REMARKS OF SENATOR JOHN HEINZ (R.PA)
NATIONAL AREA AGENCIES ON AGING
WASHINGTON, D. C.
JULY 18, 1989

Good morning. I am very pleased to meet with you today, to talk about the issues before the 101st Congress of significance to America's aged. It's a privilege to share the rostrum with my colleague from West Virginia, Mr. Rockefeller, who also takes a special interest in the elderly.

Area Agencies on Aging are uniquely situated to play an important role in the development of new aging policy for the '90's. You are charged with:

-securing and maintaining maximum independence and dignity in a home environment;
-removing barriers to economic and personal independence; and
-providing a continuum of community based and "in-home" care for the vulnerable elderly, and avoiding premature or inappropriate institutionalization.

Your involvement in public policy impacting older Americans is critical.

In thinking about my remarks for this morning, I was struck by the significant role Area Agencies play in our nation's health care system, and by the difficult choices you face each day. You are the front line M-A-S-H teams, ensuring that the social and health needs of older Americans are met. You are responsible for making sure the choices we in Congress make are workable in the community setting.

As the front line team you are charged with making critical decisions -- who gets food, transportation services and access to health care services. You must make difficult decisions and are constantly grappling with how to best serve the frail elderly without taking resources away from healthy older people. You make do with very modest means, and I particularly want to congratulate you for I certainly admire and respect your dedication and tireless effort. It is because of your efforts that many Older Americans are able to avoid premature institutionalization.

An aging agenda for the 1990s must be built upon helping Older Americans maintain a quality of life in an independent setting whenever possible. I recognize that this is one of your main goals, and I am one Senator who shares this common goal and direction with you. As ranking member of the U.S. Senate Special Committee on Aging, we share many of the same concerns, some of which I want to discuss with you this morning.

As you know better than most, we need to improve the SSI outreach program to ensure that many more elderly who are eligible for SSI benefits receive them. Recent studies reveal that for every older person receiving SSI, there is at least another out there that has not been able to receive any of the benefits of the program. These are the neediest of the needy. These elderly are in need of your help. They are in need of our help. And the first, best step is an SSI program that reaches out to them and includes them.

Another issue whose time has come is facing up to the deplorable conditions that exist in many of our nation's board and care homes, as demonstrated and documented at the Aging Committee's dramatic hearings earlier this year. Hearing testimony revealed example after example of elderly residents being physically abused. You know how important it is when you place clients in board and care homes to know that they are safe. Improving conditions in these homes to know that they are safe. Improving conditions in these homes is a desirable and much needed goal -- and I look for us on the Aging Committee to develop legislation to put some life into the Keys amendment and ensure at least a minimal standard of

safety and competence for the millions of Americans whose welfare and health are directly affected by what happens in very board and care home.

Ensuring nursing home quality remains a priority concern -- both for the Committee and for me. During my six year term as Chairman of the Aging Committee, we were able to reverse the trend towards "laissez faire" by documenting deteriorating conditions in more than half of all the nursing homes across the country. As a result, we now have new laws on the books making nursing homes a humane and dignified place for our elderly, and we are determined to see good regulations written and our laws faithfully implemented.

Another area where elderly have been vulnerable to quality problems has been in the home. Some years ago House and Senate hearings documented what, to many, were shocking and unexpected examples of elder abuse. Our Committee is concerned that the difficulty in recruiting and keeping trained and caring staff -- a problem exacerbated by the national shortage of nurses most acutely evident in hospitals and nursing homes -- is resulting in a deterioration of overall staff competence and quality of care in the home health care industry. As you are all too familiar, neglect and problems with untrained staff are prevalent in the home health industry.

While these are issues of mutual concern, the Congressional process known as reconciliation -- the process which forces Congress to achieve significant fiscal savings -- is now upon us. The Medicare and Medicaid programs have been and continue to be targets for cost savings. Congressional and fiscal pressures once again threaten to cut back not just on overutilization, but on vital and necessary health care services. Particularly threatened are those programs such as rural programs and urban hospitals which serve large numbers of the elderly and poor. Budget reconciliation was not designed to put hospitals out of business, but that will be the inevitable result if we in Congress, and especially those of us on the Finance Committee, do not act promptly -- as in my view we must -- to insist on reasonable reimbursement for high Medicare patient loan hospitals.

Another issue we will be wrestling with in reconciliation will be physician payment reform. We need to restructure the physician payment system in order to eliminate inequitable levels of reimbursement for some doctors. The present system undervalues preventive services and primary care. Until we achieve a level playing field, we will continue to reward physician overuse of exceedingly expensive technology and often in appropriate procedures, perpetuating cost pressures and shortchanging seniors of the primary and preventive services that are most needed. I am optimistic we will address this problem squarely by adopting a resource-based relative value scale method for recalibrating physician reimbursement and reforming the right incentives.

Reconciliation can also be a vehicle for substantive policy reform. To this end, I expect the Finance Committee to consider changing the Catastrophic Coverage Act enacted into law in the last Congress. Here your help is desperately needed. As many of you are probably aware, there is an increasing number of Members of Congress who want to either eliminate or delay the Medicare Catastrophic benefits. These efforts are being fueled by a minority of beneficiaries -- an extremely vocal group of seniors who are actively lobbying to cancel the program.

Some of their concerns are legitimate. There is a problem of duplication of benefits where some beneficiaries are paying for benefits they already have. Others do not like the progressive nature of the Part B supplemental premium and feel that this tax is unfair. However, we need to keep in mind that the maximum an individual would pay on a monthly basis is $66.67, and that's if they had an annual taxable retirement income of $40,000.

The benefits conferred under this program substantially outweigh the negative response it has receive. For example, the Catastrophic Coverage Act helps the elderly in the following ways:

1. Out of pocket costs for all outpatient services and physician charges is limited to $1,370 annually.
2. Unlimited hospitalization is provided, with no copayments and only a single annual deductible.
3. Continuous home health care coverage is expanded from 21 to 38 days.
4. 210 day limit on hospice care is removed.
5. Prescription drug program will cover 80% of the cost of prescription drugs after an individual has met a $600 deductible in 1992.

6. Expanded skilled nursing benefit -- 100 to 150 days.
7. Respite Care - provides 80 hours a year of in-home respite care.

While the Catastrophic program is complex, much of the controversy, I believe, is from misinformation. Those opposing the program focus on the statistic that only 7% of all Medicare beneficiaries will benefit from the Catastrophic benefit annually. This is quite literally a short-sighted view of this benefit ... and the other benefits in the bill ... because the 7% annual participation rate for Catastrophic ... and the 16.8% rate for prescription drugs ... are the odds of a single beneficiary being helped in any one year, not over the 17 years the average senior citizen lives and benefits from medicare.

The real question is --- what is the chance that a person will benefit from or use these benefits during a seventeen year period. The answer is that (when the law is fully in effect) nearly 2/3 of all Medicare beneficiaries will benefit from one or another of the bill's major benefits within the first five years.

As experts in working with and in behalf of older Americans, you are in a unique position to understand the importance and complexities of this program. Your assistance is needed to help older Americans understand the importance of the program of its benefits. Without your help, as well as that of other advocates, we are in jeopardy of losing this program.

The final matter that I would like to discuss is the U.S. Bipartisan Commission on Long Term Care and Comprehensive Health Care now quite properly renamed the Pepper Commission ... in honor of the late Claude Pepper and his remarkable contribution to the well-being of all elderly Americans. It is a privilege to serve with Senator Jay Rockefeller on this Commission. I want you to know what a fine job Senator Rockefeller is doing as Chairman.

This Commission has a dual mandate: to recommend solutions both to the problems of providing long term care, as well as to ensure access to adequate health care services for those under 65 years of age.

Some 37 million people under the age of 65 do not have health insurance coverage. They are usually working families, too well-off for Medicaid, but too poor to afford health insurance. One third of this group are children.

Our mandate will be a challenging one to fulfill under the best of circumstances. It is even more so in this era of budget deficits and constant cost-cutting pressure.

Nevertheless, I remain optimistic. Let me focus briefly on the long term care component. The key in producing enactable legislation will be our success in resolving three major issues:

--the role of private insurers.
--the guarantee of a strong case management system.
--finding an acceptable and adequate financing mix.

The first, the role of the private insurer is important because of the distrust that government has all the answer. While we recognize the limits to any long term care packages that rely too heavily on the

ability of individuals to afford substantial private insurance coverage, nonetheless we believe it is highly desirable to build in the private sector's capacity to innovate and change in response to new trends and circumstances.

The provision of expert case management for long term care is an obvious prerequisite. At the present time there is great skepticism among experts and in Congress that we have the people to do the job. Clearly, a major training effort and program that begins building a competent base of such critical people needs to begin at once. This is another reason why the 2176 waiver authority, which Jay Rockefeller mentioned, is so important.

Thirdly, we must find the means to finance a program that is equitable, adequate and acceptable to the American public. There are no easy solutions. There are no simple answers. If we are to achieve true health care reform, we will have to explore different financing alternatives. For example, it may be necessary to require a specific payroll tax aimed at creating a long term care trust fund. And it will be necessary to have a mix that spreads the cost.

Finally, it is important to recognize that no comprehensive long term care legislation will be passed without concurrently addressing the need to provide health insurance coverage to those Americans who are without protection. To fail to do so would not only be perceived as a critically serious public health policy failure, but would also risk igniting the kind of intergenerational conflagration many of us have spent a decade trying to avoid.

I began my talk this morning recognizing the pivotal role that Area Agencies on Aging have and continue to play in serving older Americans. I want to underscore that your effectiveness in stretching limited dollars is often the difference between keeping an older person in his or her home and out of a nursing home. I applaud your efforts and thank you for your dedication.