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# ADDING INDIGENCE TO INJURY: AMERICA'S LONG-TERM INSURANCE GAP

*by Claude Pepper**

## INTRODUCTION: A LEGACY OF INACTION

A little more than a year after I came to Congress in 1937, Senator Robert Wagner of New York introduced a bill calling for a comprehensive national health care system.[1] Nothing happened. In November of 1945, President Harry S Truman sent Congress a special message calling for health care for all Americans.[2] Again, nothing happened.

The year following Truman's message, the Senate Subcommittee on Wartime Health and Education, which I then chaired, recommended comprehensive health care. Once more, nothing happened. President Franklin D. Roosevelt too, in the earliest days of Social Security, wanted to add a health care component program that would provide all necessary health care to every man, woman and child in America.[3] His wish was not fulfilled.

It was not until 1965 that Congress once again seriously considered enacting a comprehensive national health care program. Yet again, Congress fell short of

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* Member, United States House of Representatives; Chairman, House Subcommittee on Health and Long-Term Care of the House Select Committee on Aging; Chairman, House Rules Committee. A.B., University of Alabama, 1921; LL.B., Harvard Law School, 1924. Pepper began his Capitol Hill service in the Senate (1936-50), moving to the House of Representatives in 1962 when a new Florida congressional district was created; between 1950 and 1962, he practiced law.

1. For a discussion of the original national health insurance proposals put forward during the New Deal of President Franklin Roosevelt and the Fair Deal of President Harry Truman, *see* T. MARMOR, THE POLITICS OF MEDICARE 9-14 (1973).

2. "Special Message to the Congress Recommending a Comprehensive Health Program," 1945 PUB. PAPERS 475 (Nov. 19, 1945). President Truman emphasized the "widespread physical and mental incapacity" among Americans revealed by wartime medical examinations, and concluded:

> In the past, the benefits of modern medical science have not been enjoyed by our citizens with any degree of equality. Nor are they today. Nor will they be in the future—unless government is bold enough to do something about it.
>
> People with low or moderate incomes do not get the same medical attention as those with high incomes. The poor have more sickness, but they get less medical care.
>
> We should resolve now that the health of this Nation is a national concern; that financial barriers in the way of attaining health shall be removed; that the health of all its citizens deserves the help of all the nation.

*Id.* at 476-77.

Truman recommended solving the basic problem of distributing medical costs by expanding the existing Social Security program, and employing the "principle[s] upon which all forms of insurance are based." *Id.* at 486.

3. *See* Truman's restatement of Roosevelt's "economic bill of rights," which includes "the right to adequate medical care and the opportunity to achieve and enjoy good health" and "the right to adequate protection from the economic fears of old age, sickness, [and] accident . . . ." "Special Message to the Congress Presenting a 21-Point Program for the Reconversion Period", 1945 PUB. PAPERS 263, 279-80 (Sep. 6, 1945). *See also* F. PERKINS, THE ROOSEVELT I KNEW 289 (1946) and MARMOR, *supra* note 1.

attaining that lofty goal. Instead, Congress that year adopted the landmark Medicare and Medicaid programs. The prevailing assumption at the time was that if the federal government took care of the elderly through Medicare and the poor through Medicaid, the middle class could take care of itself. Subsequent history has proven that assumption wrong.

Although we are justifiably proud of Medicare and the positive effect it has had on the health of America's elderly,[4] it was never designed as the be-all and end-all for meeting seniors' health care needs. Medicare does not cover dental, ocular or aural care, nor does it provide for prescription drugs or preventative services such as routine physicals.[5] Most significantly, the program does not cover long-term care in nursing homes or at home.[6]

## HUMAN EFFECTS OF THE LONG-TERM HEALTH INSURANCE GAP

The tragic effects of the absence of a program to provide long-term health care have been dramatically presented to the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging. It has received innumerable phone calls, letters and visitors, all recounting the feelings of powerlessness and impending doom victims feel at not being able to meet long-term health care costs. In many of these cases, hard-working middle-class families have been pushed to bankruptcy because one member had the misfortune to contract a long-term illness, or to have an accident with long-term effects.[7]

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4. An illustration of the impact Medicare has had on the health-care industry can be seen in microcosm by examining the case of the state of New Jersey, as was done in a recent study. Monroe & Dunham, *Slouching Towards National Health Insurance: The New Health Care Politics*, 2 YALE J. ON REG. 263 (1985). The study's authors feel the U.S. is moving inexorably towards a national health insurance program similar to those in place in many other industrialized nations:

   > A series of incremental reforms [in government-based health insurance] —each responding to immediate problems, each inadvertently setting the conditions for further change— have recast the politics of health care. In New Jersey, an industry that was powerful and autonomous in 1970 is now dominated by state officials. On the federal level, a similar process is underway. Health providers with enough political influence to shape Medicare to their own purposes in 1965 now find that public officials are using the program to pressure the industry—the latest step, we have argued, in an evolution toward the national health insurance that providers have long battled to avert.

   Id. at 284. *See generally Catastrophic Health Insurance: The New Jersey Perspective: Hearings Before the Subcomm. on Health and Long-Term Care of the House Select Comm. on Aging*, 99th Cong., 2d Sess. (1986) and 100th Cong., 1st Sess. (1987) and *Catastrophic Health Insurance: The New Jersey and New York Perspective: Hearing Before the Subcomm. on Health and Long-Term Care of the House Select Comm. on Aging*, 100th Cong., 1st Sess. (1987).

5. 42 U.S.C.A. § 1395(f)-(i) (West Supp. 1983). Two broad categories of expenses not covered by Medicare are long-term health care and medical supplies. The latter category includes such items as hearing aids, eyeglasses and prescription drugs. These expenses are all the patient's responsibility. *See also* Borger, *Health-Care Bandwagon Gets Rolling*, U.S. NEWS & WORLD REP., Mar. 2, 1987, 22, 23.

6. *See supra* notes 7 and 10.

7. Some one million Americans will be forced into poverty this year due to the costs of catastrophic health care. House Select Comm. on Aging, Subcomm. on Health and Long-Term Care, 100th Cong., 1st Sess., Paying the Price of Catastrophic Illness: From Accidents to Alzheimer's (Comm. Print 1987) at 5 (a report by Subcommittee Chairman Pepper) [hereinafter Subcommittee Chairman's Illness Report].

   A striking example of this phenomenon was presented to the Subcommittee on Health and Long Term Care of the House Select Committee on Aging at hearings held in Washington,

## THE INADEQUACY OF RECENT MEASURES

In 1987, the House and Senate both attempted to provide some relief to these persons by resoundingly passing catastrophic health care bills.[8] A compromise version of these became the Medicare Catastrophic Coverage Act of 1988.[9] Nevertheless, over one million Americans will realize no help from this legislation.[10] These citizens, many of whom have set aside considerable portions of their life savings to meet the exigencies of old age and retirement, will not be able to foot the costs resulting from catastrophic injury or illness. For, although the Congressional measures afford potential victims some meaningful protection against extraordinary hospital, doctor and medication expenses,[11] they fail to address effectively the primary cause of financial ruin among young and old

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D.C. in 1986-87. House Select Comm. on Aging, Subcomm. on Health and Long-Term Care, 100th Cong., 2d Sess., Nursing Home Insurance: Exploiting Fear for Profit? (Comm. Print 1987) (briefing report by Subcommittee Chairman Pepper) [hereinafter Subcommittee Chairman's Insurance Report]. Ed Howard, aged 72, a well-insured, middle-class Maryland native who owned his home and $140,000 in savings described how catastrophic illness impoverished him. Mr. Howard told the Subcommittee:

> In 1983, my wife was stricken with cancer. In the year that followed, prior to her death, I spent more than $17,000 for her care, of which my four insurance policies paid only $64. My own health has deteriorated . . . [I now] require round-the-clock care, all of which is uncovered by Medicare and my insurance. I have almost exhausted my life savings.

*Id.* at 3. *See also Paying the Price of Catastrophic Illness: From Accidents to Alzheimer's: Hearing Before the Subcomm. on Health and Long-Term Care of the House Select Comm. on Aging*, 100th Cong., 1st Sess. 22-24 (1987) (statement of Mr. Edward Howard).

The only foreseeable solution, in Mr. Howard's eyes, was to declare bankruptcy and then apply for assistance under Medicaid, the federal-state health program for poor persons. Needless to say Mr. Howard, a man who worked hard all his life to ensure a comfortable retirement, never expected to find himself in such vulnerable circumstances. *Id.*

Unfortunately, Ed Howard has much company. Consider the plight of an elderly man from Maine who wrote to tell the Subcommittee Chairman:

> [H]ere I sit, the loneliest man that ever lived. I have admitted my wife of 55 years to a nursing home. She has Alzheimer's and I am caught between a rock and a hard place. I can no longer provide the round-the-clock care she requires, and I will soon be unable to pay the cost of the care she now gets which has exhausted our $160,000 in life savings . . . .

Subcommittee Chairman's Illness Report at 20.

8. On July 22, 1987, the House overwhelmingly (302-127) approved H.R. 2470, designed to extend Medicare to cover some of the expenses associated with catastrophic illnesses. 45 CONG. Q. WEEKLY REP. 1637 (July 25, 1987). On October 22, 1987, the Senate passed its version of H.R. 2470 (86-11). 45 CONG. Q. WEEKLY REP. 2677 (Oct. 31, 1987). Neither of these bills covered such items as dental, aural, or podiatrical care. They also overlooked preventative medicine and, most glaringly, long-term care.
9. Medicare Catastrophic Coverage Act of 1988, P.L. No. 100-360 (July 1, 1988). President Reagan signed the Act into law on July 1, 1988. *See* "Remarks on Signing the Medicare Catastrophic Coverage Act of 1988," 24 WEEKLY COMP. PRES. DOC. 888 (July 1, 1988). The House had passed H.R. 2470 by a 328-72 margin on June 2, 1988; the Senate followed suit on June 8 by 86-11 vote. *See* 46 CONG. Q. WEEKLY REP. 1604-11 (June 11, 1988). The Act seeks to shield Medicare beneficiaries from catastrophic health care expenses related to acute illness. It does not cover most costs associated with long-term care. *Id.*
10. Some 20 million Americans confront a catastrophic illness or accident each year. For one million of those persons, two out of three of whom are over 65, insufficient or improper medical insurance coverage will permit the catastrophe to ruin them financially. That is, they will be forced into poverty and ultimately onto the Medicaid rolls. Subcommittee Chairman's Illness Report, *supra* note 7, at 48-49.
11. *See* H.R. 3900, 100th Cong. 2d Sess. (1988), H.R. 1182, 100th Cong., 1st Sess. (1987) and H.R. 406, 100th Cong., 1st Sess. (1987).

alike: extended care in either a nursing facility or at one's own home.

The new legislation does address the issue of long-term care, but it does so in an inadequate fashion. It provides for unlimited treatment in return for payment of a once-a-year deductible, but this treatment is only to be given in a hospital setting.[12] Since Medicare currently fully pays for only sixty days of hospital care, this sounds like an attractive benefit.[13] However, hospitals typically limit admissions to cases of acute illness which generally require stays of relatively brief duration.[14] Only a small percentage of seniors, therefore, will be able to take advantage of this extended hospital coverage. Because private and public funding for long-term care is so scarce,[15] seniors understandably live in fear. Even with the new legislation in place they dread the day when a drawn-out catastrophic illness will strike, leaving them bankrupt during what they hoped would be their "golden years."[16]

## FINANCIAL VERSUS PHYSICAL HEALTH: AN IMPOSSIBLE CHOICE

Long-term care, whether in a nursing home or in one's own home, can place extraordinary strains on an individual's finances. According to the Department of Health and Human Services, which oversees the Medicaid and Medicare programs, the average cost of a year of nursing home care stands at about

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12. 42 U.S.C.A. 1395(f)-(i) (West Supp. 1983). Medicare provides 60 days of full coverage followed by ninety "co-insurance" days during which the program pays for all expenses excepting a daily co-insurance amount which is the beneficiary's responsibility.

    From 60 to 90 days, the patient is liable for $130 per day. From 90 to 150 days, the patient's contribution rises to $260 per day. Beyond that, the patient must foot the bill on his or her own. Borger, *supra* note 5, at 23.

13. *Cf.* Subcommittee Chairman's Illness Report, *supra* note 7, at 48-55.

14. *Id.* at 51. In fact, the length of the average hospital stay for a senior citizen is only 7.5 days. Conversely, long-term chronic illnesses such as Alzheimer's disease and strokes require months or even years of care in nursing homes and at home, and therefore account for 80% of all catastrophic illness spending. However, this most critical aspect of catastrophic health insurance, which sorely lacks for private insurance plans, is absent from the House and Senate legislation.

15. "Medicare pays less than 2 percent of the cost of long-term care in nursing homes and in the home. In fact there is no insurance available, public or private which fully protects people from the costs of nursing home care and long-term care in the home." *Id.* at 50 (emphasis omitted).

    In most states to qualify for Medicaid, one must have an income level below the poverty level and assets less than $3,000. "Because most states are now drowning from the costs of providing medical assistance to those Americans left destitute by the gaps in Medicare and private health insurance, they have little room to do more . . ." *Id.* at 53.

    > Most private health insurance available today is geared towards covering episodes of acute illness for which care is rendered in the hospital. Most private health insurance offers very limited, if any, coverage for rehabilitation and convalescence following or not related to hospitalization.

    *Id.* at 55.

16. Absent health insurance protection, their fears are well founded. When seniors do get sick, they are hospitalized three times as frequently and stay sick three times as long as their younger counterparts, on the average. They are the age group that consumes the lion's share of long-term care services. And neither public nor private sources are adequate to meet the costs of that essential care.

    Unless public and/or private long-term health care protection becomes available, the number of Americans who become impoverished in years to come is expected to increase dramatically. According to a recent publication by the Health Insurance Association of America, by the year 1990, about 7.7 million Americans over age 65 will likely need some form of long-term care. Additionally, one out of every four elderly Americans will enter a nursing home during his or her lifetime.

$22,000.[17] If current trends persist, the average annual cost of a nursing home stay will soon exceed $56,000 per year. Consequently, the vast majority of chronically ill elderly exhaust their life savings within eighteen weeks of nursing home admission.[18]

The need for long-term care insurance will grow more urgent with the "graying" of the American population. Within the next forty-five years, the number of people over the age of sixty-five will more than double,[19] and the number of people living to age eighty-five and beyond will almost quadruple.[20] Thus, by the year 2030, 2.8% of the population (8.6 million Americans) will be over the age of eighty-five.[21] More significantly, the proportion of persons over sixty-five will approach one in four.[22]

## THE REAGAN RESPONSE

With these stark statistics in mind, President Ronald Reagan devoted part of his 1986 State of the Union message[23] to ask Dr. Otis Bowen, M.D., Secretary of Health and Human Services, to "examine how the private sector and the government can work together to address the problems of affordable insurance for those whose life savings would otherwise be threatened when catastrophic illness strikes."[24]

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17. House Select Committee on Aging, Long Term Care and Personal Impoverishment: Seven in Ten Elderly Living Alone are at Risk, 100th Cong., 1st Sess., 1 (Comm. Print 1987) (a report by Committee Chairman Rep. Edward R. Roybal (D-Cal.)).

    > [N]ursing home costs are based on Medicare's skilled nursing facility rate per day by state and nationally and are adjusted to reflect beneficiary coinsurance (up 42%), a lower skill level of nursing home care (down 27%), and an estimate of private charge differential (up 18%). As a result, the average annual national nursing home cost for this study is $22,630 (about $62 per day) . . . .

    *Id.* at 22.

    > From that analysis, the risk of impoverishment is calculated both for the nation as a whole as well as for individual states. One of the most disturbing national findings is that, after only 13 weeks in a nursing home *7 in 10 elderly living alone* find their income spent down to the poverty level.

    *Id.* at 1 (emphasis in original).

18. Subcommittee Chairman's Insurance Report, *supra* note 7, at 3.

19. If current population trends persist, by 2030 there will be nearly 70 million Americans over the age of 65; this is two and one-half times the current population of that age. *See generally* PROGRAM RESOURCES DEPT. OF THE AM. ASSOC. OF RETIRED PERSONS, A PROFILE OF OLDER AMERICANS: 1985 (brochure prepared in conjunction with the Admin. of Aging of the U.S. Dept. of Health and Human Services) [hereinafter cited as AARP PROFILE].

    As of June 30, 1985, 28.5 million people in the U.S. were 65 years of age or older. This was almost 12% of the U.S. population. *See* U.S. DEPT. OF COMMERCE, BUREAU OF THE CENSUS, USA STATISTICS IN BRIEF 1987: A STATISTICAL ABSTRACT SUPPLEMENT. In 1983, the most recent year for which statistices exist, a man who reached age 65 in the U.S. had a life expectancy of 14.5 more years; a woman could expect 18.7 more years. U.S. DEPT. OF COMMERCE, BUREAU OF THE CENSUS, STATISTICAL ABSTRACT OF THE UNITED STATES: 1987 (107th ed.) 70-71 [hereinafter *1987 Statistics*]. Even an 85 year old man or woman could look forward to 5.2 or 6.5 more years, respectively. 1987 STATISTICS at 7.

    By the year 2000, the percentage of persons in the U.S. in the over 65 age group will increase to 12.2%, or roughly one senior citizen for every eight persons in the U.S. THE 1981 WHITE HOUSE CONFERENCE ON AGING, CHARTBOOK ON AGING IN AMERICA 4.

20. *See* 1987 STATISTICS, *supra* note 19.

21. *Id.*

22. Over 21% of the total U.S. population will be over 65 by 2030. Compare this with 1.0% of the population in 1980. See generally AARP PROFILE.

23. "The State of the Union," 22 WEEKLY COMP. PRES. DOC. 135 (Feb. 4, 1986).

24. *Id.* at 138.

Bowen's primary recommendation for meeting the long-term care needs of the elderly was to "encourage development of the private market for long term care insurance."[25] However, unfortunate experience has taught us that relying on the private sector to close the gap would simply not work.[26]

## THE FAILINGS OF THE PRIVATE SECTOR

Investigation has revealed that reliance on the private sector will not fully address the needs of the elderly. There are several reasons why this is so.

### The Harsh Realities of Long-Term Care Policies

A General Accounting Office (GAO) report shows that most private long-term care insurers employ numerous restrictions and limitations which are uncommonly harsh even when judged against the most outrageous practices of other segments of the insurance industry.[27] For example, many policies fail to adjust for inflation over time—a particularly harmful omission considering that nursing home costs have risen by more than six percent a year historically,[28] a trend which is likely to continue.[29]

Also, a high number of long-term care policies[30] require prior hospitalization before benefits can be paid. Such a limitation denies numerous policyholders needed nursing home care because most elderly persons do not require a hospital stay prior to nursing home placement. This is largely due to the fact that over one-half of all nursing home residents suffer from Alzheimer's disease,[31] which

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25. *Catastrophic Health Costs: Broad Problem Demanding Equally Broad Solution: Joint Hearing Before the House Select Comm. on Aging and the Senate Special Comm. on Aging*, 100th Cong., 1st Sess. 29, 31 (1987) (statement of Dr. Otis R. Bowen, Secretary, Dept. of Health and Human Services).
26. *See generally Catastrophic Insurance: How the Bowen Plan Fails: Hearing Before the Subcomm. on Health and Long-Term Care of the House Select Comm. on Aging*, 100th Cong., 1st Sess. (1987).
27. The Subcommittee on Health and Long-Term Care requested that the GAO conduct a thorough examination of restrictions, limitations and abuses in the sale of long-term care insurance to the elderly. Subcommittee Chairman's Insurance Report, *supra* note 7, at *iii*.
28. In addition, the Subcommittee undertook to assess the States' experience with long-term care insurance by polling all 50 state insurance commissioners. *Id.* at 25-31 (Tables II through VIII). The Subcommittee also enlisted the services of several senior citizen investigators. These persons, posing as potential customers, met with over a dozen insurance agents from the metropolitan D.C. area to observe long-term care insurance presentations firsthand and to determine the extent to which insurance salesmen discuss their policies' limitations and engage in sharp marketing practices. *Id.* at 3-4.
29. Assuming a person buys a long-term care policy at age 65 and requires nursing home care at age 80, the value of the policy after 15 years would pay less than one-third of that individual's nursing home costs. After 20 years it would pay roughly one-quarter. *Id.* at 21 (Table I).
30. Some 88% of those surveyed by the GAO. *Id.* at 7.
31. *Id.* Alzheimer's disease, defined medically, is

    > [a] form of dementia (mental deterioration), usually beginning at middle age, in the 40 to 60 year old age group, marked by atrophy (wasting) of the cortex of the brain (especially of the frontal and temporal lobes). . . . Also called *presenile dementia*, . . . .[t]he term Alzheimer's disease is also applied to a condition . . . which has its beginnings in the 7th and 8th decades of life and is known as *senile dementia* (emphasis in original).

    J.E. SCHMIDT, 1 SCHMIDT'S ATTORNEY'S DICTIONARY OF MEDICINE A-159 (1986).

    The American Psychiatric Association estimates the duration of Alzheimer's disease, from senile onset to eventual death of the patient, as about five years. While few cases of Alzheimer's are diagnosed in patients under the age of 49, doctors estimate that some two to four percent of the over 65 year old U.S. population suffers from the disease. There is no known cure. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 124-26 (3d ed. 1980) [hereinafter cited as DSM-III].

typically does not demand hospitalization before entrance into a nursing home.[32] In all, only one-third of nursing home patients are admitted following a hospital stay.[33]

A considerable number of long-term care policies go so far as to exclude Alzheimer's disease and related disorders as grounds for nursing home admission.[34] This particular exclusion means that the most modest expectation an elderly consumer might have of a long-term care policy [35] may go unfulfilled.

The GAO also found that some long-term care policies required nursing home care to be provided in a "skilled" nursing facility,[36] as opposed to one providing mere custodial care. However, day-to-day custodial care is just the kind of help most nursing home residents require.[37] Finally, many seniors find provisions in their long-term policies that make renewal difficult or impossible.[38]

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32. The American Psychiatric Association's mental health diagnostic text describes the course of Alzheimer's as follows:

> The onset is insidious, and the course is one of uniform, gradual progression. In the early stages memory impairmant may be the only cognitive deficit. There may also be subtle personality changes, such as the development of apathy, lack of spontaneity, and a quiet withdrawal from social interactions. Individuals usually remain neat and well-groomed and, aside from an occasional irritable outburst, are cooperative and behave in a socially appropriate way. With progression to the middle stage of the disease, various cognitive disturbances become quite apparent, and behavior and personality are more obviously affected. By the late stage, the individual may be completely mute and inattentive. At this point, he or she is totally incapable of caring for himself or herself. This stage leads inevitably to death.

DSM-III, *supra* note 31, at 25. *See also* Subcommittee Chairman's Insurance Report, *supra* note 7, at 7.

33. Subcommittee Chairman's Insurance Report, *supra* note 7, at 7.

34. The GAO investigation, which looked at the long-term health care policies of 25 major U.S. carriers, found that over 55% of the long-term health care policies it reviewed could possibly exclude coverage—and 36% explicitly excluded coverage—for nervous and mental disorders. *Id.* at 23 (Table IB). Alzheimer's disease is considered a mental disorder under most long-term policies' provisions. *See also supra* notes 31 and 32.

35. Specifically, a policyholder's most modest expectation would be that the policy would cover expenses resulting from Alzheimer's; it is, after all, the leading cause of nursing home admissions. Subcommittee Chairman's Insurance Report, *supra* note 7, at 7-8 and 23 (Table IB).

> The failure of such expectations was exemplified to the Subcommittee by the case of Edward Lewis, an 88 year old native of St. Petersburg, Florida. Six months after he purchased a nursing home insurance policy, local paramedics took custody of his 82 year old wife, who suffered from a memory disorder similar to Alzheimer's. She was picked up after dark one evening, wandering the city streets in her night clothes. Friends and local authorities convinced Mr. Lewis to place his wife of 53 years in a nursing home, a decision that was very painful to him. Any consolation he felt at being insured quickly disappeared, however, when he found that his nearly new policy would not cover his wife's care because she had not been hospitalized prior to her entry into the nursing home. In several months, after the home's costs exhausted the Lewis' combined life savings, Mrs. Lewis was declared a ward of the state. *Id.* at 7.

36. By "skilled," the GAO means high-quality technical care that is not merely custodial in nature, and that requires special training to perform. Some 18% of policies reviewed required care to be provided in such a skilled nursing facility. *Id.* at 8.

37. *Id.* at 24 (Table IC). It is worth noting that such skilled facilities are relatively scarce. Twenty states classify less than half of their nursing homes as skilled; seven states classify less than 15% of their homes as such. *Id.* at 8. Furthermore, at last count there were fewer than 20 skilled nursing home beds per 1,000 medicare enrollees (19.9 as of July 1, 1984, the last date for which statistics are available). 1987 STATISTICS, *supra* note 19, at 98. To an extent, these figures reflect the lower demand for custodial facilities as opposed to skilled ones.

38. Stated in each renewability clause is the ultimate right of the insurer not only to revise the premium structure for an entire class of insureds, but ultimately to cancel the entire benefit package for the insured class at any point in time.

And on top of the problems with the terms of long-term care policies, abusive sales and marketing techniques plague senior consumers; misinformation and high-pressure sales tactics are all too common.[39]

## EXPANDING THE FEDERAL ROLE

The findings of the General Accounting Office and the results of the Subcommittee's research indicate that the private insurance industry, currently regulated at the state level,[40] cries out for minimum standards to govern the new and burgeoning long-term care market. In the meantime, the federal government appears to be the most appropriate entity to provide long-term care insurance for the elderly and, indeed, for all Americans.[41]

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39. Insurance officials from 44 states and the District of Columbia indicated to the Subcommittee that older citizens in their states are "confused and/or frightened" about what insurance protection they have or need for long-term care. Officials from 26 states indicated they had received complaints from policyholders relating to abusive long-term care insurance practices. *Id.* at 28-30 (Tables VI and VII). A recent bar journal article amplified these statistics:

> Even though no one is safe from fraud and exploitive practices, a number of considerations make elderly consumers particularly vulnerable. Chronological old age is often accompanied by a weakened physical condition, organic brain damage, depression, grief, loneliness, pain, anxiety, and fear of aging and death which makes older persons "good targets for swindlers and con-artists . . . ."
>
> [A major] class of fraudulent activity preys on the fears of elderly consumers that they will face abject poverty if they incur significant medical expenses. The aged consumers are convinced that their present health insurance coverage will be inadequate to cover all of their bills. Evidence of anxiety-producing advertisements is found everywhere. For example, one can hardly watch a single day of television without some articulate, well-known, compensated spokesperson advising elderly consumers to purchase additional health or medical insurance. Buying insurance based on a radio or television advertisement is fraught with opportunities for fraud or deception. Without examining the policy, the elderly consumer may find after purchasing it that the "additional" coverage really is not additional or supplementary at all. In other cases, the elderly consumer may learn that the provisions really will not afford them any protection until after they have been insured under the policy for several years. In sum, purchasing insurance coverage through the mail or by using a toll-free telephone number fails to guarantee that elderly consumers will really have all of their medical expenses covered if they are hospitalized for an extended period for treatment of the illness.

Charles, *Meeting the Challenge of Protecting the Elderly Consumer*, 50 TEX. B.J. 497, 498 (1987). *See generally* Reidinger, *Insurance: Customers Must Be Advised of Rights*, 73 A.B.A.J., May 1, 1987, at 94, col. 1; Topolnicki, *When a Nursing Home Becomes Your Poorhouse*, MONEY MAG., Mar. 1986, at 175; Fisher & Robinson, *Preparing A Guide for Senior Citizens in the Health Insurance Maze*, 19 CLEARINGHOUSE REV. 114 (1985); J. KRAUSKOPF, ADVOCACY FOR THE AGING (1983) and LEGAL RESEARCH AND SERVICES FOR THE ELDERLY, THE LAW AND AGING MANUAL (1976).

40. State regulation of the insurance industry under the so-called McCarran-Ferguson Act, 15 U.S.C.A. §§ 1011-1015 (West Supp. 1983), is itself a matter of controversy. *See generally* Anderson, *Insurance and Antitrust Law: The McCarran-Ferguson Act and Beyond*, 25 WM. MARY L. REV. 81 (1983) and Kimball & Boyce, *The Adequacy of State Insurance Regulation: The McCarran-Ferguson Act in Historical Perspective*, 56 MICH. L. REV. 545 (1958).

41. Virtually no coverage is available for the 20 million Americans who suffer from chronic heart conditions, the 10 million Americans who suffer from chronic lung disease, the three million Americans who have Alzheimer's disease, the five million Americans afflicted with cancer, the 500,000 Americans who have Parkinson's disease, and the four million persons involved in accidents each year. Once a person becomes so desperately ill that there is no hope of making him or her self-sufficient, Medicare and most private insurance coverage comes to an end, and the patient and his or her family are left to fend for themselves. The Subcommittee has found that life savings can quickly be depleted from the costs associated with a catastrophic illness, especially if one enters a nursing home, which costs between $20,000 and $75,000 a year.

With this viewpoint in mind, the Subcommittee has spent four years and held twenty-two hearings around the nation, documenting the need for national action on the problem of long-term care.[42] Following the President's endorsement in early 1987[43] of a national plan for catastrophic health care, the House and the Senate commenced hearings[44] amid a mood of rampant optimism. For the first time in decades, it appeared that the President, the Congress and the people were all standing on the same square. Each recognized the rare opportunity to achieve lasting and meaningful change with respect to the American health care system.

## A NATIONAL COMMISSION: A STEP FORWARD

To some extent, the Congress has squandered its historic opportunity. However, the one saving grace is that the Medicare Catastrophic Coverage Act of 1988 allocates $1.5 million for the establishment of a Bipartisan Commission

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The options for chronically ill Americans whose resources are almost exhausted, or non-existent, can be frightening indeed. One is advised to wait until all liquid resources, including the family home, are sold or depleted. In that way, one can reach the level of $3,000 for a couple or $2,500 for an individual that entitles the person to Medicaid benefits. As in the case of Ed Howard, *supra* note 7, first bankruptcy, and then Medicaid (the health program for the very poor), seem the only future. For a summary of Medicare's gaps, *see* Fisher & Robinson, *supra* note 39 at 121.

42. The Subcommittee was constituted under the aegis of the House Select Committee on Aging and charged with investigating the status of long-term health care in the U.S. It was also expected to make recommendations on measures to combat the twin evils of escalating health care costs and shrinking medical insurance coverage.

The Subcommittee is composed of the following U.S. representatives: Chairman Pepper (D-Fla.), James J. Florio (D-N.J.), Harold E. Ford (D-Tenn.), Mary Rose Oakar (D-Ohio), Thomas A. Luken (D-Ohio), Dan Mica (D-Fla.), (Henry A. Waxman (D-Cal.), Mike Synar (D-Okla.), Butler Derrick (D-S.C.), Bruce F. Vento (D-Minn.), Barney Frank (D-Mass.), Ron Wyden (D-Ore.), Ike Skelton (D-Mo.), Dennis M. Hertel (D-Mich.), Robert A. Borski (D-Penn.), Ben Erdreich (D-Ala.), Buddy MacKay (D-Fla.), Norman Sisisky (D-Va.), Edward R. Roybal (D-Cal.) (Ex Officio), Ralph Regula (R-Ohio) (Ranking Minority Member), Matthew J. Rinaldo (R-N.J.), George C. Wortley (R-N.Y.), Jim Courter (R-N.J.), Claudine Schneider (R-R.I.), Thomas J. Ridge (R-Pa.), Christopher H. Smith (R-N.J.), Sherwood L. Boehlert (R-N.Y.), Jim Saxton (R-N.J.), Helen Delich Bentley (R-Md.), Jim Lightfoot (R-Iowa), Jan Meyers (R-Kan.), Ben Blaz (R-Guam) (Delegate).

43. "President's Radio Address to the Nation", 23 WEEKLY COMP. PRES. DOC. 155 (Feb. 14, 1987). President Reagan's address, entitled "Catastrophic Health Insurance," announced a three part proposal: 1) changes to Medicare to provide unlimited coverage beyond a yearly cap of $2000 for out-of-pocket Medicare expenses; 2) direction to the Treasury Department to investigate options, *e.g.*, favorable tax treatment on certain savings accounts, to help families meet the costs of long-term care; and 3) direction to the states to encourage the formation of risk pools to help provide insurance, for those of all ages, who could not otherwise obtain it. *Id.*

Reagan called his proposal, "comprehensive" and claimed it would free the elderly from "an intolerable choice . . . between bankruptcy and death." "Message to the Congress Transmitting Proposed Legislation", 23 WEEKLY COMP. PRES. DOC. 185 (Feb. 24, 1987) ("Medicare Catastrophic Illness Coverage Act"). The plan drew much criticism from health care advocates for its limited scope and reliance on the old Medicare framework. Borger, *supra* note 5, at 22. Even Secretary Bowen acknowledged that the President's plan "[would] not . . . cover that many people." *Id.*

44. H.R. Rep. No. 105, 100th Cong., 1st Sess., pt. 1 (1987) explains the provisions of Committee Bill H.R. 2470, which expanded both the scope and cost of the program envisioned by the Reagan administration. *See*, "President's Message to Congress Transmitting Proposed Legislation", *supra* note 43. *See supra* note 9.

on Comprehensive Care.[45] This commission is made up of six Congressmen appointed by the Speaker of the House, six Senators appointed by the Senate majority leader, and three members appointed by the President. This body has six months in which to provide Congress the facts and recommendations upon which to consider legislation to furnish long-term care to all Americans, and another six months to devise a plan for meeting the nation's comprehensive health care needs.[46]

The full effects of the bipartisan commission's deliberations may not be felt for years. In an attempt to produce more immediate results, I introduced legislation to provide Medicare coverage of comprehensive long-term care services in the home to chronically ill elderly and children and certain disabled individuals.[47]

## THE PEPPER PROPOSAL

Though I am one of the longest-serving members of Congress, I cannot recall a more exciting moment than the introduction of H.R. 3436. This legislation, which 100 of my congressional colleagues cosponsored and 110 national organizations have endorsed, seeks to protect Americans of all ages from the financial ruin that can result when protracted illness requires extra-hospital care. If enacted, H.R. 3436 or legislation like it will mean relief for the millions of elderly people recovering from strokes, or with advanced Alzheimer's disease, Parkinson's disease, or cancer. It will also aid children born with chronic pulmonary conditions or other long-term ailments. It will reach out to working-age Americans left paralyzed or otherwise disabled by accident, injury or disease. It is a proposal, then, to protect Americans of all ages from the effects of chronic illness. It is a family protection proposal, recognizing that catastrophic health care costs are not simply a problem for the elderly, but also for young families who face destitution as they try to care for their ill children.[48]

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45. I, along with Rep. Waxman, Chairman of the Subcommittee on Health and Environment, inserted into H.R. 2470 provisions calling for the creation of a Bipartisan Commission on Comprehensive Health Care. H.R. REP. No. 105, 100th Cong., 1st Sess., pt. 2 (1987). An identical provision was inserted by Senator Lawton Chiles (D.-Fla.) into S. 1127. *See* Amendment No. 1066, 100th Cong., 1st Sess., 133 CONG. REC. S15163-64 (daily ed. Oct. 27, 1987).

46. The proposed Bipartisan Commission on Comprehensive Health Care will be of tremendous aid as we move toward our goal of comprehensive health care for every man, woman and child in America. The commission will compile existing data on all forms of health care and collect new data where necessary. It is conceived not as an "ivory tower" group concerned with theory, but as a pragmatic, industrious body, charged with formulating a workable plan that could be implemented at the federal level.

    This commission will be the cornerstone of our effort to construct a national system of comprehensive health care, a task that has eluded us for years. *See* H.R. REP. No. 105, *supra* note 45.

47. H.R. 3436, which was introduced on June 24, 1987, was not some haphazard or hastily constructed solution to the problem of long-term care. Rather, it represented a rational and workable plan for meeting this important health care need. This legislation has been the subject of close scrutiny in recent months. The Subcommittee on Health and Long-Term Care has taken testimony from senior groups, children's groups, long-term care advocates and some of the nation's most highly regarded health policy experts. The views of these individuals and groups were reflected in this bill.

48. According to pollster Paul Maslin, "The health issues are sitting out there. People from all different groups are concerned. You're concerned about your own health care, and you're concerned about your parents' health care. If the government doesn't help pay for their care, you do." Borger, *supra* note 5, at 22-23.

**Details of Care Provisions**

Under the terms of the Pepper proposal, long-term home care benefits would be provided as prescribed by an independent professional care managment team and the individual's attending physician. Services would have to be carefully managed and would have to be designed so as to complement, not replace, informal family help. Services could include nursing care, homemaker or home health aide services, medical social services, physical, occupational, speech or respiratory therapy, medical supplies and equipment, as well as patient and family education, training and counseling.[49]

I consider my home care proposal to be a hybrid, combining the best elements of several pieces of legislation introduced in the past. Quality assurance is a key feature of H.R. 3436. The bill establishes a strong system to guarantee quality care. It will accomplish this by requiring caregivers to undergo mandatory training and regular review. It also incorporates a home care consumer "bill of rights," local community review boards and various other enforcement mechanisms to ensure compliance with care quality standards.

**Controlling the Costs**

Given the current need to curb expenditures and reduce the federal deficit, cost control has been made a key ingredient of this bill. Under H.R. 3436, the

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49. This new benefit would be available to chronically ill elderly, disabled and children who have been certified to be unable to perform two or more "activities of daily living," such as eating, bathing, dressing, moving from room to room, or toileting. Technology-dependent children would also be eligible for assistance. Many of these individuals require costly nursing home and hospital care without proper home services.

Typical of children who will be helped is Katie Beckett, a nine year old from Iowa who was the subject of national attention in 1981. Little Katie, who suffered from viral encephalitis and severe respiratory distress, along with temporary paralysis, was in the hospital most of her first two and a half years. Her parents tried to bring her home, but were told that the only way to secure government funding would be to leave her in the hospital. Finally, the family contacted its local Congressman, who in turn told Vice President George Bush of Katie's plight. Eventually, the President granted Katie a special waiver so she could receive care in the home. However, thousands of other youngsters are not so fortunate and must remain institutionalized, although their care could be provided at home.

Mrs. Beckett described to the Subcommittee how she felt as she listened to the Presidential news conference where the granting of the waiver for her daughter was announced:

> As the President of the United States spoke about a little girl who had spent much of her life in a hospital, tears streamed down my cheeks. The months of preparing documentation, hearing rejection after rejection, of facing powerful individuals with the fate of my family's life in their hands — all of this had culminated in a news conference. Time stood still. I clung to every word, thinking, please just say you'll let her come home.

*Catastrophic Health Insurance—Filling the Long-Term Gap: Hearing Before the Subcomm. on Health and Long-Term Care of the House Select Comm. on Aging*, 100th Cong., 1st Sess. 18, 20 (1987) (hereinafter *Subcommittee Hearings*) (statement of Mrs. Julianne Beckett, mother of Katie Beckett).

National outcry over Katie Beckett's dilemma led the Dept. of Health and Human Services to grant individual waivers permitting families to receive federal benefits to cover home care of sick children. Granted from 1982 to 1986, these became known as "Katie Beckett" waivers. Several other similar waiver plans still exist. CARING INSTITUTE, FOUNDATION FOR HOSPICE AND HOMECARE, THE CRISIS OF CHRONICALLY ILL CHILDREN IN AMERICA: TRIUMPH OF TECHNOLOGY—FAILURE OF PUBLIC POLICY 69 (1987) *reproduced in Catastrophic Health Insurance—The Needs of Children: Joint Hearing Before the Subcomm. on Health and Long-Term Care of the House Select Comm. on Aging and the House Select Comm. on Children, Youth, and Families*, 100th Cong., 1st Sess. (1987) at 213.

cost of long-term home care services would be tightly controlled by limiting monthly payments to two-thirds of the monthly Medicare rate for skilled nursing home services. Payments for technology-dependent children could not exceed the cost of providing similar services in a hospital or nursing home.[50]

H.R. 3436 is progressively financed and completely self-funding. The new home care benefit would be paid for by eliminating the cap ($45,000 in 1988) on income which is exposed to the Medicare payroll tax of 1.45 percent. This change would affect only those five percent of American workers who earn more than $45,000 in individual income annually.[51]

The cost estimates for this home care measure are promising. The Congressional Budget Office (CBO) estimates that H.R. 3436 will more than pay for itself. In fact, this proposal would contribute $2 billion towards reducing the federal deficit next year and some $6.9 billion over the next five years. Also, by adding these excess revenues, H.R. 3436 would bolster the financial status of the Medicare trust fund. The CBO also indicated that costs of the program will level off after 1992, while revenues will continue to gradually rise. In addition, to guarantee that H.R. 3436 remains self-financing well into the future, the bill contains language that strictly prohibits the use of any general revenue funds or other Medicare trust fund monies to pay for the new care program.

**The Popular Mood**

The American people are ready for comprehensive long-term care. A recent poll commissioned by the American Association of Retired Persons (AARP)[52] and the Villers Foundation revealed overwhelming support for a government program to cover long-term care.[53] A majority of the respondents said they were "more likely" to vote for a presidential candidate who made the development of a long-term care program a major plank of his platform. And, by a margin of five to two, respondents expressed a willingness to pay higher taxes to finance such a program.

Though the people are ready for a long-term care program, Congress drags its feet. To reverse this inaction, Congress should pass legislation resembling H.R. 3436; it would represent an important step toward the development of comprehensive health care in the United States. Congress can only rest when it has put into place a federal program that addresses all of this nation's health care deficiencies. The American people will not stand for half measures. And

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50. Numerous national and state studies have demonstrated the feasibility of providing tightly controlled case-managed home-care services that is carefully planned by a team of experts so that it is of the most appropriate and cost-effective type—at a fraction of the cost of institutional care.

51. Currently, nearly 95% of American workers contribute 1.45% of their entire income to fund Medicare. However, the five percent of workers who make over $45,000 a year do not contribute on any of their income above $45,000, no matter how much they make.

52. AARP has close to 26 million members nationwide, and devotes itself to furthering the needs and concerns of older and retired Americans. It supports an overhaul of the nation's long-term care system. *Subcommittee Hearings*, *supra* note 49, at 74 (statement of Mr. Robert Maxwell, AARP Vice President).

53. This support spanned all age groups, income levels and party affiliations. More than six out of seven respondents to this survey believed the time had come to consider a government program for long-term care—92% of all Democrats, 82% of all Republicans, and 87% of Democrats who voted for Ronald Reagan in 1984. *Id.*

current legislation leaves too many needs unaddressed. However, I am confident the bipartisan commission mandated by the 1988 Act holds the key to meeting those remaining critical medical needs.

Health care, which constitutes nearly eleven percent of the gross national product,[54] is traditionally a high-price-tag item.[55] Because of attempts to curb ballooning health care spending, various cost-containment measures, such as the prospective payment system for Medicare hospital services,[56] have been adopted. These measures represent a "meat cleaver" approach to cost-cutting. What we really need is a delicate scalpel.

Congress knows that any changes to the health care system must be made with the deficits of the present and the spiraling costs of the past well in mind. However, let us not close our eyes to the human pain and suffering experienced by those persons currently unable to pay for health care because of inadequate coverage. By employing a "social insurance" method of financing akin to that of the Social Security program, many of us can make little payments and receive in return health care that is beyond price. If we determinedly tackle fraud and abuse in existing programs, and establish careful cost controls on future and existing programs—as we did in H.R. 3436—we can meet the demand for many essential services.

## CONCLUSION: THE HEALTH OF THE NATION—A NATIONAL CONCERN

My proposal to provide long-term home care is an important milestone. When it came before the House this summer, it marked the first time in the history of that body that a meaningful long-term care proposal received consideration.

If that measure is someday adopted, and if the bipartisan health care commission emerges to successfully carry out its mandate, we will be well on our way to meeting the lofty goals first articulated by Presidents Roosevelt and Truman. That fifty year old goal is comprehensive health care for every man, woman and child in America, at a price each can afford to pay.

With luck, all of us will someday grow old. Hopefully, Congress will enact legislation which can help us to age in peace, free from the fear of financial devastation due to long-term illness. No one in America will go bankrupt financing such a program—but most Americans will continue to face bankruptcy without it. Could any choice be more clear?

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54. 1987 STATISTICS, *supra* note 19, at 84.
55. Total national health expenditures topped $425 billion in 1985, the last year for which statistics have been published. *Id.* This came down to $1,721 per person. *Id.*
56. Prospective reimbursement was authorized under the Tax Equity and Fiscal Responsibility Act. 26 U.S.C. § 3304 (1983). This approach to health care reimbursement operates on the principle that patients with similar medical conditions should receive similar care and use approximately the same amount of resources; therefore, in general, a hospital should be reimbursed the same amount for each patient in a diagnosis-related group, or DRG, which refers to a particular ailment or procedure. This is a radical change from the fee-for-service method of payment traditionally used by Medicare.