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ABSTRACT

This document presents the text of the Congressional hearing held in Elizabeth, New Jersey to examine the need for catastrophic health care coverage for the elderly and what role the Federal Government can play in helping to address that need. Opening statements are included from Representatives Matthew Rinaldo, Marge Roukema, and Jim Saxton. In his opening remarks, Representative Rinaldo briefly reviews U.S. Department of Health and Human Services (DHHS) Secretary Otis Bowen's report to President Reagan which recommends extending Medicare coverage to an unlimited number of hospital days, capping out-of-pocket expenses at $2,000 for covered services, and covering the first 100 days of post-hospital skilled nursing facility care. Alternative approaches to catastrophic health insurance which have been introduced in Congress are also described. Witnesses providing testimony include: (1) Thomas Dunn, mayor of Elizabeth, New Jersey; (2) William Hargwood (Monmouth, New Jersey), who describes his difficulties in caring for his wife, a victim of Alzheimer's disease; (3) Thomas Burke, chief of staff, DHHS, who elaborates on the Bowen proposal for catastrophic health care coverage; (4) Thomas Brown, vice-president of Overlook Hospital (Summit, New Jersey); (5) Evelyn Savage, director of Somerset Hills Visiting Nurses Association (Barnardsville, New Jersey); and (6) William Matusz, director of American Association of Retired Persons Operations, Prudential Insurance Company, Inc. (Montgomeryville, Pennsylvania). Relevant materials are appended. (NB)

CATASTROPHIC HEALTH INSURANCE: A NEW JERSEY PERSPECTIVE

HEARING

BEFORE THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

APRIL 10, 1987, ELIZABETH, NJ

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CATASTROPHIC HEALTH INSURANCE: A NEW JERSEY PERSPECTIVE

FRIDAY, APRIL 10, 1987

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
Elizabeth, NJ.

The Committee met, pursuant to notice, at 10:07 a.m., in City Council Chambers, Elizabeth City Town Hall, 50 Windfield Scott Plaza, Elizabeth, NJ. Hon. Matthew J. Rinaldo (acting chairman of the committee), presiding.

Present: Representatives Rinaldo, Saxton, and Roukema.

STATEMENT OF HON. THOMAS G. DUNN, MAYOR OF ELIZABETH, NJ

Mayor DUNN. The Chairman is about to call the meeting to order. I am here to welcome each and every one of you to the City Council Chambers of City Hall in the City of Elizabeth, New Jersey.

For those of you who may not know me, my name is Tom Dunn. I am the Mayor of the City of Elizabeth and we are very proud and happy to have each and every one of you with us today.

I want to thank your very good friend Congressman Matt Rinaldo for singling out our city hall as the site for this very, very important meeting to be conducted by the Congressional Select Committee on Aging.

It is quite apropos that I be the one to welcome you in view of the fact that I am a little sleepy yet from having celebrated another birthday yesterday. And I can assure you that I am as concerned as any of you, if not more so, about becoming aged than I have been for the past several years.

It is a subject that is of great interest and concern to me personally and certainly a subject of concern to me as a long-time Mayor of the City of Elizabeth. I am in my 23rd year as the Mayor of this urban city and I doubt if there is any problem found anywhere in America that cannot also be found in our city.

And none rates a higher priority than the concern that we have for our older citizens. I mentioned to Congresswoman Roukema just a few minutes ago that about 15 or 16 years ago we had a facility in the City of Elizabeth that was commonly known as the Alms House or Poor House.

We had to tear the building down because we had no customers. We had more people on staff than we had patients. We recognized

the economics of it and when a nun came to us and said, "you pay us X-number of dollars to take care of those few people and put them in our St. Elizabeth's Hospital" and we will take care of them. We agreed.

That was about 15 or 16 years ago. We tore the building down and replaced it with a big hotel. Today the situation is so different. We have very, very serious need for more institutions of that type.

We have none that I know of in this immediate area. And yet state institutions are emptying out of their facilities patient after patient after patient who rightfully belongs in an institution. And as a result, they are shipped to cities like Elizabeth and cut loose, despite the fact that somebody is being paid to take care of them.

These institutions' budgets increase each year even as their patient loads decline. This patient "dumping" creates a tremendous burden not only for the City of Elizabeth but for other big cities as well.

There is another problem. Have you noticed that when you turn the television on now you see movie star after movie star trying to sell some sort of supplemental medical coverage to the old folks?

I get a big kick out of all of the gimmicks. There is not one of those policies that I qualify for. The only way you can qualify for those is if you never had a headache in the past 25 years. Then you might be considered.

I am 66 years old and there is not an illness or a disease or an operation that I have not had; from cataracts to prostate to open heart surgery to hernia operation, to Dengue Fever malaria, I have had them all.

The advertisements assure you that there will be no health questions raised whatsoever. True—until you get the application. The application asks if you have ever had a headache in your life. Yes. If you ever had your tonsils out, the insurance company considers you a poor risk.

I am sure that is just part of what this very, very fine Congressional Select Committee on Aging wants to hear about today. And I am sure that they are working diligently and feverishly to try to rectify some of these terrifying things that happen to us when we hit those so-called Golden Years.

I am very very, happy to have them with us today; work that they are doing is of tremendous importance to all of us. I know this is going to be a very productive public hearing and again, we are proud to have you here with us in the City of Elizabeth on such important business.

Thank you.

OPENING STATEMENT OF REPRESENTATIVE MATTHEW J. RINALDO

Mr. RINALDO. Thank you very much, Mayor Dunn. Before the Mayor leaves, I want to express my appreciation to Mayor Dunn, the City Council. and his administration. They have always been very cooperative whenever we wanted to have a hearing in this historic chamber. But more importantly, as I think Mayor Dunn demonstrated in his welcome they have a real interest in our senior citizens and their welfare.

As the Vice Chairman of the Aging Committee, I specifically requested this hearing to examine the need for catastrophic health care coverage for the elderly, and what role the federal government can play in helping to address that need.

I am pleased that two of my colleagues on the committee, both of whom are from New Jersey, are here with me today. Congresswoman Marge Roukema, from New Jersey's Fifth District, and Congressman Jim Saxton, from New Jersey's 13th District. Both Mrs. Roukema and Mr. Saxton have been active in the effort to promote comprehensive health care coverage for senior citizens, and I want to thank them for joining me this morning.

Over the last few years the cost of medical care has risen significantly faster than the general rate of inflation, and that trend shows no sign of stopping, or even slowing down. Already, a family struck unexpectedly with a serious illness or disability may find its financial stability seriously threatened by the costs associated with medical care.

This is especially true of the elderly, many of whom live on fixed incomes. Some individuals and families cannot meet those costs at all.

In New Jersey alone last year, hospitals incurred nearly $250 million in uncompensated care costs. Nearly half of that, or close to $115 million, is attributable to elderly Medicare beneficiaries. Most of that figure represents copayments and deductibles for hospital care that the elderly simply could not meet, could not afford. Only about 1 percent is attributable to Medicare beneficiaries who exhausted their benefit coverage. Those individuals, unfortunately, became charity cases.

In his State of the Union message last year, President Reagan asked Health and Human Services Secretary Dr. Otis Bowen to recommend ways in which the private sector and the government could work together to address the problem of affordable catastrophic health care so that those unable to meet the high costs of medical attention might have some protection—might keep their dignity.

Dr. Bowen's report was sent to the President on November 19 and released to the public shortly thereafter. The President subsequently endorsed the Bowen plan and it was introduced in Congress in February.

The Bowen plan would extend Medicare coverage to an unlimited number of hospital days and would cap personal out-of-pocket expenses at $2,000 for covered services. The bill would also cover the first 100 days of post-hospital skilled nursing facility care. It would be financed by increasing the Medicare Part B premium by approximately $5 per month.

In the few months since the legislation was introduced, it has sparked considerable debate on the issue of catastrophic health care. In particular, much attention has been focused on the issue of long term care for the elderly, potentially the most costly service item of senior citizens' health care.

As a result, alternative approaches to catastrophic health insurance have been introduced in Congress.

Just yesterday, the Health Subcommittee of the House Ways and Means Committee approved a catastrophic health plan introduced

by the chairman and ranking minority member of that committee. This bill would limit the hospital deductible to $541 in 1988, place no day limit on impatient hospital services, cover 150 days of skilled nursing facility care in a calendar year, and make other modest benefit expansions.

The bill, however, proposes to raise the income taxes of senior citizens in order to finance these changes. For the first time in history, it would impose a tax on the actuarial value, the value of a health benefit that you receive—in this case Medicare Part A and Part B benefits. For millions of senior citizens, it would means hundreds of dollars more in income taxes each year.

I seriously question whether or not this is the right approach to take in a catastrophic health plan. I do not like—and I make no bones about it—that type of financing mechanism, and I am eager to get the reaction of Tom Burke, from the Office of the Secretary of Health and Human Services who is here with us today. Mr. Burke was a key player in fashioning the administration's plan.

While this bill has received a great deal of attention in the last few weeks, there are 14 other proposals already pending before the House of Representatives. And I mention that just to impress upon you the fact that nothing is yet set in concrete.

These various catastrophic health insurance bills fall into 3 broad categories and almost all of them build on the existing federal Medicare system. The first category, which includess the proposal by Congressman Stark and Gradison that I just mentioned, would place an upper limit on out-of-pocket costs for Medicare coinsurance and deductibles; and would extend or eliminate the limits on the duration of covered hospital stays.

The second category includes proposals which, with varying degrees of cost consciousness, seek to provide protection against some of the costs associated with services not currently covered by Medicare, including, in some cases, long term care.

The third and final group of proposals would combine expanded protection with a radical restructuring of the Medicare program.

I commend Secretary Bowen for bringing this problem to the fore. I am an original sponsor of the administration's plan. I think its approach of placing a cap on out-of-pocket expenses for acute medical care is sound.

However, we have also seen that there is clearly a need to address the financial hardship wrecked on victims of long term, chronic illness and their families as well. At an average cost of $65 per day, for example, the cost of a stay in a nursing home can be devastating. Last year Medicare paid for only 2 percent of all nursing home expenses. Home health care delivery is another example. Under both the current program and the Bowen plan, Medicare will pay only for intermittent skilled nursing visits and then only when deemed "medically necessary." It pays nothing for custodial care or for those elderly who are not homebound.

It is clear that the Administration's proposal, the Bowen plan, is only a good starting point. In my view, it is not enough. Any catastrophic health care plan passed by Congress must include serious measures to address the very critical problem of post-acute care services. And by that I mean nursing home care, and long term

care at home. We cannot continue to bankrupt the American public without having any plan to cover those costs in place.

Because it is likely that Congress will pass some form of catastrophic health care legislation during this session, it is crucial that we understand just what are the real health care coverage needs of our nation's elderly. That is why we are calling this hearing; to hear from people who in many cases cannot get down to Washington. I am eager to hear the views of our witnesses on this matter and I want to thank all of our witnesses for coming here. I also want to thank all of you in the audience for coming to participate and for showing your support for the kind of catastrophic health care plan that is long overdue.

I now call on Congresswoman Roukema for her opening statement.

Congresswoman Roukema.

STATEMENT OF REPRESENTATIVE MARGE ROUKEMA

Mrs. ROUKEMA. Thank you, Congressman Rinaldo. I do thank you for inviting me to participate in this program today. As you have indicated, I represent the Fifth Congressional District, but perhaps some of you do not know where that is geographically. It is north of here and it sits right up in Bergen, Passaic and Sussex Counties, and I represent constituents very much like yourselves.

I also want to thank you for putting together this program today and for the excellent set of witnesses, and I am interested in getting on to hear those witnesses. I would ask if I could summarize my opening statement and have unanimous consent to put the full text of my remarks in the record.

Mr. RINALDO. Without objection, so ordered.

Mrs. ROUKEMA. In summary, let me point out that I have followed this issue with my constituents for a good number of years during my years in Congress. And it has been abundantly clear to me that the threat of long term or catastrophic illness is an issue of critical concern to all of our nation's elderly and their children, the so-called middle generation.

They worry about the financial devastation and emotional trauma which might befall them should a member of their family suffer such illness. And of course, their anxiety is growing in direct proportion to increased longevity and increased size of the elderly population.

It is an issue that evokes more frustration, anger and fear than any other issue I know, because the cost of care is outstripping the ability of prudent, hardworking people like yourselves and your families to pay for adequate care. That is clear, abundantly clear.

It has become obvious to me, therefore, that the time has come to expand the Medicare program, bring it up to date to meet the needs of our growing aging population.

The first step in this regard is obviously an approach to catastrophic illness coverage that has been so eloquently outlined by our Chairman today. And to repeat Congressman Rinaldo's report, the report is as new as this morning's paper which outlines the results of a markup yesterday in the Ways and Means Committee

that puts forward a plan for catastrophic illness coverage; not necessarily one that you and I, Mr. Chairman, might agree with.

However, one of our prime witnesses today, Tom Burke, is the chief of staff for Dr. Otis Bowen, who did present the first proposal that would cover catastrophic illness for acute hospital care through a premium increase, and we shall be going over that proposal in detail.

But these are all first steps to our approach, acute hospital care. In addition, there is another area in which I have particularly had close interest, and that is the logical extension to expanding home health care. And to that extent, I have introduced a bill just this past week that would not only expand coverage for home health care, but also increase the reimbursement level. I think that expansion of the Medicare program to allow reimbursement of home health care for 60 days and an additional benefit for assistance at home following that care, are essential components to any catastrophic illness proposal that we pass.

Mr. Chairman, I thank you very much.

[The prepared statement of Mrs. Roukema follows:]

PREPARED STATEMENT OF REPRESENTATIVE MARGE ROUKEMA

GOOD MORNING. I WANT TO THANK VICE-CHAIRMAN RINALDO FOR ALLOWING ME TO PARTICIPATE IN THIS HEARING TODAY. I REPRESENT THE FIFTH CONGRESSIONAL DISTRICT OF NEW JERSEY.

AFTER YEARS OF DISCUSSION WITH MY CONSTITUENTS AND HEALTH CARE PROVIDERS, IT HAS BECOME ABUNDANTLY CLEAR TO ME THAT THE THREAT OF LONG-TERM OR CATASTROPHIC ILLNESS IS AN ISSUE OF CRITICAL CONCERN TO OUR NATION'S ELDERLY AND THEIR CHILDREN. THEY WORRY ABOUT THE FINANCIAL DEVASTATION AND EMOTIONAL TRAUMA WHICH MIGHT BEFALL THEM SHOULD A MEMBER OF THEIR FAMILY SUFFER SUCH ILLNESS. IT IS AN ISSUE THAT EVOKES MORE FRUSTRATION, ANGER, AND PASSION THEN JUST ABOUT ANY OTHER AND MUST BE ADDRESSED.

IT HAS BECOME OBVIOUS TO ME THAT THE TIME HAS COME TO BRING THE MEDICARE PROGRAM UP TO DATE IN ORDER TO MEET THE NEEDS OF OUR AGING POPULATION. THE FIRST STEP IN THIS REGARD IS TO PROVIDE CATASTROPHIC ILLNESS INSURANCE TO MEET ACUTE CARE NEEDS.

DR. BOWEN, THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, HAS INTRODUCED A FOWARD-LOOKING, PRUDENT PROPOSAL FOR CATASTROPHIC ILLNESS INSURANCE. LEGISLATION WHICH WOULD ENACT THIS PROPOSAL, WHICH I HAVE COSPONSORED (H.R. 1245), WILL RESTRUCTURE MEDICARE TO ASSIST 1.7 MILLION BENEFICIARIES IN FISCAL YEAR 1988 BY ESTABLISHING AN OUT-OF-POCKET LIMIT FOR MEDICARE PARTS A AND B OF $2,000 FOR ALL SERVICES CURRENTLY COVERED BY MEDICARE. THIS WOULD BE ADJUSTED ANNUALLY. IN ORDER TO PAY FOR THIS INCREASED COVERAGE, PREMIUMS UNDER PART B WOULD BE INCREASED BY SIX DOLLARS OR 50 A MONTH.

ANOTHER PROPOSAL TO IMPLEMENT CATASTROPHIC ILLNESS INSURANCE UNDER MEDICARE HAS BEEN INTROOUCED BY CONGRESSMEN STARK AND GRADISON. THIS LEGISLATION DIFFERS FROM THE BOWEN PLAN IN TWO FUNDAMENTAL WAYS. IT ESTABLISHES A LOWER OUT-OF-POCKET LIMIT OF ABOUT $1,700 PER YEAR AND PAYS FOR THE INCREASED COVERAGE THROUGH THE INCOME TAX SYSTEM.

THE MINIMUM COMMITMENT WE SHOULD MAKE TO OUR NATION'S SENIOR CITIZENS THIS YEAR IS TO IMPLEMENT CATASTROPHIC ILLNESS INSURANCE LEGISLATION. STEP ONE, IF YOU WILL. AN ADDITIONAL COMPONENT IS NEEDED, HOWEVER. EXPANDED HOME HEALTH BENEFITS MUST BE PART OF ANY FIRST-STEP SOLUTION.

RIGHT NOW, MEDICARE IS GROSSLY INADEQUATE IN TERMS OF THE REIMBURSEMENT IT GIVES TO HOME HEALTH CARE, PUSHING THESE COSTS FAR BEYOND THE REACH OF MOST FAMILIES. WE MUST EXPAND THE HOME HEALTH BENEFIT TO ENSURE THAT THOSE WHO ARE BEING RELEASED FROM THE HOSPITAL "QUICKER AND SICKER" CAN BE TAKEN CARE OF IN THEIR HOME.

I HAVE INTRODUCED LEGISLATION TO DO JUST THAT. MY LEGISLATION WOULD CLARIFY AND EXPAND THE HOME HEALTH BENEFIT UNDER MEDICARE. IT WOULD ALLOW SIXTY DAYS OF DAILY CARE BY SKILLED HEALTH PERSONNEL, RATHER THAN THE CURRENT TWO TO THREE WEEKS (DEPENDING UPON INTERPRETATION BY AGENCY OFFICIALS). ADDITIONAL DAILY VISITS WOULD BE COVERED UNDER EXCEPTIONAL CIRCUMSTANCES AS CERTIFIED BY A PHYSICIAN. PERSONS WHO HAVE JUST BEEN RELEASED FROM THE HOSPITAL WILL BE ASSURED THAT THEY CAN RECEIVE DAILY HOME HEALTH SERVICES FOR SIXTY DAYS RATHER THAN THE CURRENT FOURTEEN TO TWENTY-ONE DAYS. THIS LEGISLATION WOULD CLEAR UP CONFUSION AND PROVIDE UNIFORMITY.

IN ADDITION, BECAUSE MANY ELDERLY STILL NEED SOME PERSONAL OR HEALTH CARE SERVICES FOR SOME TIME AFTER THEIR NEED FOR DAILY CARE HAS BEEN SERVED, THIS LEGISLATION WOULD ALLOW FOR UP TO THIRTY ADDITIONAL VISITS BY A HOME HEALTH AIDE IN ORDER TO MAINTAIN THAT PERSON SAFELY IN THEIR OWN HOME.

AS CURRENTLY BEING CONSIDERED, CATASTROPHIC ILLNESS INSURANCE PROPOSALS DO NOT ADDRESS THE KEY ISSUE OF LONG-TERM INSURANCE FOR THE CHRONICALLY ILL--SUCH AS THOSE WHO HAVE ALZHEIMER'S DISEASE AND NEED NURSING HOME OR LONG-TERM HOME CARE. THIS COMING YEAR AND AFTERWARDS, WE IN THE CONGRESS WILL BE LOOKING INTO ISSUES SURROUNDING LONG-TERM CARE NEEDS--BUT WE MUST NOT ACT TOO PRECIPITOUSLY. I HOPE TODAY'S HEARING WILL PROVIDE INFORMATION ON WAYS TO PROCEED IN THIS AREA.

WE MUST DO ALL WE CAN TO ASSIST THE ELDERLY WHO HAVE SAVED LONG AND HARD FOR THEIR RETIREMENT. ENSURING QUALITY, AFFORDABLE HEALTH CARE IS OF THE UTMOST IMPORTANCE. I LOOK FORWARD TO TODAY'S TESTIMONY.

Mr. RINALDO. Thank you, Congresswoman Roukema.

I now call on Congressman Jim Saxton, who will also give an opening statement.

STATEMENT OF REPRESENTATIVE JIM SAXTON

Mr. SAXTON. Mr. Chairman, thank you very much. And let me begin by commending you for setting up this hearing which I think is so important to us in Washington. You know, there is a saying in Washington that we need to get outside of the beltway of D.C. to find out what is going on, and that is why we are here today. I want to commend you for it and thank you for inviting me to take part in this hearing.

I want to take this opportunity to say to all of you that perhaps some of us are luckier than others in the representation that we have, and I think the New Jersey Delegation is, in particular, a very good one. When it comes to issues that have to do with senior citizens and health care and retirement programs, there is no one in the City of Washington, D.C. that has been more attentive to that kind of subject matter than the chairman of this committee hearing today.

Matt Rinaldo's name in Washington and in fact across this country is synonymous with names like Claude Pepper, the Congressman from Florida; and Ed Roybal, the Congressman from California; both of whom have taken it upon themselves to be leaders in this field.

And as vice chairman of the Select Committee on Aging, Congressman Rinaldo has joined those two individuals as a leader in this field. It is a special pleasure for me to be able to take part in this panel discussion this morning.

I would also like to thank Mayor Dunn for hosting us here this morning. I was here a year or 18 months ago to take part in a hearing that dealt with Alzheimer's disease. a very closely associated subject. So perhaps today's hearing is, in a way, an extension of that.

I also believe it is an honor and a privilege to be able to work on the Select Committee on Aging. We have, as a committee, address a variety of significant gaps in health care coverage. As Congressman Rinaldo pointed out, the President has led the way in the catastrohic health insurance debate with his statement of two years ago in the State of the Union Address.

Congress has taken an important step forward toward the establishment of a catastrophic health care program.

Although our current medical system provides substantial benefits to most individuals, most individuals may also run the risk of financial devastation if catastrophic illness strikes. All too often I have heard in my district stories of such devastating results from an illness. The 13th district is at the other end of the state. I represent a large portion of Burlington County, Camden and Ocean County. Many of you may have considered at one time or another retiring in Ocean County, because there are many seniors who have decided to do that at Crestwood Village, and Leisure Village and other senior communities located there.

One of our main concerns is how to develop a workable solution to the problem. Almost on a daily basis I hear stories of people who have had long-term illnesses. All too often the entire savings of a family or an individual are used to pay for those necessary services.

One of the things that we would like to do today is get you the witnesses' input about, how we can solve these long term catastrophic illness problems. Understandably, many beneficiaries mistakenly believe that they were adequately protected by Medicare. But we as members of the committee, know that this is not the case. Medicare does not cover medical expenses after 150 days in the hospital, for example.

Others have tried to plan by purchasing supplemental insurance, but these too have proven to be inefficient and very costly. Many people face acute hospital costs, and Secretary Bowen's plan, while not perfect, is certainly a step in the right direction.

However, I believe the more fundamental need lies in the need for protection against long-term catastrophic illness.

Recently in a hearing in Washington when we were discussing Secretary Bowen's plan, it was pointed out that while protection from the costs of acute care in the hospital are significant, almost 80 or 81 percent of long term care is not addressed by the Bowen plan. That is, long term nursing home care and home health care. This is a subject that we must address.

Most people are prudent in saving for their later years, but the cost of an acute or long term illness is so high that many people may not earn in a lifetime what it costs to pay for required medical care. While we all know what the problem is, the solution today is not near as clear.

Federal spending for Medicare has risen dramatically from $7 million in 1966 to $86 billion projected costs in 1988. Out-of-pocket expenditures for senior citizens which are incurred each year have also risen tremendously.

Our challenge in Congress is that which we are here to discuss today. It is how to effectively expand our coverage without placing too great a burden on the beneficiary or on the federal government.

Again, Mr. Chairman, I would like to thank you, and particularly for bringing this set of witnesses together. We are going to hear today from someone whose family has been affected. We are going to hear from the U.S. Department of Health and Human Services. We are going to hear from a health provider from Overlook Hospital in Summit. We are going to hear from someone who provides service in the home, the Visiting Nurses Society, and we are going to hear from your organization, one of which many of you are members, the AARP.

Thank you for inviting me to take part in this hearing today, Mr. Chairman. I look forward to hearing the witness testimony. Thank you very much.

Mr. RINALDO. Thank you, Congressman Saxton.

Once again, I want to thank both of my colleagues for taking time out from their very busy schedules to be here with us today. And before calling our first witness, I would like to state to all of the witnesses that normally in Washington we have a five minute

rule under which everyone is allowed five minutes to present their testimony. This morning we are changing that to allow 10 minutes for each witness. If your remarks extend beyond that you may submit a written statement, and it will be included in full in the printed record. The record will be presented to all of the members of this committee in Washington.

Our first witness is Mr. William Hargwood, who resides in Fanwood, New Jersey. Mr. Hargwood is married with three children, ages 32, 27 and 20, who all live away from home. His wife is a victim of Alzheimer's disease. He worked 20 years as an insurance agent for Prudential, and served for a time on the Monmouth City Council.

He made a good living and had in his words, "the best health insurance coverage available." In 1982, his wife was diagnosed with Alzheimer's and three years later had to be placed in a nursing home.

His insurance was not enough. The expenses associated with his wife's illness forced him to empty his savings, cash in his insurance policies and take out a second mortgage on his home. Mr. Hargwood is just one example of how devastating a catastrophic health illness can be to a family.

I want to certainly thank him very deeply for coming here and for his willingness to share his story with all of us. I am confident that the story of his personal tragedy of long term illness will help to galvanize Congress and the administration into action.

Mr. Hargwood, you may proceed.

STATEMENT OF WILLIAM HARGWOOD, FORMER COUNCILMAN OF MONMOUTH, NJ AND SPOUSE OF ALZHEIMER'S VICTIM

Mr. HARGWOOD. Thank you, Congressman Rinaldo, and good morning. I want to thank you and the Select Committee on Aging for allowing me to speak to you this morning. My name is William Hargwood and I am of Fanwood, New Jersey. I am a caregiver. My wife was diagnosed in 1982 as having Alzheimer's disease. It did not just start that simple, of course. Prior to her diagnosis, she had been doing some strange things.

Mr. RINALDO. Excuse me, Mr. Hargwood. I hate to interrupt you, but the people in the back are signaling that they still cannot hear you.

Mr. HARGWOOD. Still cannot hear.

Mr. RINALDO. Talk as directly into the microphone as you can.

Mr. HARGWOOD. As I said, she had not been doing the normal things that you are used to your wife doing after 32 years of marriage; for example, she would go to the Y. My son was there one time, and he says, "Dad, I had to go bring mom out of the men's room because she was waiting for me to come out of the Y."

That, along with some other things that were just out of the norm began to give me some indication that something was definitely wrong. She used to take walks every morning, and she would go to the store in town just to get candy or chewing gum. One morning the owner of the store told me, he says, "Bill, your wife was in, but she did not buy anything. She merely walked in, looked around and then walked out again."

I thought this was strange, and I decided it is time to take her for a checkup. I figured a physical checkup was all that she would need. Well, we went to see the doctor, and he could not find anything wrong with her. And at that point he suggested we take a blood test. However, while we were there in the doctor's office, she was very agitated and kept walking around until the doctor showed up and then she just relaxed and acted as though nothing was wrong.

Well, we took the blood test and he said that she should come back about a week later to pick these tests up. She did, and it was that time that the doctor noticed the agitation that I had noticed before. He then called my office—I was actively engaged in the sale of life and health insurance at that time for Prudential—and told me that I should take her to a neurologist, which I did. The neurologist told me that my wife had what they call Senile Dementia, and that I should follow up with further visits.

I did this and finally we were told that this was Alzheimer's disease.

I then proceeded to get second opinions. Having been in the insurance business, I know you have got to check everything out twice. So I had two neurologists, I had two psychologists, two psychiatrists and two CAT Scans. The CAT Scans on her brain diagnosed a slight atrophy. This meant that she was losing her brain cells a little bit faster than most people at her age.

When the reports were in and I asked the doctor what I should do next, he was unable to tell me. That is when I started to get really involved in the hazards of this disease. The only thing the doctor could do was to prescribe some drugs for her, and the drug bills began to mount. I think my bills alone helped to pay for some of the refurbishing of the pharmacy I was dealing with. My Major Medical helped to defray part of this tremendous cost at that time.

I then proceeded to get involved in a small support group that had started at the Westfield Red Cross building, and that was a tremendous relief for me because I was able to talk to others who were involved in care giving. The group later disbanded. However, I picked up another one in Essex County which I still belong to, and we are constantly communicating with one another.

But at that group I learned there was this book called "The Thirty Six Hour Day", and that 36-hour day book became sort of the bible for handling my wife with Alzheimer's Disease.

I then sought help from home health aides. I had at that point video taped several programs on Alzheimer's disease since I was getting into this. I used the tapes and the book as training for the home aides. The reason I had to do this is that I found out through trial and error that the home aides were not trained to handle an Alzheimer's patient. It is that simple. They are trained basically for cooking and cleaning and taking care of the house, but for handling an Alzheimer's patient, they just did not seem to have it. My wife would have to spend approximately eight hours a day in the care of these aides.

So I helped the aide to set up a schedule to guide her through the day with my wife so that they could both get along. This schedule worked until another phase of this Alzheimer's took over and then we had to change the schedule again.

The cost, of course, was getting prohibitive and my company was beginning to get very edgy about continuing its coverage of home health care expenses. At the same time my sales and income were suffering because of my lack of getting out there to continue to sell. I was constantly changing these home health aides because I was finding that some were good and some were not, and you just had to pick and choose. And I had to, of course, retrain everyone before I let them touch my wife, because they just did not know what to do with an Alzheimer's patient.

An Alzheimer's patient, as I said, is not like other patients, but requires tender care. They require love. They require guidance, because they do not really want to be in the position they are in, and they tell you that before. They tell you they do not want to be in that position but they cannot help themselves. You have got to understand that when you are dealing with an Alzheimer's patient.

There needs to be, of course, money appropriated from both government and private insurance. I think the government and these private agencies that are basically making a profit in this business should at least train their aides so that they can handle an Alzheimer's patient.

After three years of maintaining my wife at home, with the cost of doing that really burdening me, I had to borrow about all of my pension savings against my insurance policies and I also had to take out a second mortgage on my home. I ultimately had to rely on Medicaid to help me put my wife into a nursing home because she had finally gotten to the point where I could no longer keep her at home.

I had to find a nursing home, and that was difficult enough because at that time not all nursing homes would take an Alzheimer's patient. And I just thank the Union County Department of Human Services, Division of Aging, for helping me in that area, because they were able to help me get her into a nursing home which she is still in right now.

She is at the Oakview Care Center in South Amboy, New Jersey. However, she has debilitated to the point now that she is on a feeding tube and that is all. She is unable to walk or talk. And if it were not for the sparkle in her eyes when I visit her, I do not think I could go down there anymore.

We were married 32 years, as I said, before this disease devastated my family and caused me to retire from my job. Your family and friends seem to desert you at that point—they disappear. When this disease appears, I guess they think they are going to catch it. I do not know. But as a caregiver, you need to have some help, because you are feeling a tremendous burden at that point.

You know, caregivers are the people who are taking care of their loved ones, and there are a lot of them in Alzheimer's situation. As a caregiver you have got to make sure that you take care of your own health. I found, after having hospitalized my wife, that I needed to take a physical. I really got very depressed, so I had to go for some help in that area. I then took a physical and that is when I discovered that I had cancer of the prostate, and that caused me to be tied up for about two months trying to get me squared away so that I can continue, at least, taking care of my daughter who was still home with me.

I had a very strong church background and my church and their members gave me their moral and financial help, and that kept me from going off the deep end. My daughter Stacey, who was 15 at the time, showed tremendous support to me. She really had to be there at a time when she was still in her early school years. She lost her social life at school, and she also lost her mother, and yet she had to come home from school and take care of her until I got home from work.

This is truly a catastrophic disease and no one should be made to spend down to the poverty level in order to continue to exist. I can now understand why some people walk away from someone who is catastrophically ill and why others resort to harsher methods of not dealing with this disease that devastates everything that you have worked for in order for you to continue to live in this society.

The caregiver is living in two worlds. One, with the pressure of trying to maintain some semblance of order within himself, his wife and his home. And second, trying to cope with the pressures of everyday life. There are two stresses on a caregiver. One is the stress of what is going on about you, and the second is trying to explain to people who are basically normal about what it is to have this stress on you and still live. It is just not easy anymore.

I thank the committee for listening to me.

Mr. RINALDO. I want to thank you very much, Mr. Hargwood, for your testimony.

I now will recognize Congresswomen Roukema for any questions that she may have.

Mrs. ROUKEMA. Mr. Hargwood, I really do not have a specific question, but I do know that some of the people in the back of the room were not able to hear a couple of very important points that you made, and they are consistent with my opening statement. So I just want to commend you for what you have said and point out to our audience that Mr. Hargwood's experience with a long term illness, in this case, Alzheimer's disease, for his wife is a perfect example of the kind of family I spoke of in my introduction. That is, hard working people who have saved prudently, worked all their lives, have insurance coverage even, and yet find that catastrophic illness is not covered.

You know, there is a problem here. New strides in medical care have brought longevity to our older population but the cost of these services are expensive. So families like Mr. Hargwood's, no matter what they do, cannot keep up to the cost. He had to "spend down," as the bureaucrats say, to the Medicaid stage even with his own private health insurance.

The point that I also want to make, Mr. Hargwood, because we talked about home health care, is that you have explained the inadequacies of trained health aides.

I want to tell you, Mr. Hargwood, it is not only that they are not able to deal with Alzheimer's disease, but I have had an experience in my own family where there was a terminal illness of a different kind, and we found that we literally had to turn home health aides away because they simply were not competent to deal with the problem.

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You have opened up another whole area; the question of training home health aides. And I thank you very much for your testimony. You have been very helpful to the committee.

Mr. HARGWOOD. Thank you.

Mrs. ROUKEMA. Mr. Saxton.

Mr. SAXTON. Thank you very much.

Mr. Hargwood, when you were giving your testimony, you touched on the cost, your out-of-pocket expense, and I believe you mentioned a figure of $300 a week that you had to provide for home health care?

Mr. HARGWOOD. Yes, right. Exactly that, Mr. Saxton.

Mr. SAXTON. So that $300 a week went on for quite some period of time apparently.

Mr. HARGWOOD. Yes, it did.

Mr. SAXTON. Was it a matter of months, of years?

Mr. HARGWOOD. Years. Approximately two years that I had home health care services for my wife.

Mr. SAXTON. So you must have spent somewhere in the neighborhood of $30,000 on home health care?

Mr HARGWOOD. Yes, but I am fortunate to a degree because my company did help to defray some of that expense.

Mr. SAXTON. The company that you worked for?

Mr. HARGWOOD. Yes.

Mr. SAXTON. So you had some help——

Mr. HARGWOOD. Right. That help is not available to anyone else. I think agents had a different contract which contained extra insurance coverage for things like home health aids. However, the company got a little edgy about continuing that coverage and eventually cut it off.

Mr. SAXTON. You mentioned the home health care providers that you were able to have for the roughly two years. You must have had other expenses as well. You mentioned prescriptions.

Mr. HARGWOOD. You know, the regular expenses go on in a home. There is still the mortgage to pay, the electric bill everything still goes on. I still had a car I was paying for at the time. It just——

Mr. SAXTON. In addition to the regular expenses——

Mr. HARGWOOD. In addition to that.

Mr. SAXTON [continuing]. And the home health care, you had prescription drugs as well.

Mr. HARGWOOD. I had to pay for prescription drugs, too, yes. I would say I spent close to a couple thousand dollars a year on prescription drugs, because my wife needed several of them.

Mr. SAXTON. And did you have medical care, as well, provided by doctors and hospitals?

Mr. HARGWOOD. Yes, I did. I had to put her in a hospital one time because that was the only place they could do the treatment, or take some tests. That is when another set of psychologists and psychiatrists came in and that is where I had the other brain scan done was when she was in the hospital.

Mr. SAXTON. Do you have any estimate as to what those medical expenses were? Now this is other than health care at home and drug prescriptions, or doctors and hospitals. How much would you guess that——

Mr. HARGWOOD. I would like to be good on the facts, but I really cannot come up with those at this point. I know it was costly. That is about all I couid say.

Mr. SAXTON. Did you have insurance to cover any of that?

Mr. HARGWOOD. Yes, I did.

Mr. SAXTON. You did.

Mr. HARGWOOD. Right.

Mr. SAXTON. Without care provided by doctors over a two year period from what you just indicated, it cost you somewhere in the neighborhood of $34,000 to $35,000. Does that sound about right? That is without doctors.

Mr. HARGWOOD. Yeah. You know, when you are in this kind of situation and you are spending money, you do not really keep track of what you are doing. All you know is that you have got to spend it to take care of your loved one. So I really did not put the figures together. I was only concerned with the fact that she was ill and I had to do the best I could at that time to handle things for her.

Mr. SAXTON. Well, we certainly commend you for doing that. I am just trying to get at the real facts here——

Mr. HARGWOOD. I know.

Mr. SAXTON [continuing]. For our information as to how much it cost you as an individual to take care of your wife.

Mr. HARGWOOD. Right.

Mr. SAXTON. And I might say that in addition to the $34,000 or $35,000 that you estimate for those costs, even if you had the best doctor—the best health insurance for doctors and hospitals, the $35,000 that you spent must have—there must have been an additional amount added to that because you had to pay some share of those physicians and hospitals.

Mr. HARGWOOD. Yes, I did.

Mr. SAXTON. So we may be talking about expenses to you over a two year period of time of over $40,000 to $50,000.

Mr. HARGWOOD. Very easily.

Mr. SAXTON. Thank you.

Mr. RINALDO. Thank you, Congressman Saxton.

Mr. Hargwood, I just have one question. You explained how the cost of your wife's illness forced you to borrow against your pension. It forced you to cash in your life insurance. It forced you to take a second mortgage on your home. Can you just tell us very briefly and succinctly what else it did to change your entire life? How did it affect you?

Mr. HARGWOOD. Well, I have to say at this point that I did have a son that had just graduated from college, from Lehigh to be exact. He came home and he could not understand what had happened to his mother. It was not in his psyche at that point I guess. He just could not take it, so he took off. I was devastated; I did not expect him to leave me so quickly. But he went out to Colorado, I guess, to "get the clean air."

I had to go looking for him, because he never left a note. He just took off, and, his note was not very clear as to what his intentions were. That, plus the fact that I had to become a house husband and a father and a mother for my daughter, and still try to work, was getting to me. I could not handle it.

I do not know how I got through. I just have to thank the Lord I guess for giving me the strength. But I am still young to a degree. I think of this happening to people who are much older, they cannot really deal with a catastrophically ill individual. I now am seeing a woman whose husband is in the nursing home with my wife, and she is older. She said, "we have been married 59 years or so, and now my husband has come down with a disease. I do not know what to do with myself. I do not know how to handle it."

And so I try to counsel her when I am with her to try to ease some of the tension that she is under. That kind of individual, and there must be many others, you could not get to this type of hearing because they cannot deal with just trying to be normal and answer questions. This is the kind of thing that hurts really hard inside. It is a devastating illness, and it claims two people. That is what it does.

Mr. RINALDO. Okay, thank you very, very much. We deeply appreciate your testimony, and we are very grateful for your coming here today.

Mr. HARGWOOD. Thank you.

Mr. RINALDO. Our next witness is Thomas Burke, Chief of Staff for the United States Department of Health and Human Services in Washington. Mr. Burke oversees the administration of all the department's programs. He was appointed as Chief of Staff by Health and Human Services Secretary Dr. Otis Bowen in January of 1986. He is here in that capacity, and also because of the fact that he is the coauthor of the Secretary's report to the President of the United States on catastrophic health care costs and was very instrumental in the drafting of the legislation to implement the President's recommendations.

I should also say that even though Mr. Burke is on the staff of the Secretary in Washington, D.C., that he is extremely familiar with New Jersey since he is Trentonian—a native of Trenton, New Jersey.

Mr. Burke, you may begin. As I stated to our witnesses before your arrival, we have a copy of your testimony and it has been inserted in the record in full. We are giving each witness 10 minutes. If you want to summarize your testimony even more, you may. Then we will proceed with questions by the Members of Congress.

You may proceed.

STATEMENT OF THOMAS BURKE, CHIEF OF STAFF, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. BURKE. I have a short statement.

Good morning, Chairman Rinaldo, Congresswomen Roukema——

Mr. RINALDO. Mr. Burke, unfortunately with that microphone, you have to pull it very, very close to you. Otherwise, people cannot hear you.

Mr. BURKE. Is that better.

Mr. RINALDO. I think it should be if you talk directly into it. That seems to be better.

Mr. BURKE. I am pleased to be here today to talk on an issue which has been at the top of the President's and Secretary Bowen's

agenda; how to protect our elderly against the devastating effects of catastrophic health care.

The subject of today's hearing is one which I know is of utmost mutual concern. I commend you, Chairman Rinaldo, for your leadership on this issue and your concern for the elderly of this nation.

Be it through our personal experience or those of family or friends, we certainly have seen how devastating illness can destroy the financial security of a family.

President Reagan deserves the thanks of all Americans for recognizing this need. He has long been a supporter of catastrophic coverage; first as governor of California, now as president. Without his leadership, I doubt we would be having these discussions.

In the President's State of the Union address in 1986, he directed Secretary Bowen to report to him options on how the private sector and government can work together to address the problems of affordable insurance for those whose life savings would otherwise be threatened when a catastrophic illness strikes.

After ten months of in-depth study, we brought together the best minds we could in the United States—70 people from the department participated in it, and the Secretary issued his report on catastrophic health expenses. The report presented options on how to provide protection against a catastrophic event for three groups of people: the elderly facing acute care expenses; the elderly facing long term care expenses; and the general population under 65 facing expenses associated with a catastrophic health event.

In this year's State of the Union address, the President endorsed the concept of catastrophic illness coverage and said he would shortly transmit the necessary legislation to Congress. I am here today to discuss that legislation which the President transmitted to Congress.

On February 25, Republican Leader Bob Michel introduced the President's proposal, H.R. 1245, the Medicare Catastrophic Illness Coverage Act. We thank the chairman of this morning's hearing for his support and primary cosponsorship of this measure. We would also like to thank Congresswoman Roukema and Congressman Saxton for the "Dear Colleague" letter which started a ground swell of support on behalf of Secretary Bowen's proposal from both sides of the aisle, it was very timely and very important.

Of the more than 31 million elderly Medicare beneficiaries, about 1.4 million will incur personal costs for acute care services of $2,000 or more in 1988. This will be a heavy burden for those living on $7,000, $8,000, $10,000 in Social Security benefits.

Virtually all elderly have acute care insurance protection under Medicare. Nearly two-thirds also have private supplementary insurance called medigap. But there are still significant gaps in coverage.

As you are aware, the number of hospital days Medicare will cover is limited; after 60 days, a Medicare patient must begin to make increasingly costly payments. There is also a required 20 percent co-payment on all physician services covered by Medicare.

Medigap insurance helps the 65 percent of the elderly who buy it. But even with medigap, an individual may face significant out-of-pocket costs. The state-operated Medicaid plan may also help

with about 13 percent of the elderly, but there are limits on the kinds of services provided.

The President's plan would improve catastrophic protection for the elderly facing acute care expenses. Under the plan, the elderly would receive catastrophic health care coverage under the Medicare program. Medicare would be restructured to provide for coverage for those who incurred out-of-pocket costs in excess of $2,000 a year for Medicare-covered services. This coverage will be made available for a small additional monthly Medicare premium. The premium will be set annually in order to maintain budget neutrality in the Medicare program.

I would now like to outline the key features of the President's bill.

The President's bill is simple and direct. It provides peace of mind to beneficiaries for a modest premium that is paid by all beneficiaries, all 31.5 million. Finally, it is structured to be budget neutral.

Let me elaborate briefly on each of these points.

First, it is simple and direct. Since its inception the Medicare program has had a benefit package that has been close to incomprehensible for many of our beneficiaries. Hospital benefits were tied to a "spell of illness" concept and the amount of cost-sharing varied depending on the day of hospital stay.

The President's bill simplifies the Medicare benefit package. Hospital cost-sharing beyond two deductibles in a calendar year is totally eliminated. The President's bill also removes the confusing spell of illness concept—a limited hospital benefit—and replaces it with a hospital benefit for unlimited acute care benefits for covered services. Catastrophic protection is provided and financed in a direct and understandable fashion.

Second, it provides peace of mind. Under current law, Medicare requires the greatest cost-sharing from beneficiaries with the most serious health problems. Beneficiaries faced with serious acute illness have to worry about not only their recovery but also about how their illness will impact on their financial well being. Secretary Bowen has said a number of times that the elderly have to worry about their health and their finances and about which one will run out first.

Under the President's catastrophic bill, all this is changed. Beneficiaries will have the peace of mind of knowing that their total copayments and deductibles cannot exceed $2,000 in 1988 or its equivalent in future years.

Third, the program is financed by low premiums with the burden shared equally. Under the President's plan, the cost of the catastrophic benefit is shared by all 31.5 million beneficiaries. Beneficiaries will be able to purchase financial security from the devastating impact of acute catastrophic illness for a reasonable monthly premium. The price tag for an individual beneficiary is low because all can benefit from the group's large-size and the low administrative costs of the Medicare program. Medicare pays out 98 cents on every dollar that it receives in benefits.

Fourth, the proposal is budget neutral. If you examine the President's proposal, you will find that all of the costs of the catastrophic benefit—the program payout after a beneficiary meets the cap,

the cost of the restructured Part A benefit, the catastrophic-related administrative costs, and any lost income due to the "hold harmless" provisions embodied in our bill—all are included in the catastrophic premium.

The premium needed to finance the catastrophic benefit will be recalculated annually by Medicare's actuaries, and the discipline of an actuarially-determined premium and a separate accounting system will ensure that the new catastrophic benefit remains self-financed and budget neutral.

I also want to talk about an additional feature of the bill, for which we are soliciting Congress' support—this is the carryover provision.

As you know, the major expenses of illness frequently do not fall neatly into one calendar year. For example, an elderly beneficiary can be hospitalized in December and run up large out-of-pocket costs. Without some carryover in the next year, he could incur another large catastrophic expense in January. The President proposed to better protect the elderly against arbitrary, but large, out-of-pocket costs due simply to the unfortunate timing of illness.

Precisely because such a provision protects Medicare beneficiaries more completely and fairly, it is somewhat costly. We have estimated that it will increase the cost of the premium by 35 percent to provide that coverage in the package. However, we are working with congressional staffers. We think there are different ways of configuring it so we can get that cost down.

The carryover provision is just one of many ways to reduce the possible arbitrariness of an annual accounting period. There may well be other approaches which provide this type of protection at a more reasonable cost, and we are going to be looking at them.

I hope that Congress will give older Americans that last full measure of security, to provide a health insurance plan that fights the fear of catastrophic illness. We do, however, urge the Congress to proceed with caution. The problem is important, complex and potentially costly to solve. It is important that we not create new problems nor aggravate old problems while solving this one. For example, only yesterday the House Ways and Means Subcommittee approved by a nine to two vote the Stark/Gradison catastrophic health bill, which in many ways is very similar to the President's bill. There is, however, one key difference. And the difference in the Stark/Gradison plan is that it is financed by an additional tax on the actuarial equivalence of the Medicare benefit. That financing mechanism passed by a one vote margin. Will be revisited in full committee.

Unlike the President's proposal to create a self-financed insurance program, the Stark/Gradison bill falls short because it would impose a new tax and would not necessarily be budget-neutral. The President has consistently voiced his opposition to new taxes.

We have other concerns with this financing mechanism, such as the equity of the concept. The catastrophic benefit would be financed by a tax that would only impact one-third of America's elderly, and we do not, frankly, believe this is fair.

In closing, Mr. Chairman, let me thank you and the other members here today for furthering the public dialogue on this pressing issue. It is clear there is a consensus across the nation that we

must now take action to remove the elderly's fear of financial ruin due to an acute, catastrophic illness. Your hearing will help move us one step closer to that goal. At this time, I would like to respond to any questions you may have.

Mr. RINALDO. Thank you, Mr. Burke.

Let me just begin by saying that the Stark/Gradison Plan, as I mentioned earlier, and as you alluded to, will cost those elderly paying income taxes an additional $300 to $500 each year according to the estimates we have received.

Say that plan does get to the point where it passes both Houses. If asked for a recommendation by the Administration, by the President, would you recommend a veto of that particular plan because of the financing scheme?

Mr. BURKE. I think in answering that question, I would have to say that the linchpin of the President's proposal is budget neutrality. To the extent that it is budget neutral—and there is some question about that—I would think the President would be favorably disposed, but I cannot speak for the President of the United States.

Mr. RINALDO. I understand.

Mr. BURKE. I would add one thing, however. That the financing mechanism is the most vulnerable part of this. I sat through the subcommittee markup all day Wednesday, and the financing portion of that bill is definitely going to be changed in full committee. My staff informs me that on the Senate side, they are going to come with a premium-oriented approach.

I think what you are looking at with the Stark/Gradison bill and the President's proposal are the boundaries of a proposal. I think it is quite problematic, in my own judgment. The final bill which emerges from the Congress and goes to the President will probably encompass both a tax and a premium approach to pay for the catastrophic coverage.

Mr. RINALDO. For the benefit of the people who are here, I think you should recognize that the plan only passed one subcommittee in one of the Houses. It still has to pass the full committee, and the subcommittee and full committee in the Senate, and then any differences in the two bills have to be reconciled before it goes to the President.

But this bill shows that Congress is working. It shows that this particular type of legislation does have a high priority. As I mentioned earlier, I do not favor increasing anyone's income taxes any higher than they already are. I do not think we need any more taxes, and I am pleased that Mr. Burke has responded that in his judgment this is going to be changed before the bill goes much farther.

Let me ask another question: Among the costs commonly incurred by the elderly, in this State, in this district, by people in this very room, by members of my own family, are the purchase of prescription drugs, eye glasses, hearing aids, things of that nature. These expenses can have a substantial impact on a fixed income.

Are such costs counted toward the $2,000 limit?

We looked at a number of options, including that. One of the reasons that they are not included in the bill is that they are expensive. Additionally, we have some technical reasons: there is no good data base that could tell us what we would be looking at in terms

of cost far as setting a premium. We have no data in Washington on prescription drugs because Medicare does not cover them. We feel if you did cover them, however, the premium would probably be prohibitively high.

We realize that the next item that probably will go on the board for consideration is drug expenses. One percent of America's elderly account for 15 percent of the drug expenses, and 6 percent account for a third.

In a survey it took, the AARP has found that the single most important element that was excluded from the benefit package was drugs. I think of two reasons why it is not included in the package. We could not estimate the cost. We did not know what it would cost. We could not factor that into the premium; and secondly, this is not the right time to be proposing new benefits in the Medicare program.

Mr. RINALDO. As I mentioned earlier, there are about 15 plans already introduced in the Congress. Congressman Pepper has introduced a plan that would not only cover prescription drugs, eye glasses, hearing aids, but also long term home health care and nursing home care.

Could you give us your view of that bill and the costs of that particular plan and how they would be met?

Mr. BURKE. That bill scares me and it scares me for this reason. In 1979, we came very close to getting this additional coverage. There was a Durenberger-Dole-Domenici-Danforth bill, and it was hotly debated. Passage looked imminent, but more and more items were added to the bill. And, here we are in 1987. We have nothing.

I think that the price tag associated with Congressman Pepper's bill is incredibly high and not affordable at this time. We estimate that if long-term care alone were put into the Medicare program now, in 1987 dollars it would cost $100 billion by the year 2020. I think before we go down that road there are other options that need to be looked at—private sector options, some innovative financing options which are laid out in our report to the President. The Treasury Department is now studying this. These things deserve a study before we get into what is not strictly a health issue.

Mr. RINALDO. Is there the possibility, if a plan of that type were passed by the Congress, that it would be vetoed by the President because of the inability to pay for it?

Mr. BURKE. Let me answer that by saying——

Mr. RINALDO. Or because of costs?

Mr. BURKE [continuing]. I have spent much of the last two weeks on both the House and the Senate sides, mostly on House. I think the chance of a plan like that getting passed is nil, almost zero.

Mr. RINALDO. Well, then what are your recommendations for people like Mr. Hargwood? I know you did not hear all of his testimony. He was our first witness. He has already faced catastrophic cost for long term care.

Do you foresee any hope for people in his position? Do you foresee any hope for covering victims of Alzheimer's?

Mr. BURKE. I believe the Secretary, myself and others were greatly concerned about long-term care. As you know, we had as part of the department's report a private-public sector advisory committee. We had two New Jerseyians, Jim Balog from Spring

Lake, and Mayor Rafferty from Hamilton, on that committee. They held hearings throughout the United States on the issue of catastrophic insurance. The paramount concern of America's elderly, was and still is long-term care.

We have put forth in the secretary's report some very real steps that can be taken to provide assistance for long-term care.

We also realize the fact that if we do not begin to do something now, with the greying of America, there is going to be an avalanche of elderly citizens in 25 years when the baby boom becomes an elder boom. Then, the problem is going to be too massive to take care of in one or two or three years with a quick fix.

We should begin now. In our report to the President we laid out a series of steps that should be taken now: individual medical accounts; changing the legislative prohibitions for providing long term care insurance at reasonable rates; and giving people not tax sheltered, but tax-free, opportunities to put away funds such as $1,000 a year as they do on life insurance policies. They could then collect on this if they need to go into a nursing home. But if they do not need to go into a nursing home and they die at age 68, that money reverts to their estate.

So there are a lot of creative, I think innovative, approaches in our report. We are now working very aggressively with Treasury to flesh out the costs underlying these approaches and what actions need to be taken. We hope later on this year to go forth with a legislative proposal in this area that would help people like Mr. Hargwood.

I do not believe the answer though is a massive infusion at this time of more Federal monies that are not there. As I testified Monday before the Ways and Means Committee, the ways are far exceeding the means these days in Washington.

Mr. RINALDO. Thank you very much, Mr. Burke.

My time has expired. I now recognize Congresswoman Roukema.

Mrs. ROUKEMA. Thank you, Mr. Chairman.

I want to go back, Mr. Burke, over the distinctions between the plan that Secretary Bowen and the President have proposed, and the one that the Ways and Means Committee took up yesterday.

As you know, I am an original cosponsor of Dr. Bowen's and the President's proposal.

Mr. BURKE. Yes.

Mrs. ROUKEMA. And I think it is a fine one. To repeat for the audience, it is the one that sets forward a premium, pay as you go if you will, for a catastrophic insurance coverage that is very economical, about $60 or $75 a year. There would be really excellent coverage for hospital costs.

Now we have the Ways and Means proposal which brings in an entirely different question as to how you pay for it. It provides the same assurance and peace of mind, but they do it by taking a departure from the premium module by taxing the actuarial volume of the benefit. We will not go into how the finances work, but let us suffice it to say that if the New York Times report is correct, it means that those people who have a taxable income of $10,000 to $15,000 a year would pay $140 for this coverage per year. People between $15,000 and $20,000 of taxable income would pay $169 a year. And those with incomes that are higher, for example, $30,000

to $50,000 would pay about $300 a year in taxes, new taxes. And for higher incomes, it would be about $425 a year.

Mr. BURKE. And it goes up to $500.

Mrs. ROUKEMA. Pardon me?

Mr. BURKE. And then it goes up to $500.

Mrs. ROUKEMA. And it goes up to $500. Well, from what you can see is happening here is what we are getting into is an entirely different philosophy as to how to pay for these benefits.

Do you think that their figures are correct? And why did you and the President determine not to go to a new tax formula? I want to get that very clearly on the record here because this will be the crux of the argument in Congress, and I think these people should know what the dollar figures are that are involved.

Mr. BURKE. The subcommittee chairman and staff have admitted that the numbers are not going to be right the first year. They are going to be off by $800 million, but over three years it averages out.

There are a number of reasons we did not go that route. Number one, the proposal which they have basically says that the value of the Medicare benefit is worth $2,000 to you individuals, because that is basically what it would cost them. So, the government will add $2,000 to an individual's income tax then at the applicable rates.

As the value of the Medicare benefit goes up with time due to inflation, the tax is going to go up in time. But even in the first year, their proposal will bring on to the tax rolls 2 million elderly who now pay no taxes. They will begin to pay taxes. That is part of the reason we did not like it. Because of the President's very strong feelings about tax increases, it would have never gotten approved by the White House.

The other reason is that we do not look at Medicare as a welfare program; it is an entitlement program. Our premium is spread over very large numbers so that it is kept low and it does not matter if an individual is medically indigent. He or she is still entitled to Medicare. No one is turned away because he or she has AIDS or cancer or anything; they are all covered. We are covering the entire Medicare population for a very modest premium, and we think the vast majority of America's elderly can afford $6 a month. That is you can buy this coverage for the price of a carton of cigarettes. It is not going to be free to some people and cost more to others, with one-third of the people paying for the benefit of all, as in the Ways and Means Bill.

Mrs. ROUKEMA. Mr. Burke, I do not want to be difficult for you. I think you have given an excellent answer, and I do not want to put you on the spot, but I have to ask the devil's advocate question.

Why should someone who has an annual income of $50,000, $100,000 or more have to pay only the same premium as someone who has an income, a taxable income of some place between $15,000 and $30,000? That is the question you are going to be asked over and over again, and that I am going to be asked over and over again.

How do you respond to that question?

Mr. BURKE. That is an easy one. I have no objection to an income-related premium. And I do not know if the Administration would necessarily oppose it. We proposed it in 1982 with the tax

cap and it did not go anywhere. At least it was proposed. It did not go anywhere primarily because of a certain senator who chaired a certain committee in the Senate—one who we all know.

If you want to do income-related premiums, that is fine. But why choose the catastrophic addition to the Medicare program to do it? If you are going to income-relate the premiums for Medicare, then do it, but do it for the whole program. Do not do it for something that represents less than 10 percent of the program.

Mrs. ROUKEMA. Mr. Chairman, I hope I am not going over my time, but I do have one more question.

Mr. RINALDO. Sure.

Mrs. ROUKEMA. And that is related to the home health care bill that I have introduced and other proposed home health care programs.

Mr. Burke, do you and Dr. Bowen and the President see home health care as a legitimate component add on to your proposal, and perhaps one that goes hand and glove if we maintain a pay-as-you-go approach, but extend home health care to a more reasonable time, say 60 days with a 30 day add on for assistance and aides in the home?

Mr. BURKE. As you know, that is a feature of Stark/Gradison. There are three additional add-ons to Stark/Gradison: home health, elimination of the three-day prior hospitalization stay for skilled nursing facilities; and an increase from $250 to $1,000 on the cap for mental health benefits.

Mrs. ROUKEMA. Yes.

Mr. BURKE. Dr. Bowen has always advocated that care should be provided in the least restrictive environment, and he is in favor of that. I do not believe that would be at all inconsistent with our proposal. We have, in fact, waived in our proposal all co-insurance on home health, and in the Stark/Gradison bill there is an additional home health component. So we are in favor of it and I think that he has always said that we should provide care in the least restrictive environment.

Mrs. ROUKEMA. Thank you.

Mr. RINALDO. The gentlelady's time has expired, and I now recognize Congressman Saxton.

Mr. SAXTON. Thank you.

Mr. Burke, just for the record and so that no one leaves here confused today as far as the Secretary's plan is concerned and the parts of it that the President has endorsed, would you explain to the panel and the audience what it is that is covered and what important parts of long term care are not?

Mr. BURKE. The current Medicare benefit provides for a first day deductible, $520 this year, and then you receive unlimited care for 60 days. You pay one-fourth of the cost of a day of care for days 60 through 90. From days 90 through 150, you pay half of the care. If you are in the hospital over 150 days, you are at risk for all of the costs.

The Medicare benefit package pays for physician fees. It does not pay for drugs, eye glasses, dental, or vision care. We had not proposed any new additions to the Medicare benefit package.

The President's proposal would eliminate all cost-sharing on inpatient hospital stays. So if you were in the hospital 365 days, you

would pay for one day, the first one. And if you happened to be admitted five times, the most you would have to pay would be two deductibles, then you are totally at risk, and they would count toward your $2,000 cap.

Mr. SAXTON. Okay, you are saying that if an individual were admitted to the hospital, he would have the first day's coverage as his or her responsibility.

Mr. BURKE. That is correct, as it is now.

Mr. SAXTON. And there would be some additional co-payment up to $2,000.

Mr. BURKE. Not in the hospital.

Mr. SAXTON. Not in the hospital. So he would have the first day's coverage of——

Mr. BURKE. Five hundred and twenty dollars.

Mr. SAXTON [continuing]. $520.

Mr. BURKE. Which counts towards the $2,000 catastrophic cap.

Mr. SAXTON. And if he or she were unfortunate enough to have to stay in the hospital for a full year, there would be no additional hospital costs borne by the patient; is that correct?

Mr. BURKE. That is correct.

Now in addition to that, if you went into a skilled nursing home, there are co-insurances on nursing home days. Those would also be eliminated, all co-insurances.

Mr. SAXTON. Can we stay with nursing home care for just a moment.

Mr. BURKE. All right.

Mr. SAXTON. Can you explain to us exactly what the provisions are for coverage in nursing home care?

Mr. BURKE. Medicare covers only skilled nursing care. There is a co-insurance for each day of care after the 20th day, and you are limited to 100 days per benefit period. It is a restricted benefit, and there is a co-insurance associated with it, that gets steep over a long stay. The coinsurance is set at 1/8th of the hospital deductible, or about $65 a day this year.

Under our proposal, if you were into a skilled nursing facility, there would be no co-insurance imposed.

Mr SAXTON. And how long would one be able to stay in a skilled nursing facility?

Mr. BURKE. As long as allowable under the current Medicare benefit.

Mr. SAXTON. Which is?

Mr. BURKE. We are not proposing any extensions of——

Mr. SAXTON. Which is what?

Mr. BURKE. I believe it is 100 days with co-insurance beginning oin the 21st day.

Mr. SAXTON. So one could conceivably be covered in a skilled nursing home setting for up to 100 days.

Mr. BURKE. I believe that is correct.

Mr. SAXTON. Are there any other additions to the current Medicare package through the President's proposal?

Mr. BURKE. The other feature is that you are at risk now under Medicare Part B for a $75 deductible, and then 20 percent of the Medicare allowable charges.

When these charges have accumulated, plus let us say a hospital deductible, and you hit $2,000 out of picket, you incur no costs whatsoever for going to the doctors, or anything else that is covered under Medicare; i.e., durable medical equipment.

Mr. SAXTON. All right, if I may, you have I think described three significant changes to the Medicare package that we currently have: A longer stay in the hospital with only one day payment; same amount of coverage for nursing home care except without co-payment; and a maximum of $2,000 per year physician's co-payment.

Mr. BURKE. Correct.

Mr. SAXTON. Is that correct?

And how much does that cost the consumer every month?

Mr. BURKE. We have estimated that if it were enacted this year, the premium would have been, as Dr. Bowen has—$4.92. If it is enacted next year, the cost will go up to $5.83. It seems like a big jump. Part of that big jump is due to the fact the $2,000 cap was supposed to be indexed each year for inflation. When we put the bill in, we forgot to index it the first year, so there is going to be a $2,000 gap again in 1988.

Mr. SAXTON. What you are saying then is all of that additional coverage that you described can be obtained by a Medicare enrollee for somewhere between $60 and $75 a year.

Mr. BURKE. Right.

Mr. SAXTON. Thank you, Mr. Chairman.

Mr. RINALDO. Thank you, and I certainly want to thank Mr. Burke. I know how busy you are and we appreciate your taking time out to come up here from Washington.

Mr. BURKE. My pleasure, Congressman.

Mr. RINALDO. Our final witnesses will form a panel. On the panel will be Mr. Thomas Brown, who is the Vice President of Overlook Hospital, accompanied by Elana Zucker, the Director of Community Nursing for Overlook Hospital; Evelyn Savage, the Director of the Somerset Hills Visiting Nurses Association and the president-elect of the Home Health Agency Assembly of New Jersey; and Mr. William Matusz, the Director of the American Association of Retired Persons Operations for the Prudential Insurance Company in Montgomeryville, Pennsylvania.

I have been handed a note that the folks from Overlook are on a tight schedule and have to leave very shortly.

Mr. BROWN. Yes.

Mr. RINALDO. So if it is all right with my colleagues, what I would like to do is have both of you testify first. If we have any questions, we will ask you and then you may be excused and we will go to the rest of the panel.

Mr. BROWN. Yes.

Mr. RINALDO. Let me say to all of the witnesses that your entire written statements will be placed into the record in their entirety. If you would like to summarize your testimony in the interest of time, that is certainly acceptable. We will begin with you, Mr. Brown.

STATEMENT OF THOMAS BROWN, VICE PRESIDENT, OVERLOOK HOSPITAL, SUMMIT, NJ, ACCOMPANIED BY ELANA ZUCKER, DIRECTOR OF COMMUNITY NURSING, OVERLOOK HOSPITAL

Mr. BROWN. I am Tom Brown, Vice President of General Services at Overlook Community General Hospital which, as many of you know, is a hospital of about 600 beds. I am appearing before your committee on behalf of our President, Mr. Tom Foley, who truly regrets he has not been able to be here, but he is part of the crunch of schedule that we have to face in a few minutes.

We are also here on behalf of the New Jersey Hospital Association.

It is a pleasure to be here and to have a part in the establishment of a new and landmark piece of legislation.

Catastrophic illness and its effects on the general population are far-reaching problems and ones which touch upon hospitals, taxpayers, patients and their multigenerational families. The catastrophic illness coverage that has been proposed will affect our New Jersey hospitals somewhat differently than it may many hospitals in other states.

New Jersey hospitals operate under a waiver, exempt from the Federal Diagnosis Related Group, that is the D.R.G. system of reimbursement. The New Jersey system is an all-payer D.R.G. system which reimburses hospitals at the prevailing D.R.G. for bad debts incurred through the care of the indigent patient. This is termed the uncompensated care pool.

This system provides an incentive for all hospitals to care for the indigent and, frankly, discourages dumping of patients onto municipal or inner-city hospitals. Interestingly enough, although this system was viewed as radical when it was first introduced, it is the same system that is now being advocated by many throughout the United States.

It is by virtue of the New Jersey waivered system that New Jersey may be more successful than most in being able to provide the quantity and the quality of the care of the elderly beneficiaries that is required in an acute care setting. And as was mentioned before, the uncompensated care pool in New Jersey is in excess of $250 million.

Although New Jersey hospitals are proud of their excellence in delivering health care, they could be providing an even more intense and higher quality of care to elderly residents and their families if they had some respite from the maze of various federal regulations by virtue of a new catastrophic illness coverage program.

Additionally, it is not conceivable to think that New Jersey would be able to absorb the care of the indigent and the cost of catastrophic illness for an indefinite period of time. We really do need help and respite from this enormous responsibility.

It is interesting to note that in the New York Times of March 29 of this year, a front page article discussed how some states are making profits. New Jersey, however, was not one of them. As you see, New Jersey absorbs the cost of its care for its citizens on a statewide basis.

In order to maximize the time and efficiently use the D.R.G. payment of patients in the hospital, there must be a careful use of

time and resources. We at Overlook, for example, begin the process of both coordinating internal resources and planning for the patient's discharge on the very day a patient is admitted. On an internal level, criteria has been established to target high risk patients over 65 who may necessitate the use of extensive resources which includes both people resources and equipment resources.

This planning for discharge of the patient dovetails with the acute plan of care and endeavors to extend the patient's care either at home, or in a less acute facility. Although the patient is in the hospital for a short time on average, the hospitals are morally bound to plan for this patient when he leaves the institution to return to his community. Simply put, this process translates into "What needs to be done for this patient within the framework of the admitting D.R.G." is indeed done.

In order to care for patients and their families when they have limited resources, Union County health agencies, under the leadership of the Union County Office on Aging, have banded together to maximize both monies and resources.

Additionally, individual agencies and hospitals must raise monies from local communities to fund post-hospital care. Without this care, the patients would deteriorate and return to the hospital. More and more, it has fallen to these local communities and grass roots organizations to fill in the "cracks of care" and to prevent family deterioration while caring for a patient whether it be a short-term catastrophic illness or indeed a long term catastrophic illness. One wonders how long can these local governments and the communities absorb this ever increasing cost, and the burden?

It does seem that with increasing health costs, the increasing longevity of the country's elderly and the shrinking entitlement programs, fewer and fewer people are being served; but more and more are in need of both short-term assistance as is proposed, but more importantly, of long term help as well.

The proposed catastrophic coverage will mean that New Jersey hospitals would not be saddled with the entire burden of those Medicare beneficiaries who are unable to meet their deductibles and whose debts are now absorbed by the uncompensated care pool.

Having given you this brief, but broad overview of this present situation, we would like to share some thoughts on our perceptions of what we feel should be included in a catastrophic illness coverage.

I am going to cut quick here and go right to the heart of the matter which is the five suggestions that we——

Mr. RINALDO. Fine.

Mr. BROWN. Number one, we would suggest a clearer and broader definition of the term "catastrophic". We feel this must be made and it must be very clear. I am not sure actually why the original draft of the bill in question refers to a "catastrophic illness" only as an acute happening. We submit that a long, debilitating disease, such as Lou Gehrig's Disease, or as was mentioned earlier this morning, Alzheimer's Disease, is indeed a catastrophic happening and could decimate a family, as we have already found out, if several of families are forced to assume the care of their loved ones while at the same time stripping themselves of their own savings.

For example, what would happen when a patient dies and the remaining family members have no savings left for their own care? Eventually, this second generation would then require financial assistance.

Additionally, this definition of "catastrophic" must be consistent from state to state, and not subject to individual interpretation.

Two, catastrophic insurance should be an extension of present federal coverage and not a shifting of monies from one type of coverage to another. When costs are calculated, it would be wise to review not only the actual cost of the patient's bill, but also the cost of his illness as it relates to his family. One would want to know if a family member had to quit a job to care for this patient. One would want to know if someone had to build an addition on to their home to care for a patient. It really does not make sense to bankrupt one generation in order to care for another.

Three, some type of coverage must be provided after the acute care phase is over; or, as has been said before, the patient or even conceivably members of his family will surely deteriorate and then could require more hospitalization. The cost of this additional hospitalization will be borne by the catastrophic illness benefit, the individual hospital or the patient himself.

Along this same vein, I would suggest that the private insurance companies be given an incentive and an opportunity to participate in both the acute care of patients and long term care of the elderly.

Number four: Communities should be encouraged to pool their resources—both financial and human, much as Union County has done—to build upon present entitlements, and to maximize the continuum of care and to work with the individual families to care for their elderly.

Fifth and lastly, replace the cost-sharing proposal with annual deductible and/or a limit of out-of-pocket expenditures. Without this limit, it is conceivable that families could impoverish themselves meeting the cost-sharing requirement and lead to multigenerational bankruptcy which we have mentioned before.

Committee, panel, Congressmen, we thank you for letting us be here this morning and Mrs. Zucker is here to participate in the questions that you may have.

Mr. RINALDO. Thank you very much, Mr. Brown.

I now recognize Congressman Saxton for any questions you may have.

Mr. SAXTON. Mr. Brown, I have just one question. Relative to the theme of today's hearing, you touched on many interesting points. But could you give the committee a profile of the typical elderly individual who, if it were not for the health care provided by various government insurance programs, including Medicare and the New Jersey program for uncompensated care. What would incur in terms of financial expense to an individual through a large catastrophic acute care problem in terms of finances?

Mr. BROWN. You mean actual figures?

Mr. SAXTON. As close as you can come, or an estimate.

Mr. BROWN. Elana, what do you think?

Ms. ZUCKER. I don't think I can give you figures. I can give you a typical picture of somebody who would remain, for instance, in an acute care hospital awaiting placement in an institution. But we

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may not be able to find a place for that patient to go. For instance, a patient on a respirator may remain for a long length of time in a hospital when we could, if there was financing, care for that patient at home or in a long term care institution. But they may have an insurance policy that only covers them in an acute care hospital. That's a wrong allocation of money, I think.

Mr. SAXTON. Is it not true in some cases where there is not an insurance policy of some kind that other patients share in the cost for those who cannot provide that care for themselves financially?

Ms. ZUCKER. Not directly. In this state, everybody pays the same because we are an all D.R.G. system, an all payer D.R.G. system.

Mr. SAXTON. But those rates are set based upon——

Ms. ZUCKER. Yes.

Mr. SAXTON [continuing]. Hospital costs and hospital costs include care for so-called indigent people.

Ms. ZUCKER. Yes.

Mr. SAXTON. So those rates would increase. So that one way or another we are all going to pay these high costs.

Ms. ZUCKER. Conceivably, yes.

Mr. SAXTON. Thank you.

Mr. RINALDO. Let me ask a question concerning Mr. Brown's recommendation to provide incentives to private insurance companies to participate in a catastrophic insurance program for the elderly.

How would you suggest that private insurers become involved and what type of incentives would you recommend that the federal government offer to encourage their participation at a premium rate that is affordable to all who want to be included?

Mr. BROWN. I will defer.

Ms. ZUCKER. Some of the ideas that have come to us include payroll deductions or tax incentives for the employers to help their employees with this kind of insurance. One of the things I heard yesterday is that one of the reasons that the insurance industry does not help with long term care is that they do not have a data base of how much it will actually cost. Perhaps the federal government can assist them with obtaining that data base so that they can write the policies that would be applicable to this group of people.

Mr. RINALDO. Everything you mentioned so far though only covers people who are working, who are employed.

Ms. ZUCKER. Yes.

Mr. RINALDO. Where at least one spouse would have to be employed. How about people who are elderly and have already retired and no one is employed?

Ms. ZUCKER. I cannot help with that one.

Mr. RINALDO. You have no recommendation there.

Ms. ZUCKER. No.

Mr. BROWN. If I may add, that recommendation was partly triggered by a program we had at the hospital recently whereby group life insurance was offered for our children. It occurred to us that there might be some way to induce life insurance companies to provide whatever it would be called, medical retirement insurance or something like that to much younger individuals rather than waiting until "65" when we all begin to receive Medicare. It would be

kind of interesting and perhaps good practice for individuals to start a lifetime savings for catastrophic illness in their early years.

As was mentioned earlier, the technologies of medicine today are such that we are living longer and longer. And the last I recall, the fastest growing age group in the United States is over 75. If we can encourage our youngsters—our own children—through insurance, plan and save early against catastrophic illness expenses, it might help alleviate concerns about all the billions of dollars that we are otherwise going to spend in 2020.

Mr. RINALDO. Well, the committee is looking into a whole variety for proposals of that type. But my concern right now is for those people who are already retired—the current generation of older Americans.

Under current Medicaid regulations, spouses of individuals needing care, usually long term care and in particular, nursing home care, are forced to spend down almost to the poverty level to qualify for benefits.

Mr. BROWN. Absolutely true.

Mr. RINALDO. And this spousal impoverishment, as you pointed out, has a dramatic impact on the entire family.

How would you suggest that we in Congress correct that problem now so we will not devastate future generations to take care of the elderly?

Mr. BROWN. I wish I were that smart.

Mr. RINALDO. All right, if you do not have any suggestions, we have some ideas. I just wanted to see if you had any.

Mr. BROWN. As they come along, Congressman, we will send them to you. We will write if that is all right.

Mr. RINALDO. Well, if you have additional ideas, we will hold the record open so that they will be included in the record.

Mr. BROWN. Thank you.

Mr. RINALDO. My times has expired. I now recognize Congressman Roukema for any questions she may have.

Mrs. ROUKEMA. Well, I was going to say I take it that you approve of Secretary Bowen's proposal, Dr. Bowen's proposal on catastrophic illness?

Mr. BROWN. Up to a point.

Mrs. ROUKEMA. Up to a point?

Mr. BROWN. In a very brief sentence, it is not enough. It does not——

Mrs. ROUKEMA. If we add the home health care component to it, is it enough for a first step this year?

Mr. BROWN. It would surely help, absolutely.

Mrs. ROUKEMA. With the home health care component.

Mr. BROWN. Yes.

Mrs. ROUKEMA. Let me ask a question. Of the $250 million in uncompensated care that I believe you mentioned that New Jersey hospitals incur, half may be attributed to Medicare beneficiaries; do I understand that?

Mr. BROWN. Yes.

Mrs. ROUKEMA. What percentage of that amount would be eliminated, do you expect, by the Bowen proposal? Any of it? Or would that not reach your problem at all?

Mr. BROWN. About 1 percent.

Mrs. ROUKEMA. What percentage of the amount of uncompensated care losses that you incur would be eliminated by the Bowen——

Mr. BROWN. About 1 percent.

Mrs. ROUKEMA. About 1 percent?

Mr. BROWN. That's $250 million, by the way.

Mrs. ROUKEMA. I am sorry, I meant 250—I am sorry.

Mr. BROWN. That is all right.

Mrs. ROUKEMA. We never speak in thousands in Washington. I do not know what came over me, but anyway. No, I understand that.

Now I think the question that I have for you, Ms. Zucker, may be more appropriately or equally appropriately addressed to Ms. Savage. But before you leave I want to give you an opportunity to speak to the issue of home health care.

Under the present Medicare program, there is uncertainty about how much home health care is covered. In your experience, how long does the average home health care get covered under Medicare presently? What percentage of reimbursement is there, and what's the frequency of care for that period?

Ms. ZUCKER. It all varies patient by patient. A patient may in fact have home health care for as long as the patient "needs it". And this care is still——

Mrs. ROUKEMA. But has not the experience been that that ranges from two to three weeks?

Ms. ZUCKER. Maximum, probably—I would say in my experience in this area, between four and six weeks.

Mrs. ROUKEMA. And how frequent is the care? Is it daily?

Ms. ZUCKER. In some cases, but in most cases in my area it probably is about three to five times a week.

Mrs. ROUKEMA. Three to five times a week.

Ms. ZUCKER. Yes.

Mrs. ROUKEMA. That is one visit from a visiting nurse.

Ms. ZUCKER. Or a home health aide, or a therapist.

Mrs. ROUKEMA. Or a home——

Ms. ZUCKER. Yes.

Mrs. ROUKEMA. And what is the percentage of reimbursement? Is it fully reimbursed?

Ms. ZUCKER. Yes.

Mrs. ROUKEMA. All right, thank you very much.

Mr. RINALDO. I want to thank Mr. Brown and Mrs. Zucker. We recognize that your time is limited and you have to leave and we will now proceed with the next witnesses.

Ms. Savage, will you proceed, please?

Mr. BROWN. Thank you so much.

Mr. RINALDO. You are welcome.

Ms. ZUCKER. Thank you.

STATEMENT OF EVELYN SAVAGE, DIRECTOR, SOMERSET HILLS VISITING NURSES ASSOCIATION, BARNARDSVILLE, NJ, AND PRESIDENT-ELECT, HOME HEALTH AGENCY ASSEMBLY OF NEW JERSEY

Ms. SAVAGE. Congressmen Rinaldo, members, Mrs. Roukema and ladies and gentlemen. I am a member of the Board of Directors of the Home Health Agency Assembly as well as the Director of a visiting nurse agency in Bernardsville, New Jersey. On behalf of the more than 941,000 senior citizens in New Jersey who are provided community health programs and home health care by a New Jersey network of home health care providers, I would like to thank you for giving us this opportunity to comment on the role of the federal government in meeting the need for comprehensive catastrophic health care insurance.

I understand that my report is on file, so I am not going to discuss or summarize the various proposals. I think we have heard quite a lot about that today, but I do want to say that the potential impact of these programs, especially the administration bill, is limited in its emphasis on acute care and subsequent costs.

Only about 800,000 of the 31 million Medicare beneficiaries have out-of-pocket medical expenses that will qualify them for this coverage. This proposal will help less than 3 percent of this country's Medicare beneficiaries.

The catastrophy which most of these proposal address is defined in dollars. Again, let me say that that is commendable as far as it goes. Any plan, however, which is enacted to address catastrophic concerns should be comprehensive and include improved coverage for not only acute care, but for chronic, long term illnesses and debilitating impairments.

The fundamental health care need of elderly Americans results from costly care needed from chronic conditions. I think Mr. Hargwood expressed this so eloquently, and in my experience, I have to say that he is certainly not alone. He typifies so many caregivers, so many families that have faced and are facing the catastrophe of long term chronic illness.

This leads me into addressing the first of the three questions which you asked in your letter. I would like to quickly state the first question.

"Under current federal Medicare and Medicaid eligibility and reimbursement policies, are community nursing organizations able to provide the quantity and quality of care their elderly beneficiaries require? How do community nursing organizations respond to patients who require long term care for an illness yet who cannot meet the costs? What are the cost/service limitations faced by home health care providers in this situation?"

To answer the first part of this question, I have to first say "No." Under current federal Medicare and Medicaid eligibility and reimbursement policies, home health care agencies are not able to provide the quantity, and therefore, sometimes not the quality of care. The Medicare home care benefit does not cover chronic care. We have heard this repeated this morning, and I want to emphasize that. It only covers care for acute conditions where the patient has the potential for rehabilitation. The patient must be homebound

for the period of time receiving the services, but must, on the other hand, only require intermittent care, that is less than once a day, and usually only three to five times a week.

Medicare certified home health agencies typically provide an array of services that include skilled nursing, home health aides, physical speech and occupational therapy and medical social services. However, the important point to remember is that Medicare home care coverage is very limited and does not pay at all for chronic care which is the disease of the aged. As the population ages, and as Mr Brown points out, the over 75 group is the fastest growing age group in our United States, the incidence of chronic diseases such as strokes, diabetes, arthritis, heart attacks and cancer as well as conditions such as Alzheimer's Disease increase.

Federal cost containment policies have restricted the use of the home health Medicare benefit by imposing new, more stringent interpretations for determining eligibility.

For example, nurses previously were allowed to make weekly visits to pre-fill insulin syringes for blind diabetics living alone at home. Medicare no longer will reimburse an agency for such a home visit. An elderly patient such as this one, living alone, has limited options, one of which might need to be entering a nursing home.

I think I want to emphasize the fact that——

Mrs. ROUKEMA. Excuse me. I am sorry, Ms. Savage, I missed that last statement of yours. Would you repeat it, please?

Ms. SAVAGE. I said that an elderly patient such as the one that I cited, who no longer can have the nurse fill her syringes on a weekly basis, may have to go into a nursing home as an option to meet her care needs.

I have not chosen an isolated incident to illustrate my point. There are 69,000 Medicare patients and 10,000 Medicaid patients being served in New Jersey by Medicare certified agencies.

In the last year, 1986, New Jersey home care agencies experienced a 301 percent increase in Medicare claims denied compared to the previous two years. A claims denial survey, conducted by the Home Health Agency Assembly of New Jersey, our state association, revealed that the average number of claims denied in New Jersey based Medicare agencies in 1984 was 19; in 1985, 30; and the average in 1986 was 90. This translates into 17,319 Medicare visits which were denied reimbursement. This is a very, very significant increase over the past two years.

It is very important to understand that these over 17,000 visits have already been made to Medicare eligible patients.

You asked how do home care agencies respond to patients who cannot met the cost? There are really two answers to this question.

In the first instance, the agency usually does not know that the visits will be noncovered. The visits are made and the patient receives the care. It is only after the fact that the agency is informed by the fiscal intermediary that they are not going to be reimbursed for the visits.

In the last year, implementation of the Medicare home care regulations have been like quicksand. No matter how hard you try to get a firm foot, the foundation beneath keeps shifting and swallowing you up.

I started in the home health care field in 1965, which was the year the Medicare legislation was enacted, and I guess I have changed and aged in those years as the Medicare program has changed. But I must say in the last year, I have seen such restrictions as I have never seen before in my experience.

When we look at free or uncompensated care, you must realize that care is never really free. It has long been part of the history and mission, and I must say the pride of community nursing service to provide no-fee care for those who cannot pay for it. However, somewhere the care must be compensated; it must be underwritten, and somehow. The staff nurses, the home health aides, all of the therapists who provide the direct service are salaried or under contract and they must be paid. Nursing visit bags contain an array of disposable and portable equipment which are tools of the nursing profession and practice. These must be purchased. They are not free. And there are many overhead costs also which I do not want to get into. It would be too lengthy.

But my point, and also my second response to that part of the question about meeting no-fee patient care, is that we, the agencies, are underwriting the cost of this care through our own fund raising efforts. These fund raising efforts take a lot of time, creativity and hard work, but almost every Medicare certified agency in New Jersey has raised a fund of monies which covers care for no-fee patients.

However, managing this fund has become a see-saw. As more and more claims for patients whose care we expected that Medicare would cover, have been denied, they draw on this pool of monies that have been set aside for no-fee care. As a result, patients who have no other source of income or reimbursement are being forced to compete with the Medicare patient for a piece of this usually very small no-fee pie.

Let me close my portion of this response by saying that many agencies today are in financial difficulty, and even as we sit here, a number of good, well established community nursing service agencies are in danger of going bankrupt and being forced to close their doors on the very people who need their help so badly, the indigent and the aging.

I would like to move on now to the second and third questions and address them together. You have asked what are the essential components of a catastrophic health care plan. What kinds of services will result in catastrophic costs and what is the most appropriate for for the federal government to play?

I think that the essential components of a catastrophic health care plan should include at least the following:

Provisions for acute extended hospital stays; the incorporation of comprehensive coverage of out-patient skilled nursing facility and chronic care home care benefits; a provision which allows the patient and family a choice of care settings with incentives to use the least restrictive environment appropriate for the level of care; a limit on the annual out-of-pocket expenses which may involve the development of some regulatory price setting or prospective payment systems in order to effect cost controls; a mechanism to address and air public opinion on the ethical issues of health care; and development of a comprehensive screening process tool and

case management system to determine appropriate care and insure continuity.

In terms of the appropriate role for the federal government to play to address the need for comprehensive affordable catastrophic care protection, it should be one of designer and coordinator of managed services.

The National Association of Home Care has designed a three-tier program which, with some modifications, I would like to briefly describe.

The first is the basic Medicare coverage at $17.90 a month which is currently in existence.

The second tier would be Medicare plus. This plan would make available optional coverage at $20.00 per month for prescriptions, dental care and a modified home health care benefit utilizing the principles of case management referred to above.

The third tier—Medicare super—would provide long-term home care and skilled nursing care. It is in this category that conditions such as Alzheimer's Disease, Parkinson's disease, chronic kidney and heart conditions result in catastrophic costs to the elderly and their families as we have heard so much about this morning. The premium for long term chronic care would have to be worked out with actuaries. This is a big problem that I recognize. The premium perhaps could be a tax credit for the insuree or a tax deduction for a payor on behalf of the beneficiary.

And this program could be developed through federal, state or private insurers and needs the attention of experts in the field as well as input from senior consumers and the provider industry.

I am very happy this morning to recognize how aware you are of the problems of catastrophic health care, the long term care chronic problems that our elderly are experiencing.

In closing, I would like to thank you so much for listening to my testimony and providing the home health care community this opportunity for input.

Mr. RINALDO. Thank you very much for your testimony.

I now recognize Mr. Matusz for your statement.

Mr. MATUSZ. Thank you very much.

Mr. RINALDO. As I mentioned to the other witnesses, if you would like to summarize your testimony, it has all been included in the record.

Mr. MATUSZ. Fine.

STATEMENT OF WILLIAM MATUSZ, DIRECTOR OF AARP OPERATIONS, PRUDENTIAL INSURANCE CO., INC., MONTGOMERYVILLE, PA

Mr. MATUSZ. I am Bill Matusz, Vice President, Underwriting for Prudential's AARP Operations which is located in Fort Washington, Pennsylvania. Prudential provides Medicare supplement insurance and hospital indemnity insurance for over 5 million members of the American Association of Retired Persons.

Over the past several months there has been much debate and proposals concerning catastrophic care for older Americans. These proposals to enhance Medicare, such as the Bowen proposal which is supported by President Reagan, only address acute care, such as

extended hospital confinements, and generally ignore the most critical problem of growing old, that of long term care; that is, care for chronic disability in a nursing home or for a prolonged home health stay.

It has been estimated that the lifetime probability of entering a nursing home is 50 percent, and that half the nursing home confinements will exceed three months. For those confinements that do exceed three months, the average duration in a nursing home is two and a half years at a cost of approximately $25,000 a year. So you can see the magnitude of the cost involved.

Medicare, which was not designed to cover long term care needs, currently only covers 2 percent of the total national long term care expenses. And since Medicare supplement policies are designed to coordinate with Medicare, they also do not cover long term care needs.

I would like to describe how Prudential and the American Association of Retired Persons have been working together to develop and market a nursing home and home health care plan to AARP members between the ages of 50 and 80.

A big factor in developing the product design was the feedback we received from both an extensive survey and individual interviews with AARP members in 1983. Some of the interesting findings of these and later surveys were:

First, confusion over the need for long term care. Seventy-nine percent felt that Medicare would cover everything. Second, we also found there was more interest in the 50 to 65 age group than in older age groups, and third, there was a keen interest in home health care. Seventy-seven percent felt that home health care was more important than nursing home benefits.

Based largely on the input from these surveys, we designed a product that was test marketed at the end of 1985. The plan provided $40 a day in a nursing home for up to three years, and it covered all types of nursing home services, including custodial care It also covered 365 home health visits at $25 a visit for nurses and therapists, and $20 a visit for home health aides and homemakers. There was a 20 day deductible included and a three day prior hospital confinement was required. The monthly rates ranged from $15 a month for the 50 to 59 age group, to $95 a month for the 75 to 79 age group. These rates are based on your age when you buy the policy and they do not increase as you get older.

We mailed this offer to 215 000 households in six states, including New Jersey, and sold approximately 1,200 policies, including 150 in New Jersey. The response rate in the 50 to 59 age bracket was four times greater than in the 75 to 79 age group which gives you an indication how price sensitive this product can be.

We did a second test market effort at the end of 1986 which resulted in 8,000 new policies, including 700 in New Jersey. There were a few benefit design changes that were made for the second test such as eliminating the three day prior hospital confinement feature and increasing the deductible period from 20 to 90 days. We also expanded our marketing approach by mailing to 300,000 households in eight states and we advertised the availability of the nursing home and home health care plan in several AARP publications.

After both the 1985 and 1986 test, we surveyed the individuals receiving the long term care solicitations to determine why they bought the product or why they did not buy it. Sixty-six percent of the non-buyers from the first test indicted they did not need the product, and 30 percent said they could not afford it. Over 50 percent of all the responde s felt strongly that a nursing home stay is one of those subjects that they would just rather not think about which indicates the problem you have in selling this type of insurance.

The follow-up survey to the second test, which we are just in the process of completing now, indicates there is a little more awareness of the need for home health and long term health care services, but we still have a long way to go.

Prudential and AARP plan to continue to test various plan designs and marketing approaches in 1987. In addition to the traditional type of indemnity insurance benefit, Prudential is also looking into offering an asset accumulation policy so individuals can accumulate funds to help pay for their own care, and we are also considering policies that include both acute and long term care in a managed care environment. We also plan on marketing these and other types of long term care insurance products to employer groups.

At this point it is apparent that many major insurance companies are beginning to become more aggressive in marketing and developing long term care products. Although it has been estimated that there are at least 30 insurance companies with policies that cover various long term care services, the potential market has barely been touched with less than 1 percent of the total long term care expenses being covered by private insurance. But there are some significant barriers in developing a long term care insurance product.

First of all, there is a great lack of consumer knowledge about Medicare coverage and employer group coverage. Most people think they are already covered and therefore there is little perceived need for this type of benefit.

Second, is also very little data on nursing home and home health utilization which makes pricing it very difficult. The only published tables in existence were put together from sources which are not necessarily indicative of experience under insured plans. And the adequacy of premium rates will not emerge for many years.

Third, is a concern about the replacement of informal care provided by family, friends or the community by formal care provided by health care professionals. It is estimated that up to 80 percent of long term care services are currently provided by these informal services. The offering of insurance could induce a demand for services which had formerly been provided by these informal services.

But perhaps the biggest barrier is the uncertain regulatory involvement on both the state and federal levels. A number of states fail to recognize the experimental nature of long term care insurance products by being too restrictive or requiring mandated benefits.

For example, Wisconsin now has a mandated minimum long term care insurance. They limit the maximum deductible you can include in the policy to 60 days, and prohibit the use of a prior hos-

pital test. Before promulgating this regulation, there were 15 companies offering long term care insurance of some kind in Wisconsin. Now there is only one company offering long term care insurance and the price of that product has increased significantly.

On the federal level the tax treatment of long term care reserves is unclear or in some cases detrimental to providing long term care insurance protection. Companies selling long term care insurance must accumulate reserves in order to help pay future benefits. Unlike life insurance, the interest on reserves for long term care insurance is taxed at the corporate rate and if companies selling long term care insurance pass the cost of this tax on to the consumer, it results in higher premiums.

The Deficit Reduction Act of 1984 has limited the tax advantage of pre-funding retired employee benefits, which discourages employers from expanding coverage to include long term care.

I think it is obvious that the insurance industry can play an important role in helping to solve this tremendous problem that is facing our society. Companies see both the need and the opportunity in the area of long term care. But, for reasons previously mentioned, we must move with caution and there are no quick solutions in sight.

As I mentioned before, this product is very price sensitive. The probability of somebody age 80 going into a nursing home is ten times greater than somebody 65. So a typical cost for a policy for somebody age 65 might be $20 a month compared to something over $200 for somebody at age 80. This generally means that the individual who is going to purchase long term care insurance would more likely be under age 65. Therefore, the insured coverage is likely to make a significant contribution to the problem, but will not until perhaps 10 or 15, maybe 20 years from now.

There are also certain actions that can be taken by the federal government. First to help encourage and facilitate the development of private long term care policies, consumers must be educated as to their need for long term care services and their need to finance these services. It must be made clear that Medicare does not meet this need.

Second, the regulatory environment should encourage experimentation of long term care insurance by providing incentives such as favorable tax treatment of long term care reserves as now provided for life insurance. This is essential if the private sector is going to become more involved.

Third, the states and the federal government should consider relaxing some of the Medicare requirements and eligibility rules in order to protect the spouse of an individual who is confined in a nursing home from becoming impoverished.

This whole area is definitely a social problem that can only be solved if we all work together, and I thank you for this opportunity to testify today.

Mr. RINALDO. Thank you very much, Mr. Matusz.

Ms. Savage, how do you feel about the role of the private sector? Do you see a viable option in private insurance coverage for home health care services?

Ms. SAVAGE. Yes, I do, though I think it is a great unknown. There has been a lot of discussion, as you know, of how to finance

the actuarial problems in long term care, but I can see that there would be some role for private insurance in this. I just feel that Mr. Matusz is far more knowledgeable about that area

Mr. RINALDO. All right, thank you.

Mr. Matusz, in your capacity as Director of AARP Operations, are you familiar with the position of the AARP on the Stark bill which just passed the House Ways and Means Health Subcommittee?

Mr. MATUSZ. I am somewhat familiar with it, though I cannot speak for AARP. They are a separate organization from Prudential. I think they would like to see the benefits go further. They are very concerned about prescription drugs.

Mr. RINALDO. No, I was talking about the financing provisions of the Stark bill. As you recall, that would tax all the people on the value of their health insurance.

Mr. MATUSZ. The AARP is generally against any means testing, and the taxing would be a form of means testing.

Mr. RINALDO. Yes—well, what I wanted to get on record is the fact that they have already opposed that financing mechanism, although they are in favor of the items that you have mentioned.

In the report that Secretary Bowen presented to the President last year, Mr. Matusz, proposals were included for individual purchase of long term care policies. Would this type of federal policy influence the marketing of your product?

Mr. MATUSZ. It definitely would. It would definitely have a very favorable affect on the selling and marketing of individual long term care insurance products. Any incentives that the federal government can create to encourage individuals to purchase insurance, would highlight the need for these benefits. The government would be making a statement that these benefits are valuable, that there is a need for them, and by doing so would be providing an incentive for the individual to purchase it.

Mr. RINALDO. Suppose we reach an impasse. You know, right now we are having a lot of hearings. We are going to have hearings around the country, including one in Newark, New Jersey, and we are going to have additional hearings in Washington. This whole process is just beginning. Somewhere down the line—and we are hopeful and optimistic that it is going to be in this session of the Congress— we are going to come up with a bill that once again, hopefully, will be acceptable to the administration and will be signed into law. I think that is a good way for the 100th Congress to make the kind of history that it should be making because it is a historic Congress.

Suppose we get bogged down. The President has said he will not sign a bill unless it is revenue neutral. Many of us, probably most of us in Congress, are opposed to any undue burden, particularly increased taxes upon the elderly. But so far on one has come up with an acceptable alternative financing mechanism.

Do you feel, in your capacity as a representative of an insurance company, that we could proceed with something like the Bowen plan, or close to it, to take care of Part B? And then of what I would like to term as Part C: long term care, nursing home care, prescription drugs, eye glasses and things of that nature? Do you think the private sector could handle those benefits? If either there

were enough participants, or if the policy had a low enough premium to be attractive?

In other words, if the policy is going to be $100 a month, obviously it is worthless; nobody is going to buy it, or at least very few people would be able to afford to buy it.

Now, if we either mandated coverage or it became very attractive because of certain government-provided incentives, do you think that that policy could have a premium low enough to make it acceptable?

Mr. MATUSZ. I think it is definitely workable. For example, after looking at the Bowen estimates for increasing Medicare benefits, Prudential and the rest of the insurance industry concluded that it is possible for the insurance industry to provide those same type of benefits.

Mr. RINALDO. You could not do it for 4.92.

Mr. MATUSZ. No, but we could do it for pretty close to that. We estimated the cost would be roughly $6 or $6.50. And a lot of that comes from the marketing of the product. With a premium that low if, we had to market such a policy in the same way we market the rest of our products, the cost would be much higher. But if the government were to indicate that this product were available through stuffers in Social Security checks, for example, to help cut down the marketing cost, the insurance companies could definitely provide something very similar to the Bowen proposal at an affordable price. I think the same reasoning would apply to something like your Part C approach.

If the government worked with the private sector——

Mr. RINALDO. Let me just give you some statistics. Congressmen Pepper's plan which covers everything has been estimated to cost $68 billion in 1987, $100 billion by 1990. The costs are enormous.

Do you have any idea what the premium would be?

Mr. MATUSZ. Considering the 1985 national expenditures for nursing home and home health care, and projecting to 1987, the monthly costs would be approximately $140 per Medicare beneficiary. This could be broken down by age group as follows:

Age.	*Monthly cost*
65 to 74	$60
74 to 84	195
85 +	480

If this type of coverage was provided on a mandatory basis, that flat rate of $140 per month would be appropriate, although it would have to be increased to reflect the additional cost as a result of induced demand (higher utilization due to the availability of insurance). This could easily increase the $140 to $200, especially if the supply of nursing home beds increase as a result of the states eliminating the Certificate of Need and if a portion of the informal home health care is replaced by formal services.

Under a voluntary approach, the age rated approach indicated above would be more appropriate. However, in addition to induced demand, the voluntary approach would be subject to adverse selection which could result in the monthly costs by age bracket to be more than twice the costs outlined above.

Mr. RINALDO. If on the other hand, the premium is low enough, then you will have more people participating and therefore a

larger pool. But if you start out with extremely high premium, people are not going to touch it.

Mr. MATUSZ. That is exactly the problem. You are talking about types of coverages where the cost—even if the policy is mandatory, is going to be relatively high. And if you make it voluntary, because the price is relatively high to begin with, you are going to have people who cannot afford it, and others who feel there is no need for that insurance and won't be interested in it. And the few people who know they need it and therefore are willing to pay a higher price because they are going to be at risk for a long term nursing home or home health confinement would be more likely to buy the product. Because of that adverse selection, utilization is going to be much higher than on a broader risk.

But I will be able to let you know the cost of both those approaches.

Mr. RINALDO. You would be able to supply that? Well, then, asking unanimous consent, I will leave the record open, and if you would mail that information to the Select Committee on Aging, in care of my attention in Washington, I will see that it gets included. This is the kind of information that would be helpful to all of us.

I recognize that even with Part B, almost all of the plans that have been introduced in Congress have got to be mandatory; otherwise you just do not get enough participants to bring the cost down to an acceptable level.

Congresswoman Roukema.

Mrs. ROUKEMA. Mr. Chairman, I thank you for that line of questioning. As a Republican, I do look towards private sector solutions, but I have got to say that I find it difficult to imagine how the private insurance companies can handle the scope of this problem at a cost that people can afford. I am keeping an open mind, but I want to have some substantiation, not just a good wish that we can do this.

I feel the same way about——

Mr. RINALDO. If the gentlelady will yield.

Mrs. ROUKEMA. Yes, yes.

Mr. RINALDO. That is exactly why I asked the question. I think we have to find out whether or not it can be done. If it can be done, will insurance companies participate? And if it can be done, what will the cost be? We are in a position where we have got to examine all alternatives, and I, for one, am not going to give up on long-term health care just because someone says it is too expensive, or give up on nursing home care because someone says it is too expensive. We have got to find a solution to this problem, and we have got to find a solution quickly. Otherwise, we are going to get a bill that is going to be at best only a small first step.

Mrs. ROUKEMA. I understand that, Mr. Chairman. You have been a leader in focusing on this issue, and I understood the nature of your questions, and I appreciate it. I do not know where we will go in terms of private sector, but I have got to say and I will close really with what I began with.

I grant Dr. Bowen every credit for having focused on this issue, but when I hear the administration is looking toward private sector or individual medical retirement accounts, or whatever you call them, I get disheartened and somewhat skeptical because it is

another way of saying, you know, everybody has got to save for their old age. But the problem that we have today is even those who have saved for their old age cannot cope with the costs, and therefore it is not a simple solution to give new tax incentives. It is not all that simple.

It is also a reason why we may have to go slowly this year in coming to a conclusion on the nursing home component.

I appreciate what Ms. Savage has said. I have another question, Ms. Savage, because I find that we have too little contact with people like yourself who have had practical experience in the field with the home health care and the hospice programs. And I think you have been very explicit and very good in terms of your definition of the problem and the need for removing the stringent interpretations of the regulations on what is intermittent care. And that is one of the parts of my bill that we are trying to resolve.

But my question to you is, under hospice, which has not yet been talked about, what is the reimbursement level, and can you outline how you believe that that portion of the home care program should be improved at this stage in the legislative process?

Ms. SAVAGE. Are you referring to the Medicare certified, hospice benefits.

Mrs. ROUKEMA. Medicare hospice benefits, yes.

Ms. SAVAGE. Yes. That is reimbursed a bit differently than home health agencies in that it is a prospective daily reimbursement rate for the first level of care, which includes any services provided on an intermittent basis in the home.

First of all, the hospice is a home program.

Mrs. ROUKEMA. On the average, what is the percentage of reimbursement as compared to the total cost? Do you know?

Ms. SAVAGE. I do not know offhand.

Mrs. ROUKEMA. All right.

Ms. SAVAGE. It is, you know, a certain rate, and my understanding is that in the aggregate, it does cover the basic costs, but I would really need to go back and get the figures for that, and I would be happy to do that.

Mrs. ROUKEMA. All right. Well. in your experience, however, do you see this as an area that needs improvement, or do you think that we have pretty much—that that is not the area of abuse but really an area of progress?

Ms. SAVAGE. I think that the hospice program is an excellent program; care of the terminally ill in the home has proven to be both cost effective and very, very well received by families.

But I am concerned that in looking at ways to save money in the Medicare program, I am beginning to hear that there are cutbacks in what is being allowed. Would it help if I gave an example?

Mrs. ROUKEMA. That is correct. I want your real life experience.

Ms. SAVAGE. Okay. A current individual example: Someone who has opted for the Medicare hospice benefit who has a diagnosis of terminal cardiac disease. Two physicians certified that in all likelihood the prognosis was less than 6 months of life. As it turned out, after 3 months in the hospice program with the medication that he was taking, with the care that was given, this patient improved to the point where he was discharged from the hospice program. This is not a typical example, but it certainly occasionally does happen.

The fiscal intermediary reviewing this case has denied any payment for the 3 months of service saying that the hospice program should have known that this patient would have been discharged. Sometimes that is not possible. We are not God in predicting.

So I am concerned about how this benefit is going to be interpreted. I am afraid it is going to follow the route of the home care benefit in terms of so narrowly restricting it that fewer and fewer people will be covered for fewer visits. I think as it stands, it is an excellent, excellent program.

Mrs. ROUKEMA. All right.

Ms. SAVAGE. May I just add to——

Mrs. ROUKEMA. Yes, you may continue.

Ms. SAVAGE [continuing]. My response to Congressman Rinaldo.

Mr. RINALDO. Sure.

Ms. SAVAGE. I do feel that there is a role for private insurance in long-term care, just as there is a role for private insurance in the MediGap situation when that is well done. However, I think given the scope of the problem, the magnitude of the problem and the numbers involved, that we have to have Federal leadership; that it cannot be up to the private sector in total; that the basic program that is developed needs the federal leadership, needs the broad base of adding and building on to the Medicare program.

Mr. RINALDO. Would you tell me then how you would finance Part C; how the federal government would finance it when we are faced with a deficit of $108 billion, when a budget passed the House yesterday, and I might add without my vote, called for $18 billion in new taxes just to meet present requirements, without cutting back too far in present programs? Could you give me some idea? Because I might as well tell you this up front, I am not about to vote for any programs that impose unconscionable tax burdens on the public that I represent. That it is not solving the problem; it is just taking one problem and creating another.

If you could tell me now how we could solve the financing problem, then I will be in a much better position when I return to Washington.

Ms. SAVAGE. I think I would be a genius if I could tell you how to solve that. I know there are no easy answers. I just think that when all programs are looked at, those programs such as care of the aged cannot be cut to the bone and care people suffering.

I am not sure how this will be solved, and perhaps some taxation, but not excessive taxation will be necessary. I know that is not a popular statement, but I agree with you, we cannot ignore the problem and cannot deal with this problem just it is going to cost us something.

Mr. RINALDO. Well, when you say not excessive, the American Association of Retired Persons has, according to today's New York Times, already opposed the Stark/Gradison plan, and that is only, depending on how you look at it, $300 to $500 in taxes.

Now that is a very modest plan. That plan is very similar, very close—almost identical as a matter of fact—to the Bowen plan; it contains some small differences and refinements. Can you imagine then, if we take long term care and go along with your suggestion to throw in some additional taxes, what the tax burden would be? That is the problem we face.

Do you have any further questions?

Mrs. ROUKEMA. No, I have no further questions. I think the witnesses have been helpful and certainly have given excellent testimony based on their genuine experiences. I particularly appreciate the statistical data that Mr. Matusz has presented, and would appreciate any further data that he could submit for the record.

Mr. RINALDO. Well, I want to thank the witnesses also. I want to say that we are in the position of being somewhere between the proverbial rock and the hard place. You know, the suggestion has been advanced by a number of people, a number of commentators, that Congress should move slowly. And that may be true. On the other hand, we moved very, very slowly several years ago. This was a problem back in the 1970s and in the late 1960s we knew then of families bankrupted as a result of an illness, forced to go on welfare, and we moved slowly.

I see the tragedy day in and day out when people visit my district office in Union or in Green Brook. I see it in the letters that I read. I see it in the families that I meet with, and yet we have done nothing about it. It is about time we faced up to the problem.

On the other hand, if we go all the way with a truly comprehensive program that covers everything without giving enough thought to making sure that the financing mechanism is adequate, we could get a plan that will not garner enough support from the public or from the Congress to be enacted into law.

But despite these things, I still want to say that I am optimistic that a plan will be enacted in this session of Congress. I say that because in my 15 years in Congress, this is the first time we've had a Democratic Congress, and a Republican administration, both agreeing that now is the time to do something. It is impossible, obviously, for any of us to predict at this point whether or not long term health care or nursing home care will be covered; you have got to remember, we are just at an early stage in these hearings. However, I am hopeful that an acceptable financing mechanism can be devised to provide these coverages. I do not know whether it is going to have to be a combination of public, private and government initiatives, but somewhere in the scheme of things I think we have got to come up with something. I think we have that obligation to the people that we represent, and I think that this is the challenge facing all of us. I want to assure you today that we are going to do our best to meet that challenge.

Thank you, and the hearing is closed.

[Whereupon, at 12:38, the hearing was concluded.]

APPENDIXES

Appendix No. 1

Additional questions and answers from witnesses

VISITING NURSE ASSOCIATION OF SOMERSET HILLS
12 OLCOTT AVENUE
BERNARDSVILLE, NEW JERSEY 07924

TELEPHONE 201 766-0180

May 6, 1987

Congressman Matthew J. Rinaldo
2469 Rayburn House Office Building
Washington, D.C. 20515

Dear Congressman Rinaldo:

Thank you for the opportunity to respond to questions posed in your 4/17 letter. The issue of catastrophic care is such an important one. On behalf of New Jersey home care providers, I appreciate your interest and work in seeking legislative remedies.

1. You advocate a role for the Federal government as a "designer and coordinator" of catastrophic health insurance. In this type of arrangement, what specific duties would the Federal government fulfill? Where and how would the State and local governments and providers fit in?

The President's proposal for catastrophic care builds on the present Medicare system. There is great wisdom in building on this existing system, that for all its problems, has made health care more accessible to the elderly and disabled, defines uniform benefits for all subscribers regardless of what State in which they reside, and has in place the systems necessary to manage the program. It seems logical, therefore, that catastrophic health insurance that includes coverage for long term care be an augmentation of the present Medicare system. The Health Care Finance Administration has the systems in place to write the regulations, administer the funds and delegate the day to day management to the current Fiscal Intermediaries who have developed the expertise in managing the traditional Medicare program. However, the Congress must make its intent clear, to HCFA, in whatever catastrophic bill is passed, to prevent an erosion of the benefit such as is currently ocurring with the Medicare home care benefit. Representatives of State and local governments and providers should be key advisors on the shape the regulations should take. In addition, the State government should monitor providers to insure a basic level of quality assurance, as they do with the current Medicare program.

2. In your statement, you said that uncompensated care is paid for by private agency fund raising. Why are home health service providers not included in the New Jersey uncompensated care pool?

The New Jersey uncompensated care pool is linked to hospital rate setting which is a function of the New Jersey State Department of Health. According to officials of that Department, since rate setting is not done by the Department for home health agencies, there therefore is no mechanism to provide for uncompensated home care from the hospital pool.

As I pointed out in my testimony, uncompensated care is looming as the major problem for New Jersey home care providers. The urgency of this matter cannot be overlooked. With the escalation of Medicare denials coupled with the increasing need for home care due to earlier hospital discharges and a growing "old-old" population, home care providers are struggling to meet the needs of people while staving off bankruptcy. For many agencies, survival will depend on eliminating or drastically restricting "no fee" or "part fee" visits. Who then will care for these patients - the blind diabetic who needs syringes pre-filled, the amputee who needs more than one or two physical therapy visits to feel confident and competent in walking with an artificial limb? The examples are legion. Home care administrators are trying to cope with the fiscal problems created by HCFA's current interpretations of the Medicare benefit; nurses and therapists are daily being asked to make decisions to discharge patients that are creating an ethical turmoil. Agency fund raising in most instances cannot bridge the gap between Medicare cutbacks and the need for care in the community. Since home health providers are currently excluded from the New Jersey uncompensated care pool, there must be another mechanism established to alleviate this problem.

3. Do you see a viable option in private insurance coverage of home health services?

It has been very encouraging to see the interest developing on the part of private insurers in the area of long term home health services. The AARP-Prudential program needs to be studied closely as data on consumer interest in the product, utilization of services and costs can be gathered and analyzed. However, there are grave concerns on the part of private insurers that they will not have a large enough pool of subscribers to make the premiums affordable. Given the magnitude of the problems, the Federal Medicare system is the only actuarial base that could support a long term care insurance affordable to the majority of the elderly. Private insurance may cover some aspects of home health services for some individuals, but it is difficult to imagine the private insurance industry as the primary insurer.

4. Concerning case management services: who do you think should provide this type of service? What would the essential components of a case management program include?

The most logical providers of case management services are Medicare certified home health agencies, for the following reasons:

1. Medicare Conditions of Participation, monitored by Federal on-site surveys provide an established level of quality assurance. In addition, in New Jersey, state licensure standards are monitored by yearly on-site surveys.
2. Such agencies provide a broad spectrum of services (skilled nursing; physical, speech and occupational therapists; social workers, and home health aides).
3. Many of these agencies are already involved in local and state programs which have case management components.
4. The public health nurse's expertise includes a broad knowledge of community resources, the ability to coordinate multiple services and the skill to link the client to the appropriate community service.
5. Fragmentation of care is [illegible] as the client moves from needing an acute level of home care to a less acute level of long term care, if this care is case managed through the same agency.
6. Many long term care needs can be met by home health aides and a variety of other unskilled caregivers. There is concern in the industry, the press, and the Congress in the potential for abuse of the elderly by such unskilled caregivers. (an example of Federal concern is the draft report of the Office of the Inspector General released 4/87). The key to preventing such abuse is case management which includes close instruction and supervision of paraprofessional workers by a public health nurse.

5. The 3 step modified Medicare plan you outline would increase the cost of Medicare to the elderly. While the "plus" and the "super" would be optional--just as Part B is now--what effect do you think this cost increase would have on the elderly, many of whom already live on the fringes of the poverty line?

For the elderly individual, the additional costs of a Medicare "plus" or "super" plan would have to be weighed against the benefits he or she would receive. In the NAHC plan, Medicare "plus" with an estimated premium of $20./month would cover prescription drugs, dental care and a modified home care benefit. For so many elderly, these are currently a necessary out of pocket expense. It is estimated that the elderly spend 16% of their income on out of pocket health care costs. Looking at just one aspect of coverage, the elderly are the major purchasers of prescription drugs. Although New Jersey has an excellent Pharmaceutical Assistance to the Aged program (PAA), those who do not economically qualify and those in most other states face large medication expenses every year. Although costing $240.00 per year, I think most elderly would consider this an affordable insurance and that the cost incurred would be offset at some point in their lives in the savings in out of pocket expenses.

The NAHC Medicare "super" proposal does not yet have a projected cost. It may not be affordable to many elderly living on the fringes of the povarty line. However, such individuals may have family members who could assist with the cost, particularly if this were a tax deduction for them. What must also be considered is that with the large potential base of enrollees, the premium for the proposed home care "super" plan would be more affordable to more people than any one private plan is likely to be.

6. In the 3 step Medicare program you propose, you include State and private insurers as part of the system. How do you envision this arrangement working? What portions of claims would be picked up by the State and what portions by private insurers?

The three step program proposed is essentially that put forth by the National Association for Home Care (NAHC). The first step of this approach is the current Medicare B in which I do not envision any drastic change. Private insurance is already playing a role here as fiscal intermediary and in the area of "Medigap" policies which cover co-payments. Some of these policies are very good, others are so riddled with exclusions that they are virtually worthless.

The second step as discussed in Question 5, is seen as an extension of the Federal Medicare program.

The third step, "Medicare Super", will have higher premiums. The states may play a role in funding premiums through the Medicaid program for the poorest segment of the over 65 population. Private insurance would be likely to play a role with plans analogous to the current "Medigap" policies. However, any attempt to encourage private insurance participation in long term care must also insure protection for the consumers who buy these policies.

Finally, in developing a Federal long term care program, the expertise of people in State government and in private insurance companies, as well as from the provider community, should be tapped in an advisory capacity.

7. If the President's proposal is enacted, what effect will it have on your profession? That is, would VNA's operate differently? Would services change? How?

If the President's proposal on catastrophic insurance coverage is enacted, it is estimated to help only about 2% of the Medicare beneficiaries, those who qualify under the Medicare program for extended hospital stays, incurring out of pocket costs of more than $2000. per year.

All things being equal, VNA's would not operate differently if this proposal were enacted, since this bill was designed to help those who would most likely need to be in a hospital setting in any case. However, by not addressing the catastrophic nature of chronic illness of chronic illness requiring a variety of home care support, this proposal leaves VNA's still struggling to provide care for these people with. in so many cases, no funding source to pay for this. This brings us back to the question of how to fund uncompensated care.

Please feel free to contact me if further clarification of the above material is needed.

On behalf of home care providers in New Jersey, I want to thank you for this opportunity to comment on the issues of catastrophic care in relation to long term chronic illness.

Yours truly,

Evelyn K. Savage

Evelyn K. Savage, R.N., M.A.
Executive Director, VNA of Somerset Hills
President - Elect, Home Health Agency Assembly of New Jersey

EKS/pn

RESPONSES TO QUESTIONS SUBMITTED BY THE COMMITTEE TO MR. THOMAS R. BURKE, CHIEF OF STAFF, DEPARTMENT OF HEALTH AND HUMAN SERVICES

QUESTION 1:

What would be the additional cost to the Medicare program if it were expanded to cover long-term care? Have you examined public/private partnership options that may not be so prohibitively expensive?

ANSWER

In development of a long-term care strategy, the Department has sought the right mix of public and private initiatives for expanding the availability of private financing mechanisms. This Administration feels it is important to look at the potential of private sector contributions in this arena since Federal, State and local governments are already significant partners in sharing the burden of long term care expenses.

In 1985, the Nation spent roughly $120 billion on long-term care services for persons of all ages; about $38 billion was spent on nursing home services and close to half of this amount was paid for through Medicaid and other financial assistance programs. Most of the rest was paid for by individuals and their families, directly out-of-pocket. Less than 2 percent was covered by private sector insurance.

While nursing home care costs alone are expected to exceed $100 billion (in today's dollars) by the year 2020, we feel the nation cannot afford to neglect the private sector role in a financing system for long-term care.

The President's plan for addressing the problem of financing for long-term care services for the elderly includes the following elements:

- a major private/public collaboration to educate the public about the risks, costs and financing options available for long-term care;
- direction to the Treasury Department to study proposals to encourage development of personal savings for long-term care through tax-favored individual medical accounts (IMAs) combined with insurance;
- direction to the Treasury Department to study proposals to amend individual retirement account (IRA) provisions to permit tax-advantaged withdrawal of funds for long-term care expenses; and
- direction to the Treasury Department to study development of the private long-term care insurance market through legislation providing tax incentives for purchase of such care by individuals or employers.

The Department has already begun to develop a public awareness campaign and we are working with the Treasury Department on their analysis. We expect to have some results by September.

QUESTION 2:

Among the costs commonly incurred by the elderly are the purchase of prescription drugs, eyeglasses, hearing aids, etc. These can have a substantial impact on a fixed income. Why aren't such costs counted toward the $2000 limit?

ANSWER

The President's proposal does not change current Medicare coverage rules; therefore, prescription drugs, hearing aids, etc., would continue to be non-covered services. Only the beneficiary's combined copayment liabilities under Medicare part A and B would count toward the $2,000 catastrophic cap. Each beneficiary would be assured that once he or she incurred out-of-pocket expenses for approved Medicare charges of $2,000, Medicare would pay for all remaining covered charges.

Though for many elderly, prescription drugs, hearing aids, etc. are a financial burden, such expenses, by themselves, are unlikely to produce financial catastrophe. However, when added to other out-of-pocket costs of hospital and medical services, expenses of a much larger magnitude, drug expenses and hearing aide expenses, etc., can clearly exacerbate the potential for a financial catastrophe. The President's proposal to limit out-of-pocket liability for higher hospital and medical expenses will substantially lessen the burden of drug, and hearing aide expenses, etc. We believe that coverage of these items is most appropriately addressed in private sector insurance policies.

QUESTION 3:

Some have found fault with catastrophic proposals that raise premiums for beneficiaries because then all Medicare recipients are forced to pay a higher premium for a service they will probably never use. (Only about 4% of enrollees will meet the $2,000 cap). Other approaches, such as the alternatives set forth in your report which would restructure Medicare cost sharing, are criticized because the costs are born only by those who use the system, and thus they are in effect a tax on illness. How many different financing mechanisms did you look at? In a perfect world, what would be the most equitable financing mechanism?

ANSWER

We looked at a number of financing mechanisms such as premiums, increased cost-sharing both related and unrelated to income, taxing the actuarial value of the Medicare benefit, and others.

We believe that for the purposes of catastrophic expense protection, premium financing is the most equitable method of payment.

The argument that premiums are unfair because many beneficiaries pay a higher premium for a "service" they never use does not hold water. The whole principle of insurance is that people pay to protect themselves from a risk of needing the service. They are not paying for the service.

We are not in favor of increasing deductibles and copayments as a financing mechanism because that does tax the sick.

We also did not choose taxing the actuarial value of Medicare benefits because so few people would have to foot the bill for everyone. This approach would be very expensive, for those beneficiaries who would be taxed. Further, this seemed an unnecessarily complicated way to pay for a simple addition to the Medicare program.

QUESTION 4:

The study released by Harvard Medicare Project last year argued that higher premiums may be preferable to the current system of copayments and deductibles for Medicare beneficiaries because premiums, unlike copayments and deductibles: are predictable, budgetable; they spread risk over the largest available pool; they don't burden the sick; and they could be income related. Would it be worthwhile to pursue this line of reasoning when addressing the question of catastrophic financing?

ANSWER

While I have not studied the Harvard Medicare Project results, I agree with those statements about premium financing. In terms of our catastrophic proposal, we agree that spreading the risk over a pool of 31.5 million persons is an example of insurance at its best. A large risk pool benefits the insured through low cost for their protection. In addition to the advantages just mentioned, premiums are easy for people to understand and administratively simple for Medicare to handle through its existing part B mechanism.

Regarding income-relating, yes, one can do this with a premium approach. It would be administratively easier than income-relating deductibles and coinsurances. However, implementation difficulties exist in any income-relating payment methodology.

QUESTION 5:

Your report repeatedly mentions the bias of both public and private insurance policies toward institutional care. Why is this so?

ANSWER

In part, for very practical reasons--once a patient leaves the controlled and well-known environment of a hospital or nursing home, it becomes:

(1) much harder for the insurance company to strictly define "units of services"; e.g., what services are legitimately included in the definition of home care;

(2) harder to control unwarranted use of non-institutional services. There are few ways of establishing whether services provided outside of the hospital or other institutional settings are medically necessary; and

(3) most importantly, harder to predict the extent of the company's liability under a policy covering non-institutional services and to set a fair premium.

The traditional bias towards institutional care also reflects the kind of acute care coverage purchased in the past. However, institutional level of care is not always considered the most desirable for long term care needs. We need to explore ways of financing long term care in the private sector that can accommodate the wide range of medical-social needs of the elderly, without augmenting overall costs of care.

QUESTION 6:

As you know, costs for medical care are currently rising at three times the rate of inflation in general. The Medicare reimbursement system is currently based on a percentage of prevailing medical charges. Given these facts, how would you answer those who insist that expanding Medicare to cover more services would exacerbate medical cost inflation and its attendant detrimental effects on the economy?

ANSWER:

First, the Administration does not propose to expand Medicare-covered services. Rather, our proposal would cap beneficiary cost sharing liability at $2,000 for eligible services.

Second, what uniquely fuels medical inflation is "first dollar" coverage for which there is no beneficiary cost-sharing. Such first-dollar coverage is just the opposite of the Administration's catastrophic proposal, which is designed to insure not against the first dollar of costs but to limit the beneficiary's subsequent and potentially catastrophic financial risk.

Third, there are those who would argue that coverage of catastrophic expenses encourages providers to pad costs. This may have been a danger with regard to hospitals prior to enactment of prospective payments by Medicare. However, under the prospective payment system, hospitals will still have every incentive to discharge appropriately and reduce unnecessary lengths of stay.

Finally, the Department is encouraging the delivery of medical services in managed care environments. We believe that it is imperative that the financing of health services be linked with the management of these services. When the financing of care and the utilization control of services are separated, there is less ability to exercise restraint over escalating costs.

RESPONSES TO QUESTIONS SUBMITTED BY THE COMMITTEE TO MR. WILLIAM F. MATUSZ, THE PRUDENTIAL INSURANCE COMPANY

1. How would the type of insurance package that you offer for long-term care fit with the proposed plan advocated by the President which covers mostly acute-care costs?

   Since the proposed plan advocated by the President includes no long-term care benefits (with the exception of skilled nursing care up to 100 days), our insurance package would fit very nicely as a supplement since it covers all types of nursing home care, including custodial, after a 90-day deductible for a period of up to three years.

2. In the report that Secretary Bowen presented to the President last year, proposals were included for individual purchase of long-term care policies. Would this type of Federal policy influence the marketing of your product?

   Yes, any positive steps the Federal Government can take to highlight the importance of long-term care insurance and to encourage the purchase of such policies would be a real plus.

3. Concerning the response to your mailings offering the AARP policy, you said that in the first test market you mailed to 215,000 households and sold 1,200 policies. That is approximately a 1/2 percent response. Is that a good response rate? What is the typical response rate for a offering of a test policy?

   The response rate was just about what we would expect for a test plan with relatively high premiums.

4. In the follow-up survey to the second test, approximately how many people indicate that they could not afford such a policy?

   The percentage dropped from 30% to somewhere between 20 and 25%.

5. You mention the possible development of an asset accumulation policy -- could you describe how such a policy would work?

   This would be very similar to a savings account or an IRA. The goal of such a policy would be for the individual to accumulate sufficient funds (on a tax free basis) in order to help pay for his own long-term care or to be able to purchase a paid-up long-term care policy at a certain age, such as age 65.

6. What is the potential market for a long-term care product?

   The potential market is all individuals between the ages of 40 and 80, especially those under age 65 where the cost is very reasonable. Because the cost is so expensive at the higher ages and most policies include some sort of health questionnaire, few policies will be sold to individuals over 75 or 80. Ideally, it could be the same market as for pension plans, with individuals funding their long-term care costs during their working years.

7. You mention the uncertainties about Federal tax policy toward long-term care policies. Could you be more detailed and outline for the Committee what, in your opinion, would be the needed changes in the tax code to take care of some of these problems?

   The major tax issue concerns long-term care reserves. Insurance companies must accumulate reserves in order to help pay future benefits. Unlike life insurance, the interest on reserves for long-term care insurance is taxed. The change we are looking for in the tax code is to treat long-term care reserves the same as life insurance reserves.

8. In the offering of these long-term care policies, would the development of risk pools help keep the cost down and level out the disparity of the premiums between age groups?

Risk pools could help to keep the overall cost down, but it would not alleviate the disparity of the premiums between age groups. Premiums must reflect the increased utilization at the higher ages.

9. Concerning your suggestion to relax some of the Medicaid requirements, could you be more specific in what type of changes you think are needed in the Medicaid law concerning spousal impoverishment?

Approximately 12% of nursing home residents are married, so you can see this is a significant problem. Things that can be done are:

1. Split a couple's income and resources when one spouse applies for Medicaid so the remaining spouse has enough money to live on and can remain independent.

2. Medicaid could allow a more reasonable maintenance amount for spouses who remain at home.

Appendix 2

LEGISLATIVE MEMORANDUM

April 10,1987

To: Honorable Matthew J. Rinaldo,
Select Committee on Aging
U. S. House of Representatives

Re: Catastrophic Coverage Under Medicare

We are pleased at this opportunity to present written testimony on the issue of catastrophic coverage under Medicare, and the necessity for ample home care benefits. No plan for catastrophic coverage will be adequate unless it provides for the protracted home care needs of patients and for long-term care.

Cancer Care, Inc. is a voluntary social service agency which, for over 72 years, has offered comprehensive social services to cancer patients and their families. We have offices in New York City, Long Island and New Jersey and we are completely dependent upon contributions from the public and foundations. Our services include individual and group counseling, help with planning for the care of the patient, as well as some financial assistance to eligible families to help them meet the costs of home care plans and transportation to and from radiation or chemotherapy. During our '85-'86 year, we served over 10,000 patients and disbursed more than $990,000, with most of the disbursements going to elderly patients. We received over 2,000 requests for help in New Jersey during this period, and disbursed $276,126 to New Jersey patients. In the first 7 months of our current fiscal year we have assisted over 6300 patients and have disbursed nearly $640,000 of which 1050 were New Jersey patients, to whom approximately $91,000 was disbursed.

Since we deal on a daily basis with the dread and very often catastrophic illness of cancer, we are extremely knowledgeable about the many needs of these patients and the financial, practical, and emotional problems which confront them and their families. We feel that this expertise is translatable to other catastrophic illnesses which also frequently require a multitude of out-patient services.

For those with seemingly adequate health insurance coverage, an illness can still cause a catastrophe because of the "hidden" costs created by the illness. Thomas Hodgson, in an article on "Social and Economic Implications of Cancer in the United States" (Annals of the New York Academy of Science, Vol. 363, 1381), speaks to the need to study non-health sector direct costs, which he estimates may add another 5 to 25 percent to the total direct costs. The non-health sector direct costs he refers to are special diets and clothing, dwelling modifications, homemaker care.

Also, according to the NMCES study conducted by the National Center for Health Services Research and completed in September 1979, "A fifth of the nation's 80 million families incure catastrophic out-of-pocket medical expenses - costs that absorb an abnormally high percentage of their total income." (NCHSR Research Activities, May 1986, No. 85). Clearly the problem is very prevalent.

Our lengthy experience confirms that for the majority of cancer patients, inpatient care in a hospital is relatively minimal in comparison to the out-patient needs that are sparked by the illness. Therefore, we have long questioned the adequacy of any catastrophic coverage plan that is based merely on more comprehensive coverage for inpatient care. As a result, we have been critical of the President's and other proposals to ensure that Medicare patients will not be required to spend more than $2,000 a year for deductibles and co-insurance payments for hospital care.

For the great majority of the elderly, the cost of inpatient hospital care is the least of their worries, since most hospitalizations are short term and are covered by Medicare. While it is estimated that more than 200,000 elderly Americans each year experience hospital stays in excess of 60 days, this is indeed a very small segment of the many millions enrolled in Medicare — 29,284,396 as of February 1986. Further, the average length of hospital stays for patients over age 65 was only 8.9 days in 1984. Clearly the overwhelming majority of Medicare patients experience only short hospital stays.

While we certainly sympathize with the plight of those Medicare patients whose hospital stays exceed 60 days, or those who may need several hospitalizations in one year, singling them out for increased benefits does not compensate sufficiently for the other inadquacies in Medicare coverage. We must be just as concerned with those who are forced to spend great sums of money — sometimes pauperizing themselves — to secure adequate and sufficient home care services.

We must also be concerned with how much Medicare patients must spend for drugs. And, can we dare overlook Medicare's very inadequate coverage for long-term care — how to pay for nursing home care justifiably worries Medicare patients a great deal.

A very prolonged hospital stay is far from being the only definition of catastrophic illness. The definition must be broadened to include those illnesses which require extensive home or institutional care. These patients also deserve to be helped to acquire these services with dignity and without fear of impoverization. Unfortunately, your proposals, H.R. 1280 and H.R. 1281, do not expand in any way Medicare's current home health benefits and regulations.

We feel compelled to take this opportunity also to point out that while there has been a swing towards amending Medicare to completely cover hospital care, the DRG reimbursement system, designed to decrease health care costs, has led to earlier discharges from hospitals. Medicare patients are being sent home earlier in their illnesses than ever before. Simultaneously there have been cutbacks in the availability and intensity of Medicare's home health services. This has been accomplished by reinterpretations of the Medicare statute and the creation of new definitions.

We have long criticized Medicare because of its paucity of coverage for out-patient needs, and its stringent eligibility requirements for home health care: the patient must require a skilled service, must not need more than part-time or intermittent care and, in most instances, the patient's condition must be acute and short term. These rules governing home health care always eliminated a very large number of elderly cancer patients who may need daily care from a home health aide for a more protracted period of time, or, may not need a skilled service at home in the first place.

Now, because of the new rules and regulations governing Medicare's home health services, even fewer patients are receiving assistance at home. This is a situation that must be addressed quickly, and we are pleased that Representative Staggers and 13 other Congressmen have joined in a suit against the Department of Health and Human Services, challenging "the attempted dismantling of the Medicare home health benefit via actions which are violating plantiff's rights under the Medicare statute, the Administrative Procedure Act and The United States Constitution." We are hopeful that this suit will at least restore Medicare's home health services program.

Any plan for coverage of catastrophic illness is incomplete unless it includes sufficient coverage for the care-at-home needs of patients. We can and do appreciate the possibilty that opening up and broadening the home health benefit will sharply increase Medicare's expenditures for home health care. We can also appreciate that eligibility criteria would have to be carefully worked out and that adequate case management would be essential. But we must remember that ignoring the problem doesn't necessarily mean that government gets off the hook entirely.

Elderly patients who need long term home health services frequently end up depleting their resources, actually pauperizing themselves. This is called "spending-down" in the language of Medicaid, the federal-state health care program for the very poor. The patient's care is then paid for by the government, at least in those states such as New York that have spend-down programs. Other elderly folk, having caught on to the system, turn their resources over to their children so as to be eligible for Medicaid in advance of their actual need for care. Thus, in many instances, government ends up paying for out-patient care, including home care, just as it does for the nursing home care of millions who may have started out by paying for this care themselves. Shouldn't government be willing to help the elderly with their realistic home care needs in such a way as to avoid reducing them to poverty or duplicity?

In closing, we want to reiterate our belief that adequate coverage for home care must be an integral part of any catastrophic health insurance plan. Only then can a catastrophic plan be truly meaningful.

SENIOR CITIZENS COUNCIL OF UNION COUNTY, N J., INC.

2165 MORRIS AVENUE
UNION NEW JERSEY 07083
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EVELYN FRANK, PRESIDENT

April 10. 1987

Congressman Matthew J. Rinaldo
Ranking Minority Member
Select Committee on Aging
2469 Rayburn House Office Building
Washington, D.C. 20515

Hearing on Catastrophic Health Insurance:
A New Jersey Perspective April 10, 1987

Dear Matt:

The Senior Citizens Council of Union County, N.J., Inc., a non-profit organization, draws its membership from representatives of approximately fifty Union County senior citizens clubs. The prime goal of the Council is advocacy on behalf of older people. A projection of the 1980 census will reflect a population of over 95,000 in 1987 as being over 65 in Union County. The Council meets monthly, has an Executive Board, and is headed by a president/director.

The Council staffs an office funded primarily by a grant from the Older Americans Act, Title III. Some of the services made available through the Council office are, Employment Services, Dental Referral, Lawyer Referral, Physicians Medicare Assignment Courtesy Card and Self Proving Wills. Our newspaper, Union County Senior News, printed six times a year, has a free distribution of over 19,000.

The Council has been made aware by its membership and by many health care providers that health care has been diminished because of reinterpretation of regulations under Medicare. The changes that have come about in Medicare coverage were never made clear to Medicare beneficiaries. This results in the elderly having no knowledge of eroding health care until they become ill and put in a claim.

While being concerned about Medicare coverage, the elderly have deep fears about long-term custodial care and the bankrupcy that accompanies this care. At meetings these fears surface. There have been no reports on devastating acute care hospital expenses. The Council sees no advantage inBowen's Catastrophic Health Care in hospitals. If Bowen's bill will help some people, the percentage would be very small.

Without going into the feasibility of Claude Pepper's HR 65, the Council wishes to go on record that the concept presented by HR 65 recognizes the health problems faced by the aging population.

The Council has concern that Medicare is reimbursing providers for services not performed. There have been reports of medicare payment in the hospital days after the patient has been deceased: of services rendered but not identified by the beneficiary.

WHO IS IN CHARGE OF MY HEALTH CARE? Am I in charge? Is it my doctor? The hospital? The nurses? Medicare? PRO's (peer review organization) The Government? I would like to believe that I am in charge of my health care. My physician helps me to be in charge. How can my physician care for me if he cannot put me in the hospital when he deems it necessary. Nurses no longer can predict on how they can assist in home care.

Much testimony has been given that home care would be more economical than hospitals and nursing homes. The aged need continuum of care services which would include prevention and long-term care community-based support. We are afraid that by refusing support for home care, the burden then shifts to state and local governments.

If the Administration is concerned with Medicare's shrinking benefit package, then attention should be given to the erosion that took place in the Medicare Program. While attention is being focussed on improving our health care, why not turn back the clock and at least reinstate the Medicare benefits that were there before regulations were changed.

How did anyone dare to come out with a regulation that would deny a hernia operation because of age? Before the elderly could begin to learn of this discrimination the Medical Society went to bat and had this regulation changed.

Who is in charge of my health care? I hope it is not my government where insensitivity to health care demands out-patient surgery in order to save some money at the risk of neglect and complications.

If there is concern for Medicare expenses, then let a study be made of tests for people at no out-of-pocket costs in group settings and reimbursed by Medicare. Why can't I have my tests done with my doctor at no out-of-pocket costs? Why can a health group have a contract with Medicare but the family physician cannot?

If there is concern for Medicare expenses, our Council would like to advocate that no provider be reimbursed by Medicare until they have had an opportunity to review the bill for accuracy. Senior citizens want to oppose wrong payments by Medicare even if it does not come out of their pocket.

To sum up, we oppose Bowen's Catastrophic Health Care bill and recognize that the elderly need comprehensive catastrophic and preventive health care coverage as stated in the Claude Pepper Bill HR 65.

Sincerely,

Evelyn

Evelyn Frank
President/director

OLDER WOMEN'S LEAGUE OF CENTRAL NEW JERSEY,
Plainfield, NJ, April 10, 1987.

I represent the Central New Jersey chapter of The Older Women's League, a national advocacy group for midlife and older women, which was recently formed in our areas.

We are pleased to take this opportunity to inform you about the Older Women's League's stand on the issue of catastrophic illness plans.

The Older Women's League feels strongly that a more far-reaching and comprehensive plan than that proposed by the White House is essential. The White House Catastrophic plan: Applies only to Medicare beneficiaries with no protection for 37 million uninsured Americans of all ages; provides additional hospital coverage for long stays which less than 3% of the elderly need; does not address Medicare gaps, such as prescription drugs and the costs Medicare terms "unallowable" but still permits doctors to charge patients; and ignores the elderly's most feared catastrophe: long-term care costs;

We appreciate your concern and your work on behalf of the elderly and hope that you will fight for a truly comprehensive catastrophic illness plan.

Yours truly,

GRETEL D. WEISS, *Chair,*
Older Women's League of Central New Jersey.

NEW JERSEY COUNCIL OF SENIOR CITIZENS,
Cranford, NJ, April 3, 1987.

Thank you for inviting me to testify at the April 10th hearing of the Select Committee on Aging on behalf of the New Jersey Council of Senior Citizens. Unfortunately, I have a prior commitment which precludes my being able to attend and testify in person.

As you know, the 250,000 member New Jersey Council of Senior Citizens has been striving for many years to pass legislation that will cover the health needs of our older citizens. With this in view, I would appreciate your Committee's consideration of the recommendations that the executive Board unanimously approved at our March 18, 1987 meeting. We strongly urge you and your Committee to actively support and fund legislation that will:

1. Expand home care services under Medicare to eliminate the "No Care" zone and help to keep persons from being institutionalized.
2. Change the Federal Medicaid policy that forces a person into poverty when his or her spouse is institutionalized.
3. Support Part C of Medicare to give real health protection to seniors. The so called "Catastrophic Illness" Bowen Plan will help very few seniors because of the many things it doesn't cover. The cost of a Part C to Medicare would cost seniors much less than they are now paying for Medicare Supplement policies that provide very little protection.
4. Increase the $25.00 per month Personal Needs Allowance for nursing home residents that hasn't been changed since 1972.
5. Upgrade the standards and improve the squalid conditions that currently exist in our nursing homes.

We know, appreciate and thank you for your strong support for seniors throughout your career and we look to you for leadership in our continuing efforts to make our twilight years healthier and happier ones.

Respectfully yours,

DAVID KEISERMAN,
Legislative Representative.

UNION COUNTY MEDICAL SOCIETY OF NEW JERSEY,
Cranford, NJ, April 15, 1987.

CONGRESSMAN RINALDO: Thank you for asking us to submit comments on catastrophic health insurance.

Total US spending on health and medical services is expected to rise 10 percent in 1987 The increase is attributed in part to the growing number of older Americans, greater use of nursing homes and home health services, and increasing expenses of sophisticated technology. Home care is growing due to the number of elderly, rising hospital costs, and earlier discharges.

There is no doubt that a major concern of the American public is catastrophic health coverage. Of issue is how much it is going to cost and who ultimately will pay for it.

It is obvious that Medicare is neither economically or realistically sound enough to manage any further obligations. On the other hand, private insurance carriers seem to operate cost-effectively and it would seem that their expertise would be invaluable.

There are working models for insurance packages for the elderly in other parts of the country. Metropolitan Life has two benefit packages available for Medicare enrollees of the Group Health Cooperative of Puget Sound, Seattle—an HMO. Each package will insure beneficiaries against custodial care costs, and the more expensive of the two also offers home health care. Another avenue worth exploring is the operation of SHMO—social HMO, currently in four states. Medicare beneficiaries pay a premium of $25–49/month. The SHMO receives its primary funding through a monthly fee paid by HCFA for each Medicare enrollee. Covered services include case management, preventive and acute care coverage, respite care, adult day care, personal care aid, transportation, short-term intermediate care facility services and 2–4 months of nursing home care beyond that provided by Medicare.

These are not necessarily solutions but they do seem viable options, the mechanics of which should be examined while the issue of catastrophic health insurance is being investigated. Of foremost concern is that the private physician-patient relationship be maintained since this has proven to be the most beneficial care to patients of all ages.

The federal government has consistently failed to develop a coherent policy to deal with the aging population of this country. A policy must be developed to meet the legitimate medical needs of the elderly without impoverishing their children.

Thank you for inviting us to comment on the subject.

Very truly yours,

IRENE ROSENTHAL,
Executive Director.
R. GREGORY SACHS, M.D.,
President.

HUNTINGTON'S DISEASE SOCIETY OF AMERICA
140 W. 22nd Street, New York, NY 10011 (212) 242-1768

Huntington's Disease Society of America (HDSA) Testimony before the Private/Public Sector Advisory Committee on Catastrophic Illness

(August 12, 1986)

For any but the very wealthiest families in America today, the news that a member has been diagnosed with Huntington's Disease(HD) is an economic as well as a physical and psychological catastrophy. During the next ten to twenty years, the cost of caring for the HD patient will strip the family of its financial resources and the afflicted member will most likely end up in a state mental hospital where he or she does not belong. When death seems finally to put an end to this catastrophy, it in fact reappears once more; each child of the deceased victim has a 50 percent chance of inheriting HD and thus of facing this horror once more.

In order to put an end to this pattern of recurring catastrophy in the more than 20,000 American HD families, the Huntington's Disease Society of America (HDSA) urges you to consider recommendations in two areas: financial support and long term care facilities.

Huntington's Disease is an inharited progressively degenerative brain disorder which results in the gradual loss of control over both the body and mind and always ends in death. There is no cure for HD, no state of remission, no effective treatment. The following characteristics of HD present special problems for today's medical care and support systems and help explain why the disease is such a catastrophy for the afflicted family. First, HD is a disease of multiple handicaps. The victim faces the slow deterioration of physical capacity, the ability to communicate, and the processes of thought and reasoning. Second, HD strikes in mid-life, between 30 and 45 for most, after the family has been established but before children have left home. And third, HD is a long-term, progressive degenerative disease. Most patients live 10 to 20 years after diagnosis and they never get any better. They can be cared for at home for some years, but eventually they will need custodial care in a nursing home or similar institution and finally skilled care before death.

The need for better financial support is directly related to these characteristics. Families find themselves caught between "a rock and a hard place" with no where to go. Medicare is totally inadequate for a long term degenerative disease such as HD. Benefits are restricted to skilled care thus eliminating home and custodial care. In addition, benefits are limited to 100 days. Medicaid is the principal source of government financing for long-term care but the program is only available once the family is reduced to subsistance levels. Private Health Insurance is also inadequate, even when available, because it does not meet the needs of HD families; insurance for nursing home care is based on the assumption that the patient generally has been hospitalized and sent to the nursing home to recuperate and will subsequently be sent home. If the patient is terminally ill, it is assumed that they will die within a relatively short period of time and thus not need years of long term care. The opposite is true for HD families--they want to keep the patient at home as long as possbile; then after five to ten years they seek custodial care in a nursing home to handle feeding, bathing, walking, etc.; and finally after fifteen to twenty years they will need skilled care as the patient reaches the end of life.

What we propose is some kind of private/public partnership to underwrite catastrophic illness insurance for individuals with long term degenerative diseases. Such insurance should include support for home care, custodial nursing home care, and skilled nursing home care and should not strip families of all their assets or have any time limit for benefits. At least nine private insurance carries do offer nursing home insurance which, if modified and expanded to meet the above conditions, and perhaps guaranteed or supplimented by the federal governement, would go a long way toward meeting the problem. (See attached article: "When a Nursing Home Becomes Your Poorhouse," Money Magazine, March 1986.)

In addition to financial problems, HD families face a frantic search for secure and decent care facilities for patients they can no longer keep at home. The problem is that because of the age of onset plus the mental and physical nature of the disease, victims have no appropriate place to go. In nursing homes and other geriatric facilities, the staff is not trained to handle the psychiatric aspects of the disease. Patients are seen as difficult and unmanageable and

are sent to the state psychiatric facility. Furthermore, in nursing homes HD patients are usually much younger than those around them. On the other hand, the state psychiatric hospital is not equipped to handle the physical problems of the HD patient—the involuntary movements, the loss of speech communication ability and the swallowing problems. In addition, these hospitals are not hazard-free so patients are usually physically tied to chairs to keep from hurting themselves. (See attached statement on the Commission for the Control of Huntington's Disease and its Consequences.)

What we propose is a public/privat partnership to create special long term facilities for HD patients and others with similar diseases. There are several models for such cooperation and with modification and expansion of their programs they will make a major contribution to solving the problem. (In Minnesota, the "Trieds" of the Hennepin County Medical Center, the Metro Care nursing home (owned by Beverly Enterprises Inc.) and the Minnesota Chapter of HDSA, work together to provide long term care. Through referrals from the Hennepin HD clinic, Metro Care became expert in the care of HD patients; Metro currently has 20 in-patient beds for HD patients and is starting a day care center. Metro has also agreed to house the office of the local HDSA chapter. In addition, the Hennepin County Medical Center conducts a clinic every three months at the Metro Care nursing home which cuts hospital visit costs for nursing home staff and patients. In New Jersey, the federal and state government and the Robert Woods Johnson University Medical Center are negotiating with a private nursing home operator (Meridian) to build and operate a 120 bed teaching nursing home which would devote 15 beds to HD patients. In Massachusetts the Middlesex County Hospital has developed a special program of physical, occupational and speech therapy for HD patients. These are all important models, but the financial problems mentioned above restrict their availability in many cases to only a fraction of HD families.)

In closing let me introduce a brief personal note. My mother died of HD in 1964. She died in a state mental institution because there was no nursing home willing or able to keep her. I am at risk for HD and I have a wife and three children whom I love and for whom I wish to provide as best I can. We are not wealthy, but we do have some savings and a house. I believe I should pay my fair share, but I

do not believe I should be forced to strip my family of these assets if I should get HD. My options at present are to divorce my wife or to commit suicide neither of which I intend to do. Instead I am here to try and get across the message for myself and 20,000 other HD families that we need catastrophic illness insurance and we need adequate long term care facilities. We hope you will hear our ples and make it heard in the highest chambers of government so that I and others will not have to choose between inhuman alternatives.

Samuel L. Baily, Ph.D.
Chairman of the Board
Huntington's Disease
Society of America

APPENDIX 3

MEDICARE & CATASTROPHIC HEALTH INSURANCE

Background Paper

Prepared by
Congressional Research Service,
Washington, D.C.

1987

ABSTRACT

The Medicare program for the aged and disabled places no upper limit on out-of-pocket costs paid by beneficiaries either in connection with covered program services or for all out-of-pocket health care expenses. The program thus contains no catastrophic coverage provisions. A number of proposals have been offered which would expand existing coverage; however there is no universal agreement on what should be done if in fact anything should be done at the Federal level. This report outlines some of the major proposals which have been offered, as well as the principal policy issues.

MEDICARE: CATASTROPHIC COVERAGE PROPOSALS

I. OVERVIEW

Medicare is a nationwide health insurance program for 32 million aged and disabled persons. The benefits provided under the program are the same throughout the country. These benefits are targeted toward meeting the acute health care needs of the elderly. The program provides less effective protection against the costs associated with chronic illness, particularly those associated with long-term institutionalization. Further, the Medicare program places no upper limit on out-of-pocket costs paid by beneficiaries either in connection with covered program sevices or for all out-of-pocket health care expenses. The Medicare program itself therefore contains no catastrophic coverage provisions.

The combination of cost-sharing charges for covered Medicare services coupled with the potential for high out-of-pocket payments for uncovered services has led the majority of Medicare beneficiaries to purchase private insurance coverage (so-called Medigap coverage) to supplement the program's benefit package. The principal protection offered by the majority of these policies is coverage of Medicare's deductibles and coinsurance charges. Some Medigap policies cover a limited number of additional services such as prescription drugs. Few policies offer protection against the costs of long-term institutional care - potentially the most costly service item. Some low-income beneficiaries are also covered by Medicaid; however, many

beneficiaries do not become eligible for Medicaid benefits until after they become institutionalized and reduce their incomes and resources to the Medicaid standard through their expenditures on health care.

The absence of catastrophic protection, both for the elderly and the population as a whole, has been the subject of concern for several years. The President in his 1986 State of the Union Message asked the Secretary of the Department of Health and Human Services (DHHS) to examine the issues and suggest possible solutions. Secretary Bowen submitted the Department's report to the President in November 1986 which recommended a shared public/private sector response.

While a number of persons have suggested that Medicare's protection should be expanded to offer catastrophic protection, there is no universal agreement on what should be done, or if in fact anything should be done at the Federal level. Generally, the catastrophic proposals which have been offered for the Medicare population would build on the existing Federal program. There are basically two broad categories of catastrophic proposals for this population group. The first category, which includes the proposal outlined in the Secretary's November 1986 Report to the President, would place an upper limit on beneficiary liability for Medicare deductibles and coinsurance; these proposals would also eliminate the durational limits on covered hospital services. Under this type of proposal, no catastrophic protection would be provided in connection with uncovered services. Assuming this coverage were instituted on a mandatory basis, it would have the effect of spreading the risk over the entire Medicare population. It is generally agreed that it would be relatively easy and inexpensive to administer. The major impact of this approach is that it could in large measure supplant existing Medigap policies offered by private insurance companies. However, this approach would not address a major concern of the elderly, namely the need for protection against the catastrophic costs of long-term institutional care. The second broad category of catastrophic coverage would attempt to provide protection against some of the costs associated with services currently not covered under the Medicare program (for example prescription drugs). Some, though not all, of these proposals would include long-term care expenditures in the benefit package. Several proposals would combine expanded protection with a restructuring of the current Medicare program.

A number of issues have been raised with regard to catastrophic/expanded benefit proposals. These include whether the Federal Medicare program should be altered from its current acute care focus, and if so how; and the appro-

priate role of both the public and the private sectors. A key concern is how a catastrophic/expanded benefit package would be financed. Options include increased payroll taxes, increased beneficiary premiums, higher coinsurance charges, Federal general revenues, or a combination of these. In view of the current budget deficit concerns, it may be difficult to achieve consensus on a proposal involving additional Federal outlays.

II. CURRENT PROGRAM

The Medicare program consists of two parts: the Hospital Insurance (Part A) program and the Supplementary Medical Insurance (Part B) program. The Part A program covers inpatient hospital services, post-hospital skilled nursing facility (SNF) services, home health services, and hospice care. With the exception of home health services, the law places specified limits on the amount of coverage that is available under each benefit category and imposes specified cost-sharing charges for the use of covered services. Coverage of hospital and SNF services is linked to the individual's benefit period. A benefit period is defined as beginning when a beneficiary enters a hospital and ending when he or she has not been in a hospital or SNF for 60 days.

Beneficiaries enrolled in Part B pay a monthly premium which is $17.90 per month in 1987. The program covers physicians' services (including those provided in a hospital) and a range of other health services including outpatient hospital services, durable medical equipment, laboratory and X-ray services, and physical therapy services. The program generally covers 80 percent of the "reasonable charge" for such services after the beneficiary has met a $75 deductible. The beneficiary is liable for the remaining 20 percent (known as the coinsurance). In addition, where a physician or other provider does not accept "assignment" (i.e. agree to accept Medicare's determination of the reasonable charge amount as payment in full for covered services), the beneficiary is liable for the difference between Medicare's reasonable charge amount and the physician's actual charge. (This is sometimes referred to as the "balance billed" amount).

See Table 1 for a summary of benefits under Parts A and B and associated cost-sharing charges.

Table 1. Medicare: Summary of Benefits and Associated Beneficiary Cost-Sharing Charges, 1987

Coverage	Beneficiary Payments
Part A	
Inpatient Hospital Services a/	
- Per benefit period:	
- - First 60 days	$520 deductible b/
- - 61st - 90th day	$130 daily coinsurance b/
- 50 lifetime reserve days	$260 daily coinsurance b/
Post-hospital SNF services	
- First 20 days	None
- 21st - 100th day	$65 daily coinsurance b/
Home health services	None
Hospice services	Subject to durational limits and copayments for outpatient drugs and respite care
Part B	
Physicians services and other medical services a/	1) $75 deductible 2) 20% coinsurance 3) Amounts in excess of reasonable charges on unassigned claims (balance billing)

a/ Special limits apply with respect to inpatient services in a psychiatric hospital under Part A and outpatient psychiatric physician's services under Part B. Limits are also applied to annual program payments for physical therapy services provided by an independent practitioner.

b/ Part A deductible and coinsurance amounts are increased annually; coinsurance amounts are calculated as specified percentages of the deductible.

III. ISSUES

A. Acute Care Focus of Program - Coverage Gaps 1/

The original Medicare program was designed to meet the acute health care needs of the elderly. The acute care focus is evidenced in the benefit design of the Part A and Part B program with its fairly extensive coverage of short-term hospital stays and in its coverage of a significant portion of the costs of physician's services. Nationwide, the program covered $40.5 billion, or 74.8 percent of the costs of hospital services for the aged in 1984. These figures reflect the fact that Medicare covers almost all aged persons (about 97 percent of the elderly) and that a very small percentage (0.7 percent in 1983) exceed the 60 day hospital limit in a benefit period and an even smaller percentage (0.02 percent in 1985)

1/ Data in subsection A and D generally are from: Waldo, Daniel and Lazenby, Helen. Demographic Characteristics and Health Care Use and Expenditures by the Aged in the United States: 1977-1984; in Health Care Financing Review, Fall 1984, vol. 6, n. 1; Fall 1984.

exhaust their lifetime reserve days. In addition, the program covered $14.3 billion, or 57.8 percent of the costs of physicians services for the aged in 1984.

At the same time the program offers less adequate protection against the costs of many other services frequently used by this population group. Overall, Medicare covered $58.5 billion--only 48.8 percent of the aged's health care costs in 1984. The program's benefit package excludes prescription drugs, routine eye examinations, eyeglasses, hearing aids, dental care, dentures, and most preventive care.

The major gap in the Medicare benefit package is coverage of most long-term care services. Program coverage is limited to short-term post-hospital stays in SNFs. As a result, Medicare covered only $539 million, or 2.1 percent of the nursing home costs of the aged in 1984.

B. Absence of Catastrophic Protection 2/

Medicare's health insurance protection is further limited by the absence of catastrophic protection either for all out-of pocket health care expenses or for out-of pocket expenses in connection with covered program services. The liability for uncovered expenses is distributed unevenly throughout the Medicare population, depending on such factors as age, income level, incidence of acute illness, the presence of chronic conditions, and other insurance coverage. The majority of beneficiaries can be expected to face reasonable expenses in any given year. However, for a small portion of the population these costs may be viewed as excessive and sometimes catastrophic in nature.

Catastrophic medical costs are broadly defined as large unpredictable health care expenses; these are usually associated with a major illness or serious injury. Two methods are commonly employed to determine whether an individual's expenses are catastrophic in nature. The first standard measures total expenditures and defines anything over a specified amount, e.g. $2,000 or $4,000 as catastrophic. The second standard is based on expenditures that are large relative to an individual's income, e.g.

2/ The data in this section are from the Department's Report to the President, Catastrophic Illness Expenses, November 1986.

expenses over 5 percent or 10 percent of income. The Department of Health and Human Services feels that a combination of these methods is appropriate. A threshold amount is established bel which no expense level is considered catastrophic regardless of income; a percentage of income figure is then added to that amount to yield the threshold above which expenditures are considered catastrophic. Using varying thresholds and percentage of income figures, the Department estimated that the incidence of aged persons with catastrophic out-of-pocket expenditures (i.e. expenditures not met by other public or private sources) ranges from 0.9 to 2.1 million persons, or 3.4 percent to 8 percent of the aged. (This is considerably higher than the 1.5 percent - 3.4 percent recorded for the general population).

A portion of these out-of-pocket expenses are for Medicare cost sharing charges and charges above Medicare's reasonable charge amounts on unassigned claims for physicians' services. The Health Care Financing Administration's Office of the Actuary has estimated the distribution of net beneficiary liabilities in connection with covered Medicare services. (These figures underestimate liabilites since they do not include expenses for uncovered services, for example SNF services in excess of the 100 day limitation. Also, the figures do not include offsets for amounts paid by private health insurance policies. Therefore these figures do not represent actual out-of-pocket liabilities in connection with Medicar serv.ces.) In 1983, 2.8 million, or 10.3 percent of beneficiaries had annual liabilities of $1,000 or more; these accounted for 54.2 percent of the total $10.3 billion in such liabilities. A subgroup of this popula.ion, beneficiaries with $2,000 or more in liabilites, accounted for 800,000 or 3.1 percent of total beneficiaries and 28.2 percent of total liabilities. Beneficiairies with the highest liabilities, namely $5,000 or over, accounted for 100,000 persons--or 0.4 percent of the beneficiary population

Twenty-eight percent of liabilities are in connection with Part A services and 72 percent in connection with Part B services. The distribution of such liabilities is as follows: hospital deductible - 21.7 percent; hospital coinsurance - 4.6 percent; SNF coinsurance - 1.7 percent; Part B deductible - 14.3 percent; Part B coinsurance 35.5 percent; and charges above reasonable charge amount on unassigned claims - 22.2 percent.

C. Other Third-Party Coverage

The combination of cost-sharing charges for covered Medicare services coupled with the potential for high out-of-pocket payments for uncovered services has led the majority of Medicare beneficiaries to purchase private insurance coverage to supplement the program's benefit package. This protection, frequently referred to as Medigap coverage, is purchased by an estimated 65 percent of Medicare enrollees. There is considerable variation in the coverage offered under various Medigap policies. The principal protection offered by the majority of these policies is coverage of Medicare's deductibles and coinsurance charges. Many policies also provide protection against the costs of hospital stays exceeding Medicare's coverage limits; however, few policies cover charges above Medicare's reasonable charge amount on unassigned claims for physicians' services. Some Medigap policies cover a limited number of additional services such as prescription drugs. Few policies offer protection against the costs of long-term institutional care - potentially the most costly service item. Thus, despite the fact that a beneficiary may have purchased one or more private policies he or she may not have adequate insurance protection for the full range of medical expenses.

In 1980, the Congress amended the Social Security Act to provide standards for policies marketed as Medigap insurance. These amendments, known as the Baucus amendments, incorporated by reference the Medigap standards contained in a model regulatory program developed by the National Association of Insurance Commissioners (NAIC). If a State has adopted laws and/or regulations at least as stringent as those of the NAIC, policies regulated by the State are deemed to meet Federal requirements. Currently 46 States, the District of Columbia, and Puerto Rico meet these requirements.

Some low-income beneficiaries are also covered by Medicaid (the Federal-State health care program for certain low-income individuals including the aged and the disabled). About 13 percent of aged Medicare beneficiaries have such protection. Medicaid generally picks up the cost-sharing charges on behalf of these dual eligibles. However, the primary Medicaid benefits used by the dual eligibles are long-term care services - either those provided in SNFs or in intermediate care facilities (ICFs). In fact, many beneficiaries do not become eligible for Medicaid benefits until after they become institutionalized and reduce their incomes and resources to the Medicaid standards through expenditures on health care.

Approximately 20 percent of the Medicare population has no other health insurance coverage. According to DHHS, this figure includes over 2 million poor and six million near-poor elderly not covered by Medicaid.

D. Out-of-Pocket Payments.

In 1984, total per capita spending by the aged for health care was $4,202. Of this amount, $1,059 (or 25.2 percent of the total) represented out-of-pocket payments by the elderly, that is payments not met by third-party payment sources such as government programs or private insurance. These out-of-pocket figures do not include the additional amounts spent by the elderly for payment of Part B premiums ($17.90/month in 1987) or private insurance premiums. These figures are averages and may be higher or lower for individual beneficiaries depending on individual circumstances.

Out-of-pocket payments have declined as a percentage of total health payments since the inception of Medicare (dropping from 53.2 percent in 1966 to 25.2 percent in 1984). However, mean out-of-pocket payments (including insurance premiums) as a percentage of mean income is estimated to be the same as that recorded prior to the start of the program - 15 percent in both 1966 and 1984.

The notably sharp increase in the Part A deductible in the past several years has focused increased attention on beneficiary payments. The deductible rose from $356 in 1985 to $400 in 1985 (12.4 percent rise), and to $492 in 1986 (23 percent rise). In the absence of any legislative change, the figure would have increased to $572 in 1987 (a 16.3 percent rise). However, the Omnibus Budget Reconciliation Act of 1986 (P.L. 99 - 509) set the 1987 deductible at $520; further, it revised the calculation of the deductible so that future increases will be more moderate.

E. Demographic Changes

Demographic changes coupled with medical advances are fostering increasing demands on the health system. The aged population is increasing both in numbers and as a proportion of the population as a whole. The Bureau of the Census reports that from 1970 to 1984, the number of persons aged 65 and older rose from 20.1 million and 9.8 percent of the population to 28.0 million and 11.9 percent of the population.

Life expectancy is also increasing. Persons turning age 65 in 1984 could expect to live an additional 16.8 years, more than two years longer

than when Medicare began. Of particular importance to the health care system is the increasing number of the "oldest old", i.e. person over age 85. These persons are more likely to experience some form of functional impairment. In 1984, 18.7 percent of this age group were institutionalized compared with 1.1 percent of thore aged 65-69.

In 1984, the median income of families headed by persons 65 or older was $18,215; the median income of an unrelated individual in the same age group was $7,296. (There were 9.8 million such families and 7.3 millions such unrelated individuals.) This compares to $24,433 for all families and $11,204 for all unrelated individuals. Data from the 1980 Census of Population and Housing show that the cash income of the elderly is lower in each older age group. Married couples with a head aged 65-69 had median incomes of $18,400, compared to $11,710 for those 85 and over. Men aged 65 to 69 and living alone had median incomes of $8,200, while those 85 and over had incomes of $6,000; the comparable figures for women living alone were $6,800 and $5,200, respectively.

F. Long-term Care

The program offers little protection for the costs of nursing home and custodial care services required by chronically ill persons over an extended time period. The range of conditions which may result in the need for long-term care services is extensive; many of the conditions are difficult to treat medically except to maintain the status quo of the patient. Dementia, the chronic, often progressive loss of intellectual funtion, is also a major cause of disability frequently necessitating long-term institutional care. Over half and perhaps as many as 70 percent of patients with dementia have Alzheimer's disease, a chronic progressive neurologic degeneration of unknown cause.

Financing of possible stays in nursing homes is one of the most pressing health-related concerns of the elderly. Medicare covered only 2 percent of the nursing home expenses of the elderly in 1984. The Federal-State Medicaid program picked up an additional 42 percent. Six percent came from a combination of other government and private sources with only 1 percent paid for by insurance. Fifty percent of all nursing home expenditures for the elderly were paid for out-of-pocket. Many of the elderly purchasing Medigap protection are not aware that their policies do not in fact offer this protection.

Individuals can only gain coverage under Medicaid after they have reduced their incomes and resources to the State-established eligibility

levels. Many elderly dread the prospect of impoverishing themselves to these welfare levels. However, since there is limited coverage of long-term care services under either public programs or most private insurance policies, Medicaid is by default the primary source of third-party financing of long-term care services. At the same time there is a growing concern that Medicaid is moving toward a long-term care program for the elderly, many of whom were previously middle income. This raises questions with respect to the competing demands of other population groups, namely the low-income non-elderly, for limited resources.

IV. CATASTROPHIC HEALTH INSURANCE PROPOSALS FOR THE AGED

Catastrophic health insurance coverage, either for the poplulation as a whole, or just for the Medicare-eligible population, is likely to be an issue in the 100th Congress. This is not a new issue for the Congress. The absence of adequate catastrophic protection for certain segments of the population has been a subject of concern for a number of years, and Congress has been asked to consider a broad range of options to address the problem. While proposals are likely to be advanced which deal with the population as a whole, the primary focus of consideration this Congress will probably be modifications to the Medicare program. While a number of persons have suggested that Medicare's protection should be expanded to offer catastrophic protection, there is no universal agreement on what should be done, or if in fact anything should be done at the Federal level.

Generally, the catastrophic proposals which have been offered for the Medicare population would build on the existing Federal program. There are basically two broad categories of catastrophic proposals for this population group. The first category would place an upper limit on beneficiary liability for Medicare deductibles and coinsurance; these proposals would also eliminate the durational limits on covered hospital services. Under this type of proposal, no catastrophic protection would be provided in connection with uncovered services. Assuming this coverage were instituted on a mandatory basis, it would have the effect of spreading the risk over the entire Medicare population. It is generally agreed that it would be relatively easy and inexpensive to administer. The major impact of this approach is that it could in large measure supplant existing Medigap policies offered by private insurance companies. However, this approach would not address the major catastrophic concern of the elderly, namely the need for protection against the costs of long-term institutional care.

The second broad category of catastrophic coverage would attempt to provide protection against some of the costs associated with services currently not covered under the Medicare program (for example prescription drugs). Some, though not all, of these proposals would include long-term care expenditures in the benefit package. Several proposals would combine expanded protection with a restructuring of the current Medicare program.

A number of issues have been raised with regard to catastrophic/ expanded benefit proposals. Those who are against expanding the Federal role note that the majority of Medicare beneficiaries have supplementary coverage, primarily through Medigap policies. They suggest that efforts should be made to expand rather than supplant the role of the private sector. Further they feel that it is inappropriate to be considering expanded Medicare coverage both in light of the overall Federal deficit and the impending insolvency of the Part A trust fund (currently slated for the late 1990s).

Those who favor expanding the Federal role in this area do so for several reasons. They suggest that there are gaps in health care coverage of the elderly that are not currently being addressed; this is particularly so for the 20 percent of the Medicare population that has no supplementary coverage. They note that an administrative structure is already in place to implement an expanded benefit. Those favoring a modest expansion in coverage, namely just placing an upper limit on out-of-pocket payments for Medicare deductibles and coinsurance, suggest that this expansion can be achieved with no additional cost to the Federal government and small predictable increases in beneficiary payments. They further suggest that beneficiaries would in many cases pay substantially less than what they are currently paying for comparable Medigap coverage. Those favoring a more expansive Federal role feel it is appropriate to respond to the existing coverage gaps, particularly coverage of long-term care services, at the national level.

A key concern is how a catastrophic/expanded benefit package would be financed. Options include increased payroll taxes, increased beneficiary premiums, higher coinsurance charges, Federal general revenues, or a combination of these. In view of the current budget deficit concerns, it may be difficult to achieve consensus on a proposal involving additional Federal outlays.