Medicare and Medicaid: The Failure of the Present Health Care System for the Elderly

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One of the greatest problems faced by Americans today is the high cost of medical care. This problem is aggravated in the case of the elderly because many must survive on a fixed income, while their need for medical services and the cost of those services increase. The Medicare and Medicaid programs were enacted to assist older Americans by paying part or all of the cost of health care with federal and state funds.[1] These programs have failed in that purpose, however, because they do not provide the type of services and the extent of coverage which are actually needed by elderly individuals.

This Note will examine the Medicare and Medicaid programs, setting forth the type of coverage available under each and discussing those areas of health care services neglected by both programs. These shortcomings, particularly the failure to provide for adequate home health and personal care services, will be examined in the context of hypothetical health care situations commonly experienced by the elderly. Finally, suggestions for amendment of the present law, aimed at providing the type of comprehensive and coordinated health care services which are needed by the elderly, will be presented.

Present Health Care Programs for the Elderly: Medicare and Medicaid

Since the turn of the century, there have been many attempts to enact national health care legislation, especially programs for the aged. Several major efforts were begun shortly after World War II and again during the 1950's. These attempts were frustrated, however, by disagreements over methods of financing the programs and extensive nation-

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1. U.S. Code Cong. & Ad. News 1943 (1965).

wide campaigns against "socialized medicine."[2] Finally, in 1965, the Medicare-Medicaid laws were enacted[3] as a result of numerous compromises regarding the funding and organization of the programs, eligibility criteria, and the extensiveness of the coverage.[4] Medicare, the first national health insurance program for the elderly, benefits almost all older persons, but covers only a limited range of services. Medicaid is a joint federal-state program under which the federal government provides grants to the states for their medical assistance programs; it is aimed at indigent persons generally, however, not just the elderly.

Medicare

The Medicare program is divided in two parts. Part A[5] applies automatically to persons 65 and over who are entitled to monthly social security or railroad retirement benefits;[6] persons 65 and over who cannot so qualify may receive coverage if they pay a monthly premium and enroll for Part B coverage.[7] Part A covers hospital care, skilled nursing facility [SNF] care, and home health care,[8] with benefits defined in terms of a beneficiary's "spell of illness."[9] During each spell of illness, Medicare Part A covers all hospital costs for a maximum of 90 days, subject to an initial deductible of $84.00 and a charge of $21.00 per day for the 61st through 90th day of hospitalization.[10] Additionally, the beneficiary has a lifetime reserve of 60 days of hospital coverage, any portion of which may be used in the event a hospital stay exceeds 90 days.[11] Services covered include room charges, nursing care, drugs and supplies, and other services and treatment usually furnished by a hospital.[12] Doctor's fees are not covered, unless the doctor is an intern or

2. These campaigns were directed primarily by the American Medical Association [AMA]. *See* E. FEINGOLD, MEDICARE: POLICY AND POLITICS 85-100 (1966).

3. Act of July 30, 1965, Pub. L. No. 89-97, 79 Stat. 290 (codified at 42 U.S.C. §§ 1395-1396pp (1970), *as amended*, (Supp. III, 1973)).

4. For an extensive and thorough discussion of the political history of the 1965 Medicare law, the various bills offered, how compromise was achieved, and the extent of AMA opposition, see E. FEINGOLD, *supra* note 2, at 85-156.

5. 42 U.S.C. §§ 1395c-1395i(2) (1970), *as amended*, (Supp. III, 1973).

6. *Id.* § 1395c(1). Recent amendments also include persons under 65 who are receiving disability benefits. *Id.* § 1395c(2) (Supp. III, 1973).

7. 42 U.S.C. § 1395i-2 (Supp. III, 1973).

8. 42 U.S.C. § 1395d(a) (1970).

9. 42 U.S.C. § 1395x(a) (1970), *as amended*, (Supp. II, 1972), provides:

> The term "spell of illness" with respect to any individual means a period of consecutive days—(1) beginning with the first day (not included in a previous spell of illness) (A) on which such individual is furnished inpatient hospital services or extended care services, and (B) which occurs in a month for which he is entitled to benefits under part A, and (2) ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital nor an inpatient of a skilled nursing facility.

10. CCH 1974 SOCIAL SECURITY AND MEDICARE EXPLAINED—INCLUDING MEDICAID ¶ 13,825, at 1705 [hereinafter cited as SOCIAL SECURITY, MEDICARE, AND MEDICAID EXPLAINED]; *see* 42 U.S.C. §§ 1395d-1395e (1970); 20 C.F.R. §§ 405.113, -.115 (1975).

11. 42 U.S.C. § 1395d (1970).

12. 42 U.S.C. § 1395x(b) (1970), *as amended*, (Supp. III, 1973).

resident training in the hospital under an approved program.[13]

Part A also covers posthospitalization care in a qualified[14] SNF for up to 100 days.[15] Generally, the same costs covered in the hospital are covered in a nursing facility,[16] but the patient is eligible for these benefits only if his physician certifies his need for skilled nursing services rather than custodial care.[17] Such services are carefully defined in the regulations and generally refer to services which require such a degree of skill that they must be performed either by a registered nurse or under a nurse's supervision.[18] There is no initial deductible for SNF care, but the beneficiary must pay $10.50 per day after the first 20 days of his stay.[19]

Upon discharge from a hospital or an SNF,[20] a Medicare patient is entitled to a maximum of 100 home health care visits during the 1-year period following the beginning of a spell of illness.[21] In order to qualify, the physician must certify that the patient is essentially confined to his home,[22] and the visits must be made in accordance with a plan of care which the patient's physician has approved within 14 days of the discharge from the hospital or SNF.[23] The types of home health services provided by Medicare include: (1) intermittent nursing care by or under the supervision of a registered nurse; (2) physical, occupational, or speech therapy; (3) medical social services; (4) medical supplies necessary for treatment under the physician's plan, not including drugs or medication; and (5) services of a home health aide, functioning essen-

13. *Id.* § 1395x(b)(6). *See also id.* § 1395x(b)(7).

14. *See id.* §§ 1395x(j), 1395cc; 20 C.F.R. §§ 405.1101 to -.1137 (1975).

15. 42 U.S.C. § 1395d(2) (1970); 20 C.F.R. § 405.120 (1975). *See also* 42 U.S.C. §§ 1395x(i), 1395f(a)(2)(C) (1970), *as amended,* (Supp. III, 1973); 20 C.F.R. § 405.126 (1975). As a prerequisite to such coverage, the beneficiary must have been hospitalized for at least 3 days prior to admission and must be admitted to the facility within 14 days after discharge from the hospital, for further treatment of the condition for which he was hospitalized. 42 U.S.C. § 1395x(i) (1970), *as amended,* (Supp. III, 1973); 20 C.F.R. § 405.120 (1975).

16. *Compare* 42 U.S.C. § 1395 x(h) (1970), *as amended,* (Supp. III, 1973), *with id.* § 1395x(b); 20 C.F.R. § 405.125 (1975), *with id.* § 405.116.

17. 42 U.S.C. § 1395f(a)(2)(C) (1970), *as amended,* (Supp. III, 1973); 20 C.F.R. § 405.165 (1975).

18. 20 C.F.R. § 405.127 (1975).

19. SOCIAL SECURITY, MEDICARE AND MEDICAID EXPLAINED, *supra* note 10, ¶ 13,825, at 1706; *see* 42 U.S.C. § 1395e(a)(3) (1970); 20 C.F.R. § 405.124 (1975).

20. 42 U.S.C. § 1395x(n) (1970), *as amended,* (Supp. III, 1973).

21. 42 U.S.C. § 1395d(a)(3) (1970); 20 C.F.R. § 405.131 (1975). Under section 405.238, one "visit" is charged each time a home health service, defined in section 405.236, is furnished by home health agency personnel, such as a nurse, therapist, or home health aide.

22. 42 U.S.C. § 1395f(a)(2)(D) (1970), *as amended,* (Supp. III, 1973). He need not be bedridden, but his mobility must be so restricted that it would be difficult for him to leave his home in order to receive such services. An exception to the requirement that the services be furnished at the patient's residence is made where the care involves special equipment which cannot be made available in his home. *Id.* § 1395x(m); 20 C.F.R. § 405.235(b)(2) (1975).

23. 42 U.S.C. § 1395x(n) (1970), *as amended,* (Supp. III, 1973).

tially as a hospital nurse's aide.[24] Transportation, housekeeping and domestic services unrelated to patient care, and "meals on wheels" or other such food services are not covered by the Medicare program.[25]

Medicare Part B provides supplemental medical insurance for those who choose to enroll. It is financed by individual premiums and matching federal funds[26] and is available to all resident[27] citizens 65 or over, regardless of their eligibility for Part A hospital insurance benefits and in addition to Part A benefits.[28] The Part B beneficiary must pay a monthly premium of $6.70,[29] an annual deductible of $60,[30] and 20 percent of the remaining cost of covered services.[31] Part B, designed to supplement Part A coverage, reimburses beneficiaries for such services as: (1) doctor's visits, whether furnished in the office or hospital; (2) other medical services, such as diagnostic tests, x-ray therapy, physical therapy, and speech pathology; (3) supplies connected with the doctor's services, artificial devices, and durable medical equipment; and (4) up to 100 home health visits, in addition to those covered under Part A and without the prior hospitalization requirement.[32]

Even for the individual with both Part A and B coverage, however, many items and services which are crucial to the health maintenance of

24. *Id.* § 1395x(m); 20 C.F.R. § 405.236 (1975).
25. 20 C.F.R. § 405.237 (1975).
26. 42 U.S.C. § 1395j (1970), *as amended*, (Supp. III, 1973).
27. To meet the residence prerequisite, the individual must be "either (A) a citizen or (B) an alien lawfully admitted for permanent residence who has resided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment under [Part B] . . . ." *Id.* § 1395o(2).
28. *Id.* § 1395o.
29. SOCIAL SECURITY, MEDICARE, AND MEDICAID EXPLAINED, *supra* note 10, ¶ 13,825, at 1709; 42 U.S.C. § 1395r (1970), *as amended*, (Supp. III, 1973); 20 C.F.R. § 405.902 (1975). The rate is higher for those who delay enrollment after initially becoming eligible. 20 C.F.R. § 405.902(b) (1975). The amount of the premium is based on an estimate of the total cost of the program so that the aggregate amount of premiums paid will constitute half of the estimated costs and benefits of the Part B program. 42 U.S.C. § 1395r(c)(1) (1970), *as amended*, (Supp. III, 1973).

All the states except Louisiana, Maryland, Oregon, and Wyoming, SOCIAL AND REHABILITATION SERVICE, U.S. DEP'T OF HEALTH, EDUCATION AND WELFARE, CHARACTERISTICS OF STATE MEDICAL ASSISTANCE PROGRAMS UNDER TITLE XIX OF THE SOCIAL SECURITY ACT (Public Assistance Rep. No. 49, 1970) [hereinafter cited as STATE MEDICAL ASSISTANCE PROGRAMS], have entered into an optional agreement with the federal government whereby enrollment premiums of public assistance recipients and "medically needy" persons for Part B Medicare are funded under the states' Medicaid programs. 42 U.S.C. § 1395v (1970), *as amended*, (Supp. III, 1973). Under this provision, the state can elect to provide coverage for persons receiving welfare benefits under former Titles I (old age assistance), X (aid to the blind), XIV (aid to the permanently and totally disabled), and XVI (combined program of I, X, and XIV). Such agreements may be continued in effect after January 1, 1974, with modifications required by the new Supplemental Security Income program (new Title XVI). The state might also elect to cover the "medically needy" or those persons with insufficient income to cover medical expenses, but ineligible for public assistance under Titles I, X, XIV, or XVI. See text & notes 47-50 *infra*.
30. 42 U.S.C. § 1395*l*(b) (1970), *as amended*, (Supp. III, 1973).
31. *Id.* § 1395*l*(a). There are some exceptions to this. For example, 100 percent of the reasonable charges is paid for a person receiving radiological or pathological services as an inpatient of a hospital. *Id.* §§ 1395*l*(a)(1)(B). *See also id.* § 1395*l*(a)(1)-(2).
32. *Id.* §§ 1395k, 1395x(s); 20 C.F.R. §§ 405.230 to -.239 (1975).

the elderly[33] are not provided by Medicare. Among them are routine medical checkups, dental care, foot care, glasses, hearing aids, dentures, orthopedic shoes, immunizations, and drugs.[34] Additionally, physicians are often reluctant to accept Medicare assignments because of inadequate reimbursement. Both Parts A and B cover only reasonable[35] charges and costs, and a physician who accepts a Medicare assignment, agrees to accept the reasonable cost as payment in full for his services.[36] Therefore, physicians often refuse Medicare assignments, leaving the beneficiary to collect the reasonable cost from the government and to pay the difference between that amount and the physician's actual charge.[37]

Medicaid

Medicaid[38] is an optional federal-state program aimed at furnishing medical assistance to specified indigents of all ages, not just the elderly.[39] States electing to participate in this program must submit a plan for providing medical assistance to indigents to the Department of Health, Education and Welfare for approval.[40] Federal funding, which is determined by a formula based on each state's per capita income, ranges between 50 and 83 percent.[41] Such funding is open-ended, with the federal government providing payment assistance for any expenditure properly made under an approved state plan.[42]

Broad latitude is allowed in determining who will be eligible for Medicaid benefits. Federal law requires only that the state plan include the "categorically needy." Prior to 1974, this was defined as including those persons receiving money payments under federal-state assistance programs for the aged, blind, and disabled.[43] These programs were

33. See text accompanying notes 86-96 *infra.*
34. 20 C.F.R. § 405.310 (1975).
35. 42 U.S.C. §§ 1395f(b), 1395x(v) (1970), *as amended,* (Supp. III, 1973). *See generally* 20 C.F.R. §§ 405.401-.525 (1975).
36. 20 C.F.R. § 405.251(b) (1975).
37. In testimony before the Senate Special Committee on Aging, Alice Brophy, Director, Office for the Aging, New York City, noted that acceptance of Medicare assignments by New York physicians had fallen from 60 percent to 41 percent of the total claims filed for physicians services. *Hearings Before the Subcommittee on Health of the Elderly of the Special Committee on Aging,* 93d Cong., 1st Sess., pt. 1, at 17 (March 5, 1973) [hereinafter cited as *1973 Hearings*].
38. 42 U.S.C. §§ 1396-1396i; (1970), *as amended,* (Supp. III, 1973), 42 U.S.C.A. § 1396a (1974).
39. Assistance is directed toward those persons receiving money payments under federal-state programs for the aged, blind, and disabled. 42 U.S.C. § 1396a(a)(10) (1970), *as amended,* (Supp. III, 1973).
40. 42 U.S.C. § 1396a (1970), *as amended,* 42 U.S.C.A. § 1396a (1974).
41. 42 U.S.C. §§ 1396b, 1396d(b) (1970), *as amended,* (Supp. III, 1973).
42. *Id.* § 1396b.
43. *See* 42 U.S.C. § 1396a(a)(10) (1970), *as amended,* 42 U.S.C. § 1396a(a)(10) (Supp. III, 1973). The assistance programs for the aged, blind, and disabled were then codified at 42 U.S.C. §§ 301-306, 1201-1206, 1351-1355, 1381-1385 (1970) (repealed

replaced in 1974 by the federal Supplemental Security Income program.[44] A state is now required to include under Medicaid at least those persons who are eligible for Supplemental Security Income.[45] Additionally, the state must provide coverage for all persons who meet the requirement of being "essential" to the well-being of a Medicaid recipient.[46]

Although it is not mandatory, a state is free to include in its Medicaid program individuals who could qualify as categorically needy, but who have not applied for such benefits, individuals receiving financial assistance under other state plans with eligibility requirements more stringent than those of the federal government, and individuals in a medical facility who would be eligible for categorical assistance if they left such a facility.[47] The medically needy—those persons with too much income to be entitled to categorical assistance payments, but having insufficient funds to cover medical expenses—may also be covered by the state program.[48] If the state elects to include the medically needy, each individual must meet the general requirements, except for income, of at least one of the categorical assistance programs.[49] Such individuals are required to share the cost of medical care in proportion to their income.[50]

The Medicaid services are outlined in the statute and regulations.[51] For the categorically needy, the state plan must include: (1) inpatient and outpatient care; (2) laboratory and x-ray services; (3) SNF care; and (4) physician's services.[52] If the medically needy are included in the plan, the state must provide at least seven of 16 federally approved serv-

1974). Even if a state had elected to provide public assistance to only one group—for example, the blind—it would nevertheless have been required to include all three groups under its Medicaid plan. 45 C.F.R. § 248.10(b)(3) (1974) (no longer in effect for the states as of Jan. 1, 1974).

44. 42 U.S.C. §§ 1381-1383c (Supp. III, 1973).

45. 45 C.F.R. § 248.1(b) (1974).

46. 45 C.F.R. § 248.1(b)(2)(v) (1974). An essential person is the spouse of a recipient of financial assistance under the state's program for aid to the aged, who is living with the recipient, is determined by the state to be essential to his well-being, and whose needs are taken into account in determining the amount of aid received. *Id.* § 248.1(b)(2)(v)(B). Other provisions, not pertinent to the elderly, are not within the scope of this Note.

47. 45 C.F.R. §§ 248.1(c)(i)-(iii) (1974).

48. 45 C.F.R. § 248.1(d) (1974).

49. *Id.* In 1970, for the 24 states providing coverage for the medically needy, the maximum allowed income level ranged between $1200-$2500 for a single person and $1700-$3500 for a couple. In computing income, the value of the individual's home, household furnishings, some personal property, and varying amounts of other liquid assets are excluded. STATE MEDICAL ASSISTANCE PROGRAMS, *supra* note 29. For a summary of the state Medicaid plans in effect as of January 1, 1970, see STATE MEDICAL ASSISTANCE PROGRAMS, *supra* note 29.

50. 45 C.F.R. § 249.40(a)(2) (1974).

51. 42 U.S.C. §§ 1396a, 1396d (1970), *as amended*, (Supp. III, 1973); 45 C.F.R. § 249.10(b) (1974).

52. 42 U.S.C. §§ 1396a(a)(13), 1396d (1970), *as amended*, (Supp. III, 1973); 45 C.F.R. §§ 249.10(a)(1), (b)(1)-(5) (1974).

ices. These include, in addition to the four types of services previously mentioned: medical care or remedial care recognized by state law;[53] home health services, limited to nursing care, home health aides, and medical supplies; private duty nursing; clinic services; dental services; physical therapy; prescribed drugs, glasses, dentures, and prosthetic devices; intermediate care facility services; and other diagnostic, screening, preventive and rehabilitative services.[54] If the services chosen include either hospital or nursing home care, coverage must also include physician's fees while the beneficiary is confined.[55] For both the categorically needy and the medically needy, the state plan must cover home health care for those eligible for SNF care, as well as providing necessary transportation to and from providers of services.[56]

Every state, except Arizona,[57] has a Medicaid program. The range of available services is not uniform, however, and none of the state plans cover all of the services authorized under Medicaid. The Connecticut and Wyoming plans are representative of the maximum and minimum coverage possible under Medicaid.[58] Connecticut has the most thorough of the existing plans, including all services except personal care in the patient's home.[59] Inpatient and outpatient hospital services, laboratory and x-ray work, SNF care, physician's services, home health care, prescribed drugs, prosthetic devices, and other diagnostic, screening, preventive, and rehabilitative services are available without limitation, except that prior authorization is frequently required. Minor limitations are placed on the type of services of podiatrists, optometrists, and chiropractors which are reimbursable. Private duty nursing is limited to hospital inpatients, and therapy must be provided in clinics or rehabilitation centers. Hearing aids are provided only after a professional examination, and, absent special circumstances, glasses are limited to one pair. Although ambulance services are unlimited, other forms of transportation are limited to chair cars or other invalid carriers. Assistance is

53. 42 U.S.C. § 1396d(a)(6) (1970); 45 C.F.R. § 249.10(b)(6) (1974). This provision is designed to permit states to provide assistance for treatment under whatever it chooses to define as the practice of medicine. Thus, the state may include in its program certain chiropractic care, 42 U.S.C. § 1396d(g) (1970), or treatments in a Christian Science sanatorium, 42 U.S.C. § 1396d(c) (1970), *as amended*, (Supp. III, 1973); 45 C.F.R. § 249.10(b)(17)(iii) (1974).

54. 42 U.S.C. §§ 1396d(a)(7)-(13), (15) (1970); 45 C.F.R. §§ 249.10(b)(6)-(17) (1974).

55. 42 U.S.C. § 1396a(a)(13)(C)(ii) (1970), *as amended*, (Supp. III, 1973).

56. 42 U.S.C. § 1396d(a)(5) (1970); 45 C.F.R. § 249.10(b)(17)(i) (1974).

57. Arizona enacted a Medicaid program in 1974. It has not yet been submitted to the Department of Health, Education and Welfare for approval, however. Letter from Clark Tibbitts, Director, National Clearing House of Aging, Office of the Sec'y, Dep't of H.E.W., Washingotn, D.C., to Patricia G. Munger, Nov. 5, 1974, on file in the *Arizona Law Review* office.

58. For a summary of the state Medicaid plans, see STATE MEDICAL ASSISTANCE PROGRAMS, *supra* note 29.

59. *Id.* at 33.

provided not only to the categorically needy, but to the medically needy as well.[60]

At the other extreme, Wyoming's plan is probably the most restrictive.[61] Only the categorically needy and those who would be eligible for categorical assistance if they were not in a medical institution are included in the plan. Services are essentially limited to the minimum required by Medicaid, that is, inpatient and outpatient hospital care, laboratory and x-ray services, SNF care, and physician's services. The only additional coverage is for necessary transportation to another town.[62]

Under both Medicare and Medicaid, the elderly may obtain considerable assistance with their medical expenses. Nevertheless, there are many serious deficiencies. While Medicaid and the two parts of Medicare appear to provide a rather complete health care system, not every individual is eligible for all three programs, and separately their coverage is inadequate. Benefits are often severely restricted, both in scope and duration. This is especially true under Medicaid. State plans vary widely in their provisions, and in half the states, benefits are available only to the categorically needy, the very poorest of the elderly.[63] The

60. Connecticut defines the medically needy as those persons who meet the eligibility conditions for categorical assistance other than income and whose annual income does not exceed $1900 per person or $2500 per couple. If the individual's income exceeds the maximum, his coverage is reduced by the amount of the excess. In computing income, the state does not consider the individual's home, personal and household effects, car, other personal property up to $250 per person or $500 per couple, prepaid funeral contract up to $600, and U.S. government veteran's life insurance. *Id.* at 37-38.

61. *Id.* at 388.

62. *Id.*

63. STATE MEDICAL ASSISTANCE PROGRAMS, *supra* note 29. Every state plan covers inpatient and outpatient hospital services, laboratory and x-ray services, skilled nursing home services, and physician's services. The extent of coverage, however, varies under each plan. Many state plans provide unlimited services for the categorically needy or for those enrolled in Part B Medicare, but offer more limited care for the medically needy or for those without Part B coverage.

While the programs in 44 states cover the services of a podiatrist, only 20 cover routine foot care. Two-thirds of the states provide for the services of optometrists and the cost of glasses, although some states limit their coverage to the categorically needy or to the provision of glasses only after eye surgery. Two-thirds of the states cover dental services and the cost of dentures, while only 22 states cover the cost of a hearing aid. Forty-two states cover the cost of at least some drugs, although there are limitations as to type, amount, and number of refill prescriptions. Forty-eight states cover the cost of a variety of types of prosthetic devices, such as artificial organs and artificial limbs. Forty-three states cover the cost of some physical therapy; occupational and speech therapy is included in two-thirds of the states and 21 state programs cover audiology.

All state programs must include home health services for those persons also entitled to SNF care. However, coverage for personal care in the home is optional and provided by only seven states. Forty-five states cover ambulance services, and 26 cover additional transportation, usually in the event of medical or physical necessity. Some states limit their coverage to public transportation, but many cover private transportation and will pay for necessary attendants, meals, and lodging. Coverage of emergency hospital services is provided in 41 states.

Only 26 states provide unlimited coverage of physician's services. Nine states exclude routine examinations, and 17 place limits on the number of visits covered per year or the type of care covered. Of those 17, five provide unlimited coverage for those enrolled in Medicare Part B and two provide unlimited coverage to the categorically

most serious problem, however, is the overutilization of institutional care in response to periodic episodes of acute illness and a corresponding failure to develop adequate provisions for preventive medical care and supportive services in a noninstitutional setting.

THE NEED FOR EXPANDED COVERAGE OF NONINSTITUTIONAL SERVICES

The basic flaw in the present Medicare-Medicaid system lies in its failure to emphasize comprehensive preventive services designed to help the elderly to attain the optimum state of health and to prevent relapses of old health problems. Additionally, because the present programs are designed primarily to assist the patient's recovery from a particular incident of acute illness, they encourage institutionalization by providing the greatest coverage for institutional care. There is no coordinated effort to give the older individual the type of medical and supportive care necessary to maintain or improve his health, prevent serious illness, and keep him from being unnecessarily institutionalized. Yet this is the type of care that is most needed by the greatest number of elderly persons.[64]

The availability of medical and supportive services outside the institutional setting is limited in several ways. The Medicare statutes are the most restrictive. First, Medicare does not provide for any sort of routine or preventive care by a physician or nurse.[65] Second, the availability of medical and supportive care in the home is seriously limited by statutes and regulations restricting duration, eligibility, and the types of services covered. Under Medicare, the provision for 100 home health visits per spell of illness requires that they be used within 1 year and thus ignores those who are unable to regain their health within this period.[66] Even during the 1-year period, the coverage is restrictive. In order to be eligible, the patient essentially must be confined to his home.[67] Although he need not be bedridden, his condition "should be such that there exists a normal inability to leave home and, consequently, leaving [his] home would require a considerable and taxing effort."[68] The ambiguity inherent in this regulation and other federal

needy. These figures are current as of January 1, 1970. *See* STATE MEDICAL ASSISTANCE PROGRAMS, *supra* note 29.

64. See text & notes 96-135 *infra.*

65. 20 C.F.R. § 405.310(a) (1975); *see* 42 U.S.C. § 1395d (1970).

66. *See* 42 U.S.C. § 1395d(a)(3) (1970); 20 C.F.R. § 405.131(c) (1975).

67. SOCIAL SECURITY ADMINISTRATION, DEP'T OF HEALTH, EDUCATION AND WELFARE, HEALTH INSURANCE FOR THE AGED, HOME HEALTH AGENCY MANUAL § 208.4, at 16c (May 1968 revisions) [hereinafter cited as HOME HEALTH AGENCY MANUAL]. To receive benefits under Part A, the patient must also meet the 3 day prior hospitalization requirement. 42 U.S.C. § 1396x(n) (1970), *as amended,* (Supp. III, 1973); 20 C.F.R. § 405.131(c) (1975).

68. HOME HEALTH AGENCY MANUAL, *supra* note 67, § 208.4, at 16c.

guidelines regarding coverage is illustrated by the fact that "a beneficiary who is . . . senile and, therefore, requires the assistance of another person in leaving his place of residence"[69] is considered to be confined to his home, while "[t]he aged person who does not often travel from his home because of feebleness and insecurity brought on by advanced age" is not.[70] Thus, many older persons who, as a practical matter, are confined to their homes, are denied Medicare assistance for supportive and medical services in the home because they do not meet narrow and technical regulatory definitions.

The most important limitation on the availability of Medicare home health care, however, results from the restriction of coverage to services requiring a high degree of skill, such as nursing care and therapy of a type normally received in an institution, rather than general supportive care.[71] Examples of cases where reimbursement has been denied warrant the conclusions that every individual task performed by a visiting nurse must involve some skilled procedure and that she is not free to exercise her professional judgment as to what type of care is necessary for each patient.[72] The determination as to which services are reimbursable is made retroactively by nonmedical Social Security Administration personnel,[73] and any service which is considered to be general supportive care, personal care, or activities of daily living will not be covered.[74] In effect, the patient will receive much greater coverage if he enters a hospital or nursing home, rather than attempting to remain at home. This conclusion is reaffirmed by an examination of the regulations pertaining to services furnished by a home health aide, another major component of home health care covered by Medicare.[75] The home health aide must be closely supervised by a physician or

69. *Id.* at 16d.
70. *Id.*
71. *See* 20 C.F.R. §§ 405.236 to -.237, -.310 (1975).
72. Letter from Mrs. Helen L. Goodwin, R.N., Executive Director, the Greater Lansing Visiting Nurse Association, to Mr. Charles E. Chamberlain, Jan. 27, 1972, in SENATE SPECIAL COMMITTEE ON AGING, 92D CONG., 2D SESS., HOME HEALTH SERVICES IN THE UNITED STATES 130-32 (Comm. Print 1972) [hereinafter cited as HOME HEALTH SERVICES].
73. 42 U.S.C. §§ 1395f-1395g (1970), *as amended*, (Supp. III, 1973).
74. 20 C.F.R. §§ 405.237, -.310 (1975); *see* HOME HEALTH SERVICES, *supra* note 72, at 130-32.
75. HOME HEALTH AGENCY MANUAL, *supra* note 67, § 205.4, at 16. These regulations apply only to services provided under the Medicare program. Under Medicaid, a home health aide is defined as "an individual assigned to give personal care services to a patient in accordance with the plan of treatment outlined for the patient by the attending physician and the home health agency which assigns a professional registered nurse to provide continuing supervision of the aide on her assignment." 45 C.F.R. § 249.10(b)(7)(iv) (1974). There is no further amplification of this definition; however, since personal care services in the home are potentially available as a separate service under Medicaid, it is likely that the function of a home health aide under Medicaid was intended to be similar to that under Medicare.

registered nurse, who must set out specifically the tasks to be performed.[76] These tasks may include personal or supportive care, but only if they are

> *incidental* and do not *substantially* increase the time spent by the home health aide. . . . Housekeeping services which would *materially* increase the amount of time required to be spent by the home health aide to make the visit above the amount of time necessitated by care for the patient are not reimbursable.[77]

It is highly unlikely that anything beyond the barest minimum of supportive services will be provided where every additional task must be approved by a supervising nurse and a fiscal intermediary before any reimbursement is received for services already performed.[78] This is particularly true where the reimbursement hinges on such ambiguous regulatory terms as "incidental," "substantially," and "materially."

Preventive medical care and home health services are also very limited under Medicaid. Only half the states have elected to include any routine examinations or other types of preventive care in their Medicaid plans.[79] Additionally, the availability of medical and supportive care in the home under Medicaid varies according to each state plan. Under the federal regulations, a distinction is made between home health care and personal care[80] and unlike Medicare, both services may be available under Medicaid if a state elects to cover both under its plan.[81] Home health care under Medicaid consists of intermittent nursing care, home health aide services, and medical appliances. These services are defined in the regulations in a similar manner as their counterparts under Medicare,[82] and are similarly designed to provide the patient with skilled medical care rather than general supportive care. Personal care services are not defined in either the federal statute or the accompanying regulations.[83] It appears, however, that this provision was intended to include assistance with the nonmedical needs of daily living, such as

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76. HOME HEALTH AGENCY MANUAL, *supra* note 67, § 205.4, at 16.
77. *Id.* (emphasis added).
78. The uncertainty as to which specific services would be reimbursable is probably responsible in part for the underutilization of the home health services component of both Medicare and Medicaid and helps to account for the fact that relatively few expenditures have been made under these provisions.
In 1971, $50 million was expended for home health services under Medicare, as compared with $4.5 billion for hospital care. SOCIAL SECURITY ADMINISTRATION, DEP'T OF HEALTH, EDUCATION AND WELFARE, vol. 35, No. 2, SOCIAL SECURITY BULLETIN (February, 1972).
In January 1974, out of approximately $862 million spent under title XIX, only $2,609,943, or about 3 percent, was allocated to home health services. *See* SOCIAL AND REHABILITATION SERVICE, DEP'T OF HEALTH, EDUCATION AND WELFARE, MEDICAL ASSISTANCE (MEDICAID) FINANCED UNDER TITLE XIX OF THE SOCIAL SECURITY ACT (January, 1974).
79. *See* STATE MEDICAL ASSISTANCE PROGRAMS, *supra* note 29.
80. *Compare* 45 C.F.R. § 249.10(b)(7) (1974), *with id.* § 249.10(b)(17)(vi).
81. *Id.* §§ 249.10(b)(7), (17)(vi).
82. *Compare id.* § 249.10(b)(7), *with* 20 C.F.R. § 405.236 (1975).
83. *See* 42 U.S.C. § 1396d (1970), *as amended,* (Supp. III, 1973); 45 C.F.R. § 249.10(b)(17)(vi) (1974).

would be provided in a hospital or nursing home.[84] Only seven states have included this component in their Medicaid plans, however.[85] Thus, in the vast majority of the states, only home health care services will be available, and while they do not suffer from the same durational limits as under Medicare, they are nevertheless limited to skilled medical procedures rather than general supportive care.

The present Medicare and Medicaid programs are clearly oriented towards skilled medical care in an institutional setting, rather than at a combination of medical and supportive care in the home. Yet only about 5 percent of the elderly are presently institutionalized, and it has been estimated that from 10 to 50 percent of those that are in institutions are unnecessarily placed there simply because of the lack of alternative types of care.[86] Lesser forms of custodial care either do not exist or, more commonly, the patient cannot afford them because they are not covered by Medicare or Medicaid.[87] Of the remaining 95 percent of the elderly population who are not institutionalized, a minimum of 75 percent suffer at least one chronic condition and some 20 percent experience some limitation on activity as a result of that condition.[88] Because of its inappropriate emphasis on institutional care, therefore, the present health care system has clearly failed to meet the primary health needs of the elderly. The consequences of this bias are doubly unfortunate in

84. This is suggested inferentially both by the recognition of personal care services as a separate component of Medicaid services, 45 C.F.R. § 249.10(b)(17)(vi) (1974), and by the brief description of covered services in, for example, New Hampshire and Indiana. STATE MEDICAL ASSISTANCE PROGRAMS, *supra* note 29, at 97, 219.

85. Illinois, Indiana, Minnesota, Nebraska, Nevada, New Hampshire, and Oklahoma. *See* STATE MEDICAL ASSISTANCE PROGRAMS, *supra* note 29, at 90, 97, 165, 196, 205, 212, 270.

86. *See* SENATE SPECIAL COMMITTEE ON AGING, 92D CONG., 1ST SESS., ALTERNATIVES TO NURSING HOME CARE: A PROPOSAL 2 (Comm. Print 1971) [hereinafter cited as ALTERNATIVES TO NURSING HOME CARE] (25 to 50 percent are inappropriately placed); *1973 Hearings, supra* note 37, pt. 1, at 17 (10 percent of New York's nursing home population are placed there because of lack of home care).

In a study of the welfare elderly in Massachusetts nursing homes it was determined that 14 percent needed no institutional care for medical conditions; 26 percent required minimally supervised living; 23 percent needed periodic nursing care that might be provided at home. Only 37 percent required full-time skilled nursing care. ALTERNATIVES TO NURSING HOME CARE, *supra* at 13-14.

87. The availability of home health agency services has actually declined in recent years due largely to the failure of Medicare and Medicaid to cover this type of care. *See* HOME HEALTH SERVICES, *supra* note 72, at 26-27.

88. This statistic varies, depending on the definition given to key words such as "chronic condition" and "limitation on mobility." According to the Administration on Aging, 85 percent of the elderly have chronic conditions and 20 percent have a physical condition which interferes with mobility. ADMINISTRATION ON AGING, DEP'T OF HEALTH, EDUCATION AND WELFARE, NEW FACTS ABOUT OLDER AMERICANS (June, 1973) [hereinafter cited as NEW FACTS]. Older estimates place those figures as high as 80 percent and as low as 18 percent. *See* HOME HEALTH SERVICES, supra note 72, at 3.

According to a 1970 Public Health survey, 42 percent of the elderly suffer some limitation on activity due to a chronic condition. PUBLIC HEALTH SERVICE, DEP'T OF HEALTH, EDUCATION AND WELFARE, VITAL AND HEALTH STATISTICS, DATA FROM THE NAT'L HEALTH SURVEY, ser. 10, No. 80, LIMITATION OF ACTIVITY DUE TO CHRONIC CONDITIONS—UNITED STATES, 1969 and 1970, 5 (April, 1973) [hereinafter cited as NATIONAL HEALTH SURVEY].

light of the individual's general preference to lead an independent life in his own home. Additionally, once he is in a nursing home he is bombarded with unnecessary supportive services which cause him to become increasingly dependent and incapable of returning to his former lifestyle.[89] The older person in this intermediate state of health—not too sick, but not really well—is faced with rather grim alternatives. As one report to the Senate Special Committee on Aging expressed it, "We offer the disabled, the chronically ill of all ages but especially in our aging population one of two choices: helpless isolation 'at home' or the sterility of an institution."[90]

The older person suffering from a disabling chronic condition, who can neither care for himself nor afford to hire anyone to assist him, is often forced to enter an institution simply because he has no other choice.[91] In New York City, for example, one of the two major reasons for nursing home placement was simply the diminished ability to walk.[92] In many cases, the certifying physician will exaggerate his patient's condition in order to obtain reimbursable care in an SNF, knowing that the only alternative would be to discharge the patient to live alone with no assistance.[93] In this type of situation, the availability of relatively unskilled personnel to provide general supportive care—to assist in shopping, cleaning, cooking, personal care of the patient, and other chores—would enable the individual to live at home and would save the government the high cost of nursing home care.[94]

A similar problem arises as a result of the failure to provide for adequate preventive medical care. The elderly who cannot afford to pay

89. *1973 Hearings, supra* note 37, pt. 1, at 9 (statement of Alice M. Brophy, Director, Office for the Aging, New York City); HOME HEALTH SERVICES, *supra* note 72, at 3, 21. *See also* Gaynes, *A Logic to Long-Term Care*, THE GERONTOLOGIST, Autumn 1973, at 279.

90. HOME HEALTH SERVICES, *supra* note 72, at 2.

91. The restricted range of alternatives allowed by the Medicare regulations was often severely criticized during Senate hearings. *See, e.g., 1973 Hearings, supra* note 37, pt. 1, at 12-13, 16-17 (statement of Marjorie H. Cantor, Director of Research, New York City Office for the Aging); *id.* at 22 (statement of Leslie S. Libow, M.D., F.A.C.P., Chief of Geriatric Medicine, Mt. Sinai Hospital, New York); *id.* at 153-56 (statement of Professor Charlotte Muller, Center for Social Research, Graduate School, City University of New York).

92. *Id.* at 22 (statement of Leslie S. Libow, M.D., F.A.C.P., Chief of Geriatric Medicine, Mt. Sinai Hospital, New York).

93. See text & note 86 *supra*.

94. *1973 Hearings, supra* note 37, pt. 4, at 324 (statement of Edith Heide, R.N., Assistant Chief, Division of Nursing, Illinois Department of Public Health).

The results of a study of nursing homes located in Tucson, Arizona, gives an idea of the cost involved. Of the 15 homes that were willing to disclose information about their charges, only two based their rates on the patient's ability to pay. The rates of the remaining 13 homes ranged from $14-$20 per day, with an average just over $15 per day. M. House, Pima County Nursing Homes: A Less Drastic Means? (undated) (unpublished paper on file in the *Arizona Law Review* office). If reimbursement were available for nonmedical assistance in the patient's home, a patient could receive 3 hours of assistance per day, and at the minimum wage the government would still be paying less than half the current cost of nursing home care.

for such services themselves are often obliged to neglect their health until it deteriorates to the point where they must be institutionalized.[95] The same result occurs where those individuals are discharged from a hospital or nursing home, still needing general supportive care at home, but unable to pay for such assistance themselves. Again, the aged poor are forced to forego needed care until they are sick enough to be reinstitutionalized.[96]

The present Medicare and Medicaid programs clearly fail to provide the type and degree of coverage actually needed by the elderly. The resulting cost to the individual, both in economic terms and in loss of personal independence, may be illustrated by considering two health problems commonly experienced by the elderly—stroke and congestive heart failure[97] —and examining the manner in which these problems are dealt with under Medicare and Medicaid.

The exact occurrence of strokes cannot be predicted,[98] but a stroke is usually preceded by arteriosclerosis and high blood pressure, which can be detected in a routine examination and treated by medication and diet. Medicare does not cover such routine examinations under either Part A or B, nor does it cover the cost of any necessary medication.[99] Routine examinations are provided for the categorically needy under 39 state Medicaid plans, and this service is also extended to the medically needy in 19 of those states.[100] The extent of coverage for prescription drugs varies widely from state to state. Only 11 states cover both routine examinations and unlimited drug supplies.[101] While provision for such coverage would not eliminate the occurrence of strokes altogether, early treatment of related conditions might well prevent some or at least minmize their effects.

After a stroke occurs, most, if not all, of the initial hospitalization costs will be covered under Medicare, Medicaid, or a combination of the two.[102] Although the services of physicians are generally not covered under Medicare Part A,[103] the patient will be reimbursed if he has

95. ALTERNATIVES TO NURSING HOME CARE, *supra* note 86, at 2.

96. The paradox is that our programs are designed to pay too little to keep such persons at home (a national average of $77.60 per month under Old Age Assistance), but will readily pay an average of perhaps $400-$500 a month to keep the same person in an institution.
ALTERNATIVES TO NURSING HOME CARE, *supra* note 86, at 5.

97. The medical background for these examples was obtained in an interview with Dr. Martin Meyerson, M.D., resident in radiology and oncology, University of Arizona Medical Center, in Tucson, Ariz., Dec. 1, 1974.

98. Stroke is the third most common cause of death of older persons, accounting for 14 percent of the total number of deaths. NEW FACTS, *supra* note 88.

99. See text & note 34 *supra.*

100. STATE MEDICAL ASSISTANCE PROGRAMS, *supra* note 29.

101. *Id.*

102. See text & notes 10-12 *supra.*

103. See text & note 13 *supra.*

enrolled in the Part B supplemental medical insurance program or if he is eligible for Medicaid.[104] Therefore, if the patient is covered by both Medicare and Medicaid the bulk of his hospitalization costs will be met by those programs.[105] Assuming stabilization of the patient's condition, he will likely be transferred to an SNF to continue his convalescence. The nursing staff will continue to observe his condition, provide any medication that cannot be self-administered, and generally care for the patient's needs. The patient will also begin therapy to regain his speech, mobility, and motor skills, where possible. The length of the patient's stay depends upon how quickly he recuperates from the debilitating effects of the stroke.[106] Assuming that the patient must remain in the nursing home for 180 days and is charged at a rate of $400 per month,[107] he will be fully covered in all but eight states if he is categorically needy and eligible for both Medicare and Medicaid.[108] Absent any of those factors, his expenses will total anywhere from about $100 to $2400, depending on which state he lives in and which programs, if any, will provide assistance.[109]

104. In stroke cases, the purpose of the hospital stay is to stabilize the patient's condition. If the patient's stroke was not totally disabling, nor beset by any complications, his need for hospitalization should terminate well within 60 days. Interview with Dr. Martin Meyerson, *supra* note 97. If the patient is eligible for Medicare Part A, his entire hospital bill should then be covered after the initial $84 deductible. This presupposes, however, that the hospital's charges are "reasonable;" if they are not within the government's definition of that term, the patient will have to pay the excess. If the patient is also eligible for Medicaid, those funds will cover the $84 Medicare deductible. In 25 states, this will be the case only if the patient is "categorically needy." STATE MEDICAL ASSISTANCE PROGRAMS, *supra* note 29. If the patient is not covered under Medicare, but is eligible for Medicaid, his hospital bill will be fully covered in most states. *Id.* Again, coverage extends only to the categorically needy in half of the states. Eleven states limit the number of hospital days covered to less than 60; two provide unlimited coverage for the categorically needy, but limit the protection of the medically needy. *Id.*

105. If the patient is covered under both parts of Medicare, but not Medicaid, he must pay the $84 deductible, the $60 Part B deductible, and 20 percent of the physician's fee and other items not covered under Part A, but covered under Part B. *See* text & notes 10, 29-30 *supra.* If he is eligible for only Medicaid, he will be covered if he is categorically needy. If he is only medically needy, he will have no coverage at all in 25 states. STATE MEDICAL ASSISTANCE PROGRAMS, *supra* note 29.

106. Interview with Dr. Martin Meyerson, *supra* note 97.

107. One survey has estimated the average charge to be $600 per month. *See* PUBLIC HEALTH SERVICE, U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, Vol. 23, No. 6 Supp., MONTHLY VITAL STATISTICS REPORT (Sept. 5, 1974).

108. *See* STATE MEDICAL ASSISTANCE PROGRAMS, *supra* note 29; text & notes 14-19 *supra.*

109. Those eligible for Medicare Part A benefits are covered for 100 days in an SNF, but must pay $10.50 per day coinsurance after the first 20 days. Many services are covered, including the various types of therapy. Medicare Part B provides no additional assistance for these services.

Under Medicaid, coverage varies from state to state. In 18 states, a patient's expenses are fully covered without limit, up to the "reasonable" cost of care or a rate negotiated between the state and the facility. STATE MEDICAL ASSISTANCE PROGRAMS, *supra* note 29. Six states cover both the categorically needy and the medically needy, but place a limit on the number of days covered or the maximum daily or monthly rate which the state will pay. *Id.* Of the 25 states which cover only the categorically needy, 15 provide unlimited coverage, and 10 place restrictions on the number of days covered or the maximum rate of payment. *Id.*

Assuming that the patient must stay in the nursing home 180 days at a rate of $400

The patient's greatest problems arise when he has recovered to the point where he no longer needs skilled nursing care. Often a stroke victim is left with some permanent loss of mobility and other handicaps. He may be able to speak, if at all, only with great difficulty. His general physical condition may be greatly weakened as a result of the stroke, perhaps in combination with preexisting chronic conditions such as arthritis, emphysema, or congestive heart failure. While he may regain his health to the extent that constant medical observation is not required, he may not have returned to the state of health he enjoyed before the stroke.[110] At this point the elderly stroke victim is in a difficult position. While he is no longer eligible for SNF coverage, he is hardly in a position to assume complete responsibility for his own care. Beyond this point, Medicare provides very little assistance,[111] although the patient who is eligible for Medicaid will continue to receive help, particularly if he is categorically needy. In most states, Medicaid coverage is provided for treatment in what is termed an intermediate care facility [ICF].[112] This is defined as an institution which provides health related care and services to individuals who do not require the degree of care and

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per month, the cost to him will break down as follows:

a) If he is categorically needy and covered by both Medicare and Medicaid, he will be fully covered in all of the states having Medicaid plans. *See* STATE MEDICAL ASSISTANCE PROGRAMS, *supra* note 29; text & notes 14-18 *supra.*

b) If the patient is covered by Medicare, but is not categorically needy, he may nevertheless be eligible for Medicaid if he is medically needy. If he resides in one of the 25 states that do not include the medically needy in their state plans, however, his bill for 180 days in a nursing home will be approximately $1900. Medicare covers the first 20 days fully. The patient must pay $10.50 per day for the next 80 days; he must then pay the full rate of approximately $13.30 per day for the remaining 80 days. Of the states which do cover the medically needy, all but four states provide full coverage. Those four states limit coverage so that the patient will pay between about $164 and perhaps as much as $1900. STATE MEDICAL ASSISTANCE PROGRAMS, *supra* note 29.

c) If the patient is ineligible for Medicare, but is categorically needy, he will still receive full coverage in all but nine Medicaid states. In those nine states, the patient will pay between $200 and $1000. *Id.*

d) If the patient is ineligible for Medicare but is medically needy, he will be fully covered in 20 states. In four states he will have to pay between approximately $350 and $2000, and in 25 states he will have no coverage at all. *Id.*

e) If the patient is eligible for Medicare, but ineligible for Medicaid, he will incur costs of approximately $1900. Medicare coverage extends for 100 days. The first 20 days are fully covered. During the next 80 days, the patient must pay $10.50 per day. There will be no coverage for the patient's remaining 80 days. See text & notes 14-19 *supra.*

110. Interview with Dr. Martin Meyerson, *supra* note 97.

111. *See* text and notes 120-21 *infra.*

112. Federal funding of state assistance to the aged, blind, and disabled, in the form of institutional services in intermediate care facilities [ICF] was originally provided under title XI of the Social Security Act. *See* Act of Jan. 2, 1968, Pub. L. 90-248, Title II, § 250(a), 81 Stat. 920 (repealed 1971). In 1971, this provision was placed under Title XIX (Medicaid), 42 U.S.C. § 1396d(c) (1970), *as amended,* (Supp. III, 1973), in order to make this benefit available to the medically needy and to discourage improper and costly placement of patients in SNF's. Forty-four states had intermediate care facility assistance programs under the old law. These have been approved for Medicaid funds pending the issuance of new regulations governing ICF's under Medicaid. For a general discussion of the law pertaining to ICF's, see SOCIAL SECURITY, MEDICARE AND MEDICAID EXPLAINED, *supra* note 10, ¶ 755.61, at 389; Brown, *An Appraisal of the Nursing Home Enforcement Process,* 17 ARIZ. L. REV. 304, 306-07 (1975).

treatment which a hospital or SNF is designed to provide, but who, because of their mental or physical condition, require care and services above the level of room and board which can be made available to them only through institutional facilities.[113] An ICF may be a separate facility or a distinct part of a hospital or SNF.[114] The extent of coverage for an ICF varies from state to state, but the medically needy will be eligible for such care in many states.[115] Additionally, the Medicaid patient will be eligible for various home health services, including intermittent nursing care, home health aide services, and medical appliances.[116] These services are generally defined to include only skilled medical procedures, as under Medicare, but the great majority of states do not place limitations on the extent to which these services are available.[117] In a majority of states, Medicaid also covers the services of physical, speech, and occupational therapists.[118] Forty-two states provide coverage for prescription drugs, although there are various limitations on type, cost, and number of refills.[119] The cost of personal care in the home is paid for in only seven states.[120]

Unfortunately, the patient who is not eligible for Medicaid will receive little assistance beyond care in the hospital or SNF. Medicare contains no provision for coverage in an ICF, and its home health care provision is inadequate in terms of scope and duration of coverage. As previously noted,[121] Medicare home health services do not include transportation, drugs, or what may generally be considered assistance with daily needs unrelated to health care. Further, to be eligible for any home health care, the patient must be essentially confined to his home and require skilled care from a nurse, home health aide, therapist, or social worker.[122] No provision is made for those whose illnesses are less severe and yet who may need supportive care in order to return to full health or to avoid being reinstitutionalized. Thus, as soon as the Medicare patient no longer needs skilled nursing care in an SNF, he must return to his own home, often to live either by himself or with a spouse who may be equally frail. While some may be cared for by younger members of their family, many do not have relatives who are able and willing to take on the responsibility. The patient must cope with fixing meals, taking care

113. 42 U.S.C. § 1396d(c) (1970), *as amended*, (Supp. III, 1973).
114. 45 C.F.R. § 249.10(b)(15) (1974).
115. STATE MEDICAL ASSISTANCE PROGRAMS, *supra* note 29.
116. *Id.*
117. *Id.*
118. *Id.* Forty-three state programs cover physical therapists, 37 cover speech therapy, 35 cover occupational therapy. Only about half the states include the medically needy in these plans. *Id.*
119. *Id.*
120. *Id.*
121. *See* text & notes 24-25 *supra.*
122. *See* text & notes 67-78 *supra.*

of personal needs, cleaning house, running errands, administering medication and treatment that does not qualify for home health care coverage, and obtaining medical assistance where necessary.

Financial problems also plague the individual who no longer requires institutionalization since the cost of care shifts increasingly to the patient, at a time when he can usually least afford it. If he is covered by both Medicare and Medicaid, his medical care for this particular illness will be reasonably thorough and the cost to him will be minimal.[123] If he is ineligible for either program, however, he will either have to assume the cost of certain medical care[124] or do without it. A far more serious problem involves the type of care not furnished under either program, that is, care designed to assist the patient with the daily needs of living so that he is able to maintain the optimum state of health and to avoid reinstitutionalization. The patient must bear the entire cost of hiring persons to assist him with cooking, cleaning, nonmedical personal care,[125] shopping, and other necessary chores which he may be unable to perform by himself. These additional expenses come at a time when his income is at the same level it was before his illness, or possibly reduced if he is unable to continue employment. At the same time, he must also pay the cost of hospital, nursing home, and home health care services not paid for by Medicare or Medicaid. The elderly patient of limited means may often be forced to do without medical and supportive care necessary to maintain his health and prevent institutionalization.

Many of the problems faced by the stroke victim are shared by persons suffering from chronic illnesses which do not require hospitalization. Such illnesses are another health problem common to the elderly for which there is inadequate provision under Medicare and Medicaid. As previously noted,[126] three out of four elderly persons suffer from chronic conditions that are serious enough to limit normal activity but which do not generally require hospitalization. Among the more common of these conditions is congestive heart failure,[127] a general insufficiency of the heart brought on by such problems as coronary artery disease. The exact causes are not known, but poor diet, smoking, lack of

123. *See* text & notes 105-08 *supra.*

124. For example, if he is ineligible for Medicaid, he will have to pay the coinsurance fee after 20 days in a nursing home, plus the full cost of nursing home care after the first 100 days. See text & notes 14-19 *supra.*

125. This is not true, however, in those seven states that include personal care services under their Medicaid plans. *See* STATE MEDICAL ASSISTANCE PROGRAMS, *supra* note 29.

126. See text & note 88 *supra.*

127. Heart disease is the leading cause of death among the elderly. It is the second leading cause of activity limitation due to chronic conditions. NEW FACTS, *supra* note 88; NATIONAL HEALTH SURVEY, *supra* note 88, at 5.

exercise, and the aging process in general are probably important contributing factors.[128] The initial effects of congestive heart failure are shortness of breath and easy fatigue, which in turn force the victim to curtail his activity increasingly as the disease progresses.[129] Daily activities—climbing stairs, lifting packages, doing housework—become increasingly difficult, and the more the person exerts himself, the worse the strain on his heart. Left untreated, congestive heart failure will most likely result in pulmonary edema,[130] which requires hospitalization. Because the patient's system is generally weakened by the condition, he is also much more susceptible to heart attacks, strokes, and pneumonia. Although congestive heart failure cannot be cured, remedial steps—including medication and diet control—can be taken to arrest its development.[131]

Again, Medicare's emphasis is on care for those persons sufficiently ill to require hospitalization, and its failure to provide preventive care which will avoid or delay hospitalization, such as routine medical examinations, results in the complete absence of a health service which is essential to the elderly. While Part B supplemental insurance covers the services of a physician, routine medical checkups are specifically excluded.[132] Even under Medicaid, only 10 states pay for routine examinations for both the categorically and medically needy, with an additional 20 states covering only the categorically needy.[133] Medicare does not cover the cost of drugs when the patient is not institutionalized, and state coverage under Medicaid varies widely.[134]

Left untreated, the patient's condition will worsen and his general health will decline. His situation is similar to that of the victim of an acute illness who returns to his home in a partially disabled condition; his mobility is restricted and daily chores become increasingly difficult. Such routine tasks as shopping, fixing meals, laundering, cleaning house, and bathing become more physically taxing or impossible. Since the older person of limited means is usually unable to hire someone to help care for his needs, his physical condition forces him to do less for himself. Thus, without some supportive care the older person suffering from a disabling chronic condition may undergo such a general physical and mental decline, as a result of inadequate medical care, nutritional deficiencies, and inattention to sanitary needs, that he will ultimately

128. Interview with Dr. Martin Meyerson, *supra* note 97.
129. *Id.*
130. Pulmonary edema is a condition where the lungs fill with fluid. *Id.*
131. A physician will generally prescribe digitalis and diuretics, and the patient will be advised to lose excess weight and restrict his intake of salt. Naturally, early diagnosis and care gives a better chance of successful treatment. *Id.*
132. 42 U.S.C. § 1395y(a)(7) (1970).
133. STATE MEDICAL ASSISTANCE PROGRAMS, *supra* note 29.
134. *Id.*

have to be institutionalized.[135] His health may deteriorate to the point where he must be hospitalized, or he may be so weakened that he may fall and be injured. Hospitalization may also be required when a confused and unassisted older person fails to take proper doses of medication.[136]

These examples underline the failure of the current Medicare and Medicaid programs to meet the actual needs of the persons they are supposed to serve. Both programs concentrate on short term institutional care. Although the elderly require economic assistance when a catastrophic illness occurs, their greatest need is for a health care system which aims at preventing illness or minimizing its consequences, and avoiding unnecessary institutionalization. The focus of the government aid programs, therefore, should be directed toward long term health maintenance so that the elderly may continue to lead productive lives without the fear that they will lose their health simply because they cannot afford the cost of health maintenance services.

PROPOSED CHANGES IN HEALTH CARE FOR THE ELDERLY

Any changes in the present health care system must start, at a minimum, with amendments to the Medicare law providing a broader range of health care coverage. Many basic services which are presently available only to the very poor under Medicaid should be available to all elderly persons under Medicare. This would include routine examinations, prescription drugs, glasses, hearing aids, dentures, and orthopedic shoes.[137] Above all, the home health services provision should be amended to include less sophisticated but equally necessary forms of care.[138] This could be accomplished by expanding coverage to include all services which a doctor or supervising nurse determines to be necessary for the welfare of the patient, even such nonmedical care as homemaker services and meals-on-wheels.

As important as such amendments are, however, more fundamental changes must be made if the health care needs of the elderly are to be

135. Many examples of the effects of neglected health care may be found in *Hearings Before the Subcomm. on Health of the Elderly of the Special Comm. on Aging*, 93d Cong., 2d Sess., pt. 13, at 1285-88 (1974) [hereinafter cited as *1974 Hearings*].

136. *Id.*, at 1289.

137. Such changes have repeatedly been proposed in Congress, but without result. In 1973, for example, 14 bills were introduced into the House of Representatives to amend Medicare to cover eyeglasses; 7 were introduced providing coverage for hearing aids; and 32 were introduced regarding coverage of prescription drugs. All were sent to the Ways and Means Committee and none were acted upon. *See* 1 CCH 1973-74 CONG. INDEX, 93D CONG. 261 (index heading on Medicare).

138. Recent Medicare amendments authorize funds for experimental projects to determine the need for and the benefits of expanded home health services. *See* 42 U.S.C. § 1395b-1 (Supp. II, 1972), *as amended*, (Supp. III, 1973).

met. The present programs must be reorganized into a unified, comprehensive, and coordinated system of health care services. The first step should be to combine all federal health care assistance under one program.[139] This would not only eliminate the waste caused by duplication but also ease the burden on older people by allowing them to deal with a single government agency.[140]

The current existence of many diverse programs makes the establishment of a comprehensive health care system a practical impossibility. Rather than concentrating on a single program which provides a broad spectrum of assistance, the federal government has dissipated its funds and its energies in the present uncoordinated and overlapping maze of programs. A total health care assistance plan is needed, and the logical vehicle for such a plan is a vastly overhauled Medicare law.[141] Medicare is currently the only national program of assistance in this area and could continue to function as such on a more expanded scale, both in terms of eligibility and coverage.[142]

If Medicare is to succeed in redirecting its focus upon health maintenance for the elderly, however, it will not be sufficient merely to increase the number of services provided and the persons covered. The government must take the initiative in bringing these services to the elderly in order to ensure that the goals of preventive care and early treatment of disease are achieved. This need could be met through the development of a health care system that has as its focal point local

139. Several of the proposals for a national health insurance program which have been introduced into Congress move in this direction, especially the Griffiths-Kennedy Health Security Act, S. 3286, 93d Cong., 2d Sess. (1974). Even this supposedly comprehensive plan, however, would not abolish Medicaid, nor does it combine the various medical services found under other laws into one administrative body. *See* SOCIAL SECURITY ADMINISTRATION, DEP'T OF HEALTH, EDUCATION AND WELFARE, NATIONAL HEALTH INSURANCE PROPOSALS (1974).

140. Consolidation would, of course, mean the termination of federal funds for state assistance and service programs. All 50 states have such programs, funded under Medicaid, the Older Americans Act, Title VI of the Social Security Act, and the federal revenue sharing program. 42 U.S.C. § 1396-1396i (1970), *as amended*, (Supp. III, 1973), 42 U.S.C.A. § 1396a(a) (1974); 42 U.S.C. §§ 3001-3045i (1970), *as amended*, (Supp. III, 1973); 42 U.S.C. §§ 801-805 (Supp. III, 1973); 31 U.S.C. §§ 1221-1264 (Supp. II, 1972), *as amended*, (Supp. III, 1973), 42 U.S.C.A. § 1264 (Supp. 1975).

Diverse programs are supported by these federal funds, and the degree of assistance to the elderly varies from state to state. Under the Older Americans Act, matching funds are available to the states to develop a comprehensive system for delivering social services to the elderly, 42 U.S.C. § 3023(a) (Supp. III, 1973). Federal assistance is also available for the development of nutrition programs and multi-purpose senior centers. *Id.* §§ 3041-3041f, 3045-3045i. The effectiveness of this law, however, depends on the initiative of the individual states. If they are not willing to undertake the development of comprehensive service programs, the elderly will receive no benefit from the available federal funds. The same criticism is applicable to the federal revenue sharing program. The federal funds distributed to state and local governments under this program may be used for many different purposes, only one of which is health care for the elderly. There is, therefore, no guarantee of assistance.

141. This is true unless Congress approves a national health insurance program for all citizens. In that event, Medicare might well be abolished and its provisions and organization incorporated into a new and more expanded health care system.

142. See text & notes 137-38 *supra*.

organizations having close ties with hospitals, nursing homes, medical and nonmedical personnel, whose purpose would be to provide each individual with the services appropriate to his needs.[143] Such community or county organizations would have three basic functions. First, they would develop outreach or case-finding programs designed to make contact with the elderly and bring them into the ambit of the organization. Second, they would periodically assess each individual's condition in order to determine what medical and supportive services are required. Third, they would make the arrangements necessary to ensure that each individual receives those services appropriate to his needs.

There are several types of organizations in existence which could perform this role of intermediary between the individual and the health care system, such as home health agencies and visiting nurse associations. These organizations currently provide nursing care and other health-related services, such as therapy, medical-social services, or home health aides.[144] Under Medicare, they are authorized as providers of home health services,[145] but the services for which they may receive reimbursement are limited largely to skilled medical care.[146] Medicare does not cover the cost of case-finding, referral services, or other assistance that is not strictly medical.[147] For this reason, the agencies have often been forced by the economics of the situation to limit the services they offer to those reimbursable under Medicare.[148] Amendment of the existing law would allow these agencies to function to their full capacity, performing case-finding, administrative, and referral duties as well as purely medical skills.

The central role in a comprehensive health care system might also be performed by health maintenance organizations [HMO's]. HMO's are large group practices, generally associated with a hospital, SNF, or laboratory, which provide a full range of health services to enrollees on a per capita prepayment basis. These organizations provide efficient, eco-

143. An example of such an organization is the Minneapolis Age and Opportunity Center, whose history and operations are detailed in *1974 Hearings, supra* note 135, at 1254-310. In its report to the Special Committee on Aging, the Levinson Gerontological Policy Institute proposed a different approach. Instead of encouraging the development of a unified, comprehensive system of services, they recommended the development of a separate system of personal care organizations whose nonmedical supportive services would be available to, but not a component part of, the general health care system. There is an implied assumption in this report that if the two types of care were combined into one system, the medical personnel in charge would always choose the more expensive and sophisticated forms of care. *See* ALTERNATIVES TO NURSING HOME CARE, *supra* note 86, at 10.

144. For a description on the history, organization, and operations of these home health care organizations, see HOME HEALTH SERVICES, *supra* note 72, at 1-36.

145. 20 C.F.R. § 405.1201 (1975).

146. See text & notes 71-78 *supra*.

147. *See* 20 C.F.R. § 405.237 (1975).

148. HOME HEALTH SERVICES, *supra* note 72, at 13.

nomical delivery of services.[149] If the HMO included a home health services component or had a working relationship with a local home health agency, it would be in the best position to provide the elderly with a complete health care system.[150]

A final consideration in any proposed reorganization of medical assistance programs for the elderly is the cost. It may be argued that the cost of providing an expanded range of services to a greater number of people would be far higher than the cost of programs currently available. This is probably not the case, however. The cost of providing supportive home care can only be estimated, but to a large extent its funding would simply be a matter of reallocating monies from presently existing programs, such as Medicaid, and channeling them into one coordinated system of services. One study has suggested that as much as $500 million could be obtained from payments presently being made for unnecessary institutional care.[151] In addition, the cost sharing provision for the medically needy under Medicaid could be incorporated into Medicare.[152] Under this provision, each individual would be required to contribute to the cost of his care according to his income. Supportive home care and routine checkups would not only reduce the frequency of hospitalization resulting from neglected health problems, it would also shorten those hospital stays which are necessary by making it easier for the patient to return to his own home. The effect this would have on program costs is indicated by the statement of the Department of Health, Education and Welfare that a 1 day reduction in hospital stays of Medicare beneficiaries in 1968 would have reduced costs by $315 million.[153] Costs would also be reduced by substituting less skilled personnel for highly skilled personnel. Home health aides could often be employed instead of nurses, and nurses could be utilized instead of doctors. It should be emphasized that less sophisticated forms of care and less skilled personnel would not be substituted merely to reduce costs; rather, these are the services most elderly people actually require. The purpose of the proposed system would be to make all forms of medical care available, but to utilize only those services which are actually necessary and appropriate in each case.

149. For this reason, Medicare was amended to allow prospective reimbursement to HMO's for approved services. 42 U.S.C. § 1395mm (Supp. II, 1972), *as amended*, (Supp. III, 1973).

150. This is especially true in rural areas where the population is widely scattered and medical facilities and personnel are in short supply.

151. ALTERNATIVES TO NURSING HOME CARE, *supra* note 86, at 8-9. In Massachusetts alone, the report estimated that $40 million was spent in 1 year to support 10,000 persons in nursing homes who were probably capable of living elsewhere. It was estimated that approximately 16,000 persons would use the supportive care services of a personal care organization. This would cost about $30,720,000 per year—still well below the amount estimated to have been overspent on nursing home care. *Id.* at 21.

152. *See* 42 U.S.C. § 1396a(a)(14) (Supp. III, 1973).

153. *See* HOME HEALTH SERVICES, *supra* note 72, at 60.

CONCLUSION

Because of their limited income and the lack of coverage, many elderly persons are forced to neglect their health until they must be institutionalized. This is a tremendous waste, not merely of public funds, but more importantly of human resources. While Medicare and Medicaid furnish much needed assistance once the person is institutionalized, the present programs fail to provide the type of preventive health care and supportive services that are actually needed by the elderly. Those services of this type which are currently provided, are available only to the very poor.

Although the elderly would benefit simply from an expansion of services covered by Medicare, their needs call for much more radical changes in the present law. Federal laws pertaining to health care for the elderly should be reorganized and redirected to provide the elderly with a truly comprehensive and coordinated system of medical and social services designed to enable them to maintain their dignity and independence.