYMAN WATSON: You are going to speak for the Federation and Mr. Malanga is going to speak as an individual, fine.

MRS. EDELSON: We thank you very much for the opportunity to give this Committee the viewpoint of the seniors with whom we have contact. It is very important, and I am glad to see that committees are turning more and more to the population for their input. We are getting away from committees and commissions doing things without consulting with the people. That is a very healthy trend.

We are very grateful to Assemblyman Deverin for introducing A-608, and we urge the passage of the bill, with an amendment mandating that the Commissioner of the Department of Human Services carry out a medically-needy program -- mandating it instead of just authorizing the Commissioner to do so.

What perhaps has not been brought out clearly -- at least not to me -- is the reason why this program is so important. There are many people who do not realize that AFDC benefits are below the poverty level -- considerably below. According to the census, the poverty level for a family of four in 1982 was almost $10,000. The AFDC benefit was about one-half of that, or almost $5,000. So, even with these programs, we are still way below the poverty level.

Insofar as SSI is concerned, that is also below the poverty level, because for a number of years the State absorbed the cost of living adjustment instead of passing it along to the recipients. While the State no longer does this, the Social Security COLA applies to only the Federal part of the benefit and not to the State supplement. So, it doesn't cover the full amount.

We support option 2, that the Department of Human Services has estimated, or drawn up. We are very disappointed that the Commissioner says it will take a year to put this through. You know, the Federation has been fighting for the medically needy since about 1976 or 1977. The Department continually made estimates about the medically needy during all these years, and to say at this time that it will take another year is very discouraging to us.

Take, for instance, an example of a couple in Edison, New Jersey. They are over 80 years old, with an income of $425. Their rent is $400. The wife is a diabetic, has high blood pressure, is overweight, has to have her teeth removed, is losing her sight, has needed a hernia operation for over two years, and has to postpone visits to the doctor until she has enough money. This is an emergency. How long is this woman going to live? Where will she be a year from now; or, will she be in a nursing home?

We have an example of someone who had a brain operation. She had a tumor. She was sent to a nursing home which was supposed to give her physical therapy. In that nursing home she was strapped to a

chair; she was never allowed to walk; and she didn't talk. When her family took her home over the weekend, she improved. When she went back, she fell right back into this passive, vegetable role. She is now at home, at great cost to her children who are trying to pay a woman to come in and take care of her while they work. She is moving around. She is talking. She is doing things in the house. That is the kind of thing a medically-needy program would help to bring about -- keeping people out of institutions. For the elderly, what is more crucial than that? For the population, what is more crucial than health? Therefore, there is an emergency situation here, and it should be taken care of quickly and completely.

Besides, the question was raised, "Is there a possibility this will be escalated?" Well, you can't provide any particular thing forever and ever. It can always be amended. The provisions can be amended if it turns out that the State cannot cover it. But, for the present time, there is money, there is the casino fund -- and that too creates an emergency, because the casino fund is being nibbled at in many other directions. They are many important kinds of programs, but not as important as health. Therefore, we can't wait a whole year; there won't be any money left in the casino fund if they continue this way.

There is a question of the percentage -- 100 percent versus 133 percent. We feel that it is very important it be 133 percent of the medically-needy program. Under that, one person, or a couple, could have an income of up to $585, instead of $343 under SSI, and less under AFDC. I think if we had only 100 percent, there would be terrific frustration on the part of the people. They would say, "All right, here is another program. What is it doing? It is not doing anything for me. It leaves out too many people who should be under it."

As for being afraid the cost will escalate, you have the Federal government that puts restrictions on it -- asset restrictions. They have to be people who would be eligible for SSI or AFDC, except for their income. Therefore, the asset level could be fixed in some way that would ensure that millionaires could not get in under this program, and so forth.

Some of the hidden benefits: Mr. Scalera referred to some of them, so I am going to skip that. It is in the paper I am going to give you.

Also, I am going to give you a paper which gives you a few individual cases, so I am not going to go through them. I mentioned two.

Take children -- a child who needs glasses. We talked about the importance of education. We want them to take tests. We want to make sure they are above the average, and so forth. If they have no glasses, how can they function in the classroom?

What about children with dental problems? Think of the escalation of health needs for that kind of child.

Pregnant women giving birth to premature children -- think of what cost would be saved for the State if they had the proper care, and the child was born in a healthier condition.

Thank you very much.

ASSEMBLYMAN WATSON: Thank you, Mrs. Edelson. You know, given the problems when they were implementing the PAA Program back in 1978, the deluge of applications led to delays of six or more months due to the processing of the applications. You know, one can't expect this kind of a program to be enacted overnight. We have to have some patience. We are gathering a lot of information through these hearings, and through what the Commissioner of Human Services is getting for us from other states, in order to really refine A-608 to a point where we are going to have a good program. It is just something we can't do overnight.

I understand your concern about this. I just want to be realistic about the approach to it.

MRS. EDELSON: We certainly appreciate the thoroughness with which it is being looked at, but we have confidence in the Department that they can do things a little faster than a whole year.

ASSEMBLYMAN WATSON: We will give them a little push then, okay?

Assemblyman Kavanaugh?

ASSEMBLYMAN KAVANAUGH: Mr. Chairman, through you to Mrs. Edelson, we appreciate the effort you have put in over the years on

behalf of the senior citizens. I am just wondering about the priorities. I just listed two of them. You talked about nibbling at the casino revenue fund. There are four bills: One is $39.7 million; another is $150 million; another is $10 million; and another is $28 million. This is an area where the Legislature is, I guess one can say, less than responsible when implementing some of the new programs, or when proposing them. The concern I have is with the groups here, as far as priorities are concerned and the programs that would constitute the input, because in the bill itself it includes the Commissioner. He will define it, insofar as services are concerned.

I am just wondering if not only you but the other speakers, when they come before us, could list some programs or priorities in a way that would be beneficial to the Committee?

MRS. EDELSON: I am glad you mentioned that. The main priority for the Federation of Senior Citizens is health, which is the thing everybody is getting concerned about. So, we would say that the medically needy is our prime priority. After that, we need renters relief. Renters have gotten nothing from the casino funds. Also, we are concerned about home health care. A little bit is being done in that direction, and much more has to be done. Transportation -- certain things about transportation -- is another concern.

I might add that as far as the disabled are concerned, it was the Federation that got the Constitutional Amendment extending the programs to cover the disabled; so, today they are in the same boat we are in. We have been working very closely with the disabled.

It is very difficult for the Federation to come out against, let's say an increase -- an automatic increase in energy assistance. But, it is ridiculous. Lifeline is ridiculous because each time they get $25 from Lifeline, they fall further and further behind in their debts to the utility companies. More shutoffs are taking place. So, it is not really achieving what it is supposed to be doing. We have urged that these things be held up until priorities are established. We are so disappointed that the Legislature -- Karcher, Otlowski, and Orechio -- did not appoint a commission for the use of the casino funds. It is a whole year and it has not been put into place. Their job would be to set priorities. So, that is the push we need. I am

glad there are bills now to constitute the commission, and so on. We have to push in that direction and hold off on other programs until priorities are established.

ASSEMBLYMAN WATSON: Assemblyman Kavanaugh, are you finished with your questions?

ASSEMBLYMAN KAVANAUGH: Yes.

ASSEMBLYMAN WATSON: Assemblyman Frelinghuysen.

ASSEMBLYMAN FRELINGHUYSEN: Mrs. Edelson, I have heard you testify before. I am new to the Legislature, and I just have a few questions, along the same lines as Assemblyman Kavanaugh's questions, in terms of the Federation's priorities, and in terms of the expenditure of casino funds for new programs. You mentioned that the medically needy were the number one priority. What are your feelings relative to dental assistance for the elderly, personal care services, and plans by some legislators to expand the Pharmaceutical Assistance Program and increase the utility payments for Lifeline credit? Where do those stack up after the medically-needy priority?

MRS. EDELSON: We cannot, as an organization, say we are against any of those programs, but we do say we cannot support them. Again, it is a question of priority.

As far as dental care is concerned, in our testimony we urge that instead of taking $19 million out of the casino funds, they take $21.1 million and include dental services -- dentures, optical services, and podiatry. So, we have included that in what we recommend for the medically-needy program.

ASSEMBLYMAN FRELINGHUYSEN: If there is a word I would like you to change, it would be to change "nibbling" to another description. (Whereupon Mrs. Edelson laughs at Assemblyman Frelinghuysen's request) I don't find that people are nibbling down here at all. I think their appetite is rather voracious and insatiable. I am glad you are willing to be a watchdog by making sure that we have enough funds, and that there are not too many demands being made on the casino funds. Thank you.

ASSEMBLYMAN WATSON: Thank you, Assemblyman. Assemblyman Tom Deverin.

ASSEMBLYMAN DEVERIN: Edith, I appreciate your support, and I understand that asking you to pick a priority for the casino funds is a very difficult thing to do. However, like you, I think the health care of the senior citizens is just as important as having a light on or off in their homes. Without their health, they have nothing.

In answer to your question, Mr. Frelinghuysen, the medically-needy program will take care of some of the dental work, so nibbling, or grabbing, or biting at that fund is not what we are going to do.

I say this to you publicly, and I will say it again: The casino funds have not been overtaxed; they have not been over-spent. There is more money there than anybody really wants to realize. And, when we sit down and figure this out, we will realize that with the new casinos there will be sufficient funds to fund this and other programs. I appreciate your coming, Mrs. Edelson.

ASSEMBLYMAN WATSON: Mrs. Edelson, I would just like to add to what Assemblyman Deverin is saying. The Legislature is very aware of the amount of available casino revenue funds, and it will ensure that the programs will not exceed the revenues. On top of that, the casino revenue funds are targeted for the poor and the disabled. We will always keep that in mind.

Assemblyman Weidel, would you care to ask any questions?

ASSEMBLYMAN WEIDEL: No.

ASSEMBLYMAN WATSON: Hearing no other requests, I would like to thank you for appearing here this morning.

Mr. Malanga.

SAL MALANGA: I was elected, for ten years, to the Executive Board of the New Jersey Federation of Senior Citizens. I am in favor of this bill, A-608. At the same time, I am on the Board of Directors of the Essex County Council and I am an honorary member of the State Council. I wish you to implement A-608 immediately. That is all I have to say.

ASSEMBLYMAN WATSON: Thank you, Mr. Malanga. Are there any questions for Mr. Malanga? (no response) Hearing none, I want to thank you for coming, Mr. Malanga.

Is Mr. Joseph Morris in the hearing room? (affirmative response) Mr. Morris is representing the Department of Health. Good morning, Mr. Morris.

JOSEPH MORRIS: Good morning, Assemblyman.

ASSEMBLYMAN WATSON: Do you have a prepared statement, Mr. Morris? (affirmative reply) Thank you.

MR. MORRIS: Good morning, Mr. Chairman, and thank you very much for the opportunity to appear before your Committee on behalf of Commissioner Goldstein. Unfortunately, a prior commitment by Dr. Goldstein prevents his appearing before you. He is addressing the Commission on Alzheimer's Disease, a very serious disease and one that is very crippling and debilitating, affecting citizens from all walks of life; otherwise he would have appeared before you today.

I will present our general comments regarding the medically-needy legislation, but first I would like to address a specific issue which was addressed to Commissioner Goldstein in a letter, dated June 28th. That issue was one regarding the amount of uncompensated care for the medically indigent, or bad debts which could be attributed to the population who will be affected by this bill, and how much that made up the approximately $200 million in uncompensated care.

Unfortunately, precise calculations of the uncompensated care costs that would affect certain persons or households are not possible. The Department of Health does not calculate data on that specific a level to be able to give you that detail.

The amount of uncompensated care in all the hospitals varies by geographical location, and as one can expect, the inner city and urban hospitals have a greater degree of uncompensated care. On a gross level, we can estimate that approximately 20 percent of all uncompensated care is due to outpatient services, and 80 percent of it is related to inpatient services.

To the extent that the Medically Need Bill covers services for outpatient and inpatient services, then the effect of this legislation, aside from those cited by Commissioner Albanese in terms of the human element, from the Department of Health's perspective would reduce the pressure we see right now of ever increasing uncompensated care burdens on the hospitals, which under our DRG system is then shifted to other payers, such as Medicare, Blue Cross, and commercial insurers.

The New Jersey Medicare/Medicaid waiver expires on December 31, 1984. The Department of Health is currently in the process of

applying for an extension of that waiver for an additional three years. A crucial factor in the ability of New Jersey to extend these waivers would be the assurance that New Jersey can make to the Federal government that what will be paid out from New Jersey's DRG system will be no more than what Medicare would have paid under its own perspective payment system.

Key in that is, hospital services which result in uncompensated care are then included in all other payer's bills. And, to the extent that we can keep the burden of uncompensated care lower, we decrease the differential between what the New Jersey system would have Medicare pay out and what its own system would produce. So, a desired effect from this bill would also be to address the uncompensated care burden, rather than having it all picked up by Medicare and jeopardize the waiver.

What I would like to do now is to make some general comments about the legislation itself. Upon reviewing this legislation, we support the substance and intent of such a program, which would extend health care coverage to low-income population groups who are not income-eligible for such assistance programs as Aid to Families with Dependent Children or Supplemental Security Income and their accompanying Medicaid coverage; yet, who are below the Federal poverty level. In view of the enactment of more restrictive AFDC guidelines and pockets of high unemployment levels, it seems appropriate for a highly urbanized and prosperous State, such as New Jersey, to join the approximately 30 other states which provide coverage to the medically needy, as permitted under revised Federal Medicaid regulations.

It is also appropriate that the major groups to initially benefit from this are children and pregnant women. It is self-evident that, given the high cost of living in this State, many unemployed and underemployed families must use the greater part of their incomes for basic subsistence items, such as housing and food, and consequently cannot afford to pay for private medical care and insurance coverage. What basic health care coverage is made available to the marginally employed does not provide for the crucial ambulatory and preventive care services which can prevent serious and more costly medical problems in the young and unborn. As low-income children have been

shown to be at higher risk of illness and disabling health problems, the long-range costs to the health care system cannot be ignored.

In addition, may poor people who are not eligible for Medicaid coverage, particularly in the large inner cities, turn to hospital emergency rooms and use them as primary health care providers. In New Jersey, this costly uncompensated hospital care for the poor element is paid for through the hospital rate-setting mechanism under Chapter 83, Public Laws 1983, and the Health Facility Claiming Act of 1971.

As I indicated, these are provisions included in the Medicare and Medicaid Waivers, and these costs for uncompensated care, which are increasing, result in an additional burden on third-party payers, and jeopardizes those Waivers for the New Jersey DRG system. While hospitals currently receive payment for services rendered to the medically needy under New Jersey's Medicaid Waiver, this may not be renewed beyond three years, and in 1987 the inner city hospitals may face financial disaster in carrying out their service responsibilities.

We would support the options identified by the Department of Human Services to extend this medically-needy coverage to the aged, blind, and disabled for the same reasons as above.

Obviously, the greatest impact with regard to the Medicare Waiver will be those options in the medically-needy bill which include coverage of hospital services to all affected populations. The Department of Health supports the coverage of both hospital inpatient and outpatient services.

At the pleasure of the Chairman and the Committee, I would be more than willing to answer any questions, Mr. Chairman.

ASSEMBLYMAN WATSON: Thank you, Mr. Morris. I have a couple of questions I would like to ask you.

Would the Department, in cooperation with the New Jersey Hospital Association, undertake a one-time study as to the numbers of indigent persons who utilize hospital services and who would qualify for a medically-needy program?

MR. MORRIS: Such a study, if we pursued it, would have to be done on a sample basis. We would have to pick selected hospitals because the detail upon which we would have to base this investigation

would include going back into the financial records of the hospital from a prior period, going back into the records of the detailed interviews of the patients, and looking into those records to determine income levels.

ASSEMBLYMAN WATSON: That's what we are looking for -- just a sampling. Could you, as an administrator, pick a certain week and just take that week and do a study for us, to make us aware of just who would be using this kind of service?

MR. MORRIS: What I could do is-- Since requirements of the hospital are more akin to retrospective data collection, we would be more than willing to work with the New Jersey Hospital Association to devise that kind of study, and to indicate how they should proceed to take to take a sampling projection.

I myself, or my staff, could not do it. It would have to be done by the hospital staffs. I do believe such a study could be done; however, I would have to consult with the hospitals in the Association regarding how to pick a sample and do it with as much reliability as possible, without making it too much of a burden for them.

ASSEMBLYMAN WATSON: I think the initiation should come from the Health Department with regard to the way we would like to see it done as a Committee. I would like to have that kind of information so that we might be able to, along with other evaluation studies we are doing, come up with some idea. I would like to see that done.

MR. MORRIS: I agree with you. The nature of my remarks were that I do not have the staff to go out and do this myself, but I assure you that we will certainly talk with Mr. Scibetta of the Hospital Association in order to try and find out how his member hospitals could participate in such a study.

ASSEMBLYMAN WATSON: Would you be so kind as to keep this Committee informed on how you are approaching this situation? This is a very important part of this piece of legislation.

MR. MORRIS: I certainly will, sir.

ASSEMBLYMAN WATSON: By regulation, the Department must monitor the amount of uncompensated care -- bad debts reported by hospitals. To what extent does the Department monitor this provision?

MR. MORRIS: The monitoring is one of an audit function. We use retrospective years, after the hospital has closed out their financial records. We employ subcontractors -- Blue Cross and Prudential Insurance Company -- who have auditors on their staffs. They go out and they review the hospital records on a sample basis to assure that the amounts written off for uncompensated care or bad debts are legitimate, and that the hospitals followed adequate credit and collection procedures. At this point in time, it is a process of verifying that an account -- one that is written off as uncollectable -- was indeed uncollectable. We do not keep data as we go through this process as to "this person's income was this level or that level." But, that is how we make sure the amount of uncompensated care was appropriate, and that someone was not just letting a very wealthy individual avoid paying his bill.

ASSEMBLYMAN WATSON: Could you, in any way at all, tell us what your audits have determined so far with regard to this?

MR. MORRIS: The audits, to date, show generally -- with regard to your question -- that it seems about 20 percent of the total uncompensated care burden of approximately $200 million is for outpatient services; and, of course, the majority -- 80 percent -- is for inpatient services. The reason for that is because of the costliness of the inpatient services.

ASSEMBLYMAN WATSON: What amounts are involved -- insofar as bad debts and things like that are concerned -- in these hospitals? What are we talking about in terms of the dollar amounts?

MR. MORRIS: By specific hospital, or just by aggregate sum?

ASSEMBLYMAN WATSON: Just give me an idea. Say it is a specific hospital. Where does that fit into the category of all of of them put together? Is there a norm? Just what kind of a situation are we in with regard to dollar amounts?

MR. MORRIS: Generally speaking, uncompensated care is approximately six percent of total hospital revenues, which roughly runs into about $200 million. It varies by hospital. Some hospitals may have even less than one percent uncompensated care and bad debt, as opposed to other hospitals having ranges of up to 15 percent.

ASSEMBLYMAN WATSON: Who verifies this, your Department?

MR. MORRIS: The auditors working for our Department under contract.

ASSEMBLYMAN WATSON: Are you satisfied with those verifications?

MR. MORRIS: Yes, to date we are.

ASSEMBLYMAN WATSON: Assemblyman Frelinghuysen.

ASSEMBLYMAN FRELINGHUYSEN: Thank you, Mr. Chairman. My comments are piggybacked on the Chair's question. Hospitals -- I am active with one hospital -- do have information relative to indigents. The six general hospitals in our neck of the woods have a working relationship with the county government, and the county has historically provided, even under the DRG Program, a certain amount of county tax dollars to pay for indigent health care -- in other words, I guess you would categorize this as unpaid bills. I think our hospitals have an analysis of the number of individuals who come through their doors -- as has been stated by others here, and you as well -- primarily for emergency help. I think that data exists on the local hospital level, and I am sure the Hospital Association may have that data.

I have a question. Are you assuming that this bill includes hospital inpatient services? It is one of the options that has been identified, but as I understand it, it is not option number one or number two. Are you assuming something?

MR. MORRIS: No, I wasn't assuming anything, sir. That is why in my comments I said the Department of Health supports the option which includes services for outpatients and inpatients at hospitals. I believe that is option three.

ASSEMBLYMAN FRELINGHUYSEN: All right. I am not trying to be antagonistic.

MR. MORRIS: No, I am not trying to be either.

ASSEMBLYMAN FRELINGHUYSEN: I am just trying to draw out some information.

I do have another question, but I will yield the floor to someone else.

ASSEMBLYMAN WATSON: You can ask your question, Assemblyman.

ASSEMBLYMAN FRELINGHUYSEN: I will wait.

ASSEMBLYMAN WATSON: You care to wait? That's fine. Assemblyman Kavanaugh.

ASSEMBLYMAN KAVANAUGH: Mr. Chairman, through you, if we are moving down to option three, are you familiar with-- If I am correct -- maybe one of our staff people can tell me -- wouldn't we be going into option three?

MR. KOHLER: Yes. Inpatient hospital care is not included in option 1 or 2.

ASSEMBLYMAN KAVANAUGH: You would have to go to three. I was not here earlier when Assemblyman Deverin was talking, but I think we have moved ourselves out of option one and two and we have gone from $35 million up to $100 million with that response.

MR. MORRIS: In the information that has been provided to the Department of Health, and in the basic bill, as it appears now, it is not clear in the flexibilities given to the Commissioner of Human Services. It has been indicated that this bill has the potential to reduce uncompensated care and effect the ability of the State to retain the Medicare Waiver. So, my comments were such that this bill can only affect the Medicare Waiver to the extent that it applies to hospital inpatient and outpatient services. And, if it is $100 million and it didn't cover inpatient and outpatient services, then there is no effect on the Medicare Waiver. If it is $35 million, however, and $30 million is for hospital services, then it does have an effect. So, I cannot be precise in my answer, except to say that in order for it to provide a benefit to the Medicare Waiver, the services have to be included for hospital inpatients and outpatients. And, by no means am I trying to connote support for a $100 million program as opposed to a $35 million program. I am just trying to give information to the Committee so that you don't think a program will be beneficial to the Medicare Waiver unless you realize it affects hospital services.

ASSEMBLYMAN KAVANAUGH: I remember when we were talking about the PAA Program. I can still remember those numbers being $6 million and $8 million. I think that we are certainly aware of the need, and we want to respond to our constituents and the people of New Jersey. I also think that we have to tread very cautiously.

You, as Assistant Commissioner, are the expert as far as DRG. If anyone talks about it, Joe Morris is the guy who knows all the answers. I appreciate that. The only thing is, as we go through the alternate service packages and we look at cost, I think we cannot bury our heads in the sand just because of pressures. We all have seniors and disabled people in our immediate families.

I have looked at these things, and some of them are a little frightening, because the figures that come forth range from $35 million to $200 million, and we are not sure, with the spend-down, where we are going to end up. That is the thing that frightens me. I think it is very important for this Committee, during the hearing today, to find that bottom line. I think it would be worse if we promise -- and this is what has been done in the past -- that we are going to do things for people, and then we can't afford to keep that promise. I am concerned that we are going to raise people's hopes and enter into almost a verbal contract with our citizens as their elected officials, and then down the line we are going to see that this is a runaway program.

I certainly admire what Assemblyman Deverin has introduced; I think it is something we should strive for. But, it is like riding horseback without a bridle or a saddle; I wouldn't want to end up, after I get out in the field, being unable to control the horse.

ASSEMBLYMAN WATSON: Just one minute, Assemblyman. I would just like to ask a question. Absent this legislation, what would the cost of the Medicare Waiver be?

MR. MORRIS: I'm not sure I understand. Do you mean the cost to Medicare, under the Waiver, to pick up uncompensated care?

ASSEMBLYMAN WATSON: What would the cost be?

MR. MORRIS: Approximately $90 million is what Medicare is picking up in uncompensated care payments under the Waiver.

ASSEMBLYMAN WATSON: If we did not get the Waiver, what would the State cost be?

MR. MORRIS: At the Joint Appropriations Committee meeting, the Commissioner indicated that there are two ways of looking at that. One involves the $90 million that Medicare would not pay. If we assume that Medicare would allow the Federal portion of the Medicaid Program to go up if the State included a medically-needy bill that would cover

the services for that amount of uncompensated care, it would be approximately $45 million, with another $45 million in Federal match. That is the lowest number that would meet that $90 million gap.

Now, the problem inherent with that simplistic assumption is that one can pass a bill and make sure you only pick up the services in hospitals, but utimately you would then have to pass a bill that would entitle recipients to any number of other services, and that would cost more than the $45 million.

In the absence of the Medicaid Program doing it, the other two options are, direct appropriations to the hospitals, or the ability of the hospitals to save through the way they provide their services -- say there is a lesser amount of services -- and to include the provision of uncompensated care to the remaining payers who are in the system.

ASSEMBLYMAN WATSON: Assemblyman Frelinghuysen.

ASSEMBLYMAN FRELINGHUYSEN: Mr. Chairman, Commissioner Albanese provided each of us with the medically-needy material and New Jersey's options. I draw the Committee's attention, and perhaps the Assistant Commissioner's attention, to pages 13, 14, 15, and 16 of a bill, where the inpatient hospital cost is anticipated for adults, needy children, needy disabled, blind, and medically-needy aged. It might be valuable to have the Department of Health verify, or at least do their own homework, perhaps, so that the Committee would then have at its fingertips the opinion of the Department of Health regarding the Department of Human Service's figures on anticipated cost. I think that might be extremely valuable, because the total of what Commissioner Albanese provided comes to $111 million, which is a considerable sum of money for inpatient hospital care.

ASSEMBLYMAN WATSON: Is that a request to the Chair, that you would like that to be done?

ASSEMBLYMAN FRELINGHUYSEN: If it is possible. It might be valuable.

ASSEMBLYMAN WATSON: Could you repeat your request again, please?

ASSEMBLYMAN FRELINGHUYSEN: Referring to pages 13 through 16 of Commissioner Albanese's Medically-Needy, New Jersey Options Report,

provided to this Committee -- and I believe you have a copy also -- if we could get the Department of Health's anticipated figures, and perhaps reaction to what the Department of Human Services has provided, I think that would be helpful.

I have one additional question which has to do with--

ASSEMBLYMAN WATSON: (interrupting) Before you go to your other question, that is a request that you want to deliver through the Chair?

ASSEMBLYMAN FRELINGHUYSEN: Yes.

ASSEMBLYMAN WATSON: We will send that to you in writing. (speaking to Mr. Morris)

MR. MORRIS: Okay. Just so I understand, what you are basically looking for is the Department of Health's verification, or its estimate of what these figures would be, is that correct?

ASSEMBLYMAN FRELINGHUYSEN: Yes.

ASSEMBLYMAN WATSON: All right. Assemblyman, you still have the floor.

ASSEMBLYMAN FRELINGHUYSEN: I have one other question. I, with the full cooperation and assistance of the Commissioner, made up a resolution to the Joint Appropriations Committee that would set up a prenatal program. Perhaps one already exists, but at least in that case it was an additional $625 thousand. As I understand it, is there a renewed effort on the part of the Commissioner and the Department to see that program develop, and does it have a bearing on this proposal we are discussing here today? Are you familiar with that?

MR. MORRIS: No, I am not familiar with that. I believe that comes under one of the other Divisions' community health services.

ASSEMBLYMAN FRELINGHUYSEN: Would you be able to provide -- as was provided to me -- background information to the Chair for this Committee? That was a very positive program which we have not given -- perhaps due to the lack of funds -- enough attention to in the Joint Appropriations Resolution process.

ASSEMBLYMAN WATSON: I would just like to make you aware of the fact that earlier we questioned Commissioner Albanese on that, and under Federal law we are doing most of this now in the prenatal care field.

ASSEMBLYMAN FRELINGHUYSEN: We may be doing some of it, but Commissioner Goldstein seemed to have a desire to do more, and maybe we could just take a look at exactly what that proposal was, or at least have the information available.

ASSEMBLYMAN WATSON: All right. Would you repeat your request again to the Chair?

ASSEMBLYMAN FRELINGHUYSEN: One of the Joint Appropriations' Resolutions, that was introduced but not acted upon, was a request from the Department of Health for a prenatal program -- I believe it was a pilot program. My request is to have provided, through the Chair, background information on that program so that we can have it for our review. Thank you.

ASSEMBLYMAN WATSON: Thank you, Assemblyman. Assemblyman Deverin.

ASSEMBLYMAN DEVERIN: I am a little concerned about this $100 million. We are not talking about that kind of money at all. As far as the DRG is concerned, if we are going to lose that Waiver we are going to go back to where we were before this became a fact. Indigent care will be picked up by the hospitals, by the patients who pay, or by the county -- which will make an appropriation to pick it up -- or else the hospitals will go bankrupt, especially the inner city hospitals. Am I aiming my remarks in the right direction?

MR. MORRIS: Except for one thing. It will not precisely go back to what we had before the amendments, because Medicare, right now, has changed its method of reimbursement and it has a perspective payment system of its own.

ASSEMBLYMAN DEVERIN: But, if we don't get the Waiver, somewhere along the line the hospitals are going to get-- There is going to be about $90 million voted on that someone is going to have to pay in those hospitals.

MR. MORRIS: That's a very good way of projecting it.

ASSEMBLYMAN DEVERIN: Now, let me ask you a question. Whether we give you inpatient care or outpatient care, if we don't give you inpatient care, does the Department still feel that this is a pretty good piece of legislation?

MR. MORRIS: Yes, it does, sir. The nature of my comments is to make sure that the Committee understands we support the legislation. We don't want you to misconstrue the effect it will have on the Medicare Waiver. But, you are entirely correct, we support the legislation even if it doesn't affect the inpatient services. One distinction to make is that the Department of Health will still be under considerable pressure to make sure that the New Jersey system is sufficiently rigorous to provide uncompensated care for everyone and still retain the Medicare Waiver.

ASSEMBLYMAN WATSON: Thank you, Assemblyman Deverin. Would any other Committee member care to speak? (no response) Hearing none, thank you for appearing this afternoon, Mr. Morris. We will be sending you some questions to be answered.

MR. MORRIS: Thank you very much, Mr. Chairman.

ASSEMBLYMAN WATSON: Craig Becker, from the New Jersey Hospital Association.

I would just like to announce to the audience that we intend to go right straight through. We are not going to break for lunch. It is important that we sit here and go through the witness list.

CRAIG A BECKER: Thank you, Mr. Chairman. I think most of my comments have already been made by Deputy Commissioner Morris, and also by Commissioner Albanese, so if I may, I would like to just reiterate some of our main concerns regarding the potential loss of the DRG Medicare Waiver.

We feel the $90 million is a very real figure. It is a grave concern that it will have to be made up somehow. The position of the Hospital Association is that any bill that can help us surmount this problem, or take care of this $90 million shortfall, is a good piece of legislation. Our main concern is, should be lose our Waiver, many of our inner city hospitals, and many of our teaching hospitals, will be faced with bankruptcy. We saw this prior to the DRG Waiver -- the DRG experiment that New Jersey has undertaken — and it has been our belief that New Jersey has always been in the forefront in taking care of the disabled and the elderly, by providing access to all. Therefore, we consider bills like A-608 to be good legislation, and it would be helpful to us should we lose this Medicare Waiver.

If I may, I would like to just add one more thing. We will work very closely, as we have in the past, with Mr. Morris on getting you the information you requested. I am sure the Association will be as helpful as it possibly can.

ASSEMBLYMAN WATSON: Thank you, Mr. Becker. I would just like to ask you the same question I asked Mr. Morris with regard to the study -- the joint study between your Association and the State with regard to the medically needy. It would be a one-week study on the different kinds of patients you have coming in. That would give us some handle on the percentages we are looking for.

MR. BECKER: I am sure the study can be completed. I am not sure one week would be representative, particularly because of all the variations. I am not really a statistician, but working closely with our financial people I am sure they can come up with a statistic that will be agreeable to you, the Committee.

ASSEMBLYMAN WATSON: I think we would accept your opinion regarding the best way to do it; you are the expert.

MR. BECKER: Sure.

ASSEMBLYMAN WATSON: Whatever it takes to give us the kinds of percentages that would make us feel are a little more reliable than we are presently working with would be great. You can expect some letters from us with regard to this.

Does anyone else care to ask any questions of Mr. Becker? (no response) Hearing none, Mr. Becker thank you again.

Do we have a Mr. Pike from the University of Medicine and Dentistry here? (affirmative response) Mr. Jim Pike. Do you have a prepared statement, Mr. Pike?

JAMES PIKE: No, sir, I don't. Good afternoon, and thank you for letting me present a very brief statement this afternoon. I guess one of the advantages of being close to last is that it has all been said before.

As a provider of health care to a large population of the medically indigent, University Hospital strongly supports Assembly Bill 608, which would provide medical assistance to the medically needy. Thank you.

ASSEMBLYMAN WATSON: That was quite short. I don't suppose there are any questions. Thanks a lot for your appearance today and for your support of this bill.

MR. PIKE: Thank you.

ASSEMBLYMAN WATSON: Would there be a Ms. Carol Kientz from Christ Hospital Home Health present? (affirmative response) Good afternoon, Ms. Kientz.

CAROL KIENTZ: Good afternoon.

ASSEMBLYMAN WATSON: Do you have a prepared statement?

MS. KIENTZ: I do, sir, with an apology and an explanation, if I may. I think you will quickly notice the number on that text is incorrect. I am a last minute fill-in here for our organization, and the typist was commandeered at the last minute, very quickly, and given mixed signals in her chore to type the text very fast. I have to apologize both to the Committee and to Assemblyman Deverin for that error. The text is in support of A-608, although in truth we support all legislation we have been currently reviewing in the State for medically-needy care. So, I ask you to accept my apology for that number.

As I said, we support Assemblyman Deverin's bill. We find him to be extremely knowledgeable and compassionate about the needs of the people we deal with in the community.

I just want to thank you for the opportunity to speak on behalf of the Home Health Agency Assembly of New Jersey. We represent 52 State certified home health agencies in this State.

I am not going to read my text; but, rather, I am going to try to give you the essential points that we feel are most important.

Our position is a simple one. There is a large reservoir of unmet needs in all communities in New Jersey. Most of those needs are for basic, simple services which would keep people in their homes, where they want to be, and would keep them clean, safe, and fed, which they deserve to be.

Basic part-time help and care at home for the medically needy who are elderly and disabled can reduce the enormous nursing home bill being paid by the taxpayer, since without this care at home people are often forced into nursing homes by means of Medicaid, with its higher eligibility limits for that type of care.

Some also believe that these needs can be met in other ways--for example, Medicare. One of the saddest misconceptions of the elderly is that Medicare will meet most of their health care needs. In fact, it covers none of the day-to-day survival needs which the chronically ill experience. It was designed essentially for doctors' and hospitals' costs during periods of acute illness. Most of the elderly have chronic conditions, and chronic maintenance care by definition is not covered by Medicare.

It is not unusual for a 70 or 80-year-old to have heart disease, arthritis, diabetes, and lung disease, or the remnants of a stroke which has left that person in a wheelchair. If such a person wants to stay at home to live out his or her life, I hope there is a good family to assist them, and either lots of money or so little that they qualify for Medicaid, because otherwise they are out of luck. Medicaid will not touch that type of cost with a ten-foot pole.

I would like to just share the experience of one woman that I described in my text, who is not in that elderly category. Sometimes I think we lose sight of those disabled in the middle-aged spectrum, particularly those with the devastating disease of multiple sclerosis. Mrs. A. is a lady in her 40's, and she has had multiple sclerosis for several years. It is a disease which strikes the young adult and can progress within a few years to severe disability -- I mean total, bed-bound inability to do anything for yourself. But, you don't die from this; you live for years and years in a bed.

Again, it is a chronic condition; therefore, although Mrs. A is bed and wheelchair bound, she does not qualify for Medicare assistance. She does have Medicare, but it will not pay for the care she needs at home.

She lives with her husband, whose income is marginal, but just enough to disqualify them for Medicaid. The irony of her particular case is that if she were less motivated and determined, she could have the help of a nurse and a home health aide at home several days and several hours -- for instance, three to four hours a day -- Monday through Friday by means of Medicare. But, because she chose to fight her disease and maintain control over her bladder, she cannot get that help.

You see, there are a lot of clauses in Medicare, and in this situation if she were incontinent and she needed something called a catheter to drain her bladder, we could provide her help under Medicare because we would be dealing with the care that a catheter requires. But, she doesn't need that catheter because she had the courage and determination to fight that problem of her disease. So, the existence, or lack of existence of a plastic tube means the difference between her being home alone during the day while her husband works, without any care, and not getting that care.

I ask you to look over some of the other examples. We have tried to give you some in all age spectrums. One of the other misconceptions we deal with is that people often feel there are other programs in the community: "If Medicare will no longer help Mrs. A, isn't there something else?"

We do have Title 20 help in many of our communities, but in Jersey City, for example -- and the experience seems to be true throughout the State -- there is such a waiting list -- now 125 people -- for Title 20, which is basic help at home for personal care and everyday needs. It is part-time care, and that list of 125 means that those people essentially won't get any help this year from Title 20. They will be lucky if their number comes up early next year. That also means that most of them, because they are elderly, will wind up, instead, in a nursing home, back in the hospital -- because they have gotten sick again -- or they will be dead before Title 20 can come to their assistance.

Other programs are going out of existence, such as the Senior Companion Program. We still have one in Jersey City, but it is teetering on the verge of extinction because it is an expensive program to administer, and the funds just aren't there to do it.

All in all, we have had to deal with many, many cases like this, only to give them the sad news that there is very little, if any, help to assist them, and for that reason -- as I said -- we support any legislation which will assist the medically needy. We feel this bill is a significant step in the right direction.

It is obviously not a magic wand to help everybody, but I don't think we as a State, or any state, can afford to do that. But,

we do support these efforts, and would certainly assist the Committee in any way if there is other information we can provide. I thank you.

ASSEMBLYMAN WATSON: Thank you, Ms. Kientz. Could you tell me the income levels of people using home health care?

MS. KIENTZ: People using home health care can come from any income level. It is home health care, per se, just as a doctor's service is available to anyone who needs it. If it is covered by a reimbursement source, such as Medicare or Blue Cross, that reimbursement source would pay for it. If the person has the money to pay for it himself, he might be paying privately.

So, home care, per se, is not an income-eligible service.

ASSEMBLYMAN WATSON: Would you have any suggestions for us on that income level?

MS. KIENTZ: Do you mean to determine what the income levels are?

ASSEMBLYMAN WATSON: Yes.

MS. KIENTZ: (continuing) Of our clients? We might be able to come up with some figures. Again, as the previous speaker just said, statistics are very poor, and we don't really have the money to do that kind of statistical work.

ASSEMBLYMAN WATSON: You probably didn't quite understand what I was trying to get from you. What income level would you suggest to us would be appropriate?

MS. KIENTZ: I'm sorry, I understand you now. We would support, ideally, the 130-plus eligibility, with support option 2. We can certainly understand if eligibility has to be started at a lower base, Assemblyman, the results of that would have to be evaluated. But, we feel that would be reasonable.

If I might just speak to the resource problem -- eligibility in terms of financial resources -- 1500 certainly isn't very much, and that is a problem. I might just say if that is determined to be the level that must be used, that some means, if possible, should be worked out to cut the red tape as quickly as possible.

This week I am working with a woman who probably will be reinstitutionalized because she has gotten very sick, emotionally, from a lack of resources. She came home from a State hospital after many

months with $1600 in the bank. She is eligible for SSI, but it took over four months to get that SSI reinstated, simply because of paper work and the fact that she was about $100 over the limit and had to spend-down. She spent down within a week because she owed rent, she had to buy over $50 worth of medication the first week she was home, she had things stolen and had to buy sheets -- she was faced with all the little things that happen to people. But, it took four months to get all of that validated, with photocopies of bankbooks, etc. She now has less than $300 left, and she is so emotionally devastated that, as I said, she will probably be reinstitutionalized this week.

So, if red tape can at least be done in such a way that people have the knowledge that the $1500 won't disappear before they are eligible, that would certainly be a kindness.

ASSEMBLYMAN WATSON: The estimates here for home health care under this program are close to $20 million.

MS. KIENTZ: I realize what it might cost. I think, again, it is difficult to estimate. Some people could get by with care that would cost $50 to $100 a week. Others might need care that would cost $200 or $300 a week. It is variable, but, yes, I think that is probably accurate.

ASSEMBLYMAN WATSON: Are there any other questions? Assemblyman Frelinghuysen.

ASSEMBLYMAN FRELINGHUYSEN: I think we all recognize that you do good work, and you work with some difficult clients. I know, coming from a county background, that our County Welfare Board works very closely with VNA and the Visiting Homemaker Service.

We seem to be collecting quite a lot of statistics around here, but I believe that County Welfare Boards would be able to provide, perhaps through the Department of Human Services, or through your Association, statistics regarding the number of clients they are dealing with -- not only the ones they are able to deal with because of available resources, but also estimated figures on those they can't serve because of the lack of money.

I know in some counties there are county government contracts with VNA's and Visiting Homemaker Services and it might be good to get those dollar figures from the 21 counties as to what some of the

counties are doing. Quite frankly, I don't mind State government doing a lot of this, which, of course, is the basis of this program; however, I think it is also a positive factor to have the county level of government doing their fair share of this. It is the County Social Worker who is closest to the people in need. This follows some of the comments we heard from previous speakers. I would like to echo that I think County Welfare Board social workers are very close to the problems, and they are close to the providers, such as you or the groups you represent.

Thank you, Mr. Chairman.

ASSEMBLYMAN WATSON: Thank you, Ms. Kientz for appearing here today.

Is Mr. Keiserman present? (affirmative response) Mr. Keiserman and Mr. Tergis.

DAVID KEISERMAN: Mr. Tergis stepped out for a moment. He will be right back.

ASSEMBLYMAN WATSON: Okay.

MR. KEISERMAN: However, if I may, I will proceed.

ASSEMBLYMAN WATSON: Sure, that will be fine.

MR. KEISERMAN: Thank you. Mr. Watson, and ladies and gentlemen of the Appropriations Committee, thank you for giving me this opportunity to present the views and concerns of the more than 20,000 members of the Monmouth County Senior Citizens Council.

My name is David Keiserman. I live at 5K Pine Cluster Circle, Manalapan, New Jersey, and I am President of this Council.

This Council views with alarm the vast array of bills that are filed each year that look for financing from the casino revenue fund. While we are well aware of the much needed benefits that these bills can provide, we are also very aware of the limitations of these casino funds. The Monmouth County Senior Citizens Council, and every major senior citizens organization in the State of New Jersey, has supported the establishment of a legislative commission to review the disbursements of casino funds. Are these funds being utilized in the best way possible?

Last year, SCR-75 was passed, establishing a review commission. Unfortunately, no commission was appointed, and the

legislation died. This year -- and I understand it was just this past week -- ACR-104 and SCR-97 passed, again establishing a joint legislative commission to review casino fund expenditures, and to make recommendations.

Also pending is AJR-27, which directs the Department of Health to conduct a study and make recommendations for the development and implementation of a Social Health Maintenance Organization program. Incidentally, that program has been proven throughout the country as being very cost-effective. If we continue with the cost figures, the same procedures, and the same programs we are following, we will never be able to afford the terrible increase in the cost of medical care and hospital care. Fortunately, the DRG Program has helped to contain hospital costs. But, this same program of doctor care, etc., has just been overly-expensive and it is running away at three times the actual rate of inflation.

In addition, every major senior citizen organization in the State has voted home health care and rental assistance as their highest priority programs -- and those most needed by senior citizens.

We do not question the need for this medically-needy program, nor do we question the good intentions of the many other good bills pending. But, we are acutely aware that the Casino Revenue Fund is projected to receive an income of $160 million this fiscal year, and already $176 million has been appropriated.

Thanks to a surplus carried over from last year, some very limited funds are still available. We call upon this Committee to restrict further casino revenue expenditures until a complete review of all programs currently being funded from this source is done and recommendations are received. We must make certain that all future programs provide the most benefits for every dollar spent.

Thank you for allowing me this time to make this presentation to you.

ASSEMBLYMAN WATSON: Mr. Keiserman, thank you for appearing here today. I see that you directed your remarks to a specific part of the expenditure in the bill and not the bill itself. We are discussing the bill today. I let you continue because of the fact that it is, in the end, part of what we are going to discuss -- the funding.

MR. KEISERMAN: Well, more than half of the funding is coming from the State.

ASSEMBLYMAN WATSON: If you have anything to say insofar as the need for the bill is concerned, I would like to hear that from you.

MR. KEISERMAN: The need definitely exists, Mr. Watson. There is no question about that. The need does exist. What we would like to see is AJR-27, which will review the various types of medical programs that are currently containing costs throughout the country, and see if they can be implemented in order to save tremendous amounts of money by keeping people well, rather than waiting until they are hospitalized -- as with HMO's, which have proven to be very effective.

New Jersey should become more progressive and look to better programs, rather than just continue on with the very costly programs we have in effect today, which this bill will continue.

ASSEMBLYMAN WATSON: It is my understanding that the Social Health Maintenance Organization referred to is an experimental program.

MR. KEISERMAN: It is in effect in a number of areas. I can tell you where it is in effect. It has been proven to be very successful. It is in Middlesex County. It has been in California for many years. And, it is being used in New York very extensively as well, and it has been proved to be very cost-effective.

ASSEMBLYMAN WATSON: Is that the Channeling Project that is going to be terminated?

MR. KEISERMAN: Yes, the Channeling Project.

ASSEMBLYMAN WATSON: It will be terminated.

MR. KEISERMAN: I am not that well versed in that particular program to go into it in depth, but I am interested in the fact that we should look toward new ways to provide these services in a far more cost-effective manner.

ASSEMBLYMAN WATSON: Are there any other questions from the Committee? Assemblyman Deverin.

ASSEMBLYMAN DEVERIN: If we funded this directly from the general appropriations, you would be very much in favor of the idea, is that correct?

MR. KEISERMAN: No, I still feel we should look into a much more cost-effective plan. I feel the methods that are presently being

used to provide medical care to the public are not in the best interest of the public.

ASSEMBLYMAN DEVERIN: It is not a matter of just medicine; it is a matter of health care.

MR. KEISERMAN: Well, when I speak of medicine, I mean the entire field of medicine.

ASSEMBLYMAN DEVERIN: How can you run a statistic on people who aren't even in the health care system? They are simply not in it because they are not eligible for it. How do you run a statistic on that, Mr. Keiserman?

MR. KEISERMAN: When you say they are not in it, most of the time they are not in it because they can't afford it -- and that applies as well to seniors.

ASSEMBLYMAN DEVERIN: Well, that is what we are talking about. I am aware of that. This bill is geared to help senior citizens. I am kind of surprised to hear you say you are not in favor of it. You don't understand it, obviously.

MR. KEISERMAN: No, I am for it. I am for these bills, but I would like to see studies made so these programs could be made more effective before they are implemented. Once they are implemented, invariably they just go on and on. As long as the commission hasn't been appointed -- The programs are there to look into, and I would like to see that done before the implementation of the programs that you are speaking of takes place, sir.

ASSEMBLYMAN DEVERIN: Fine.

ASSEMBLYMAN WATSON: I think the Legislature and the Department of Health are aware of all the studies that are being done with regard to this, and they will be incorporated in this.

Hearing no other questions, I want to thank you for your appearance.

MR. KEISERMAN: Thank you, Mr. Watson, and thank you ladies and gentlemen.

ASSEMBLYMAN WATSON: Is Mr. Tergis present? Mr. Tergis is from the New Jersey Council of Senior Citizens.

JOHN P. TERGIS: That's right.

ASSEMBLYMAN WATSON: Do you have a prepared statement, Mr. Tergis?

MR. TERGIS: Yes, I do, Mr. Watson. You already have it. It was delivered this morning by Ed Keiserman.

My name is John Tergis. I am from the New Jersey Council of Senior Citizens. Thank you for permitting me to testify today.

Before you pass the issues you have before you today, we -- speaking as a senior citizen, regarding senior citizen moneys -- request that you go into all the options and priorities concerned with the expenditure of casino revenue funds, including home health care and rental assistance, before you make your decision about the issue which is before you today.

We are not arguing against medically-needy at all. As a matter of fact, it has some elements in it which provide for home health care. What we are saying is that there is a need to review all of the proposed benefits in the legislation, which is before you and before the Legislature concerning senior citizens before you make your decision.

We don't agree with the concept that the casino revenue funds are an endless source of money and will keep on coming in. If you look at the study which I have attached to my testimony today, you will see that the expenditure from the Fund for the new Fiscal Year, 1985, is $176 million. The income of the Fund is projected to be $160 million. That $160 million includes a very liberal estimate of $20 million more than is provided this year. In other words, you are expecting a $20 million increase in the Fund. Naturally, you can't balance a budget of $176 million with an income of $160 million; you are depending on a very liberal estimated amount being carried over from this year.

If either of these extremely optimistic estimates as to income and carryover amounts should prove to be very wrong, you will really have a shortfall in casino revenue funds this year.

I think another thing which must be considered, and which I bring out in my report -- and we have been watching this very carefully -- is that there is a built-in liability, even with respect to the senior citizen programs that are on the books now.

Under the PAAD Program, because the benefits transfer over as people reach $1200 under the old plan, they go into the new plan. That, with the cost of drugs, has caused the casino portion of the PAAD

Program to accelerate very rapidly. The same thing holds true for the Tax Reduction Program. And, with the present promise to increase the Lifeline legislation by another $25 next year -- which we don't agree with; we don't think it is a good idea -- this will raise the expenditures of that Program from $5 to $8 million a year, just because of one $25 increase. We think it is really necessary to go over these programs and decide which program is the most important.

Ladies and gentlemen, two years ago the Legislature passed Bill SCR-75, and in that bill they said it was the policy of the Legislature of New Jersey, before expending any more casino revenue funds, to consider the resources of the Fund, the expected income, and the expected outgo, to review present programs, to review what is before the Legislature, and to make a study, hold hearings, and decide just what the priorities of the Casino Revenue Fund are. That legislation was passed, but unfortunately it was never implemented.

This year the Legislature has passed another bill, recreating the commission, and the study is to be made. Now, what is the policy of New Jersey? In this legislation you say it is the policy of the Legislature to have this study by the commission made before any further expenditures from the Fund are made.

We certainly support that legislation, and what we are asking you to do is to please consider the options which are before you, and await the study of the Fund. If that is not possible for you to do, then consider all of the other options.

I haven't presented any testimony in favor of rental assistance, but we think it is very important. At the proper time, during a hearing on the proper subject, we would be willing to come before you and explain just what the very, very great needs are of the elderly in New Jersey, especially the elderly people who are paying very, very high rents.

Thank you very much, ladies and gentlemen.

ASSEMBLYMAN WATSON: Thank you, Mr. Tergis. I would just like to reiterate a statement I made earlier. The Legislature is very much aware of the amount of available revenue we have, and we will make sure we will not exceed those revenues.

You made another statement regarding an estimate of those funds. That is not an estimate; those are dollars in the bank. That $176 million is there.

MR. TERGIS: That is expenditure. That is the proposed expenditure.

ASSEMBLYMAN WATSON: But, the moneys are there.

MR. TERGIS: It all depends on the income and the carry-over.

ASSEMBLYMAN WATSON: Assemblyman Frelinghuysen.

ASSEMBLYMAN FRELINGHUYSEN: I haven't made your acquaintance. I didn't know people like you existed. I am glad to see there is somebody--

MR. TERGIS: You didn't know I existed?

ASSEMBLYMAN FRELINGHUYSEN: No. I am new down here. It is so refreshing. I will have a better appetite for lunch after listening to you.

MR. TERGIS: Thank you.

ASSEMBLYMAN WATSON: Assemblyman Kavanaugh.

ASSEMBLYMAN KAVANAUGH: We have had the opportunity of hearing Mr. Tergis before. In fact, after hearing him quite a few times, I think we can call him John.

If what you said in the statement -- and I think it is important-- I don't know how to say this because this is something that is strictly nonpolitical. We have Assemblyman Deverin offering you a program that is endorsed by our Governor, who is not a member of my Party; he is in the other Party. But, I think that what has been done insofar as casino revenues are concerned-- Even though a portion of this funding will come from casino revenues, it seems that spending has been whatever is politically expedient, and the ones who are going to be hurt in the future are the seniors.

I think, John, when you mention revenues and expenditures, if one runs a business he can't do it that way, and we are hoping that it will balance out.

When SCR-75 was put forth, it was an agreement. The members of the Legislature took that Senate Concurrent Resolution and passed it, and everything was fine; but, nothing was done. Now, another one has been introduced. Are we going to have the same results we had with

SCR-75? That was nothing. Now, we have additional programs being put forth with the expectation of spending casino dollars. The priorities, as I mentioned earlier, have not been reviewed. That is why we asked what would be done, insofar as what is here.

But, there is a section -- a cross section -- of the senior population, and the disabled population, that has expressed their concern to us insofar as, "Where are you people going? What planning have you done?" We don't plan. It is crisis government. Right now, this is something that is on the front burner, and it is very nice. It is coincidental that some of us are going to be up for reelection next year when this thing is hot and heavy.

I think what we have to do is to look at the long haul and review what is going down the road.

As I said regarding Tommy Deverin, he is very sincere about what he is doing. But, you mentioned the PAAD program, and the expansion of these programs. I just don't like to do something in haste and repent at leisure, and I am concerned that we should take-- You have it in here, and I think it is very important. You didn't read it, but you mentioned the reasons, and if you don't mind, I will paraphrase it. You say you suggest an intense study of the high-priority needs of the seniors and disabled should be made now, and that a planned approach to casino revenues be made so these needs will be met before the fund levels off.

Listening to testimony, and I think this is what I have heard all day, I think it is important, and I would like to see an Assembly Resolution, or whatever the proper mechanism is, where we would limit any additional expenditure of the fund until the commission reports back, and we have input from all segments of the society that are involved, and for which the money was dedicated. It is their money. Yet, I think by almost mismanagement we said, "Right now we will do this, and tomorrow we will do something else." I think that before we do anything -- we can move ahead on A-608, but there is no funding mechanism, per se -- and before this moves through, I think the commission better get started. I would say, "Let's go out and have a study commission and call the seniors together, and use a room down here." If the Legislature doesn't want to do that, then I think it is

incumbent upon those of us who are concerned about this to do it ourselves. Thank you.

ASSEMBLYMAN WATSON: Thank you, Assemblyman. Assemblyman Deverin.

ASSEMBLYMAN DEVERIN: John, if we funded this thing through the general revenue, would your Association be in favor of it as something the senior citizens of New Jersey need and can use?

MR. TERGIS: Well, I have always considered that a trick question.

ASSEMBLYMAN DEVERIN: Let me change it then. We had someone talk from the Federation of Senior Citizens who was very much in favor of it, and called it a number one priority. Now, I am not sure, even though I am a senior citizen. I am not a member of either council, so I am not sure which is which. I asked you a very serious question.

There is nothing in this bill that says it would be funded by casino revenues. But, I would like an answer from you as to whether you believe the idea of a medically-needy program is a bad thing for senior citizens, or if the idea of funding it through the casino funds is a bad thing. Which of the two things are the lesser of the two evils for you?

MR. TERGIS: I have always considered it this way: We are not opposed to a medically-needy program. As a matter of fact, it might have some elements in it which provide home health care, and we are very much in favor of that. But, we still think that since part of it is coming from the casino funds -- and I think I have tried to point out that these funds are very limited -- that it is really necessary to find out just what the primary needs are. There are many, many conflicting things before the Legislature. There is a bill in there to increase the PAAD Program.

ASSEMBLYMAN DEVERIN: Yes, but we are only concerned with the medically-needy at the moment.

MR. TERGIS: In answer to your question, if I thought something was not good, I would not say it was all right to do it under the general funds. I wouldn't say that. I think that would be pretty inconsistent, and it would be sort of selfish.

ASSEMBLYMAN DEVERIN: Do you think there is a need for a medically-needy program in New Jersey?

MR. TERGIS: If it doesn't come out of our money; it should come out of your money, or something like that.

ASSEMBLYMAN DEVERIN: Do you think there is a need for a medically-needy program in New Jersey?

MR. TERGIS: Speaking of the medically-needy, I do think that it is a good program. But, I still think this kind of a study should come first. There are many other things, such as rental assistance -- and I don't want to get into this area, but I think rental assistance is awfully important. If we are going to allow people to remain in their homes, we have to do something about these very, very high rents poor people are paying. We have to balance these things out, one against the other. This is why I say this kind of a study should be made.

ASSEMBLYMAN WATSON: Thank you for your appearance here today.

MR. TERGIS: Thank you very much.

ASSEMBLYMAN WATSON: Elizabeth Holland, representing the New Jersey Catholic Conference. Ms. Holland happens to be from my county.

ELIZABETH HOLLAND: My statement is brief, very general, and it is devoid of the facts and figures you are looking for, but it is, I think, full of the common sense impression that most of us have, that there are an awful lot of poor people out there who need a program such as this.

The cost of medical care is at an all time high. Those whose incomes are so limited that there is barely enough to pay for their daily necessities of life, like food and shelter, must often ignore the need for medical care. If care is sought, the location may be inappropriate, such as hospital emergency room treatment, and unpaid hospital bills often accumulate, to be paid by the State.

In other situations, persons are inhibited from seeking medical attention, since most individual providers insist on a cash-on-delivery system. Obviously, in light of the increased cost of care, and the restrictions of the Omnibus Reconciliation Act of 1981, which denied Medicaid coverage to tens of thousands of New Jersey's poor children and their families, the State's conscience must demand that a medically-needy program, as outlined in Assemblyman Deverin's bill, A-608, be implemented.

New Jersey is but one of two northeastern states without such a program. Even states considered less socially advanced than New Jersey have instituted such coverage for their poor citizens.

As discussed, A-608, and its companion Senate bill, S-1718, should meet all the requirements of individuals who demand that public money be carefully used. Recognizing that many families have incomes above AFDC and SSI levels, thereby disqualifying them for Medicaid but placing them below the poverty level, obviously makes them incapable of meeting their own medical expenses. A family with an income at 133 percent of the AFDC and SSI standard could qualify for the medically-needy program.

A spend-down provision would require that individuals whose incomes exceed 133 percent, expend income in excess of that limit before being deemed eligible. This provision further assists those many families and individuals whose incomes are decimated by medical costs.

The New Jersey Catholic Conference, representing the Bishops of New Jersey, respectfully requests the support of this Committee in releasing this bill for a vote. It makes neither good moral nor financial sense to deny medical coverage to the marginally poor of our society. Medical care is a necessity of life. Lack of care at the appropriate time takes a greater toll in human and financial costs.

I apologize because you have heard all of this before, but at least we are on your record.

ASSEMBLYMAN WATSON: Thank you, Ms. Holland. Would anyone care to ask any questions? (no response) If not, thank you for your appearance here today.

MS. HOLLAND: Thank you.

ASSEMBLYMAN WATSON: Adam Kaufman, New Jersey Dental Association.

ADAM KAUFMAN: Mr. Chairman, Jack Roemer will be speaking for us.

ASSEMBLYMAN WATSON: Doctor Roemer?

MR. KAUFMAN: Yes.

ASSEMBLYMAN WATSON: Proceed, Dr. Roemer.

DR. JACK ROEMER: Mr. Chairman, and Committee members, on behalf of the 5,000 member New Jersey Dental Association, I would like to thank you

for this opportunity to speak to you today about the medically-needy legislation.

I am Doctor Jack Roemer. As a member of the New Jersey Dental Association, I serve as Vice Chairman of our Council on Legislation and I am Editor of our quarterly journal. My private practice is located in Princeton.

The New Jersey Dental Association supports the medically-needy legislation, A-608, sponsored by Assemblyman Thomas Deverin, and S-1718, sponsored by Senator Louis Bassano.

I speak before you today on a mission of concern. The New Jersey Dental Association believes it is tragic that nearly 200,000 of this state's senior citizens, disabled, children, and working poor, those who can least afford it, have been squeezed out of adequate health care coverage.

I am sure this Committee has heard compelling arguments for enactment of this legislation from the previous speakers. The New Jersey Dental Association would add to that chorus of concern and remind the members of this Committee that we live in a society that has a responsibility to its citizens. We diminish the value of any individual by denying them access to basic health care.

Approximately two months ago, in testimony before the Joint Appropriations Committee, Human Services Commissioner, George Albanese, stated he was charting a new course for action by his Department that would stress prevention over treatment. As he indicated today, a medically-needy program is an essential component in this new direction.

We in dentistry enthusiastically embraced the Commissioner's remarks because they embodied the very essence of dentistry's purpose and philosophy: Prevention.

Dentistry is one of the few health professions to consistently advocate preventive care. We have also seen the positive fiscal results of prevention. It has been said by some that dentists will some day put themselves out of business because of good preventive dentistry.

The medically-needy legislation is a preventive program that should prove cost-effective to the State. In dentistry, we know it is

more cost-effective to follow a maintenance and prevention program, rather than respond to neglect.

Preventive dentistry refers to procedures in dental practice and health programs which prevent the occurrence of oral disease.

What has occurred in dentistry through its advocacy of nutrition, education, fluoride, and regular checkups, has been remarkable. According to the Director of the National Institute of Dental Research, "The tooth decay rate has been cut in half as compared with 20 years ago."

Additional data reinforced the continued positive results of prevention:

A 65 percent reduction of cavities in school age children who have been exposed to fluoride since birth.

A 75 percent decrease in loss of first permanent molars in 12 to 14 year-olds.

A sixfold increase in the number of children who reach their teens with no cavities.

A 30 percent decrease in adults who need dentures.

And, one-third of the children 15 to 17 years old are cavity free.

The New Jersey Dental Association believes that the medically-needy legislation represents this State's strong commitment to a prevention-oriented public policy, which holds great promise for the future through the intelligent allocation of efficient use of available resources.

This Association is firmly committed to the belief that dental care should be available to all, regardless of income. With the commitment of public policy makers, such as yourself, and dentistry's continuing commitment to the delivery of cost-effective preventive oral health programs, the medically-needy legislation makes quality dental care a reality to the needy people of our State.

Each of the population groups that would benefit from this legislation, the elderly, disabled, and children, have dental concerns unique to their age or condition.

If childhood dental problems are treated early, you alleviate a lifetime of pain and cost. The elderly frequently neglect dental care for economic reasons.

For the elderly, poor oral health is merely the start of what can become a vicious cycle of poor general health. Pain, discomfort, and disfigurement coexist and heighten nutritional deficiencies. Poor nutrition impacts on an individual's overall health, and can mushroom into other physical problems, including a multitude of gastrointestinal problems.

I want to emphasize that dentistry is indeed a crucial element in any proper health maintenance program.

This Association would like the medically-needy legislation to reflect the importance of dentistry by including it as a mandatory service for the seniors and the disabled. Currently, under Federal medically-needy provisions, dental care is included for children. Your colleagues on the Senate Institutions, Health, and Welfare Committee, in their release of S-1718 stated: "It is the intent of the Committee that dental care shall be one of the noninstitutional care services available to elderly and disabled persons."

We can correlate our experience with the New Jersey Dental Association's Senior Dent Program for possible utilization data. Senior Dent was founded, and is funded, by the New Jersey Dental Association. The only State involvement is the manning of a Senior Dent toll free hotline. Eligibility is based on the State's Pharmaceutical Assistance to the Aged Guidelines. This program enables eligible senior citizens to receive a minimum of 15 percent reduction in fees, from nearly 2,000 participating dentists. Over a three-year period, the program has handled 9,000 referrals for all types of dental treatment.

In conclusion, I would ask this Committee to consider release of both A-608 and S-1718, with the inclusion of dental services as a mandatory service for seniors and the disabled. The New Jersey Dental Association commends both Assemblyman Deverin and Senator Bassano for their compassionate efforts to help the neediest people of this State.

I thank you for your time and attention.

ASSEMBLYMAN WATSON: Thank you, Dr. Roemer. I have one question. You indicated that 9,000 PAAD recipients have taken advantage of your Senior Dent Program. Is more data as to the income levels of the 9,000 persons who took advantage of the Senior Dent Program available?

DR. ROEMER: We have data, I believe, up until 1982. We are correlating data from 1982 to 1984 at the present time, and we could provide that to you.

ASSEMBLYMAN WATSON: Could you provide that to this Committee?

DR. ROEMER: Yes.

ASSEMBLYMAN WATSON: Does anyone else care to question Dr. Roemer? Assemblyman Frelinghuysen.

ASSEMBLYMAN FRELINGHUYSEN: Thank you, Mr. Chairman. We have a Senior Dent Program in our county. We certainly congratulate the dentists who participate in it. Do you have any ideas about how the Department of Human Services could be responsible for overseeing this medically-needy program, or how you would like to see it structured? What sort of relationship should there be between the State and those who would be providing the services on a professional basis?

DR. ROEMER: Well, those who would be providing the services on a professional basis would be providing it at Medicaid fees, through the Department of Human Services. All we have at this point is an approximate estimate of those who would qualify and the approximate cost to the Department.

ASSEMBLYMAN FRELINGHUYSEN: I found, in dealing with a number of senior citizen clubs and organizations in my area, that this certainly is an important aspect of people's lives -- to eat, and to have proper teeth and dental health. I also found -- and I think this is a factor -- that efforts are being made by other medical people to provide eye care at reduced cost, as well as efforts -- in our area -- by podiatrists to assist with the care of feet.

I know you are here, and I recognize and salute you for this aspect of the care. However, quite frankly, I think there are other concerns that are legitimate concerns to older people and I thought I would mention them. Thank you.

ASSEMBLYMAN WATSON: Assemblyman, I think the provision for reimbursement would be through the existing Medicaid reimbursement procedures.

ASSEMBLYMAN FRELINGHUYSEN: For this program?

ASSEMBLYMAN WATSON: Yes. Does anyone else care to ask a question? (no response) Doctor, it was nice to have you appear here today.

DR. ROEMER: Thank you very much.

ASSEMBLYMAN WATSON: Thank you for coming.

Is there someone here from the Eastern Paralyzed Veterans' Association? (no response)

Is there a Fred Kessler present? Fred Kessler represents the Atlantic City Casino Association.

DAVID GARDNER: I am taking Fred's place, Mr. Chairman.

ASSEMBLYMAN WATSON: What is your name, sir?

MR. GARDNER: David Gardner. I am Acting Director of the Atlantic City Casino Hotel Association.

ASSEMBLYMAN WATSON: Fine.

MR. GARDNER: Well, first I would like to commend Assemblyman Deverin for identifying what sounds like a very important need. I am attempting to provide a solution to that need.

Second, I would like to commend this Committee for very carefully paying attention to details, in trying to look at the need and the resources of the State to meet that need.

The Atlantic City Casino Hotel Association does not oppose, in concept, legislation expanding and improving New Jersey's Medicaid program.

I had a very short statement, and it is now going to be even shorter. What I would like to do simply, but strongly, is to support the call by Mr. Keiserman and Mr. Tergis for an examination of the impact of additional appropriations on the casino revenue funds which must proceed any legislation that extends the range or the sum of the casino revenue fund commitment.

Our Association strongly supports SCR-97, which reconstitutes the commission to review the expenditure of casino revenue, and we would hope that the commission would carefully examine disbursements from the casino revenue fund and recommend funding priorities.

I will not read the rest of this, because I think Mr. Keiserman and Mr. Tergis said it far better than I can. Thank you.

ASSEMBLYMAN WATSON: Thank you. Would anyone care to address a question to Mr. Gardner? (no response) Hearing none, Mr. Gardner, let me thank you for your appearance here today.

MR. GARDNER: Thank you.

ASSEMBLYMAN WATSON: Do we have a Donald Carolan present? Donald Carolan is representing the Union County Division on Aging.

DONALD CAROLAN: First of all, my name is Donald Carolan, and I am the Community Service Planner from the Division on Aging. I am here on behalf of Mr. Peter Shields, Director of the Division on Aging in Union County. Mr. Shields, unfortunately, was unable to testify in person, due to a conflict in scheduling. It is interesting that he has a legislative luncheon today up in Union County, meeting with elected representatives. Basically, they are going to be discussing this issue, the legislation on medically-needy that Mr. Deverin has sponsored, with the seniors and other representatives of State government.

At this time I would like to read Mr. Shield's testimony into the record:

My name is Peter Shields. I am the Director of the Union County Division on Aging with almost 50 years of government service, mostly serving the elderly. I have received 18 commendations and other honors for my work with the elderly in my present position. Previously, I had been employed as a Field Representative of the U.S. Social Security Administration.

Simply stating the fundamental need in A,B,C fashion:

A. There is an absolute great need for the passage of medically-needy legislation in order to provide home health care for the elderly. This is an established fact in view of the conditions here in Union County, where we in the Division on Aging are making some small contribution for home care to approximately 600 seniors who do not qualify for Medicaid but are too medically poor to be able to afford the cost of nursing and home health aide visits.

The care we are paying for, while helpful, is still not sufficient nor comparable to that which is ordinarily available to the Medicaid-eligible.

B. In addition to the 600 we are helping, there are hundreds of others who we are unable to help due to our limited funds.

C. If we do not continue to try to provide more home health care, we will continue to be faced with the problem of unnecessary institutionalization, and the placing of our aged in nursing homes who may not need nursing home care.

Thank you very much.

ASSEMBLYMAN WATSON: Thank you, Mr. Carolan. Does anyone care to ask any questions? (no response) Thank you for your appearance here this afternoon, Mr. Carolan.

We have someone here from the Gray Panthers of South Jersey, Victor Volpe. Mr. Volpe? Mr. Volpe, someone wants to know if you were declawed? They call you the Gray Panther, and someone on my right wants to know if you were declawed or not.

VICTOR VOLPE: That is another organization; don't get it mixed up with the Panthers.

ASSEMBLYMAN WATSON: You are on, Mr. Volpe.

MR. VOLPE: If you are going to expect any expertise on this problem, abandon the idea, because I am not going to be able to offer you that. What I do want to do is to address the legislation in this respect: Philosophically. This legislation wants to put into practice an approach to a need, and not to greed. On that basis, we support this legislation wholeheartedly. We think it is one of the finest pieces of legislation that has ever come out of Trenton, if it passes. That is how we feel about it.

I have been working on this problem for years, and our organization has formed a coalition with the New Jersey Federation to support this program. We are for it 100 percent.

Now, I would like to digress for a moment. I am on the Health Committee of the National Gray Panthers, and we are working on the Kennedy-Gephardt bill, which has to do with the perspective payment systems and DRG's. While on this Committee, we have had people from the American Association of Retired People, an organization of 15 million, and we have had people from Rutgers University come to us with certain information. One of the figures I heard, while sitting on the Committee, was that there are from 25 to 30 million people in America who do not have health insurance of any kind. We always thought that in New Jersey the figure was 200 to 300 thousand, and we accept that.

It seems that everyone is concerned about the cost of this. I think what we should do, instead of worrying about the casino funds, is to determine what our needs are and then look at the casino funds to see if they can cover them or not. We should not just turn around and destroy a program because we are supposedly in doubt about that.

One more point I would like to raise is -- and then I will stop -- while sitting there, a question came up from the American Association of Retired Persons. You may have gotten this information, because they distributed it all over the country. Since 1967, the cost-price index has been at a rate of 189 percent. For physicians, the figure has been 227 percent. For hospitals, it climbs to 442 percent.

Now, these figures are for 1982. The 1983 figures go much higher. In 1984 it may hit a plateau because of the DRG's. But, it means this: As that climbs, more and more people have been put in a position where they cannot afford health care. That is why I think this legislation targets in on a very serious and dire need, and I think the Legislature should give it a lot of attention.

Thank you very much.

ASSEMBLYMAN WATSON: Thank you.

MR. VOLPE: May I say something else before I leave?

ASSEMBLYMAN WATSON: Yes.

MR. VOLPE: I heard people talk about priorities here today. I wouldn't profess to say I know what programs senior citizens consider should come first. I was a VISTA volunteer for three years, and I worked with the Federation. I talked to more senior citizens than probably anybody you can think of. It is true that there are senior citizens who are greedy, but there are also senior citizens who are conscientious, and they recognize that this program is directed to most of the senior citizens that I keep in contact with. They would wholeheartedly approve this. Thank you very much.

ASSEMBLYMAN WATSON: Thank you for your appearance here this afternoon, Mr. Volpe.

Is there a Marvin Burden from the Health System Agency of Bergen County here?

MEMBER OF AUDIENCE: He was here, but he left.

ASSEMBLYMAN WATSON: All right, just for the record, I would like to indicate that the Public Advocate's office sent written testimony in, and it will be made part of this hearing.

Does anyone else here care to testify? Hearing none, I would just like to thank each and every person who appeared here today. I would also like to thank our staff and the members of the Committee who appeared here today.

I would like to make one other statement. In the event we should receive the kind of information that we requested and it should require another public hearing, I think we will call one other public hearing, after we get that information and all of our research is finished. We will then make it known to you. Thank you for your appearance here this morning and afternoon.

This hearing is now concluded.

(Hearing Concluded)

APPENDIX

BARBARA FAITH KALIK
CHAIR

JOHN WATSON
VICE-CHAIRMAN

STEPHEN ADUBATO, JR.
BYRON M. BAER
WILLIE B. BROWN
JOSEPH W. CHINNICI
MARLENE LYNCH FORD
ROBERT D. FRANKS
RODNEY P. FRELINGHUYSEN
FRANCIS J. GORMAN
WALTER J. KAVANAUGH
ROBERT A. RANIERI
ANTHONY M. VILLANE, JR.
JACQUELINE WALKER
KARL WEIDEL

State of New Jersey
NEW JERSEY LEGISLATURE
ASSEMBLY
REVENUE, FINANCE AND APPROPRIATIONS COMMITTEE
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MICHAEL J. BASARAB
COMMITTEE AIDE

June 28, 1984

Honorable George Albanese
Commissioner
Department of Human Services
Capital Place One
22 S. Warren St., CN-700
Trenton, NJ 08625

Dear Commissioner Albanese:

On July 12, 1984 the Assembly Revenue, Finance and Appropriations Committee will hold a public hearing on A. 608 which would extend New Jersey's Medicaid program to include those persons and households considered "medically needy."

There are a variety of substantive issues regarding the extension of the Medicaid program to the medically needy which the Committee is interested in and is concerned about and upon which the Committee would appreciate your opinion:

1. Your department's report, MEDICALLY NEEDY. NEW JERSEY'S OPTIONS, indicates that 50,000 adults, 100,000 children, 12,500 blind and disabled, and 90,000 aged would qualify for the program.

   a. What income standard (e.g., 100% of standard, 133 1/3% of standard) was used to develop these estimates?

   b. How were these estimates developed?

   c. Were assets considered in developing these estimates?

2. It is estimated that 12,500 blind and disabled and 90,000 aged would qualify for the program.

   The Community Care Waiver Project though somewhat different in focus is similar to the proposed medically needy program. It has been found that many aged, blind and disabled persons have assets above the $1,500 level allowed by federal law and do not qualify for the Community Care Waiver Project.

In view of findings in the Community Care Waiver Project regarding the assets of the aged, blind and disabled, are the estimates regarding the number of aged, blind and disabled persons who may qualify for the medically needy program realistic?

3. The Federal Omnibus Budget Reconciliation Act resulted in the termination of upwards of 70,000 people from AFDC and the subsequent loss of Medicaid benefits.

   Is the estimate that 150,000 adults and children would be eligible for the medically needy program realistic?

4. What are the department's estimates as to the number of Pharmaceutical Assistance recipients who may be eligible for a medically needy program?

5. Eligibility determination is currently a function of the county welfare agencies. Will counties be responsible for medically needy eligibility determinations? If not, how does the department intend to determine eligibility? What income standard does the department intend to apply?

   What accounting period will be used to determine the amount of medical expenses a recipient incurs?

   How will the department insure that it does not reimburse for medical expenses which are the recipients responsibility?

   What are the estimated costs with respect to eligibility determination? With respect to general administration?

6. What services should a medically needy program provide outside of those mandated by federal law? Are institutional services to be provided?

7. The State's Medicaid Quality Control Error Rate is below federal targets, therefore the State is not liable for fiscal sanctions.

   If the State adopts a medically needy program will the State be able to meet federal error rate targets? If the State will not be able to meet these error rate goals, how much could the State lose in federal reimbursement?

   What are the error rates in States with medically needy programs?

   Have federal fiscal sanctions been applied to any State whose error rate is above federal requirements?

What are the error rates in States with medically needy programs?

Have federal f)scal sanctions been applied to any State whose error rate is above federal requirements?

8. In those States which do have medically needy programs what has the)r experience been with the program: Is it more difficult to administer than the regular Medicaid program? Do expenditures increase at a more rapid rate than the Medicaid program in general? Who are the prime beneficiaries of the program?

I look forward to your response and any additional information you may wish to bring to the Committee's attention at its public hearing on July 12.

Sincerely,

Assemblyman John S. Watson
Vice Chairman
Assembly Revenue, Finance and
Appropriations Committtee

JSW:H/gh

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
CAPITAL PLACE ONE
222 SOUTH WARREN STREET
TRENTON, NEW JERSEY 08625

GEORGE J. ALBANESE
Commissioner

July 9, 1984

The Honorable John S. Watson
Vice Chairman
Assembly Revenue, Finance
and Appropriations Committtee
State House Annex
CN 066
Trenton, New Jersey 08625

Dear Assemblyman Watson:

This correspondence is in response to your letter of June 28, 1984 requesting information regarding various aspects of a Medically Needy program which is included in the provisions of A-608.

I appreciate this opportunity to review with you and your Committee some of the substantive issues regarding the extension of the Medicaid program to the medically needy. As you are aware by the eight points raised in your letter, the Medically Needy program is a complex program which requires considerable thought, time and effort to implement in an efficient and effective manner which will be of maximum benefit to the recipients and be least cumbersome to the provider community. I believe the questions you have raised highlight many of the important issues and affords an opportunity for adequate discussion of the policy determinations which must be made prior to the implementation of the program.

The attached material addresses the points contained in your letter and includes background material as needed. Each page concerns a separate point and they are numbered in relationship to your letter.

Thank you once again for this opportunity to be of assistance to your Committee. I am available to clarify any of the responses or to provide additional materials as needed.

Sincerely yours,

George J. Albanese
Commissioner

GJA:2
Att.
c.c. Larry J. Lockhart
Geoffrey S. Perselay, Esq.
Thomas M. Russo

4x

DEPARTMENT OF HUMAN SERVICES

Assembly Revenue Finance & Appropriations Committee
Questions on A-608

Question No. 1

Your department's report, MEDICALLY NEEDY. NEW JERSEY'S OPTIONS, indicates that 50,000 adults, 100,000 children, 12,500 blind and disabled, and 90,000 aged would qualify for the program.

a. What income standard (e.g., 100% of standard, 133 1/3% of standard) was used to develop these estimates?

b. How were these estimates developed?

c. Were assets considered in developing these estimates?

Answer

The population estimates used in the Department's report, MEDICALLY NEEDY. NEW JERSEY'S OPTIONS, were developed from census data. The 133 1/3% income standard was used to identify the potential population.

Due to the lack of data, the asset limitations were not included in the estimates. In addition, the potential population which would become eligible under the "Spend-down" provision of a Medically Needy program were also not included in the estimates.

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Question No. 2

It is estimated that 12,500 blind and disabled and 90,000 aged would qualify for the program.

In view of findings in the Community Care Waiver Project regarding the assets of the aged, blind and disabled, are the estimates regarding the number of aged, blind and disabled persons who may qualify for the medically needy program realistic?

The Community Care Waiver Project though somewhat different in focus is similar to the proposed medically needy program. It has been found that many of aged, blind and disabled persons have assets above the $1,500 level allowed by federal law and do not qualify for the Community Care Waiver Project.

Answer

The Medically Needy Program is very different from the Community Care Program for the Elderly and Disabled (CCPED).

Under the CCPED Program, clients cannot have assets which exceed the SSI asset limitation. Under a Medically Needy Program, the state must establish a "reasonable" asset limit. In addition, the asset limit established under a Medically Needy Program must vary according to family size.

Under a Medically Needy Program, persons with incomes above 133 1/3% of the standard must incur medical bills for their "Spend-down".

Clients in the CCPED program must pay for a portion of their care if their income exceeds 100% of the SSI eligibility standard.

Finally, in order to qualify for CCPED, the client must require nursing home care. There is no similar restriction under a Medically Needy Program.

Question No. 3

The Federal Omnibus Budget Reconciliation Act resulted in the termination of upwards of 70,000 people from AFDC and the subsequent loss of Medicaid benefits.

Is the estimate that 150,000 adults and children would be eligible for the medically needy program realistic?

Answer

Many of the AFDC families who lost Medicaid as a result of the Omnibus Budget Reconciliation Act of 1981 would become eligible under a Medically Needy Program. In addition, persons whose income is insufficient to cover their medical expenses would also become eligible under this program. There are always some problems with population estimates, but based upon the information available at this time, the estimates appear realistic.

Question No. 4

What are the department's estimates as to the number of Pharmaceutical Assistance recipients who may be eligible for a medically needy program?

Answer

Most of the elderly and disabled clients who would qualify under a Medically Needy Program are probably receiving benefits under the Pharmaceutical Assistance to the Aged and Disabled Program.

Frequently, persons enrolled in Medically Needy programs may be eligible one month and ineligible in the next month due to changes in health status or income. Therefore, the Department recommends the drug benefits to continue to be provided under PAAD rather than under a Medically Needy Program. This would assure continuity of service to the elderly and disabled clients. In addition, the PAAD $2.00 co-pay could be counted towards the client's "spend-down" liability.

Question No. 5

Eligibility determination is currently a function of the county welfare agencies. Will counties be responsible for medically needy eligibility determinations? If not, how does the department intend to determine eligibility? What income standard does the department intend to apply?

What accounting period will be used to determine the amount of medical expenses a recipient incurs?

How will the department insure that it does not reimburse for medical expenses which are the recipients responsibility?

What are the estimated costs with respect to eligibility determination? With respect to general administration?

Answer

A major issue is the designation of the appropriate agency which will be responsible for the determination of eligibility for the Medically Needy Program. At present, this area is still under study by staff and a designation of the agency which will be responsible for this function will be made after reviewing the results of the study.

The decision of what standard to utilize for determination of eligibility for the Medically Needy Program is still under review. Although the estimates of the eligible population basically utilize the 133% AFDC income standard, this will require an SSI-related two person household to spend-down below the current SSI income eligibility standard before federal funding would be available for medical expenses. Staff are currently studying all available options before proposing an appropriate income standard for the medically needy.

The attached material is a summary of the appropriate federal regulations and other pertinent material regarding the budgeting period that must be established for the eligibility determination in a Medically Needy Program. In addition, the material contains data on the accounting periods of the other states which currently administer a Medically Needy Program and an attempt to note some of the advantages and inequities in utilizing either the one-month or a six-month period for budgeting purposes.

As can be seen from the attached material, the determination of a budgeting period is a difficult issue which is still under review at this time. Administratively, any decision made will have to balance the increased risk of higher error rates of a longer budgeting period with the increased costs of reviewing eligibility on a more frequent basis.

The issue of insuring that the department does not reimburse for medical expenses which are the recipient's responsibility is a crucial one in implementing a Medically Needy Program. This concern is especially important one since it is an area which can substantially increase the Medicaid Quality Control Error Rate.

Question No. 5 Continued

In order to assist in the identification of medical expenses which are the responsibility of the recipient, two areas have been identified which should be developed to adequately meet this concern. This includes development of a data processing capability and an appropriate method of eligibility determination which will incorporate sufficient methods to identify the medical expenses which are not eligible for reimbursement.

In general, the estimated costs with respect to eligibility determination and general administration is approximately 9-10% of the estimated budget for services. This includes an estimate for the increased costs as a result of the additional complexity of eligibility determination and the consequent increased time necessary to process an application. It should be noted, however, that this estimate does not include the start-up costs necessary to implement the program. We are currently in the process of preparing a time-cost estimate which should provide us with an approximate breakdown of the various costs associated with implementing and administering the program.

BUDGETING PERIODS UNDER A MEDICALLY NEEDY PROGRAM

Under federal regulations, a state must establish for the Medically Needy program, a budget period for medical eligibility of not less than one month, nor more than six months in duration. After the budget period has expired, it is necessary to redetermine the applicant's eligibility for medical assistance. It must be noted, however, that whatever budget period the state has selected to utilize for a determination of eligibility, federal procedure requires that, in general, the state must apply the budget period consistently across all groups of recipients and all types of services.

States have established the budget periods for their Medically Needy programs anywhere from one month to three months to six months for a variety of reasons. According to the Data Base maintained by the National Governor's Association, twenty of the states which have a Medically Needy program utilize a six month period of eligibility. Of the twenty states which use a six month accounting period, however, five noted they have exceptions, including one state which allows the applicant to elect the budgeting period applicable to his case. Arkansas, Kentucky, Louisiana and Montana utilize a three month budget period while California, Hawaii, North Dakota and Utah use a one month period to determine eligibility.

The following material will attempt to outline the advantages and inequities of establishing a one month or six month period for budgeting purposes for both the applicant and the administering agency.

One Month Budget Period

For the state, the advantage of utilizing a one month budget period allows the opportunity to more closely monitor eligibility and the error rate. This is particularly true in instances where available income varies from month to month.

Administratively, however, it is more costly for a state to redetermine eligibility monthly. Several states have made a determination that the benefits of monthly budget periods outweigh the costs. For example, New York City has instituted a monthly budgeting period for their Medically Needy program.

For the recipient, there is an obvious inconvenience in having their eligibility redetermined monthly. In addition, depending on the cash flow into the household, a monthly budgeting period could create an inequity for differing patterns of income.

For example, assume there are two households each with three persons and each household will receive $2,700 income over the next six months. One household will receive the income regularly over the six months but the other household's income will vary. Also assume that for this example, the medically needy income level is $400 a month and there is a one month budgeting period.

	One Month Period				
	Countable Income	Spend-down Liability	Total Medical Expenses	Covered by Medicaid	Net Medical Expenses
Regular Income	$ 450	$ 50	$100	Yes	$ 50
	450	50	25	No	25
	450	50	150	Yes	50
	450	50	50	Yes	50
	450	50	75	Yes	50
	450	50	30	No	30
	$2,700	$300	$430		$255

	One Month Period				
	Countable Income	Spend-down Liability	Total Medical Expenses	Covered by Medicaid	Net Medical Expenses
Irregular Income	$ 500	$100	$100	Yes	$100
	300	0	25	Yes	0
	600	200	150	No	150
	400	0	50	Yes	0
	500	100	75	No	75
	400	0	30	Yes	0
	$2,700	$430	$430		$325

As can be seen by this example, although both households received the same amount of income for a six month period of time, due to differences in the cash flow of the income and the use of a one month budget period, one household incurred more out-of-pocket medical expenses than the other.

However, there is an advantage to certain applicants if a one month budgeting period is utilized. This occurs for those applicants who have incurred large medical expenses in a short period of time. The example usually given is in the situation of a hospitalization, but could occur in the case of an unexpected illness, an accident or

purchase of a large expensive item, such as dentures, a prosthetic device or a hearing aid. As a result of monthly budgeting periods, the individual could meet the spenddown limit for a month but would not be able to do so if the medical expenses were budgeted over a longer period of time.

Six Month Budget Period

For the agency administering a Medically Needy program, a six month eligibility period can be less costly but also affords less opportunity for the agency to monitor for quality control accuracy. Some states, however, advocate a six month budget period because they maintain that it provides eligibility to applicants who are truly medically needy and have ongoing unmet medical needs and does not, therefore, provide services to those individuals who are not medically needy, but have a one-time large medical expense.

For the recipient, a six month budget period can be advantageous because once eligibility is established, there is a longer period of time before a redetermination of eligibility is required to be completed.

In certain circumstances, a six month budgeting period can be advantageous to the recipient in terms of the amount of expenses the applicant is responsible for in addition to the medical coverage. The example below illustrates this point. In this illustration, it is assumed that the 3-person household has income which varies monthly and also that the medically needy income standard is $400. As can be seen, the six month budget period is more favorable than the one month budget period to the recipient with variable income because the recipient incurs $25 less in net medical expenses over the same period of time.

	Six Month Period			
Countable Income	Spend-down Liability	Total Medical Expenses	Covered by Medicaid	Net Medical Expenses
$ 500	$300	$100	No	$100
300	200	25	No	25
600	175	150	No	150
400	25	50	Yes	25
500	0	75	Yes	0
400	0	30	Yes	0
$2,700	$300	$430		$300

One Month Period				
Countable Income	Spend-down Liability	Total Medical Expenses	Covered by Medicaid	Net Medical Expenses
$ 500	$100	$100	Yes	$100
300	0	25	Yes	0
600	200	150	No	150
400	0	50	Yes	0
500	100	75	No	75
400	0	30	Yes	0
$2,700	$430	$430		$325

However, in another example, using the same six month total income, the same household size and the same medically needy standard, but using a different cash flow situation (in this case, a regular monthly income), it can be seen that a six month budgeting period would not be as equitable as a one month budget period to the applicant in terms of net medical expenses.

Six Month Period				
Countable Income	Spend-down Liability	Total Medical Expenses	Covered by Medicaid	Net Medical Expenses
$ 450	$300	$100	No	$100
450	200	25	No	25
450	175	150	No	150
450	25	50	Yes	25
450	0	75	Yes	0
450	0	30	Yes	0
$2,700	$300	$430		$300

One Month Period				
Countable Income	Spend-down Liability	Total Medical Expenses	Covered by Medicaid	Net Medical Expenses
$ 450	$ 50	$100	Yes	$ 50
450	50	25	No	25
450	50	150	Yes	50
450	50	50	Yes	50
450	50	75	Yes	50
450	50	30	No	30
$2,700	$300	$430		$255

There are other instances when a six month budget period can be inequitable for selected applicants. This can be illustrated by an example where the individual applying for assistance primarily receives ambulatory care services and has a large spenddown liability. Since the total liability for the six month budget period must be incurred prior to eligibility, a person who utilizes ambulatory services, such as pharmacy and physician, may find it more difficult to receive credit for the spenddown liability than another individual who received primarily institutional services, such as hospitalization during the same budget period.

Therefore, it would appear that whatever budget period a state elects to utilize to determine eligibility for a Medically Needy program, there will be costs and benefits to the administering agency and advantages and inequities to the applicants for such assistance.

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Question No. 6

What services should a medically needy program provide outside of those mandated by federal law? Are institutional services to be provided?

Answer

The options presented in the Department's report Medically Needy: New Jersey's Options, were designed to serve as examples of the kinds of services packages that can be developed under a Medically Needy Program.

A Medically Needy Program must offer ambulatory care services for children and prenatal, delivery and postnatal care for pregnant women. States can elect to offer services and expand coverage to other eligibility categories. However, the scope of the Medically Needy Program cannot exceed the scope of the State's regular Medicaid Program. In the report, Option I represents the minimum program that could be established, while Option IV represents maximum program allowed under federal law. Between these two polar options exist a great deal of flexibility in designing a program of services which could be tailored to fit the needs of each eligibility group.

If the DRG/all payor system waiver is not extended, the state may wish to create a Medically Needy Program which will cover at least inpatient hospital care for all potential clients.

This will reduce the amount of uncompensated care liability for hospitals in New Jersey.

The projected cost for providing inpatient hospital services for each group of potential clients can be found in the Department's report.

Question No. 7

The State's Medicaid Quality Control Error Rate is below federal targets, therefore the State is not liable for fiscal sanctions.

If the State adopts a medically needy program will the State be able to meet federal error rate targets? If the State will not be able to meet these error rate goals, how much could the State lose in federal reimbursement?

What are the error rates in States with medically needy programs?

Have federal fiscal sanctions been applied to any State whose error rate is above federal requirements?

What are the error rates in States with medically needy programs?

Have federal fiscal sanctions been applied to any State whose error rate is above federal requirements?

Answer

It is likely that New Jersey may initially exceed the federal Medicaid quality control target if a Medically Needy Program is implemented. The federal sanction is based upon the amount by which the error rate exceeds the 3% target. The fiscal sanction for New Jersey would be approximately $5.8 million for every 1% the error rate exceeds the target.

A listing of the Medicaid Quality Control error rates for all States is attached.

The 3% federal target was established under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). The error rates from the first review period under TEFRA will be published in August 1984. Prior to TEFRA, several states did receive sanctions, however, these sanctions may be waived by the Federal government.

MQC ELIGIBILITY PAYMENT ERROR RATES

REVIEW PERIOD	7/78-12/78	4/79-9/79	10/79-3/80	4/80-9/80	10/80-3/81	4/81-9/81	10/81-3/82	4/82-9/82	10/82-3/83
NAT'L AVERAGE	6.2	5.0	5.2	5.0	4.1	N/A	N/A	N/A	N/A
ALABAMA	4.9	5.2	6.8	8.8	1.6	3.3531	1.4915	3.0478	3.7652
ALASKA	0.7	0.3	0.5	5.1	11.7	13.4219	0.9623	1.8769	3.8038
ARKANSAS *	6.8	11.1	4.9	6.5	3.2	2.1578	2.8960	2.4694	0.8217
CALIFORNIA *	7.5	3.4	3.5	7.0	8.1	4.0442	3.6957	6.0961	1.1151
COLORADO	3.2	7.1	1.6	9.7	5.1	5.3543	6.2983	3.8119	5.5500
CONNECTICUT *	10.2	6.0	1.9	5.8	6.6	3.6015	1.5746	2.6593	1.2217
D.C. *	7.1	3.5	4.4	4.7	3.3	1.9710	12.9419	7.7338	6.7997
DELAWARE	9.3	11.1	8.0	8.3	15.4	2.5989	2.4682	4.4213	0.1745
FLORIDA	2.8	10.8	1.7	8.0	6.3	3.4472	2.1020	5.9230	2.3194
GEORGIA	9.1	6.9	6.9	12.7	6.9	4.7667	4.9248	4.7825	2.4154
HAWAII *	4.5	0.7	0.2	1.5	7.2	4.0184	2.6780	6.1497	3.3073
IDAHO	3.9	4.7	1.2	4.4	11.8	2.9212	3.2156	1.7067	1.5488
ILLINOIS *	6.3	8.0	7.1	2.8	5.6	4.2562	1.2554	1.4206	1.8840
INDIANA	3.0	2.5	0.6	1.5	0.9	1.2402	1.2988	4.1201	7.2354
IOWA	10.1	11.7	6.7	6.8	3.3	1.7134	2.6753	4.1807	2.4823
KANSAS *	1.8	4.6	3.9	3.2	2.9	2.4299	1.1883	4.6721	3.4893
KENTUCKY *	6.2	3.9	4.0	2.0	5.1	3.8713	3.6275	1.0710	2.4015
LOUISIANA *	4.1	6.4	5.3	3.4	1.8	3.1731	3.8547	1.8689	4.0603
MAINE *	14.5	18.7	12.1	10.9	8.7	4.0957	6.5615	6.6167	6.1572
MARYLAND *	6.2	6.5	9.2	2.4	2.9	7.5803	1.7778	1.9815	2.2437
MASSACHUSETTS *	4.9	8.6	14.2	13.2	6.6	4.6419	4.5732	4.0978	5.2907
MICHIGAN *	8.3	5.5	3.1	4.3	4.0	1.4563	1.4754	2.9361	2.3912
MINNESOTA *	11.5	0.9	4.2	0.5	0.3	0.6304	0.4676	0.6044	1.7234
MISSISSIPPI	7.2	5.9	2.5	1.1	3.7	3.3057	7.3806	3.6695	5.4387
MISSOURI	2.5	4.7	3.0	2.3	0.6	0.4550	3.2974	6.5379	2.7552
MONTANA *	10.5	15.7	13.0	16.6	18.3	9.4584	10.5133	1.6000	1.8172
NEBRASKA *	1.9	0.6	2.3	1.0	2.8	3.7011	2.1204	4.3877	0.5556
NEVADA	0.0	0.2	0.0	1.2	0.0	2.8118	1.3016	1.3803	0.2853
NEW HAMPSHIRE *	1.2	1.4	0.8	1.3	1.5	4.7309	0.7049	4.5813	0.8994
NEW JERSEY	6.2	4.4	5.4	4.3	4.4	1.2420	2.2215	1.5439	1.3721
NEW MEXICO	0.9	4.5	1.5	5.9	1.6	4.8850	3.5386	11.4237	9.6227
NEW YORK *	2.1	2.1	2.6	4.6	2.7	2.0844	1.5114	1.3797	2.6957
NORTH CAROLINA *	8.0	3.5	6.0	5.9	5.4	1.8766	2.2917	1.2376	1.5498
NORTH DAKOTA *	1.9	6.5	2.2	1.4	5.3	2.6005	1.1869	1.6015	0.9289
OHIO	11.6	6.5	11.4	3.8	2.1	2.2627	3.4858	2.2136	2.4798
OKLAHOMA *	5.8	6.8	1.4	2.4	3.4	5.0653	2.6028	2.7178	4.2652
OREGON *	3.4	4.3	7.3	2.0	2.9	3.1026	4.4200	2.6195	0.8100
PENNSYLVANIA *	9.0	7.0	7.5	8.1	3.7	3.5784	4.9910	3.6623	1.9215
RHODE ISLAND *	4.1	2.3	2.5	5.5	4.1	4.5136	2.4405	1.0769	4.1357
SOUTH CAROLINA	5.3	7.1	2.8	6.2	2.2	1.6882	2.4157	5.9218	5.6899
SOUTH DAKOTA	11.6	3.6	8.0	1.5	6.8	0.8678	1.7607	2.7998	0.8925
TENNESSEE *	3.0	8.4	4.8	3.7	3.1	2.4986	2.6417	2.0638	1.4716
TEXAS	5.2	3.1	4.5	5.2	2.4	3.6744	4.3943	5.3362	3.6811
UTAH *	1.9	3.5	12.1	3.4	4.8	4.9655	2.4514	4.2198	1.8297
VERMONT *	5.4	9.9	6.9	11.7	2.5	5.3184	4.8598	0.3108	3.3976
VIRGINIA *	6.1	3.5	1.6	2.4	1.9	1.5744	2.4248	1.3423	1.2044
WASHINGTON *	5.0	6.6	8.1	2.0	4.0	7.8019	1.3682	4.1618	2.2743
WEST VIRGINIA *	1.7	4.9	8.8	3.7	12.7	6.3191	6.5272	2.3655	2.3483
WISCONSIN *	11.5	8.0	8.9	6.2	3.5	2.9469	3.0913	2.4599	3.1340
WYOMING	7.7	8.9	6.3	6.2	2.8	2.5851	2.9154	2.2749	1.5255

* STATES THAT HAVE MEDICALLY NEEDY

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Question No.8

In those States which do have medically needy programs what has their experience been with the program: Is it more difficult to administer than the regular Medicaid program? Do expenditures increase at a more rapid rate that the Medicaid program in general? Who are the prime beneficiaries of the program?

Answer

Due to the "Spend-down" requirements, it is more difficult to administer a Medically Needy Program.

A recent study by Urban Systems Research and Engineering of Cambridge, Massachusettes, has shown that after adjusting for nursing home clients, Medicaid per capita expenditures for Medically Needy clients are approximately 1.8 times the per capita cost for categorically needy clients.

It is difficult to identify the prime beneficiaries of Medically Needy Programs in other states, since they classify nursing home residents as Medically Needy clients. In New Jersey, nursing home residents are covered as categorically related Medicaid clients.

BARBARA FAITH KALIK
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State of New Jersey

NEW JERSEY LEGISLATURE

ASSEMBLY

REVENUE, FINANCE AND APPROPRIATIONS COMMITTEE

STATE HOUSE ANNEX
CN 066
TRENTON, NEW JERSEY 08625
(609) 984-0017

MICHAEL J. BASARA
COMMITTEE AIDE

June 28, 1984

Honorable Jay R. Goldstein, M.D.
Commissioner
Department of Health
Health & Agriculture Building
Room 805, CN 360
Trenton, NJ 08625

Dear Dr. Goldstein:

On July 12, 1984 the Assembly Revenue, Finance and Appropriations Committee will hold a public hearing on A. 608 which would extend New Jersey's Medicaid program to include those persons and households considered "medically needy."

New Jersey's hospital rate setting program (DRGs) currently provides upwards of $200 million in reimbursement for indigent costs and bad debts.

The Committee would be interested in knowing if there are any estimates as to the amount of indigent costs and bad debts which are attributed to persons and households who would be considered medically needy.

I look forward to your response and any additional information you may wish to bring to the Committee's attention at its public hearing on July 12.

Sincerely,

Assemblyman John S. Watson
Vice Chairman
Assembly Revenue, Finance and
Appropriations Committee

JSW:H/pb

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201/643-3876

ACNJ

ASSOCIATION FOR CHILDREN OF NEW JERSEY

17 Academy Street, Suite 709
Newark, New Jersey 07102

TESTIMONY PRESENTED:

ASSEMBLY REVENUE, FINANCE AND APPROPRIATIONS COMMITTEE

THURSDAY, JULY 12, 1984

TRENTON, N.J.

Presented by:
CIRO A. SCALERA
Executive Director

I am here today on behalf of the Association for Children of New Jersey (ACNJ) to express our strong support for A-608 which expands New Jersey's Medicaid program to include "medically needy" individuals. ACNJ, along with the Federation of Senior Citizens is actively involved in the Medically Needy Coalition in our state and has been consistently supporting this legislation and initiative.

As a statewide, citizen-based child advocacy organization, ACNJ recognizes that the lack of adequate health care is one of the most pressing problems facing children in our state today. We believe that enactment of a Medically Needy program is one of the most important steps that can be taken to begin to address these health care needs.

Medicaid is an Important Children's Program

Medicaid is the largest government health care program for the poor, and children represent the largest group (approximately 50%) of individuals covered under Medicaid. According to a 1982 Bureau of Census report, Medicaid covered 40% of all poor households...52% of all poor households with children under 19 years. Clearly, poor children depend heavily on Medicaid.

I have attached the Executive Summary report commissioned by the American Academy of Pediatrics (AAP) entitled Medicaid and Children: A Policy Analysis for your information. This national report and others pointed out some disturbing trends in terms of the poverty and health status of Medicaid children.

Poverty Status of Medicaid Children

In the past year there have been various Census Bureau reports on the increase in poverty in America. The House Select Committee on Children, Youth and Families recently estimated that one out of

five children and one out of two black children live in poverty. In discussing federal and state programs designed to help these children, the AAP report found that eligibility standards have not been adjusted for inflation, particularly for AFDC recipients whose families must be increasingly poor to qualify for Medicaid under AFDC.

> "The implications of the failure of eligibility standards to keep pace with inflation, it notes, can be summarized as follows:
>
> - Unlike other population groups, children in low-income families rely largely on Medicaid with fewer other financial resources to pay for medical care.
>
> - A smaller percentage of poor children than before are eligible for Medicaid. This trend will worsen unless current eligibility standards are raised.
>
> - A decreasing proportion of families below the national poverty standard are covered by AFDC.
>
> - In many two-parent households, poor families with children do not qualify for AFDC.
>
> - In 1980, less than 50% of dependent children under age 21 in families with incomes below the national poverty standard received Medicaid."

Health Status of Medicaid Children

The AAP report cites documentation of the fact that poor children have more health problems than other children. Children in low-income families were 3.5 times as likely as children in high income families to be judged as being only in fair or poor health. Low-income children have higher infant mortality rates despite nationwide improvement in all income groups. Dental disease is another area showing disparity between children of different income groups. The report also points out the growing medical problems for infants needing newborn intensive care, children with chronic conditions and adolescents.

It concludes that because of the restrictive nature of eligibility criteria, a substantial number of poor children are not covered by Medicaid, and cites the drastically growing number of children without coverage in the last five years.

The situation in New Jersey reflects many of these national trends. Two recent reports completed by ACNJ, Through the Safety Net: The Child Watch Project and Not Enough to Live On, a Survey of Living Costs and Conditions of Head Start Families in Newark, provided us with important data on problems in the health area. Both identify the need for a medically needy program as a priority in New Jersey. We support A-608 for several reasons:

TENS OF THOUSANDS OF NEW JERSEY'S POOR CHILDREN LOST MEDICAID ELIGIBILITY AND ARE WITHOUT ACCESS TO HEALTH BENEFITS.

Our Child Watch report indicated that at least 18,500 children lost Medicaid benefits due to the 1981 federal budget cuts. Although they and their families lost benefits because their income was considered too high for AFDC eligibility, their income remains below the poverty level. Because new families were being enrolled at the same time as families were deleted, this number may not represent the actual number of children removed from eligibility. We believe it may have been as high as 40,000 children.

For a family of three, for instance, $571.73* a month is set as the income above which AFDC, and thus Medicaid coverage, can no longer be given. That translates to a yearly income of $6,860.75. The official federal poverty level for such a family is $8,460.**

For a family of four, $666.14* a month is the AFDC eligibility limit with a year salary for this income level of $7,993.62. The official federal poverty level for this size family is $10,200.** In both cases, families unable to qualify for Medicaid are between $1,600 and $2,200 below the poverty level sum.

According to our Head Start survey, Not Enough to Live On, families without Medicaid pay an average of $23 for each visit to the doctor, although the range of payments is from $5 to $55. This represents an average of 4% of income for each visit as contrasted to the 1% of income that families with incomes of $25,000 pay for each visit. Over 40% of the Head Start families not receiving Medicaid reported that they have not gone to the doctor with a sick child because they did not have the money.

FOR PREGNANT WOMEN AND YOUNG CHILDREN, THE CONSEQUENCES OF GOING WITHOUT HEALTH CARE ARE PARTICULARLY DIRE.

The infant mortality rate in New Jersey as a whole increased from 10.6 in 1981 to 11.7 in 1982. In addition, fetal deaths increased from 9.16 to 10.3, neonatal deaths from 7.13 to 8.1 and perinatal deaths from 16.7 to 18.7. Because of the exceedingly stringent eligibility limits, large numbers of pregnant women and

*This AFDC eligibility level has been revised to indicate latest benefit levels incorporated in the 1985 New Jersey budget.

**Latest Federal Poverty Guidelines, revised as of February, 1984.

children are excluded from health coverage that more affluent segments of the population take for granted.

LOSS OF MEDICAID ELIGIBILITY HAS PROHIBITED CHILDREN FROM PARTICIPATING IN PREVENTIVE HEALTH CARE PROGRAMS.

Preventive health care programs such as the Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT) have resulted in savings in state health costs. Strengthening cost-effective preventive child health and maternal health programs mean long term budget savings. Studies show that screening and treating young children under Medicaid saves $8 in later costs for every dollar spent now. In New Jersey, it costs about $21 per child to perform a Medicaid screening while the cost of a one-week stay in the hospital is well over $1,000.

Low birth-weight babies are 20 times more likely to die in infancy than other infants and to suffer handicapping conditions. One in 20 pregnant women and one in 11 nonwhite pregnant women receive prenatal care late or not at all. Babies born to women who receive adequate prenatal care are three times less likely to be born underweight.

Studies show that women who receive Medicaid while pregnant are less likely to have low birthweight babies and are less sick themselves than those who have no health coverage during pregnancy. Hospital bills are significantly lower.

It cost $1,400 for Medicaid to provide complete maternity care, including delivery, to a pregnant woman. It costs $1,000 a day to hospitalize an infant born sickly and underweight because a mother did not receive prenatal care, and the average length of stay is 20 days.

It costs $600 to provide a baby with a complete schedule of checkups and immunizations under Medicaid and to care for any illness that occurs over an entire year. It costs thousands of dollars to hospitalize a child who was not immunized and thus contracted diphtheria or measles.

MANY OF THE MEDICALLY NEEDY NOW RELY ON EXPENSIVE HOSPITAL AND EMERGENCY ROOM CARE, WHETHER THIS IS MOST APPROPRIATE OR NOT, AND ACCOUNT FOR A LARGE PORTION OF UNPAID HEALTH BILLS IN OUR STATE'S HOSPITALS.

Many poor people who do not qualify for Medicaid use the state' hospitals, particularly the large inner city hospitals, receive costly hospital care and leave behind a trail of unpaid or "uncompen sated" bills. Evidence of this turned up in our Child Watch survey wherein emergency room personnel and doctors indicated that hospital emergency rooms were used as if they were primary health care clinic

The state and third party insurers ultimately pay for this uncompensated care. It could be paid with federal Medicaid dollars if more low-income people were Medicaid eligible.

There are least four options to funding a medically needy program presently under review by the Department of Human Services. Each option varies as to the persons covered and the state costs involved. Option II is the most fiscally realistic option. However, we recognize the importance of covering mothers of medically needy children which is included in Option III.

The strong financial incentive to draw down more federal dollars has led 30 states and the District of Columbia to enact medically needy programs. At least 10 additional states are presently considering such programs. New Jersey is one of two states in the Northeast presently without this medically needy program.

We hope that this Committee will act favorably on A-608.

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MEDICAID AND CHILDREN:

A POLICY ANALYSIS

Prepared by

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Commissioned by

The American Academy of Pediatrics
Division of Pediatric Practice

for

The Committee on Child Health Financing

November, 1982

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I. FORWARD

The paper which follows was commissioned by the American Academy of Pediatrics (AAP) to aid the organization in its deliberations on the Medicaid program. The analysis is that of the authors, not the Academy. Thus, the conclusions and recommendations should not be construed as an AAP policy statement.

The AAP Medicaid Policy Statement can be requested from the AAP's Central Office:

American Academy of Pediatrics
1801 Hinman Avenue
Evanston, Illinois 60204
(312/869-4255)

II. EXECUTIVE SUMMARY

Major gains have been made in providing health care to low income children since the inception of Medicaid. As many as 50 percent (10½ million) of the total Medicaid recipients in 1980 were individuals under 21. Further, they accounted for nearly $4 billion of Medicaid expenditures. In the aggregate, low income children receive about the same amount of health services as other children. However, changes in eligibility criteria and limits on mandatory and optional benefits may reduce previous utilization rates and undermine the gains that have been made. Infants requiring newborn intensive care, chronically ill children, and adolescents are three subgroups who are at highest risk and suffer inadequate Medicaid coverage. Moreover, 34 percent of poor children under 18 had no insurance coverage whatsoever in 1977.

Efforts to reduce program expenditures should focus on more equitable and efficient distribution of dollars among all eligibles, not on reducing the number of eligible children, especially since only about one-third of the poor are covered by Medicaid. Increased physician participation, which should be an important part of any such cost-reducing strategy, can be encouraged by some or all of the following: expanding restrictive eligibility criteria; offering a comprehensive list of covered services; eliminating arbitrary limits on the amount, duration, and scope of benefits; increasing administrative efficiency; and reimbursing physicians at fee levels which approach those obtained in the private market.

These conclusions were reached following a study of available data on the Medicaid program undertaken for the American Academy of Pediatrics, which long has been concerned about the extent to which low income children were able to obtain medical care of good quality. The study describes the program, presents data on the ways in which it has been changing, examines interstate differences, and considers proposals for further changes. Finally, it concludes with a series of general recommendations based on the analysis. It is intended primarily as a source document containing current information and analyses to be used by the Academy and other child health experts in developing positions and strategies to help protect the gains made to date in behalf of poor children and to contain program expenditures by encouraging greater participation of office-based physicians and experimenting with promising new methods of organizing and paying for medical care.

Medicaid is a medical vendor payments program operated by the states under general federal rules and with federal financial assistance. The states, which also share in the cost, make important decisions in four principal areas: eligibility, benefits, payment of providers, and administration.

The largest Medicaid recipient group is dependent children under 21, amounting to approximately 50 percent of all eligibles. States decide which groups to cover (AFDC and SSI recipients only or several optional groups, as well, including the medically needy) and what criteria to use to define them (income, assets, and family composition).

States also determine the benefit package to a considerable degree. They must cover the following mandatory services: hospital (both inpatient and outpatient); physicians' services; lab and x-ray services; early and periodic screening, diagnosis and treatment (EPSDT) services for children under 21; skilled nursing facilities (SNF); family planning; and rural health clinics. In addition, they may choose to cover virtually any other service at their option (including drugs, dental care, and intermediate care facilities (ICF)). For each service which a state includes, it must decide on the amount, duration, and scope to cover.

States pay providers for the services rendered to eligibles and are reimbursed by the federal government for a portion of those expenditures (from 50% to 78%, depending on a state's per capita income). All but 11 states pay hospitals on the basis of their reasonable costs, as under Medicare. States pay physicians and other practitioners on a fee for service basis. Hospitals and physicians alike claim that Medicaid programs do not pay them enough.

Finally, in order to operate a complex Medicaid program, a state must perform certain administrative tasks. It must establish policies and procedures to determine eligibility, pay bills, monitor the program's activities, and plan for the future. On average, states spend on these administrative functions 5.5 percent of the amount spent on services.

Since each state has considerable latitude, it is not surprising that the programs vary considerably from state to state. Data are presented which demonstrate that state programs are different from one another in important ways; that such differences have been observed from as long ago as 1970; that the programs have changed over the years; and that the policies which together comprise a state's Medicaid program are not always consistent with one another. From 1970 to 1975, the general tendency among the states was to liberalize the programs, primarily by including the medically needy and by adding optional services to the list of covered benefits. This trend was reversed by 1978, however, as the states retrenched. From 1978 to 1980, although many changes were adopteds, they folowed no clear pattern. The programs were somewhat less restrictive in 1980 than they had been in 1970, but much more restrictive than they had been in 1975. Fragmentary

evidence suggests that, since 1980, the trend continues to be more restrictive.

Unfortunately, the effects of state Medicaid program discretion have not been well researched. Preliminary analyses reported here suggest that a program which is more service-oriented and less restrictive is more likely to be an expensive program. The reason may be simply that more eligibles are entitled to more services in such programs. On the other hand, lowering the fees paid to physicians or failing to raise them with inflation is associated with higher expenditures, contrary to the expectations of the policymakers who introduced them. It is apparent that programmatic outcomes (utilization and expenditure rates, for example) are the product of complex interactions between Medicaid program characteristics, economic conditions, the local medical care environment, and other factors.

Medicaid is very important to meeting the medical care needs of low income children. Fifty percent of all Medicaid recipients are children, a proportion which has remained relatively constant since at least 1973. While children represent half of the Medicaid population, however, they account for less than one-fifth of Medicaid expenditures because the services used by children are much less expensive than those used by other groups, particularly the elderly and disabled.

Children, unlike the elderly who rely on other sources of public spending (e.g., Medicare), depend heavily on Medicaid. Further, it is twice as important as a source of payment for physician services for children than it is for non-elderly adults, and four times more important than for the elderly. It is even more important as a source of funds for children's hospital services than for physicians' services. Thus, children, their doctors, and their hospitals rely on Medicaid more than other groups of eligibles and other providers.

These gains are threatened by the actions which the states and federal government have been taking in an effort to cope with their fiscal problems. Eligibility standards are not keeping pace with inflation, and the numbers of eligibles in many states are actually declining even though the current recession has put many out of work. Limitations on benefits and the failure to raise reimbursment rates are having similar effects.

The Omnibus Budget Reconciliation Act of 1981 included several major reforms affecting children: (1) reductions of federal contributions to state Medicaid programs of 3 percent in FY 1982, 4 percent in FY 1983, and 4.5 percent in FY 1984; (2) block grants which replaced and reduced the amount of several formula grants

and categorical health programs; and (3) increased state discretion in the operation of Medicaid and the block grants. Since passage of the Reconciliation Act the following changes have been documented by the Intergovernmental Health Policy Project, the National Governors' Association, and the National Association of Childrens' Hospitals and Related Institutions:

1. Mandatory benefits

   - Some 16 states have limited or propose to limit the numbers of hospital days covered either by a yearly maximum or a limit per spell of illness.

   - The most common changes noted in outpatient care and emergency room services are limits on the number of visits and imposition of copayments.

   - Eight states report decreasing the number of annual physician visits reimbursable by Medicaid.

   - Seven states have adopted or proposed changes in the EPSDT program -- reducing the scope of services, reducing outreach, eliminating EPSDT for general relief recipients and medically needy recipients, reducing dental services. Texas and Arkansas are the only states taking a more generous approach.

2. Optional Benefits

   - Mississippi officials have said that the state will drop optional services altogether if Medicaid is underfunded.

   - Prescription and over the counter drugs are the optional services most affected by changes in 1981 and 1982 -- 19 states adopted or propose to adopt or increase copayments; several states are eliminating coverage of certain drugs; others are setting limits on the annual number of prescriptions reimbursable by Medicaid.

   - Restrictions on the number of eyeglasses per year and new cost-sharing requirements are being set for prosthetic devices, eyeglasses and hearing aids.

- States generally have taken a more generous approach to coverage of home health care.

- Dental care has been dropped or reduced in several states. Seven states plan to impose copayments on each dental visit. Only Maine has expanded the range of reimbursable dental services.

- Coverage for mentally retarded individuals in intermediate care facilites has been added in five states.

3. Eligibility

- Several states have adopted or proposed more restrictive eligibility requirements for mandatory eligibles.

- Only two states report changes in income disregards or excluded assets.

- California has recently decreased the market value of real property exempt in computing eligibility from $25,000 to $6,000.

- The most common practice followed by states is not adjusting the eligibility standards or actual payments according to inflation. In 1980, only five states were within 90 percent or more of their comparable 1970 standard; 27 states were at 60-89 percent; and 18 states had eligibility standards set at only 24-59 percent of the 1970 level. Only five states increased their payment standards at or above the rate of inflation during the 1970 to 1980 period.

- Three out of four states reporting changes in SSI are adopting more generous eligibility policies.

- The medically needy eligibles have been the target of the greatest number of changes. Income standards are increasingly restrictive. Other state initiatives include restricting aliens' eligibility; eliminating recipients whose eligibility was based on Title XX Child Care payments; eliminating medically needy caretaker relatives whose eligibility was based on AFDC, except for prenatal and delivery services.

- Ten states eliminated coverage of 18-21 year olds.

- Families with unemployed parents (AFDC-U) is another optional group increasingly being eliminated.

- Several states have extended coverage to pregnant women for the care of their unborn child while other states have reduced it.

4. Reimbursement

- Since 1980, 11 states had been approved to reimburse hospitals at other than the Medicare rate. Another 11 states have established and two more are considering adopting new payment plans, primarily prospective hospital reimbursement.

- Limits have been set on the amount of Medicaid reimbursement for inpatient hospitals in several states.

- Only three states are planning to change their outpatient hospitals' reimbursement methods. Some are placing limits on emergency room use to prevent non-emergency use. Others are just lowering the rate.

- Physician reimbursement method changes will occur in six states. The trend is to decrease, freeze or place limits on reimbursement increases for providers.

- EPSDT fees to physicians were increased in five states.

5. Medicaid Waivers and State Plan Amendments

- Home and community-based waivers in long term care are the most commonly requested waivers, with case-management waivers running second.

- State plan amendments have been primarily in the area of changes in methods of hospital reimbursement, towards prospective reimbursement.

- Under HCFA's research and demonstration authority, some 141 projects with waivers are still in operation, with long term care demonstrations as the most popular. Only a handful of projects relate directly to child health. They include: a test of alternative reimbursement methods of physician reimbursement in continuing care for children; integration of comprehensive health and special eduction services in schools; improving access to obstetrical services for Medicaid eligible mothers; assessment of capitation and case management for dental services for AFDC Medicaid beneficiaries; and examination of the effects of copayment on referral and utilization.

The most important trends occuring besides those in long term care are in the areas of case management and cost-sharing.

Federal officials have estimated that 661,000 eligibles will lose Medicaid coverage between 1982 and 1983. Conditions of participation for providers, too, will result in reduced availability of services. Physicians will increasingly be faced with such financial and ethical dilemmas as whether to treat Medicaid patients at all and, if so, whether to alter the nature of the treatment to compensate for the increased uncertainty inherent in the new policies. More turnover in eligibility will result in further loss of the opportunity for children to receive comprehensive, continuous treatment provided by office-based physicians. For adolescents, eliminating their eligibility can only further reduce their already low use of health services.

The most important issue facing providers concerned with child health is Medicaid eligibility. The gains made by expanding access to care for all children are being threatened by current efforts to reduce the number of low income children eligible for benefits. This is an issue which seriously affects the ability of physicians to serve low income children.

Strategies to contain Medicaid costs should focus not on reducing eligibility and benefits, but on increasing the participation of low-cost, office-based primary care physicians. This goal can be accomplished by some or all of the following: stabilizing eligibility; covering a comprehensive range of services; omitting arbitrary limitations on the amount, duration, or scope of benefits; administering the program with efficiency; and paying physicians at rates which approach those received from private patients. Available evidence cited in the report suggests that this approach will contain expenditures without adversely affecting low income children.

In addition to increasing physician participation in the program, experiments should be conducted in new ways of paying for and delivering services. These experiments should be approached with caution and tested on a limited scale to permit adjustments and fine-tuning if problems arise. Case management, an arrangement in which a patient receives care from or through a specific primary care physician, limits the patient's freedom to choose a provider in an attempt to encourage more appropriate use of the system. Prepayment, under which outlays are known in advance and incentives encourage providers to avoid the overprovision of services, is another promising idea which has not been widely

tested with a Medicaid population. It, too, is worth experimentation under limited conditions.

Cost-sharing, on the other hand, is an approach to reducing utilization which is inappropriate for Medicaid recipients, especially children. The problem is that it causes low income people to forego services, but provides no guidance to help them differentiate between those which they can safely eliminate and those which they need. Further, copayments have their greatest effect on relatively inexpensive services, like physician care, which should not be discouraged.

If Medicaid is federalized, as the administration has proposed, a residual will be left to many of the states which have broader programs than would be encompassed by a federalized Medicaid. If, at the same time, AFDC is turned over to the states, it is likely that both programs would face greater financial pressures than either does now. The states would have the full AFDC burden, which is now shared with the federal government, as well as the Medicaid residual. Under those circumstances, states would be likely to cut eligibility, benefits, and reimbursement still further. Thus, a federalized Medicaid program must also be approached with caution. Present versions of the proposal appear to harm low income children and the professionals who provide their medical care.

The challenges facing Medicaid today center primarily on protecting the gains already achieved and, at the same time, on improving the program so that necessary efforts at containing expenditures do not reduce the access of people in need to the services they require. Whether those challenges can be met successfully depends on good ideas and the political skill to see that they get a chance to be tested. The stakes are high and the outcome is uncertain.

This paper, commissioned by the American Academy of Pediatrics*, presents a comprehensive analysis of the role of Medicaid as a funding source of health care for children. The program will be described as it has developed over the past 17 years -- its acomplishments, its problems, and the recent proposals which have been advanced to solve some of the difficulties. Emphasis has been placed on analyzing changes in the Medicaid program before and after The Omnibus Budget Reconciliation Act of 1981 as well as on identifying the major areas of state variation affecting children. The information presented is the most current and complete we have been able to find. Yet, states are constantly changing their Medicaid programs, and they do not always report the changes promptly. Thus, it is possible that some changes have occurred since the paper was completed and others, which occurred prior to completion, may have gone unreported. For both reasons, the material available to us may occasionally not reflect the present situation.

In many ways, the challenges posed by Medicaid today are greater than ever before because the current recession has increased the need for such programs at the same time that it has reduced the capacity of governments to meet that need. Moreover, dramatic proposals -- first to "cap" the federal share of Medicaid's expenditures and then to "federalize" the program -- have surfaced and are being debated and negotiated. Consequently, the Academy requested that a White Paper on Medicaid be prepared to summarize what is known about the Medicaid program as it relates to children, to identify the most important changes that have occurred at the federal and state levels, and to assess the likely effects of these changes on children. The principal purpose of the paper is to provide background information and analysis which can assist Academy leaders and other child health experts to determine how best to contribute to the debates on Medicaid's future.

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* Committee on Child Health Financing, R. Don Blim, M.D., F.A.A.P., Chairman and Division of Pediatric Practice, Samuel Flint, Director.

New Jersey Federation of Senior Citizens, Inc.
A NON PARTISAN ACTION COALITION
439 MAIN STREET, ORANGE, NEW JERSEY 07050
(201) 677-3750

July 12, 1984

TESTIMONY IN FAVOR OF
A 608

The NJ Federation of Senior Citizens, as a participant in a Medically Needy Coalition, is grateful to Assemblyman Deverin for introducing A 608. We urge the passage of the bill with an amendment mandating that the Commissioner of the Department of Human Services carry out a Medically Needy Program instead of just authorizing the Commissioner to do so.

Under such a program, free medical care - Medicaid - would be extended to cover persons who, except for their income, would be eligible for the federal categorical programs, Aid to Families with Dependent Children (AFDC) and Supplementary Security Income (SSI). These two programs set the income guidelines below the poverty level. According to the Census, the poverty level for a family of 4 in 1982 was $9,862. AFDC benefits for such a family is just about half of this level; it is $4,968. SSI is also below the poverty level because for several years in the past, the State absorbed the social security cost-of-living adjustment instead of passing it along to the recipients. And while the State no longer does this, the social security COLA applies only to the Federal part of the benefit and not to the State supplement.

The Department of Human Services has drawn up several alternative service packages. We support Option II under which children would receive free ambulatory care, pregnant women would get prenatal, delivery and postnatal care, and the aged and disabled persons would receive selected services. The Department estimates that under this option, 100,000 aged and disabled persons, 100,000 children, and 3,000 pregnant women would be covered by a Medically Needy Program.

The cost of the program is estimated to be about $73 million. But the federal government would pay about half - $36 million - and the State would pay the rest with $18 million from the general fund and $19 million from the Casino Fund.

We urge the Department to add to the selected services for the aged and disabled dental, podiatric and optometric care and optical appliances, which would bring the total out of the Casino Fund to about $21.1 million.

What are some of the Less Obvious Benefits of Such a Program?

1) It would encourage primary and preventive care, thus reducing misuse of emergency rooms and complications from unattended health care.

2) There would be an incentive for low-income workers to stay on the job even if they lost their AFDC benefits, since their children's health care would be covered by Medicaid.

3) More people would get home health care and so would not have to be institutionalized.

4) The pregnant women would give birth to healthier children needing fewer health care services.

In view of the great need for a Medically Needy program and the availability of $36 million of federal funds, we think it would be inexcusable for the State to refuse to adopt such a program.

Enclosed: a fact sheet explaining a Medically Needy Program in greater detail; anecdotal notes; & a list of organizations endorsing this program.

41 X Submitted by Edith Edelson

MEDICALLY NEEDY COALITION

July 5, 1984

The Medically Needy Coalition consists of the following organizations:
Association for Retarded Citizens of NJ
Association of Children of NJ
Bergen Co. Coalition of Retired Seniors and Disabled People
District 65 Retirees of Bergen County
Here to Help, Inc.
Home Health Agency Assembly
NJ Assn. of Rehabilitation Facilities
NJ Coalition of Citizens with Disabilities
NJ Dental Assn.
NJ Federation of Senior Citizens
NJ Podiatry Society
Old Bridge Office on Aging
Senior Clubs of Bergen County Inc.
Social Action Center, School of Social Work, Rutgers University
Union County Division on Aging
Woodbridge Township Involved Senior Citizens

Health Services Agency of Bergen - Passaic Counties
State Public Advocate

The campaign of the Coalition has been endorsed by:

Child Advocacy Coalition of Hunterton County
Community Life Commission, NJ Council of Churches
Community Outreach Program for Senior Adults (COPSA)
DIAL for Independent Living
Essex County Division of Aging
Family Planning Advocates of NJ
Middlesex County Association of the Blind
NJ TEnants Organization
PrincetonFriends Meeting Peace & Social Order Committee
Princeton Senior Resource Center

Visiting Nurse Association in Middlesex County
National Council of Jewish Women--NJ State Public Affairs Commission
Family Planning Advocates of NJ

Assemblyman Deverin's Medically Needy bill, A 608 has been supported by:

Health & Welfare Council of Bergen County
Middlesex County Human Services Council

New Jersey Federation of Senior Citizens, Inc.
A NON PARTISAN ACTION COALITION
439 MAIN STREET, ORANGE, NEW JERSEY 07050
(201) 677-8780

May 30, 1984

FACT SHEET EXPLAINING A "MEDICALLY NEEDY" PROGRAM

WHO ARE MEDICALLY NEEDY?

They are some of the poorest people and some people of moderate income, all of whom cannot afford the health care they need. They are people who meet the eligibility requirements - except for their income - of the federal catergorical programs, "Aid to Families with Dependent Children" (AFDC) and "Supplementary Security Income" (SSI). These two programs set the income guidelines below the poverty level. According to the Census, the poverty level for a family of 4 in 1982 was, $9,862. AFDC benefits for such a family is just about half of this level; it is $4,968. SSI is also below the poverty level because for several years in the past, the State absorbed the social security cost-of living increase (COLA) instead of passing it along to the recipients. And while the State no longer does this, the Social Security COLA applies only to the federal part of the benefit and not to the State supplement.

HOW WOULD A MEDICALLY NEEDY PROGRAM WORK?

Under the Federal Medicaid Law, income eligibility for the Medically Needy Program is tied by formula to the AFDC guidelines. In accordance with this, the State Department of Human Services has set the income standards of eligibility as follows:

FAMILY SIZE:	1	2	3	4	5	6
*MAXIMUM STANDARD	$584.93	$584.93	$760.40	$885.96	$1001.52	$1117.08

*Note: These are the maximum standards allowed for Federal Financial Participation, which means that the Federal Government will reimburse New Jersey for about half the payments under Medicaid.

Medicaid would pay for the services covered in the State's Medically Needy Program for persons whose monthly income does not exceed the above standards - provided they meet the other eligibility requirements of AFDC or SSI.

WHEN INCOME EXCEEDS THE STANDARD

A "spend-down" provision would permit persons with incomes higher than the above standards to be eligible for Medicaid benefits when their incurred medical expenses equal the amount of excess income.

EXAMPLE: Mr. A's countable monthly income is $700.00; his medical expenses at the time of application equal $119.73. The amount of excess income is $115.07 ($700 - $584.93).

MEDICALLY NEEDY INCOME STANDARD	$584.93
AMOUNT OF INCURRED EXPENSES NEEDED TO ESTABLISH ELIGIBILITY	115.07
TOTAL INCURRED MEDICAL EXPENSES AT THE TIME OF APPLICATION	119.73

Mr. A would be eligible under a Medically Needy Program since his countable income of $700.00 has been reduced below the Medically Needy standard of $584.93 by $119.73 incurred medical expenses.

The Department of Human Services has drawn up several alternative service packages. Option II of these packages would provide For Children: ambulatory care (outpatient hospital, lab/x-ray, clinic, drugs, physician, dental, optometric, optical appliances, prosthetics and medical transportation)

For Pregnant women: prenatal, delivery and postnatal care.

For Aged and Disabled Persons: selected services (home health, lab/x-ray, clinic, medical day care, physician, medical transportation and medical supplies and equipment.)

Option II would cover about 100,000 aged and disabled persons, 100,000 children and 3,000 pregnant women.

WHO WOULD PAY FOR A MEDICALLY NEEDY PROGRAM?

The Federal Government would pay about half of the cost, and the State would pay the rest, using the General Fund and the Casino Fund.

The estimated cost of Option II is $73,718,000 Of this, the Federal share would be about $36 million; the State's share would be $37 million - $18 million from the general fund and $19 million from the Casino Fund.

Because of the importance of dental, podiatric and optometric care and optical appliances to the aged and disabled persons, these services should be included, bringing the Casino Funding up to about $21.1 million.

A Medically Needy bill has been introduced in each house- A 608 by Deverin in the Assembly, and S 1718 by Bassano in the Senate.

In view of the great need for a Medically Needy program and the availability of $36 million of federal funds, we think it would be inexcusable for the State to refuse to adopt such a program.

PEOPLE IN NEED OF A MEDICALLY NEEDY PROGRAM

Mr. A in New Brunswick, 35 years old, gets SS disability benefits
Lives alone.
Income is $5 above Medicaid guideline.
Problems: muscular dystrophy; debilitated; needs expensive food supplements; has to go to doctor about every week needs portable oxygen - provided by an agency.

Couple B in Edison, over 80, income is $425 for both; rent is $400.
Wife is diabetic, high blood pressure, overweight, has to have teeth removed, losing sight, has needed hernia operation for two years; has to postpone visits to dr. until she has enough money.

79 yrs old
Widow C/lives alone in mobile home. Income is $380/mo. Rent is $189; has health insurance $120/quarter.
Problem: diabetic, losing sight, very nervous, needs glasses, needs dental work and special shoes, has skin problem.

Widow W in Carteret, 62 years old, lives with working daughter.
Income is $439/mo. Blue Cross is $24.06/mo. as Medicare supplement
Problem: Had brain surgery for a tumor in 1982, one eye paralyzed has diabetes, phlebitis, arthritis of legs, needs dentures, under care of doctor and neurosurgeon. Needs to go to eye doctor to overcome double vision. Cannot be left alone. Needs encouragement to be active and to do things for herself. When in nursing home she was strapped in chair, was fed, wasn't helped to walk, and didn't talk, while at home she does things for herself, does light chores.

Needs to attend a day care center but cost is $172.50/wk. Woman stays with her - $125/wk. When she can't come they pay a homehealth aide $6/hr. When woman was hospitalized daughter had to stay home from work.

Impact on children

(Report of 1982 study of impact of termination from welfare on health of former recipients in Middlesex County;prepared by Research Center, School of Social Work, Rutgers U; Isabel Wolock, PHD Assoc.Dir)

In Middlesex County 687 families lost welfare benefits as result of revised welfare eligibility under 8/81 Omnibus Budget Reconciliati Act. 78% had at least one medical or dental problem they couldn't afford. 49% of parents couldn't afford care of children's severe problem Child A with asthma couldn't afford prescribed drug; child B had serious back problem and needed brace but couldn't afford it, also needed dental

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NJHA NEW JERSEY HOSPITAL ASSOCIATION

at the Center for Health Affairs (609) 452-9

746-760 Alexander Road
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Louis P. Scibetta FACHA
President

TESTIMONY OF

CRAIG A. BECKER
ASSISTANT VICE PRESIDENT
AND DIRECTOR OF GOVERNMENT RELATIONS

BEFORE THE

ASSEMBLY REVENUE, FINANCE AND APPROPRIATIONS COMMITTEE

ON ASSEMBLY BILL 608

JULY 12, 1984

GOOD MORNING, I AM CRAIG A. BECKER, ASSISTANT VICE PRESIDENT AND DIRECTOR OF GOVERNMENT RELATIONS OF THE NEW JERSEY HOSPITAL ASSOCIATION. I AM HERE TO SPEAK IN SUPPORT OF A-608 WHICH WOULD EXTEND NEW JERSEY'S MEDICAID PROGRAM TO PERSONS AND HOUSEHOLDS DEEMED MEDICALLY NEEDY.

NEW JERSEY HAS BEEN HISTORICALLY IN THE FOREFRONT OF PROVIDING ACCESS TO CARE FOR ITS ELDERLY, DISABLED, AND POOR. THE MOST RECENT INITIATIVE IS ITS SUCCESSFUL DRG EXPERIMENT THAT HAS BEEN ONGOING FOR THE PAST FOUR YEARS. UNDER THIS EXPERIMENT, NEW JERSEY HAS CREATED AN ALL-PAYER SYSTEM WHICH DISTRIBUTES THE COST OF PROVIDING FREE CARE TO THE INDIGENT TO ALL INSURERS, INCLUDING THE STATE. THIS SYSTEM DIFFERS MARKEDLY FROM THE NATIONAL PROSPECTIVE PAYMENT SYSTEM, WHICH DOES NOT RECOGNIZE OR PAY FOR INDIGENT CARE.

NOW, HOWEVER, WE ARE AT THE CROSSROADS WITH THIS INNOVATIVE AND EFFECTIVE SYSTEM. THE FEDERAL GOVERNMENT, UNDER THE AUSPICES OF THE HEALTH CARE FINANCING AUTHORITY IS NOW LOOKING VERY CLOSELY AT WHETHER OR NOT TO ISSUE US A NEW DRG WAIVER. SHOULD HCFA CHOOSE NOT TO ISSUE A NEW WAIVER, IT HAS BEEN CONSERVATIVELY ESTIMATED THAT IT COULD COST THE STATE OF NEW JERSEY ANOTHER $90 MILLION IN INDIGENT CARE. THIS WOULD HAVE TO BE DISTRIBUTED OVER OTHER

INSURERS WHICH WOULD CERTAINLY RESULT IN SIGNIFICANTLY HIGHER PREMIUMS OR COULD RESULT IN THE CUTBACK OF SERVICES OR EVEN CLOSING OF SOME OF OUR INNER CITY HOSPITALS. ALL OF THESE SCENARIOS WOULD HAVE DISASTROUS EFFECTS ON THE HEALTH CARE DELIVERY SYSTEM IN NEW JERSEY.

FOR THE NEW JERSEY HOSPITAL SYSTEM LEGISLATION LIKE A-608 REPRESENTS A HEALTHY HEDGE AGAINST THE TIME WHEN UNCOMPENSATED CARE WILL ONCE AGAIN BE A PROBLEM. BEFORE THE DRG EXPERIMENT, MANY OF NEW JERSEY'S HOSPITALS WERE PUSHED TO THE BRINK OF BANKRUPTCY CARING FOR THOSE LESS FORTUNATE. BY INCREASING THOSE WHO WOULD BE ELIGIBLE FOR MEDICAID COVERAGE, THE STATE LEGISLATURE WILL BE PURCHASING INSURANCE AGAINST THE DAY NEW JERSEY WOULD LOSE ITS CURRENT SYSTEM OF EQUITABLY PAYING FOR CARE TO THE POOR.
WE MUST PROVIDE FOR THE FINANCIAL INTEGRITY OF OUR HEALTH CARE SYSTEM AND CONTINUE OUR EXCELLENT TRACK RECORD OF PROVIDING ACCESS TO CARE FOR ALL.

STATEMENT IN SUPPORT OF SENATE No. 1718
BY CAROL J. KIENTZ, R.N., M.S.
ASSISTANT DIRECTOR, CHRIST HOSPITAL HOME HEALTH SERVICES
JERSEY CITY, NEW JERSEY

On behalf of the Home Health Agency Assembly of New Jersey, Inc., and the fifty-two providers of home care represented by the Assembly, I would like to thank the Committee for this opportunity to speak in support of Senate Bill 1718. We support this bill, and in truth support all well-designed legislation which can increase the chances for the people of this state to live longer, safer, and more satisfying lives in their communities, rather than be forced into institutions in order to have their basic needs met. Nursing homes are an extremely costly method of care, and the cost is usually borne by the taxpayer via our Medicaid system. In addition, the quality of life can seldom replicate one's own home. Many of our patients living in even the poorest cramped apartments beg to remain there because their fear of institutionalization is so great, and their desire to have a home is so strong.

S1718 can be the means to meet the needs of many such citizens. Estimating the numbers actually requiring some type of personal care and help at home, who are not covered for this care by any presently existing form of reimbursement, is difficult. Many are in nursing homes prematurely, and it is hoped that the new Medicaid Community Care Program for the Elderly and Disabled will bring some of these individuals home, while keeping others at home. Many are probably in our communities in need of help but afraid to ask for fear of being considered incompetent and in need of institutionalization. Some are just too unsophisticated to know where to call for help in our increasingly complicated health care system. Home health and social service agencies learn about such people every day, when a neighbor or clergyperson calls and asks for aid.

Of the elderly and disabled known to us, and for home health agencies this numbered about 100,000 people in New Jersey in 1982, we can estimate that anywhere from fifty to one hundred people each week remain in need of care, but must be discharged from our services because of inadequate funding. This includes expiration of Medicare eligibility, severely restrictive Medicaid income eligibility, and too little in the way of community contributions to agencies to finance as much free or reduced-fee care as is needed.

One of the saddest misconceptions of the elderly is the belief that Medicare will meet most of their health care needs. In fact, it covers none of the day to day survival needs of the chronically ill. It was designed primarily to pay for hospital and doctors' services during periods of acute illness. But most of the elderly suffer from several chronic conditions - and chronic care, by definitio is not covered by Medicare. It is not unusual for a seventy or eighty year old to have heart disease, arthritis, diabetes, and lung disease, or the remnants of a stroke which has left that person in a wheelchair. If such a person wants to stay at home to live out his/her life, I hope there is a good family and either lots of money, or so little that ne/she qualifies for Medicaid. Otherwise, they may be out of luck, because Medicare won't cover the cost of that care at home with a ten foot pole!

So many such people exist in our communities that the scattered programs set up under Title XX or by private grants and local donations are strained to the breaking point. The waiting list of the chronically-ill elderly in Jersey City, for example, to receive part-time homemaker/home health aide help at home from Hudson County's Title XX program now has 125 people on it. That means that some will die or be in nursing homes before their "number comes up" months from now. The Senior Companion program has gone out of existence in most parts of the state both due to an inadequate supply of workers, and inadequate funding. So most home health agencies have very little advice to offer the frustrated, frightened, and angry patient and family when we have to give them the bad news that Medicare is a very short term form of help and won't go on providing the nurse and home health they have come to depend upon. These are the people of our so-called middle class, and they are truly caught in the middle, with too little savings to meet their own needs, but too much social security or pension income to qualify for any assistance. As an agency administrator, I get calls from them every week. They don't want to believe their visiting nurse when she tells them Medicare just won't go on helping. They ask me if they can call their legislators for help, or can an order from their doctor force Medicare to go on paying for the care that's needed. The anger and despair is palpable over the phone, as I answer no - there just is no way around Medicare's regulations.

I would like to share with you some specific examples of patients in Jersey City, who are similar to people all over the state in need of care at home, but at the end of the line in terms of financial resources to pay for that care:

> Mr. M.is an 81 yr. old gentleman with chronic leukemia. He also has heart disease and arthritis. Until his wife died about a year ago, they helped care for each other. Their two sons live several states away and don't have sufficient income to help their father. Mr. M. has gradually become extremely weak. On a good day, he can walk around his apartment, but he can't get out or do much to help himself. The chronic care he needs isn't covered by Medicare, but until this January he qualified for

Medicaid, and therefore was able to have a home health aide through Medicaid to assist him a few days a week. This year, however, his income went up to about $650.00 per month, so he is way over the income eligibility limit for Medicaid. We've helped him apply for Title XX but he's still on the waiting list. In the meantime, our agency is giving free care so that he can stay at home. Combining the free care with a Senior Companion for a few hours two days a week has meant the difference between an institution and independence in the community.

Lower down on the age spectrum is Mrs. A. She is in her forties and has had multiple sclerosis for several years. This is a disease which strikes the young adult and can progress within a few years to severe disability. But again - it is a chronic condition. Therefore, although Mrs. A. is bed and wheelchair-bound, she does not qualify for Medicare assistance. She lives with her husband whose income is marginal but just enough to disqualify them for Medicaid. The irony of this type of case is that if Mrs. A. were a less motivated and determined individual, she could have the help of a nurse and a home health aide several hours a week via Medicare. But because she chose to fight her disease and maintain control over her bladder, she cannot get that help. You see, if she were incontinent and required a catheter to drain her bladder, Medicare would pay for visits by a nurse to change and care for the catheter periodically. Thus in addition, Medicare would also pay for a part-time aide, which she needs so badly. But she doesn't need a catheter, as I stated, due to her own courage and determination. It seems sad that the presence or absence of a plastic tube can make that much difference to someone's life.

Even younger, is little Hank. He's 12 years old and recently had to have hip surgery. Now he needs physical therapy to help hime walk again. His father works as an unskilled laborer in New York, and the company he works for discontinued Blue Cross coverage for their employees a few months ago. What little savings the family had went to pay for the surgery. Now they have nothing left to pay for the therapy. We are trying to convince them to let our physical therapist visit Hank for a reduced fee (or no fee, if need be), but they don't believe us yet -- and Hank still needs the therapy. They are a proud family, after all, and have resisted charity and welfare. Entitlement to a State Medical Assistance program, however, would probably be acceptable to such a family.

Finally, may I close with another situation involving an elderly couple. Just because both spouses are still alive, it can't be assumed that they can somehow meet each other's care needs. Often they are both in need of care. Mr. and Mrs. D. are in their eighties are now chronically ill. Mrs. D. is in a wheelchair, incapacitated by severe arthritis. Mr. D. has Parkinson's Disease and the tremors and loss of balance which are part of this illness make it difficult for him to help himself, let alone his wife. For awhile, we were able to provide rehabilitaion services via Medicare, and were able to increase their function to one of partial

independence for Mrs. D. and almost full self-care independence for Mr. D. This was the maximum function each was capable of. Therefore, this was the point at which Medicare coverage ended. The couple still needed outside help on a part-time basis, a few days a week. Mr. D.'s pension put them over the limit for Medicaid eligibility. But fortunately, the waiting list for Title XX help was shorter last year, and they've been able to survive quite well at home with this help ever since. A couple in their situation this year would have been out of luck - the need, and the waiting list grows each year, as our society grows older each year.

These are just a few of the people at every point in the age spectrum who could be helped by S1718. These happen to come to my mind because I've been in touch with them recently. If we had the money and personnel in our Home Health Agencies to tabulate all the cases similar to these over the past five years, they would probably number in the thousands. Of that, perhaps a third or more would fall within the financial and spend down provisions of this legislation. That would mean a significant step forward in giving the elderly, disabled and needy a chance to live with some dignity and happiness, rather than suffering a survival existence and finally wishing for the end to come. If you think the latter isn't happening right now all over New Jersey, I invite you to spend a day with the Visiting Nurse in your constituency. The stories are heartbreakers, but they're true.

SUBJECT: Testimony before Assembly, Revenue Finance and Appropriations Committee concerning A-608, July 12, 1984.

BY: John P. Tergis, Legislative Chairman, New Jersey Council of Senior Citizens.

Before you pass on the issues before you today, the New Jersey Council requests that you consider all options and priorities for the expenditure of casino revenue funds, including rental assistance and home health care for senior citizens and disabled residents which have been rated as very high priorities by all senior organizations.

The Casino Revenue Fund is quickly approaching a saturation point. If you will refer to the attached study you will see that in order to meet the Casino Revenue Fund budget of $176 million for 1984-1985, it will be necessary to attain a projected increase in the fund's revenue of $20 million in 1984-1985 and an optomistic carry-over of $34 million this year's budget. If either of these estimates should prove to be overly optimistic, the fund would indeed experience a serious short-fall.

Of importance, too, is our prediction of three years ago, which has been borne out in the meantime, that the PAAD and tax reduction programs will continue to require additional expenditures from the fund even though these programs remain the same. Certainly the lifeline program will cause an additional drain of between $5 and $8 million each year if the budget is increased by a promised $25 in 1985-1986.

We are not questioning the desirability of a medically needy program but there are other programs which should be considered along with it to insure the best use of these limited resources.

Two years ago SCR-75 was passed by the legislature which stated it was the policy of New Jersey to form a commission to study the resources of the Casino Revenue Fund and make recommendations as

to the priorities for which the funds should be spent in order to secure an efficient use of these monies. Unfortunately their legislation was never implemented. However, new bills have been introduced which would re-create the commission.

Since the resources of the Casino Revenue Fund are not sufficient to satisfy every want, we request that the committee await the study which has been promised before expending any further casino revenues. If the committee does not wish to do that, then we sincerely request that the committee consider all options, including the importance of rental assistance and home health care, before moving on the one issue which is before you now.

Analysis of Casino Revenue Fund with Particular Emphasis on PAAD, Lifeline and Property Tax Reduction Programs ---- Relationship Between General Fund and Casino Revenue Fund.

PAAD

In fiscal year 1982-83 (the last completed year) there were 201,000 elderly participants under the General Fund and 60,938 under the Casino Revenue Fund for a total of 261,938 which was close to the total of 259,295 all of whom were included under the General Fund in fiscal year 1980-81.

From the above and other data in the chart there is evidence that a considerable amount of shifting of participants from the "old program" (General Fund) to the "new program" (Casino Revenue Fund). (For a description of the "new program" see item #1 of the footnotes in the chart.)

Even though the numbers in the General Fund are decreasing the cost to the General Fund is increasing. If we compare fiscal year 1978-79 with fiscal year 1982-83 (the last completed year), we find that eligibles have decreased by 28% whereas costs have increased by 26%. This trend seems to be holding in the revised estimated figures for 1983-84 and in the Governor's budget for 1984-85. This increase in cost is primarily due to the rapid acceleration in the cost of drugs.

The trend of the General Fund portends what we think will happen to the cost of the PAAD under the Casino Revenue Fund where we have not only perhaps a greater increase in the cost of drugs due to inclusion of the disabled but, in addition, a rather steep increase in the number of eligibles besides.

Comparing fiscal year 1982-83 with the Governor's budget for 1984-85, we find that the numbers of eligibles will have increased by 8.5% and the expense to the Casino Revenue Fund will have increased by 17.5% during this period. If this trend continues it could result in a considerable drain from the casino fund.

LIFELINE PROGRAM

This program has increased in cost from $21.0 million in 1979-80 to a projected cost of $72.6 million for 1984-85 (a 250% increase). Beginning with an initial benefit of $100 in 1978-79, the benefit has been increased each year as outlined in item #2 of the chart. Besides the planned increase for 1984-85, the Governor's budget message last year stated that another increase is planned for 1985-86 which would bring the cost of this program to almost $80 million per year.

The Task Force on Legislative Concerns has taken the position that any future increases should be discontinued. The Governors Management Improvement Task Force has taken the same position.

PROPERTY TAX REDUCTION PROGRAM

The Chart reveals a shifting of a considerable portion of the cost of the property tax reduction program from the General Fund to the Casino Revenue Fund. This has been due to people transferring from the "old" to the "new program" (see item #3 of the footnotes) and to those coming under the "new program" for the first time.

GENERAL

Spending under the Casino Revenue Fund is budgeted at $176 million in 1984-85 against a projected income of $160 million. It is planned that the projected income will be supplemented by a projected surplus carried over from this year's revised estimate of spending.

CONCLUSION

It would seem that funds are being committed as fast as they are generated.

Moreover in the past at least it is evident that even the original programs could not have survived without constant increases in the Casino Revenue Fund. The table below shows how built-in liabilities under the present PAAD, Lifeline and Tax Reduction programs were fed on these increases:

	YRS. 1979-80	'80-81	'81-82	'82-83	'83-84 (est.)	'84 (bud
Increase from previous year:						
In Casino Revenue Fund	39.3	13.9	31.4	27.2	9.4	20
In PAAD, Lifeline and Tax Reduct. (total)	21.0	5.9	23.0	46.9	28.8	
Remaining portion of increase	18.3	8.0	8.4	(-19.7)	(-19.4)	18

If the 1984-85 budget is correct that year will be the first in which the built-in liability of the three programs listed above will nc have used up a considerable portion of the projected increase in the fund for that year. However, we would expect further increases in the portion of the PAAD program financed by the Casino Revenue Fund and in the Lifeline account if the Governor proposes an 1985-86 increase in the program.

If the Casino Revenue Fund should level off there is the possibil: that revenues will be insufficient to finance present programs let alone unfulfilled needs which have a very high priority.

For these reasons we suggest that an intense study of the high priority needs of seniors and disabled be made now and that a planned approach to the Casino Revenues be made so that these needs will have been met before the fund levels off. We, therefore, suggest that the administration and the legislature work with us to this end.

John P. Fergie

GENERAL FUND EXPENDITURES FOR SENIOR CITIZEN AND DISABLED PERSON PROPERTY TAX REDUCTION AND PAAD PROGRAMS

(IN MILLIONS) (COMPILED BY JOHN P. TERGIS)

ENDITURES	1978-79	1979-80	1980-81	1981-82	1982-83	1983-84 (Est.)	1984-85 (Governor's Budget)
PAAD	33.86	36.29	39.60	44.1	42.8	44.2	43.9
(June eligibles)	280,938	380,514	259,295	232,518	201,000*	192,000*	182,000*
Property Tax Reduct.	30.3**	29.3**	28.2**	27.6	15.8	15.4	15.4

CASINO REVENUE FUND - EXPENDITURES

(IN MILLIONS)

	1978-79	1979-80	1980-81	1981-82	1982-83	1983-84	1984-85
ENUES	18.3	58.1	72.0	103.4	130.6	140.0	160.0
ENDITURES							
Homestead Rebates	11.0	17.0	17.0	80.0	19.4	20.5	21.0
PAAD	0	0	0	1.5[1] Elderly* Disabled*	19.4 60,953 25,693	26.2 68,600 28,900	22.8 69,000 25,000
Lifeline Programs	0	21.0[2]	26.9	41.1	51.6	69.0	72.6
Property Tax Reduct.	0	0	0	7.3[3]	25.8	30.4	30.4
Home Health Care	0	0	0	0	0	10.5	17.6
Transportation Act	0	0	0	0	0	3.0	10.0
Congregate Housing	0	0	0	0	0	0.55	0.62

*Average Monthly Participants
**Estimated

FOOTNOTES:

1. Increase in PAAD from $12,000 to $15,000 eligibility and addition of disabled financed from Casino Revenue Fund.

2. The lifeline program was $100, year 1979-80; $125, year 1980-81; $150, year 1981-82 $175, year 1982-83; $200, year 1983-84; increase to $225, budgeted year 1984-85. Lifeline (tenants) started in year 1981-82 - amount same as lifeline.

3. Increase in property tax reduction from $160 to $200 and eligibility from $5000 to $8000 in year 1981-92; to $225 and $9000 eligibility in year 1982-83; to $250 and $10,000 eligibility in year 1983-84 - all increases financed by Casino Revenue Fund.

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dg 05/2/84

TESTIMONY OF THE DEPARTMENT OF THE PUBLIC ADVOCATE ON ASSEMBLY BILL 608 (A BILL WHICH WOULD EXTEND THE MEDICAID PROGRAM TO COVER MEDICALLY NEEDY INDIVIDUALS) BEFORE THE ASSEMBLY REVENUE, FINANCE AND APPROPRIATIONS COMMITTEE

JOSEPH H. RODRIGUEZ
PUBLIC ADVOCATE
BY: EDWARD H. TETELMAN
ASSISTANT DEPUTY PUBLIC ADVOCATE

JULY 12, 1984

The Department of the Public Advocate supports A-608 which would expand the Medicaid program to cover medically needy individuals. This legislation would provide health care services through the Medicaid program to approximately 100,000 persons.* This population is made up of low income women and children, disabled individuals, and elderly persons who presently do not qualify for Medicaid. Some characteristics of this population include:

(1) Individuals and families whose income is substantially below the national poverty guideline. (Approximately $5,600 for a family of four to qualify for the medically needy program as compared to $10,200 under the national poverty guideline);

(2) Elderly individuals who have to choose between paying the rent, purchasing food, or obtaining medical care because their fixed incomes are too low to purchase the basic necessities they need;

(3) Children who need primary care services to treat various illnesses and conditions, but whose families lack sufficient funds or insurance. These untreated conditions and illnesses may deteriorate and result in substantial hospitalization or permanent disabilities. These conditions often cause children to perform poorly in school and keep children from ever reaching their full potential; and

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* Based on a previous Department of Human Services'estimate and other state medically needy programs actual eligibility numbers.

(4) Finally, low income pregnant women who often forego prenatal care because they do not have funds to pay for this care.

The lack of prenatal care is a major factor in the cause of infant death and morbidity. The establishment of a medically needy program would make a substantial number of these individuals eligible for Medicaid services.

Medicaid is a comprehensive health care program that covers preventive, primary, long-term, and acute health care services. We recommend that for the initial phase of establishing a medically needy program that the ambulatory services and medical support services be provided by the program. These services and items include: physician services, lab and x-ray services, clinic services, dental services and appliances, optometric services and appliances, orthotic and prosthetic devices, medical day care, drugs for children and adults who do not qualify for PAA, medical transportation, early periodic diagnosis and treatment, and prenatal, delivery and post natal care for pregnant women. These services and items provide basic ambulatory health care needs, emphasizing prevention and primary care and keeping individuals out of costly institutional settings. With these services available, the health status of the aforementioned population should greatly improve, and the cost of hospitalization, preventable disabilities, as well as the loss of human potential should drastically decline.

In addition, over thirty states and territories have medically needy programs. Most recently, Mississippi and Oregon established

medically needy programs. Only three industrialized states, of which New Jersey is one, have no medically needy program. New Jersey should take its proper place as a leader in providing health care services to low income persons, who would qualify for medically needy services, as it has in other areas of health care delivery such as hospital rate setting.

A medically needy program is also cost effective. First, it reduces the use of emergency rooms by giving qualified persons the ability to obtain primary care services from physicians in their offices and in free standing clinics which are much less costly. For example, Medicare reports that a routine physician visit averages $25, whereas a hospital emergency room visit averages about $70. Second, it will also help to offset the cost of some medical services that are provided by the counties and municipalities that use only local and state funds to pay for care. Most importantly, a medically needy program, besides providing medical services, will bring federal dollars into New Jersey. The medically needy program, as part of Medicaid, requires the federal government to pay for half the cost of the program.

It is estimated by the Department of Human Services that providing selected ambulatory services for different segments of the medically needy population at 133% of the AFDC eligibility level would cost approximately $73 million for 250,000 individuals. The federal share of this cost will be $36.5 million. In comparison, actual figures from the state of Massachusetts, using the same eligibility level and providing care for 79,111 medically

needy persons, including adult single parents, for selected services cost $50.4 million if drugs are included (Massachusetts has no PAA program and reports that most of the drug cost is for elderly persons) and $32.8 million if drugs are not provided. Under the Massachusetts program, the federal and state share is $16.4 million. Obviously, any estimate of cost of the program and of the number of eligible persons must be carefully calculated. It is our opinion that the Department of Human Services estimate of the cost may be high in light of Massachusetts actual experience.

In conclusion, a medically needy program will provide comprehensive preventive, primary and non-institutional health care services to low income elderly and disabled persons, children and their parents, and pregnant women who are living below the national proverty line. It is cost effective by providing health care services in more dignified and less costly settings and will bring in federal funds to match the cost of services. The establishment of this program in New Jersey is long overdue. We urge the committee to review the testimony presented here today and then vote A-608 out of committee as soon as possible.

IMPACT OF TERMINATION FROM WELFARE ON THE HEALTH OF FORMER RECIPIENTS: A STUDY OF MIDDLESEX COUNTY, NEW JERSEY

Testimony before the Assembly Revenue, Finance and Appropriations Committee Supporting A-608

Prepared by Research Center
School of Social Work
Rutgers University

July 13, 1984

Isabel Wolock, Ph.D.
Associate Director

The Ominbus Budget Reconciliation Act (OBRA), first signed into law on August 13, 1981 radically revised welfare eligibility and resulted in the elimination of hundreds of thousands of welfare recipients from the AFDC rolls. In Middlesex County, N.J. alone the number of discontinued families was 687. For the vast majority of these families the loss of welfare eligibility also meant the loss of Medicaid eligibility. In the summer of 1982 the Research Center of the Rutgers University School of Social Work, in cooperation with the Middlesex County Board of Social Services, carried out an interview study of 129 terminated families to determine how the loss of welfare had affected their lives. All but 14% stopped receiving Medicaid when they lost their welfare benefits. Somewhat more than half (57%) had some type of medical insurance for themselves at the time of the interview but only 44% had coverage for the children. A third of the respondents paid for the insurance entirely themselves and an additional 22% for some portion of the insurance costs; employers paid for the full costs of medical insurance in only a third of the families. After the grant had ended 40% of the parents obtained medical or dental care for themselves and 46% for their children. Families were more likely to seek care for a severe condition than for a routine problem or for preventive care. Sixteen percent of the families obtained preventive care (immunizations and medical and dental check ups), 28% sought care for a routine medical or dental condition (allergies, bronchitis, sore throat, dental cavities, etc.), and 46% for a severe condition (major surgery, pneumonia, fracture, diabetes, high blood pressure, heart condition, etc.). Fifty-seven percent of the families obtaining medical care after the grant ended went to a private physician, 23% to a hospital emergency room and 18% to a clinic. Families with medical insurance were far more likely to have obtained medical care after termination than those without insurance (71% compared to 46%; $X^2=7.33$; 1 df; $p=.007$). Most respondents (83%) had to pay for some portion of the medical or dental costs themselves and reported extreme difficulty doing so. A number of families still owed money months after the medical or dental care had been received. Others were forced to borrow money to pay the bills and some had to use money earmarked for food and rent in order to meet medical and dental expenses.

The profound impact of the loss of Medicaid is even more sharply reflected in the finding that the vast majority of families (78%) had at least one medical or dental problem for which they could not obtain professional care or follow up treatment or medication because of the cost. The particular problems and percentage of families reporting them are shown below.

Problem	% Families Reporting N=129
Respondent did not get care for medical problem(s)	36%
Child/children did not get care for medical problem(s)	28%

Respondent did not get care for medical problem(s)	41%
Child/children did not get care for dental problem(s)	32
Respondent and/or children unable to get eyeglasses	30
Respondent and/or children unable to obtain medication	27

Thirty-two percent of the parents were not able to go for preventive care, 49% had routine conditions that went untreated, and 53% severe problems that were unattended. Thirty percent of the respondents said they had to forego preventive care for a child, 54% were unable to attend to a routine medical problem, and 49% could not afford care for a child's severe medical problem. Three quarters of the families who said that they could not afford some medication needed a prescription drug. Most parents' and children's untreated medical and dental conditions (72% to 79%) were problems that had received professional attention prior to termination.

A more in depth analysis of the interview material provides a clearer picture of how the loss of Medicaid endangered the health of so many families in our study. In many families the health of several members was threatened by the inability to obtain professional care or to get some prescribed medication for a medical or dental problem. Many of the conditions (e.g., heart condition, thyroid condition, and hypertension) were potentially life threatening if untreated. Other problems such as untreated dental cares or the failure to get eyeglasses were conditions, which, if not attended to could seriously impair the functioning of the individual in either the short or long run. A number of typical situations depicting the plight of many of these families, are presented below:

> The mother of this family had throat surgery while still on welfare and was supposed to return for a post surgery check up. Prior to this, however, she was terminated from welfare and could not go for the check up because she could not afford to pay for it. In addition, this woman had colitis which flared up after the grant had ended. She could not afford to go for medical care or even to purchase the medication which had previously been prescribed. In addition, her son had asthma and although it had not bothered him since the grant ended she worried constantly about how she would pay the doctor bills when he did have another attack.

> In this family the mother had diabetes and after being terminated had to cut back on her medical check ups because of lack of funds. One son had asthma and had had an attack after the loss of benefits. She could not afford to get the prescription which she had used before and had to resort to using an over the counter remedy. She had to borrow money from a friend to buy this drug.

The mother had been planning to have surgery to correct a heart condition. After she lost her Medicaid benefits this was no longer an option. In addition, her son had a serious back condition which required a special brace; their Medicaid had stopped prior to getting the brace and they did not know whether they would ever be able to afford it. The son also suffered from bronchial asthma, severe allergies, and an exceptionally bad case of acne. Although these problems had been treated while the family had been on assistance, the family could not afford to pay for the medical care after termination. The mother said she was still renewing the prescriptions which had been recommended for these conditions but that she had to use the family's food money. In addition, the son needed dental work and the mother stronger reading glasses.

In other cases the loss of Medicaid was somewhat less dramatic in its impact but nevertheless had severe consequences for the current and future health of family members. Typical of such cases is the family in which the children had frequent colds and sore throats but the mother could not send them to a doctor. The mother herself had a gum infection and went to the dentist for an initial visit. Although she was supposed to have returned for further treatment she was unable to do so because of the cost. A son in the family was badly in need of orthodontic work but the family could not afford it. The daughter needed eyeglasses but there was no money to pay for them.

In another family the son had lost a number of fillings and complained of considerable pain but was not able to go to the dentist. The mother needed a new prescription for glasses but could not pay for the examination or the new glasses.

The daughter in still another family had a foot infection for which penicillin had been prescribed. The family could not afford the penicillin. Similarly, the mother needed an ointment for a hand infection but did not get it because of the cost. The daughter had cavities that had to go untreated.

Not only this study but research done in other states as well as a national study provide clear evidence that access to health care is a critical problem for most families who were terminated from AFDC (Maryland Dept. of Human Resources, 1982; Moscovic and Craig, 1982; Sarri, 1983; Rhode Island Dept. of Social and Rehabilitative Services, 1983; and Research Traingle Institute, 1983). While the specific percentages vary across studies, a sizeable proportion of each of the samples of terminated clients (close to, or more than half) were left without medical coverage. Furthermore, several studies show as we do, that many families had to delay or forego medical and dental care because they could not afford the out of pocket costs of such care (Maryland Dept. of Human Resources, 1982; Moscovice and Craig, 1982; and Sarri, 1983).

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Township of Jackson

MUNICIPAL BUILDING
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July 11, 1984

State of New Jersey Legislature Assembly
State House Annex CN 066
Trenton, New Jersey 08625
Att: Assemblyman John S. Watson

Dear Assemblyman Watson:

The Mayor's Senior Citizen Advisory Commission of Jackson, N.J. and the Senior Citizens we represent, are in complete accord with Bill #608, which would extend New Jersey's Medicaid Program to persons and households deemed medically necessary.

This Program would be of great benefit to the needy seniors of New Jersey.

Respectfully,

Lucas Krom (jg)

LUCAS KROM, CHAIRMAN

jg

70x

July 12, 1984.

TO: Assembly Revenue, Fianance & Appropiations Committee.

SUBJECT: Assembly #608.

FROM: Gray Panthers of So. Jersey.

This proposed legislation will target the over 200,000 unfortunate persons, families with their children who for financial and age reasons have been shut out of our health care system of state and nation.

The irony of the situation is that we are speaking of the wealthiest country in the world.

This great country which boasts the finest medical system

ranks

12th in preventing cancer deaths

11th in infant mortality deaths

26th in lower cardovascular deaths

14th in longer life expectancy

We expend 10% of our gross national product on health Before the year expires the figure according to those who know will rise to 12%.

The U.K. which has a comprehensive Health Service Plan and spends only 5% of its gross national product on health,

Yet it surpasses the U.S. on the above categories.

Health care should not be based on the ability to pay..

This legislative body can feel proud of itself for passing Bill #608.

It shows an understanding and grasp of the dilemma faced by these unfortunate persons.

And the compassion such an act would declare.

Respectfully submitted,

Victor Volpe

Legislative representative
Gray Panthers of So. Jersey.