REMARKS OF SENATOR JOHN HEINZ (R-PA)
Chairman, Special Committee on Aging
Monday, March 26, 1984, Washington, D.C.
National Association for Home Care

Elsie Griffiths, Val Halamandaris, members of the board, and members of the National Association for Home Care: I am honored to be with you this afternoon. Jim, I appreciate your kind words about my work as Chairman of the Senate Special Committee on Aging and for my legislative efforts to improve the delivery of long term care for our nation's frail elderly.

I am here to tell you that even my initiatives in this area are like sending one fire truck to a three alarm blaze. The national crisis we face in our long term care delivery system cannot be resolved by one legislator alone, it requires the full attention of the American people and the Congress.

Before we go any further, let's be honest -- for many Americans, long term care is not even an issue, much less a crisis. Those of you involved professionally realize that there are some real problems. But from my perspective, there are more than just issues and problems; There is a real crisis.

It is more than just a problem when the gap between services people need and the care they get is as wide as it is today, and all indications point to an increasing disparity. It is not just a dilemma when we spend billions of dollars each year on long term care, and yet millions of Americans still can not get the level of care they need. Is it not inhumane when thousands of older Americans must pauperize themselves to obtain health and long term care services? Based on the trends I see, I fear that this crisis will soon turn into a catasrophe.

Let's look at these trends.

If we look at the demographic data, we can see that the population group most likely to need long term care will increase dramatically over the next few decades. Well over one out of two people aged 85 and over will need some form of long term care support. Today, there are approximately 3 million persons aged 85 and over. By 1995, this group will grow to include another 1.5 million persons, and yet another million by the year 2000. We should now prepare for the anticipated growth of this population group by expanding our ability to serve the severely impaired in the community.

As it is, there is a real shortage of available home-based care. And this problem will get worse for two main reasons. First, as Medicare's new prospective payment is fully implemented, hospitals will try to reduce costs by shortening inpatient stays. More Medicare beneficiaries will be placed back into the community when they still need skilled care. In New Jersey and Maryland, for example, States with some experience with prospective payment, hospitals have reduced inpatient stays, but the demand for home and community based care increased significantly. We can use the experience of these two states to predict a similar response on a national level.

Second, over the next fifteen year period, the total disabled noninstitutionalized population will increase by over 2 million persons. Unless Federal or State governments shift funding priorities within both Medicare and Medicaid, the unmet need for noninstitutional care will only magnify.

These numbers and projections point directly to the need for an expansion of long term care services. Yet, current financing problems of Medicare and Medicaid make such an expansion difficult.

Let's look at the Medicare program. It is important to note that Medicare was not originally designed to finance long term care. But, as you know, Medicare covers some nursing home and home health care -- when that care is used for short term treatable conditions. What this has meant in dollars for the Medicare program, however, is a 15-fold increase in outlays over the past decade for home health care, or, an increase from one hundred million dollars to 1.5 billion dollars. Opponents of home care use these numbers to suggest that an expansion of the home health benefit is foolhardy at a time when we are struggling to maintain the solvency to the HI trust. But, they miss the point. Our investment in home health, would certainly save billions of dollars from reduced inpatient stays. It would also apply those savings by serving many now desperately in need of care. What we are talking about is making the system more rational. It would be ironic - as well as catastrophic - if in the name of restoring Medicare's solvency, we were forced to perpetuate today's irrational and inadequate delivery system.

Medicaid, which finances ninety percent of all public funds spent on long term care, is in no better shape. Over 55% of this is state money. And state legislatures worry about projections indicating that total expenditures for nursing home care will double in the next five years!

All of these facts and figures can be summarized very simply in this way: we spend over $110,000,000 each day on long term care and it is still not enough. It is not enough to meet our current needs and falls way short of meeting our future needs.

But the real price of these shortfalls cannot be tallied on paper. It is a cost borne by millions of older Americans who sacrifice their savings, their health and their dignity.

The ultimate consequences can be severe indeed. For example, at a recent Senate Aging Committee hearing, a witness described the human cost of what is commonly referred to as the "spend down" problem. We were told of Mrs. Jones whose husband has Alzheimer's disease and was recently admitted to a nursing home.

At the time she was told he could live for another four to ten years. Mrs. Jones has cancer herself and resides in the apartment she had shared with her husband. Because Mr. Jones was seriously ill, she had control of most of their life savings -- just under $130,000 dollars. She realized, however, that to pay for the care of her husband in the nursing home she would have to pay $40,000 dollars each year. In other words, the $130,000 dollars of savings would be depleted in just over three years. At this rate, and with good reason, Mrs. Jones was afraid that she wouldn't be able to support herself. Like so many middle-class couples, she learned that there is no financial protection against the costs of such long-term illnesses. Driven by panic, Mrs. Jones asked her lawyer how to get her husband on Medicaid to avoid impoverishing herself.

Her situation represents the special problems of couples where one spouse must support the other's long term care needs. It has become commonplace for lawyers to advise their elderly clients to file for divorce. In this way, the couple avoids the spend down problem and the ill spouse qualifies for Medicaid. What kind of system force a man and woman married for fifty years to choose between poverty and divorce?

Worse, as I read some of the new Medicare regulations, we seem to be moving in the wrong direction, as illustrated by the case of a constituent of mine, Mr. Smith, who was arbitrarily denied urgently needed medical care. Mr. Smith is 77 years old. He was discharged from the hospital following gastrointestinal surgery. Mr. Smith's physician ordered daily nursing care to attend to the draining wound. At the end of three weeks, the wound had not healed, so his doctor ordered another week of nursing care. Because of new Medicare guidelines, coverage was denied for the additional week. The result -- there was no one to care for Mr. Smith's draining wound, except his blind wife.

Older Americans who need long term care are falling through widening gaps into what I call, NO CARE ZONES. We Americans have every right to boast that we have the finest health care system in the world, but the strength of this system lies in the delivery of acute care and not in long term care.

What's happened is that while Medicare and Medicaid offer different levels of care ranging from hospital to nursing home to home care, the design of each program impedes the placement of people in the most appropriate, least restrictive setting. In an ideal so-called continuum of care, we would cover a wide range of services that allow the necessary movement from one level of care to another.

But, we all know that this ideal does not exist today. What we have now is not a continuum of care, but something that works like a radio that picks up only certain channels. Our public health programs generally support discrete bands of services. A person who wants to enter a nursing home can "tune in" to Medicaid, if they are poor enough to be eligible for this welfare program. A person who needs acute care can "tune in" to Medicare. But those who want to remain independent, those who need to "tune in" to community based services, may only get static.

Let me summarize our discussion so far by simply saying that the existing situation is bad and it will soon be much worse. I would like to take the rest of our time today on what we should do about it. There are four priority areas for action, that I propose for your consideration.

First -- although it should be obvious, maybe that is why it receives so little attention -- We must increase support for research.It doesn't make sense to spend billions of dollars each year on care while we skimp on research. We have seen, for example, how our investment in research has effectively decreased the incidence and death rate of heart disease. The same investment, in say, Alzheimer's disease and Arthritis, should yield similar benefits.

The second item is manpower. Given the expected growth of the long term care population, we will need a cadre of hospital, health and home care workers to provide quality care to the American people. These workers will need training to provide appropriate, skilled care to an increasingly complex patient population. As it is, few practicing physicians can claim an expertise in geriatric medicine. Of the 127 certified medical schools, only fifteen currently require the "physicians of the future" to take courses in geriatric care. And while those 127 medical schools are affiliated with over 400 teaching hospitals, they are affiliated with the grand total of five -- I repeat - five -- teaching nursing homes. It's bad enough to be short-handed, but let's not be short-sighted as well.

And, while we are at it, lets eliminate some totally unnecessary gaps in the continuum of care that we have today. That's the point of the Health Care Coordination Act, my bill to merge the provision of both acute and long term care services for persons eligible for both Medicare and Medicaid - our poorest, our most frail, our oldest citizens.

Item three is significantly expanding home health care. Why Congress hasn't acted here is hard to understand. Given the choice of institutional or community based care, most families

prefer home health care. Furthermore, we know that home care, as a substitute for hospital or nursing home care, can save Federal and State governments a considerable amount of money. We should expand coverage for home and community based services, as I and others proposed to do, last year, in S. 1244, the Senior Citizens Independent Community Care Act, our bill to provide home care to the frail elderly. And, as you know, I most recently introduced S. 2338, the Home Care Protection Act -- a bill that will correct a serious problem in the delivery of Medicare's home health benefit. I thank you for your support for these proposals - and look forward with you to their enactment.

The fourth and final item is to identify and promote a financially secure and dependable concept of what long term care is all about. I am thinking of an "independent living insurance concept" to meet the future needs of millions of older persons. It would, at the same time, guarantee a stable source of financial support for those who provide the range of insured services. After all, older persons, their spouses and their children all have an insurable interest in avoiding both the loss of dignity and the threat of pauperization that those with chronic illnesses often face. We know that about one third of all people who live to 65 will need these services at some point in their lives. So why can't we put together an insurance approach to protect against this risk? It wouldn't have to be another expensive entitlement program -- it would probably work best as a partnership between public and private sectors. But most important of all, such a program, if appropriately managed and coordinated, would support the entire range of long term care services and lest there be any doubt, that clearly and necessarily must include home health care.

I suppose the reason this idea hasn't yet caught on is that most of us potential buyers still believe that "it ain't gonna happen to me". But, as the life insurance industry has learned to market insurance for "life", rather than "death", so too we need to promote not long term care insurance, not nursing home insurance, not Alzheimer's insurance, but insurance to promote independence, health maintenance, and dignity. None of us have done a very good job of developing this kind of insurance concept. But it's benefits are tangible, it's need irrefutable, and its promise unlimited.

Let me suggest that these four goals that I have just outlined would provide a solid foundation for meeting the care needs of our elderly - present and future. Our task is formidible, but it is not insurmountable. But we in Congress can't do it alone. We will need your help to convince the American people that this is a job well worth doing and that the time to act is now.