Citizens' Health Care Working Group
Houston, TX
Public Hearing
Tuesday, July 26, 2005

Attendees

Members

Randy Johnson, Chair
Catherine McLaughlin, Vice Chair
Dorothy Bazos
Montye Conlan
Therese Hughes
Rosario Perez
Christine Wright

Staff

George Grob, Executive Director
Andy Rock
Caroline Taplin
Jessica Federer
Rachel Tyree

Randy Johnson, Chair, opened the public hearing at 8:00 a.m.

PRESENTATIONS

Pat Carrier, Regional Director, Christus Healthcare, Houston, welcomed the Working Group.

Hispanic Health Issues

Adela S. Valdez, M.D.
Past Presiding Officer, Health Disparities Task Force
(See Power Point Slide Presentation)

Karl Eschbach, Ph.D.
Associate Professor, Department of Internal Medicine,
Division of Geriatrics, University of Texas
(See Also Power Point Presentation)

My training is as a demographer. The Hispanic population of the United States has grown rapidly: from 1.4 percent of the population in 1940 to 14.1 percent of the population in 2004, 41.3 million persons. In Texas, there are 7.6 million Hispanic individuals in 2003 representing 1/3, 34.2 percent, of the population. The projections are that 22 percent of the population of the

United States will be Hispanic by 2040; and as high as ½ the population of Texas by that time. In Texas, 86 percent of the Hispanic population is of Mexican origin; 1/3 of the total Hispanic population is comprised of immigrants.

In general, Hispanics have lower levels of education. They tend to be concentrated in service work, precision production, crafts, repair, and construction; this has implications for health care coverage.

The "Hispanic paradox," is the finding of low age-specific mortality rates for the Hispanic population of the United States compared to the non-Hispanic white population, despite the socioeconomic disadvantages of Hispanics. Hispanics have lower heart disease and cancer mortality; and birth outcomes are similar to whites. The Hispanic "advantage" is larger for immigrants than it is for natives.

The cause of the mortality advantage is a matter of debate.

- One cause seems to be the better health behaviors of Hispanic populations on average, particularly immigrants, in terms of diet and lower smoking rates. For younger adults, the suicide rate and deaths from drub abuse and sexually transmitted diseases is much lower for Hispanics.
- The other important reason is health selected migration. Healthier people are more likely to move long distances, more likely to cross international borders; people are moving largely for economic reasons, and if they're doing so, people who expect a greater return are more likely to move. Consequently, the people who come to the United States are more likely to be in good health.

As a consequence of these factors, Hispanics do not impose an excessive health care burden because of poor health habits, an extra burden of illness, or a higher use of medical care. However, there are many disadvantages: higher rates of diabetes, hypertension, risks like obesity and low rates of physical activity in leisure time. Nonetheless, there are counterbalancing advantages with respect to this population, which means that the presence of large numbers of immigrant Hispanics is not particularly overburdening the United States health care system overall with respect the health care system needing to provide services for individuals in poor health.

But, the major issue for the Hispanic population is their limited access to health insurance coverage because of their employment concentration in industries and occupations with limited employer-based insurance coverage (the primary means for the provision of health care coverage in the United States) and also because unauthorized immigration status limits accessibility to public programs.

The health implications of lower insurance rates include lower rates of health care utilization, lower screening and immunization, less likelihood of having a regular provider of care, shorter survival time after diagnosis, and a burden to seek health care in informal sectors by crossing the border. For example, many Hispanics get prescriptions in the United States and then have them filled in Mexico.

There are 1.4 million undocumented aliens in Texas. More than 10 percent of the population consists of unauthorized immigrants. Implications include:

- We have a system where a large portion of our labor supply comes from illegal immigration.
- Neither employers nor the Federal or state governments want to take responsibility for paying for their health care.
- Because we have a stable system taking labor without paying for it, we put the burden on local hospital districts and on the immigrants themselves.
- Thirty percent of undocumented households have at least one citizen child, so the burden of lack of health care coverage falls on these children as well.

The border is not the principal destination for immigrants; the towns along the border have large citizen Hispanic populations with low health care coverage; high poverty rates are an extra burden. Borders are areas of special need.

In conclusion: Health care for the Hispanic population in the United States is a growing problem that must be addressed.

Discussion

Randy Johnson – If you were to make a recommendation to the President and the Congress regarding Hispanic health, what would it be?

Valdez – For the best long term investment, I'd recommend providing aid to education to help provide individuals with a solid start. Education is life-changing; it provides raised expectations for the future. The more educated you are, the more likely you are to have health care and a healthy lifestyle. Having seen what education can do, I find that this is the most successful investment.

Catherine McLaughlin – How do you choose the best alternatives among different investments? For example, how can we decide whether to focus energy and money on education or on diabetes/nutrition/health?

Valdez – I recommend funding education as the most fundamental and most valuable long term investment. As far as in what areas of health care, spending is most needed, I'd say tobacco cessation, nutrition, and encouraging physical activity since the latter is especially relevant to diabetes and obesity.

Montye Conlan – I read an article on the link between Hispanic obesity and the shift to wheat flour tortillas.

Valdez – New immigrants have better nutrition; as they become more "Americanized," they definitely change their diets. The dietary changes have been significant; most kids don't even know what a vegetable is. Nutrition education is needed and there needs to be a focus on health and health services research so that we can be assured that we are giving good advice.

Catherine McLaughlin – The Community Health Centers (CHC) program in Texas can't keep up even though the President, when he was governor of Texas, was pushing this approach. Do you think CHCs are a solution?

Valdez – I am biased in favor of CHCs, having been involved with them; the problems are immense, including waiting periods, but you can provide a full range of services. Providing more resources for CHCs is important. Electronic medical records are also important and, in order to be able to provide seamless care, more resources are required. CHCs don't turn away people for lack of funds. CHCs have very caring physicians even if they are not Hispanic. CHCs do work, but we don't have enough; the over all need is just too great and CHCs are overtaxed.

Catherine McLaughlin – Would you advise we recommend we more funds for this purpose?

Valdez – Definitely.

Therese Hughes – Do you have a problem in Texas when residents need to cross county lines for care services?

Valdez – This is not a problem for Medicaid.

Rosie Perez – We do have county hospitals that only want to see residents of their county. Some other facilities will serve patients from across the state.

Eschbach – I think we need to distinguish between citizens and foreign born. There is an advantage of the foreign born regarding Hispanic health disparities. They have lower rates of death from alcohol and drug abuse. We need to figure out what's going wrong with acculturation and address those needs. With current circumstances, we can't really address needs of immigrants themselves. Increased border security work hasn't discouraged the flow of immigrants. Until we get a way to get medical care, we need to do that. If you want to stop the flow, then stop it. Otherwise, we need to address the needs of the immigrant workers. There is a structural unfairness as it is currently. We need different solutions for immigrant and native born. For immigrants, it is access to health care and for native born it's addressing the erosion of health itself.

Catherine McLaughlin – Births to American-born Hispanics have the worst low birth rates for babies. They also have high rates of smoking and poor nutrition (as indicated by Dr. Valdez). A study found that there were two distinct populations of immigrants from Mexico and that the health habits in Mexico are also changing. One of these subpopulations is coming to the United States already smoking and with unhealthy eating habits.

Valdez – Yes, if you look at the advertising in Mexico, you can't tell major Mexican cities from American cities; acculturation is also happening across the border.

Randy Johnson – What can be done to enhance likelihood of employers offering health care?

Eschbach – The program that Dr. Valdez described is one example. If a company can leverage other resources, since it is indirectly paying for the care anyway, it might do so. Whether that is practical or whether there will be a sufficient commitment from employers is unclear.

Valdez – In Texas, legislation to encourage employer-sponsored coverage never passed the legislature. Small businesses are very concerned about being able to stay abreast competitive; I would like to see the 3-Share program succeed.

Montye Conlan – What about promoting education opportunities in health sciences?

Valdez – One barrier to such an effort succeeding is the considerable fear among Hispanics about leaving the area where they grew up – and doing so would be necessary in order to obtain such training. The big thing we find (missing) is the importance of basic math and language skills in order to be able to succeed in health sciences.

Rural Health

Patti Patterson, Vice President for Rural and Community Health,
Texas Tech University Health Sciences Center, Lubbock, TX
(See also her Power Point Slide presentation)

Texas is a very rural state; there are concentrations of population but most is rural. There have been big population changes including population declines in many Texas areas in the west of the state. It is hard to get data on rural areas; it is lacking partly because, due to privacy concerns, it is not reported. Death rates in the rural counties, however, are known to be twice as high as in urban and suburban counties. Mental health treatment is an issue. Suicide rates are highest in rural and isolated areas, so there is definitely a problem in the large rural areas. We know some of the features of a rural health care delivery system that can make it more likely to be successful, including:

- employ a workforce that is from the local area;
- have an institution-based mission; and
- link the health care system to the family and to the local educational system.

Rural people are more likely to be poor, uninsured and dependent on government funding sources. Any changes made to the Medicaid program more rapidly impact on rural areas.

Telemedicine is part of the solution. It reduces the necessity for some travel; it isn't necessary to avoid very much vehicle transport to have this system pay for itself. One problem is that Medicare will not pay for telemedicine that originates from nursing homes. Our pharmacy program put together a program for mailing drugs in order to avoid 75 mile trips for medicines. Obesity is also a major problem in rural areas. It looks like obesity is rurally correlated; the most isolated women are the most obese. Obesity varies across regions some.

The key elements of solutions to address health needs of rural areas include:

- not trying to use urban solutions
- solutions must be practical

- these systems must be built on trust
- the number one credential for local health professionals is that they are from Texas; this is more important than the formal health position that the health professional holds.

Ernest R. Parisi, Administrator and Chief Executive Officer
East Texas Medical Center, Quitman, TX

I'm the administrator of a non-profit 30-bed acute care hospital that is one of a system of 10 rural hospitals in north east Texas. Our system is Joint Commission accredited. My hospital serves a population of about 35,000; the town itself is only 2,000 people. The county is a medically underserved area as are the four neighboring communities. We have four rural health clinics for these areas and I've been credited with establishing the first provider-based rural health clinic in the state of Texas—in 1990. Rural health clinics are a primary source of care in Texas. My hospital also provides for four women's and children's clinics in the four-county area. We have grants from both the state and federal governments to provide primary care.

Hospital volumes are lower, and Medicare and Medicaid utilization higher, in rural America, and specifically in rural Texas. There are 2,166 rural hospitals in the United States, representing 45 percent of all hospitals in the country. In the case of Texas, there are 185 rural hospitals representing 35 percent of Texas hospitals. Sixty-two percent of the licensed hospitals in rural Texas have fewer than 50 licensed beds. On average, only about 20 of those 50 beds (or 40 percent) are occupied at any one time. Some of those hospitals may have only two or three occupied beds.

Seventy-five percent of the hospitals in rural Texas are owned by local government. That means they're tax subsidized. That's the infrastructure issue. Medicare/Medicaid, and underinsured inpatient utilization in rural Texas runs about 70 percent of inpatient utilization (leaving 30 percent for private pay patients).

Our facility in Quitman is a larger survivor than some of the smaller places that are out there—particularly in West Texas—we have 80 percent Medicare/Medicaid, and we also provide 8 percent for charity care and 3 percent for bad debt. That doesn't give you a large margin for private pay insurance within a community. Total Quitman outpatient utilization runs around 76 percent.

In the United States, rural hospital admissions have declined by 40 percent. United States rural outpatient revenue as a percent of gross revenue increased from 13 to 47 percent, which tells you the shift in how care is being provided specifically in rural Texas and in rural America.

Quitman's outpatient revenue as a percent of gross revenue runs around 52 percent. And I tell you these figures because it's essential for you to understand that part of public policy is to shift it from inpatient to outpatient, and part of public policy is that the care that's provided on an outpatient basis is factored by the amount of patients that you have in your community. And when you shift to that and you have low density, what are you talking about? You're talking about failure.

Texas rural populations are older and poorer. In Texas, 9.9 percent of the population is over age 65. In rural Texas, 30 percent of the population is over age 65. In Wood County, which is where my hospital is, 20 percent of our population is over the age of 65. I just got my Medicare card this week; I call it my "extended warranty." There's a great dependence on Medicare in rural hospitals; in addition 20 percent are covered by Medicaid; and 25 percent have no private health insurance.

Now, how do we as a small community hospital respond to the presence of a significant uninsured population? Our hospital charity care (of 8 percent) is about $2.6 million in gross revenues. We have a county indigent care program that all counties in Texas must participate in. Whether it's funded or not or the money's expended or not is a local Texas issue; generally speaking, it's 8-10 percent of the general tax revenues. And in Quitman, Texas, or Wood County, Texas, that's about $45,000.

Our Texas healthcare primary clinic grant is about $252,000. With those funds, in FY 2004, we provided for: over 2,800 primary care visits, a total of 930 "unduplicated patients," as we call them, about 1,800 lab and x-ray visits, including CT and ultrasound procedures, and $647,000 in prescription patient assistance.

We had a person to provide prescription assistance. We actually spent, ourselves, out of our grant money, which is not a requirement of the grant, about $30,000 in raw costs for prescription services to those primary healthcare clinics. Through our Title V federal maternal and child health grant, we've received a total of $40,000 for maternal, child health and family planning. In our four rural health clinics, we have four medical levels and three physicians. We have them in four different rural health clinics, three different communities, and two different counties.

We also have a social worker, which is unique to rural health, because we have a mental health care crisis in this state. And I don't think there's anyone at this panel's table that would deny that, or would anyone from Texas. This year, we expect to see 26,000 patients through the four rural health clinics. We have four women, infant, and children's clinics in which we have 411 unduplicated clients. We also provide for nutrition programs; we're providing education, food, breastfeeding counseling and assistance, and immunizations as well.

We've literally had outreach into these communities that we serve. We have four counties that we serve, and we literally have everyone who is eligible that we can find participating in those programs. We have an extremely well-orchestrated Women Infants and Children (WIC) program. In rural hospitals, we're paid on a wage index like everybody else is, through the Medicare programs, which shifts down to hospitals and it shifts down to the Medicaid program as well. The rural Texas wage index currently, as established by law, is 0.7997. The metro Dallas wage index is 1.0068. So there is a 20 percent disparity in funding using the wage index and funding care in rural hospitals. So we're already down 20 percent in how we fund rural health care services.

We're down further than that by virtue of the fact that our volumes are not there. When you have the low density population issues that we have in rural America, you can appreciate that. The

rural hospital Medicare margins are lower than the urban. In a recent MEDPAC report, the rural margin was negative 3.9 percent, and the urban is 2.3 percent.

Most of the rural hospitals in Texas that are subsidized by tax dollars are running negative margins; it's only the tax subsidy that's enabled them to remain open. Thirty-four percent of all rural hospitals have negative margins, and 75 percent of Texas rural hospitals are tax supported. Texas' non-metro hospitals generated only 10 percent of the total net Medicare revenue. And we call it "pennies on the dollar." It's pennies on the dollar for the infrastructure issues that are necessary to support our rural communities. There are access-to-care issues limiting care, and we talk about disparities in the number of available physicians. There are issues about physician recruitment, and recruiting for mid-levels in the rural areas.

The Medicare program, on which rural hospitals are largely dependent, does not allow adjustments for these additional costs of doing business (e.g., recruiting physicians). That doesn't make good public sense or good public policy. There's isolation of community and patient volumes, there's availability of equipment and technology that you can't get in rural because you don't have the capital dollars.

In rural facilities, it is essential to have capital dollars; most of the facilities in rural Texas were built with the old Hill-Burton funds (an earlier federal program supporting hospital construction). Most of the facilities are aged and having to be replaced. We also have workforce issues and shortages. It is difficult to find nurses, radiology technicians, social workers, and ultrasound technicians; try to find one out in West Texas. Try to find an ultrasound technician that can do carotids; you can't. Where do patients have to go for these services? They have to go to Lubbock or El Paso. Salaries are lower in rural Texas, and this is sometimes an issue so it's necessary to pay more.

Nationally, there are 1,122 critical access hospitals and in Texas, there are between 65 and 70 of these. These are cost-based activities, and not all of them have positive margins yet and that's not the answer for every hospital. There are 3,400 rural health clinics the United States; 51 percent are provider based. In Texas there are 333; 53 percent provider based.

In balancing the budget in 1998, there was a significant reduction in the amount of rural health clinic operations. Other stabilizing projects out there include the national Rural Community Hospital Demonstration Project; however, these funds went to 14 hospitals in only 6 states with the lowest density populations (and didn't include Texas). But, these projects are important and are essential for the survivability of rural hospitals within the United States. Another such stabilizing project is the FQHC Rural Health Clinic Collaboration.

Also, there are more rural health clinics in Texas than community health centers (but the funding is going the other way) and that doesn't make sense. We'd recommend finding a way, including changing the law in some way, to put the money where the people are being treated and to find some way to work this out with community health centers.

Of the 133 Texas counties that are rural, 47 percent do not have a hospital; and 64 counties are considered "frontier," having 7 or fewer people per square mile. There is one hospital in West

Texas that serves the combined square mileages of Rhode Island, Massachusetts, Vermont, and Connecticut—that's rural! The economic impact of rural hospitals, in Texas, and across the country, is significant. They are either the largest or second largest employer in their communities. It's the anchor for other healthcare services, pharmacies, and physicians. Without a hospital, most physicians would leave.

We have one demonstration project in which the Office of Rural Community Affairs encouraged use, by the community, of local 4(b) sales taxes for economic development, including healthcare facility construction. In my town of Quitman, so you can understand the financial impact, we have 207 employees and a payroll of $5.5 million; we're the largest employer in the county. We have 7 independent physicians and specialists in the community. We have one independent pharmacy and we have one pharmacy through a grocery chain. We don't have a Wal-Mart; and that's sort of a measurement because if you've been successful in your community, you've got to have a Wal-Mart. In our case, the nearest Wal-Mart is 8 miles away.

Rachel Gonzales-Hanson, Chief Executive Officer
Community Health Development, Inc. (CHDI), Uvalde, TX

My program is a federally qualified health center (FQHC) and is a community migrant health center. In 2004, CHDI served almost 1/3 of its service population, covering an area the size of Rhode Island. Our patient demographics are similar to other community migrant health care populations in rural Texas: a disproportionate number of uninsured, high teen pregnancy rate, and a significant number of geriatric cases with multiple chronic conditions and polypharmacy.

The community health centers program began in 1965, nationally, as a demonstration program serving migrant farm workers. Migrant seasonal farm workers work in the fields with the crops and need to be distinguished from immigrants since migrant laborers may not be immigrants. The overarching goals of the program were to improve health and empower the community; these goals still exist today. Every health center is governed by a Board of Directors, a majority of which is comprised of patients of the center, so I am accountable to the patients through the Board. This is a bottom up approach that is different from the norm for most other health care services across the country.

The Federal law establishing the health centers program includes four main elements:

- governance by a community board;
- being open to all, regardless of ability to pay;
- offering a comprehensive array of primary care services; and
- being located in a medically underserved area of the country.

Beyond that, every decision is left to the local Board and, therefore, the patients. This empowers the local community to expand access to care and address health issues in ways that make sense for the community.

Unfortunately not all federal programs are as clear in their purpose yet as flexible in their local design. We have literally hundreds of health care programs in the country: some overlapping, some completely disjointed, all well-intentioned. I was very encouraged by the recent HHS effort to improve coordination among various programs and believe more should be done to ensure

federal efforts are coordinated in their design and management. This is not to say that all programs should be rolled up into one insurance programs but rather that much can be done by improved coordination of existing programs. This would save the local health centers time and save the federal government resources.

Health centers wholeheartedly support the expansion of health insurance to more individuals across the country; to put it simply, insurance matters. However, even with insurance, it is hard to obtain health care in rural areas, and more often this latter is the major hurdle. A couple recent cases illustrate this:

In once instance, one of our patients, who had lost his wife to cancer two months previously, was himself diagnosed with cancer. The closest treatment center was a five hour drive away. When the treatment center was contacted by our staff, we were told there was a waiting list for referred cancer patients especially if they were not from the area and had no resources. Fortunately, this family was able to travel the five hours and found a creative way to get into the treatment program.

Another patient had diabetes, high blood pressure, congestive heart failure and the doctors realized he was also suffering from severe depression. Phone calls for a referral to a mental health specialist proved to be an exercise in futility. While the patient had coverage, the specialist, who was a two-hour drive away, did not accept the particular insurance and the next available appointment was four months away. The elderly patient had no transportation and no support system.

While getting patients to health care is a tremendous challenge, recruiting and retaining medical, dental, mental health professionals and administrative staff is also a struggle. Therefore, as you examine insurance coverage options, I urge you to consider levels of reimbursement to health professionals that will be sufficient to enable rural communities obtain the workforce needed. The problem is that when a patient comes to us newly insured, they will typically have inadequate coverage. But we will provide the necessary care anyway; thereby exacerbating our financial condition.

I urge the Working Group to consider advocating adequate levels of care for rural providers who are frequently the only providers and represent the local safety net. Unless you guarantee that everyone will be insured, FQHCs will remain the health care safety net for those who have no or inadequate levels of care. Congress recognized this and in 1993 enacted cost-based payment rates under Medicare and Medicaid for health centers although this was restructured again in 1997 and 2000. Health centers are one of the lowest cost sources of care, averaging $450 per patient per year. Each Medicaid patient served by a health center saves 30 percent of total health care costs.

However, it is not cheaper to provide care in rural area than urban and any reimbursement mechanism must keep this in mind. Communities must factor in the rising cost of medical insurance into expenses in the local area. The Federal tort claim act coverage for health center employees is a recruitment tool in hiring health professionals; it is estimated that the malpractice

coverage saves health professionals $200 million each year in malpractice insurance costs. If coverage is inadequate, local health providers suffer.

Summer farm migrants have different health needs than others. Medicaid coverage needs to address portability issues since migrant farm workers are discouraged from signing up for coverage in any state because it can't be carried to another state. This problem exists in part because Medicaid is a state-run program. Insurance coverage for rural areas should be shaped in a way that encourages access to primary care, preventive services, and specialty care as needed, while not creating additional barriers. I encourage the Working Group to consider the soon-to-be-released report by DHHS on the subject of farm worker health insurance coverage.

Here are some suggested solutions:

- create an expedited eligibility process including, but not limited to, migrant farm workers who must cross state lines;
- allow for presumptive eligibility for special populations, including migrant farm workers, who have Medicaid eligibility in one state when they move to another state, during the first period of time while they are going through the eligibility process;
- develop uniformity and consistency in the Medicaid program throughout the various states to encourage health care professionals to provide coverage to beneficiaries; and
- Establish accountability measures at the federal level for state and local Medicaid offices, regarding enrollment procedures and enrollment numbers for the existing program, as well as any future program.

Discussion

Randy Johnson – To what extent is telemedicine a significant part of the answer and to what extent would it be helpful for the Medicare and Medicaid programs to reimburse for it?

Patterson – We need to be really smart about this and proceed wisely and with integrity since there are people out there that don't meet those qualities.

Gonzales-Hanson – We needed "T1" (high-speed internet) lines to enable some of this; we need to build the infrastructure to achieve this.

Chris Wright – How can we promote the use of midlevel professionals to provide care?

Parisi – Telemedicine is part of the answer; using rotating specialists is also valuable. Location is critical. There is still bias against use of midlevel staff to provide care. The younger physicians are more geared to it. Some medical technologies are just not available in the rural areas. Some services can be provided on a mobile basis; but it becomes a volume and reimbursement issue. Quality mammography services and technology are expensive and resource intensive to maintain and provide. So there are health care facilities that are refusing to do it.

Chris Wright – Individuals may be making some health care decisions not based on being able to opt for a lower intensity level of care but rather based on the simple fact of not being able to come back for follow-up treatment. For instance, we found that we had a high rate of

mastectomies versus lumpectomies. When we looked at it we would find that women would tell us that they wanted the whole mastectomy so that they could get back to their farm rather than having to come in every day for six weeks for more limited treatements.

Therese Hughes – Lack of health care has replaced electricity and water as the significant need in rural communities.

Parisi – In rural health areas we depend heavily on Medicare dollars; when there is a change in Medicare policy, it has extreme effect on rural areas. We lost over 200 hospitals in Texas as a result of the 1984 changes in Medicare program reimbursement. If there is inadequate reimbursement, people are unable to have health care.

Patterson – Mail-order pharmaceuticals are a great idea; however, there are three points I want to make: prevention, prevention, prevention. Obesity is second driver of health care problems after tobacco.

Randy Johnson – What's the biggest opportunity for Working Group to emphasize: the reimbursement rate or some other issue?

Parisi – Medicaid is significant because we have an aging and poor population. Amount of money to rural is low. Funding for health care infrastructure is essential since without it, the other elements of care can't take place. Also, the Federal government needs to be more timely in its policy changes, making sure that changes being made are relevant at the time and are not geared to addressing circumstances that no longer exist.

Patterson – Let's find ways to make normal systems work.

Randy Johnson – I'm hearing you say: "Make sure your public solutions don't undermine your private solutions."

Patterson – Excellent; yes.

Gonzales-Hanson – Make sure the reimbursement rates for the public systems are adequate, while assuring that both the public and private systems are on an even scale. It's not just one answer; we need several actions. Encourage communities to grow their own, partner with others, and find local solutions.

Long-Term Care, Home and Community Options

Speaker:

Nancy Wilson, Huffington Center on Aging, Baylor College of Medicine
(also See Power Point Slide Presentation)

The concern of the 21st century is the aging population and the need for long term care. My county (Harris, Texas) is as big as the state of Rhode Island. We recognize that our mission is to

help families prepare for the risk of long term care and live better in elder age, and how organizations can assist individuals better prepare for their long term care needs. Issues that need to be addressed include the social and physical circumstances in the community as well as transportation and housing needs so that individuals can live successfully in later life.

Individuals who need long term care assistance are those with functional limitations and include: elderly with health challenges; mentally retarded; and the chronically ill. Long term care is the only health care population we define by the discrete list of services they need. Unlike other health care, services are distinct from the settings in which the services are received. With long term care, people may receive acute care services in nursing homes, for instance. Although nursing homes are thought of as long-term care settings and are reimbursed as long-term care settings, they provide acute care; and similarly with receiving medical care in the home.

Robyn Stone has identified 4 things to keep in mind about long term care:

- It's primarily concerned with maintaining or improving the ability of older people with disabilities to function as independently as possible for as long as possible;
- It encompasses social and environmental needs, and so it's much broader than the medical model that we typically think about;
- It's primarily low-tech (high-touch, low-tech) in terms of people's needs for personal care and assistance; and
- People are discharged into the community with complex medical needs

The challenges of providing long term care services shouldn’t be understated. One out of every two people will experience some time in a nursing home some time in the future, and the likelihood increases with age. Most people with long term care needs by practice and preference live in their own homes. Only 8% rely on paid full time caregivers; most rely on family.

Cost is expensive for long term care. Assisted living is increasingly popular but only a portion of people can afford to buy it. It can be a catastrophic expense. The expense of long term care includes “free” care from family caregivers. Even modest long term care insurance purchased in advance is not in everyone’s reach.

Medicaid is the dominant source of payments for LTC. But states can develop waiver programs so that it leaves some covered and some not and is very uneven across the country. All our care is financed in very discrete silos; there is a schism between acute and long term care. Information systems are not integrated. One demonstration project, PACE, allows experimenting with combining all the funding and providing for an interdisciplinary care team that decides what is best package of care the individual needs. This is one model that should be looked at; in Texas there are only two in the entire state.

Another model that has some cost impact is EverCare, an integrated care program inside the nursing home, rather than having to transfer people out for acute care needs. We need to look more at integrating acute and long term care. Right now very difficult to do so because of rigid differences and separateness of the different programs.

Another approach is the power of consumer-directed services; the Robert Wood Johnson Foundation is looking at this. This effort encourages looking at how Medicaid money is being used for clients and it allows the individual to take the Medicaid money and manage it directly and redirect it. This has been effective in some other states and I would like to see this expanded.

Long term care is expensive and we can't realistically expect for people to save for it. The middle class are dealing with college and long term care needs. But the two are very different issues. Long term care is potentially prolonged, with large costs and an indefinite future. Private insurance is one method; but we haven't done a good job of making sure the plans are well structured well designed.

We need to focus on evidence-based health prevention (fall avoidance, arresting depression, and managing medications) and seek ways to avoid the need for long term care services or institutionalizations. We need to recognize what the threats to well being are for older adults and realize that they are not all acute care needs.

Lanette Gonzales, Sheltering Arms, Houston
(See Power Point Slides for more of the presentation)

Only about 15% of seniors could afford to pay for in home care if they needed it. Most vulnerable adults: 75 and older, have greater frequency of chronic health conditions. These conditions are not going to go away; these needs are seen to continue for up to 20 years. These older individuals are largely living alone, are primarily women who outlive men, and are minority. The elder female baby boomer population is growing right now.

Individuals may pay as much as $11,000/month for full coverage in-home assistance. Direct care workers work hard; it may be easier to go to a local "Jack-in-the-Box" rather than working in the home providing direct care.

There are strategies needed to recruit and retain direct care providers. Case managers are doing grass roots work with clients.

Discussion

Randy Johnson – What kind of training would you provide for aging individuals with professional careers who are interested in providing care?

Gonzales – We have a 16-hour program we could offer as well as continuing education and would then place you in employment; with an average hourly wage of $7.00-$12.50.

Catherine McLaughlin – What is the difference between care for elderly families and children? We don't expect the government to pay for children. There's the same fear regarding caretakers for children regarding how well they will be cared for. What's the difference?

Gonzales – We expect children will grow up and go on to become self supporting individuals. With elderly, they typically have functional limitations that are only going to get worse. The

elderly don't necessarily have the opportunity to earn more money. They don't have the resources. Older adults need more help in the home. Day care is more limited for adults, and it is costly.

Catherine McLaughlin – There are some economies of care in a group setting. They can be better provided than going to someone's home. So, why don't we see more day care for adults?

Wilson – The biggest issue around adult day care is the big capital investment. Also, centers cannot address easily the range of disabilities; we've done almost nothing to subsidize cost of adult day care development. Adult day care can cost up to $70/day. There are some demonstrations around adult day care. Medicare hasn't had this as an option.

Catherine McLaughlin – If we make recommendations; where do we get better investment return: emphasizing staff development or focusing on adult day care?

Gonzales – The need for adult day care workers is critical. Without additional resources, we could not keep services available. There are also huge transportation issues in setting up adult day care: getting them there and home. So it becomes more cost effective to provide the care in the community, allowing home care worker to provide assistance to 2-3 people a day.

Wilson – There needs to be a concentration of need to justify any type of care in the community. Given the prohibitive nature of costs of care, we need some social insurance mechanism. Right now people don't do long term care and individuals seek to obtain eligibility under Medicaid while avoiding costs through transfer of assets. We need to think creatively about the minimum level of need and to think creatively about a system that has more equity than Medicaid does across the states.

Dotty Bazos – What are the costs of nursing home versus in home?

Gonzales – People in nursing homes typically need 24 hour-a-day care; people in home typically don't need that level of care so it is more cost effective to service them in their home.

Dotty Bazos – Does it slow down peoples' functional decline (to be in their own homes)?

Wilson – We don't typically have a seamless system providing a whole range of services. Part of the challenge right now is that in long term care, people have incredible acute care costs and needs.

Montye Conlan – I'm interested in role of volunteers: family, churches, and other organizations. What if there were a call to action; a health care volunteer program that could help the paid workers and invigorate this area?

Wilson – We do have some of that going on with an emphasis of self-management in programs that are peer-led and these programs have had success with reducing acute care costs. Aging programs are focusing on training elderly individuals to train those who are healthy. Also, high

school students can help. We have to recognize the need to help older adults and families understand the needs and issues.

Randy Johnson – Motorola has offered its employees a long term care program; however, only 3% of our company has it. We need to find some alternatives to that. One related issue is that a significant proportion of costs are for the last 6 months of life. What tradeoffs are we willing to make; are we willing to accept palliative care? What trends are you seeing?

Wilson – I think we need to start with the values and orientations of our health care system and look at these attitudes. Right now there are disincentives within the system. We want to get intensive care and get all specialties involved. Palliative care is not raised. There is increasing attention in medical education to the subject of palliative care. At present, in the absence of knowing what their alternatives are, people tend to stick with what they now. We need to focus on provider education since they are often the ones who need, and are in the best position, to initiate that conversation.

Gonzales – In the minority population, there hasn't been a conversation about palliative care as an option. At Sheltering Arms, we try to have those conversations. We are opening up a hospice center.

Wilson – People need options; they need to know what they can do.

Retiree Health Care

Paul Dennett, American Benefits Council (over 200 members)
Addressing the Growing Gap in Retiree Health Coverage
(See Power Point slide presentation)

Gerry Smolka, AARP
Health Coverage in Retirement
(See Power Point slide presentation)

Marshall Bolyard, U.S. Family Health Plan (over 100 primary care providers)
Providing High Quality, Cost Efficient Health Care to Military Beneficiaries
(See Power Point slide presentation)

Discussion

Randy Johnson – What's your advice to large corporations which appear to be in big trouble regarding health needs and coverage and costs? How do we balance the challenges of global competition on the one hand, and the needs of retirees to have assured coverage on the other?

Smolka – Financing of health care has to be a balance of government, employer and individual responsibility.

Dennett – First and foremost, we have to make sure spending for health care is effective and efficient. This is even more urgent for retirees, since they have higher needs and costs. There aren't going to be any new start ups for defined benefit plans for retirees; we need to get individuals without this benefit to get into long term savings. We need to add the additional incentives and encouragement to save for health: tax incentive savings vehicles for savings that would be there for retirement.

Catherine McLaughlin – We need to reduce costs of health care all around because other shifting of expenses or savings is a very short run solution.

Dennett – I agree; also, the kind of vehicles that young workers will have will be different. There is really no comparable vehicle to the 401(k) (which is a pension option) that is the equivalent in the health care area.

Smolka – People often don't realize that unlike pensions, health coverage is not a pre-funded benefit and can be lost easily if companies change their coverage. Also, government rules in the public sector are going to be changing as well as at the state and local government level and will be debated and changed so there is a high degree of uncertainty.

Catherine McLaughlin – The Michigan Supreme Court has declared that employee health benefits are not a guaranteed protected benefit. The only area that has been really solid is the military. It was an explicit contract in the military. It sounds like it's good you are addressing the financial benefit as well as providing the guarantee.

Bolyard – Once we expanded from free care to requiring some costs to the recipients, there were objections; but we've done it in a fair and measured fashion.

Randy Johnson – Is our retirement age going to change and will the expectations change; will the population need to consider working longer?

Smolka – The Social Security retirement age is already rising but not yet for Medicare. I'm not ready to say it should, but people need to consider working past the formal retirement age until both spouses are eligible for health care under Medicare. Many people do take jobs beyond 65 to help pay for health premiums. That's what some people have to do to be able to afford health care.

Bolyard – Many employers will try to encourage employees to work longer since they are more valuable. Health care benefits are less likely to be provided to new employees and will decline significantly. That's why we need more solutions that are more individually based rather than trying to reestablish a system that is not likely to be recreated again, at least as it has for past generations.

Randy Johnson – Clearly some people will not be able to put money aside. For middle income people, will tax incentives help encourage setting money aside?

Smolka – We are looking at ways to encourage and make it possible for older employees to set aside money for health coverage. We hear about retirements of teachers that will be happening. We've got to be looking at those people that will not necessarily be able to save for future health care. Retirees just above the Medicaid level in some respects have the toughest issues to address in meeting their health care needs.

Bolyard – Three tax incentives that should be considered are:

- A broad deduction for health care spending for health insurance premiums in the same way taxes are reduced for preferred savings;
- For lower, more modest income people, we need to consider tax credits; and
- For the lowest income individuals, we need to consider refundable tax credits.

But the fundamental problem is that if you leave employment, you are spending pretax money on health care. We need a fundable set of tax preferences to encourage people.

Smolka – In tax proposals, we really have to pay attention to what we are buying. The issue with all the tax credit proposals is that people of limited income may not have a very great "take up" rate since the insurance plans may still not be affordable.

The Chair adjourned the hearing at 2:15 p.m.