CITIZENS HEALTH CARE WORKING GROUP

PUBLIC HEARING

9th Floor Conference Room
George Strake Building
Christus St. Joseph Hospital
1919 La Branch
Houston, Texas

Tuesday, July 26, 2005

The hearing convened at 8:00 p.m.

MEMBERS PRESENT:

RANDALL L. JOHNSON, Chairman
DOTTY BAZOS, RN
MONTYE S. CONLAN
THERESE A. HUGHES, MA
CATHERINE G. McLAUGHLIN, Vice Chair
ROSARIO PEREZ, RN
CHRISTINE WRIGHT, RN, MPA

ALSO PRESENT:
PAT CARRIER, Regional President, Christus Healthcare, Houston
KIMBERLY PENN, Executive Director, East End Family Center
GEORGE GROB, Executive Director
ANDY ROCK, Senior Program Analyst
CAROLINE TAPLIN, Senior Program Analyst
RACHEL TYREE, Program Analyst
JESSICA FEDERER, Program Analyst
and
Members of the Public

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P R O C E E D I N G S

CHAIR JOHNSON: Good morning, everybody. We'd like to welcome you to our hearing today. And we're going to begin. I'd like to introduce myself. I'm Randy Johnson, and serve as the Chair of the Working Group.

And this morning before we get started, Pat Carrier, who is the Regional President of the Christus Healthcare Houston is here to welcome us, and we welcome you. Thank you very much.

MR. CARRIER: Thank you Mr. Chairman, and as you said, I'm just here to welcome you this morning. We are certainly honored to have this distinguished committee here today. We understand the task that you have before you is a very significant one and important to us that operate in the field of healthcare, or use healthcare, quite frankly, because access to healthcare for the general public is about as important an issue as we have in the United States today. And we have many of them, I understand that.

I would like to welcome you to Christus St. Joseph Hospital. St. Joseph is the oldest continuously operating hospital in the city of Houston. It's one of the first in the state. It's been here for 118 years. It was founded by the Sisters of Charity of the Incarnate Word.

And we have long served a mission for people who have trouble to access to healthcare, and we very well understand what you're all about, because we think we've been about it for a long time also.

We're also very proud to have our own Rosie Perez as part of this committee, and she very deftly let me know that, Hey, you need to come and welcome these folks today, so welcome to Texas. Welcome to Houston. If there's anything we can do to make your stay more pleasant, please don't hesitate to ask, because we're here to make this day go as well as it possibly can, and we wish you great success in your task. Thank you.

CHAIR JOHNSON: Thank you very much, Pat. And we are equally indebted to Rosie for her contribution on our behalf in preparation for our meeting today. We've gotten to know Rosie a little bit, and she's been a significant part of what we're trying to do here, so. We value her participation in the Workgroup, and we're looking forward to our day today.

So thank you very much, Rosie, for all you've done.

Just briefly, we'd like to invite your attention to our agenda. This morning we're going to start by having a review of Hispanic initiatives and issues, and Karl Eschbach, who's not here yet but is on

his way, will be joining Adela Valdez, who is seated at the head of the table, in discussing some of those issues and initiatives.

A little bit later we'll be talking about rural health. Even later in the morning we'll talk about long-term care, home and community options.

And finally, early afternoon we'll be talking about retiree healthcare.

So that's our agenda, and we'd like to just move right into our initiative, and Adela, we're just pleased to have you here this morning. Thank you for your joining us.

Adela is a person who has experience in both clinical and administrative duties, and they include a clinical faculty at two family practice residency programs, as well as being a hospital administrator from South Texas Hospital, and Area Health Education Center Director in the early '90s.

We're glad you're here. We have your resume -- bio, rather, and have had a chance to look at that.

Karl Eschbach will join us at the table when he gets here.

Our practice has been to ask you to make a presentation of 10 to 15 minutes, and then the other speaker to make a presentation of 10 to 15 minutes, and

then to take time for questions from the Working Group.

DR. VALDEZ: Very good.

CHAIR JOHNSON: So we'll look forward to your comments.

DR. VALDEZ: Well, first of all it's a great privilege for me to be here. I would like to thank you for being here in Houston and hearing the voice of the community, because I think that's very essential in moving forward with any kind of agenda, and I also I would like to say that I really like the name of your group: Working Group. I think it says a lot about the focus that you have and the interest that you have in making this thing work.

As part of my background, let me say that I am from South Texas. I grew up there. I went back to practice there. I've been involved in not only in private practice, but I've been involved in a lot of state agencies, and I understand the public health issues of the Border.

More recently I was past Presiding Officer of the Health Disparities Task Force for the State of Texas, and as such I had the privilege of meeting a great number of people, going to national meetings, and understanding kind of a common theme that was there, as far as the underserved.

I'd like to go ahead and start with my presentation.

The objectives for today will be to review how the Health Disparity Task Force and the Department of State Health and Services approach health disparities. And I have an overview of the Hispanic health disparities, as well.

I'd like to review the organizational process that we utilized to address the health disparities, and then highlight some best practices in the Region, and then lessons learned.

So what was our approach at the state level?

First of all we looked, actually, at the national guidelines that there were, and the priority health areas were infant mortality, cancer, cardiovascular disease, diabetes, HIV-AIDS, and immunizations.

In Texas, although we had very similar focus, we tried to focus more towards core issues or core preventive attacks to the problem.

So yes, we had immunizations, but we combated obesity and diabetes prevention, therefore targeting cancer, cardiovascular disease. And physical activity and fitness, addressing both diabetes and cardiovascular disease. Tobacco use for cancer prevention, responsible sexual behavior, and prenatal care.

We quickly found out that really the burden of most of our healthcare costs and our suffering is with chronic diseases, and that's where, actually, where we have a lot more ethnic disparities.

When you look at the leading causes of death in the United States, and you looked at the fact of the actual causes of death, tobacco really is the number one, followed by poor diet, lack of exercise, alcohol, infectious agents, pollutant toxins, firearms.

But if you look, it really translates to a common clinical heart disease, cancer, stroke, and lung diseases.

When you look at Texas, obviously heart disease seems to be the number one, then cancer, cardiovascular disease, accidents, respiratory diseases, diabetes, and then infectious diseases.

And our overall discussion of kind of our main focus areas that were most significant in our findings was that obesity seems to be a more growing epidemic, and will certainly affect our youth.

This is just a CDC guideline I'm showing that Texas right now is between 20-24 percent of the population now is considered obese.

And we unfortunately have the rank of having some of the fattest cities: Houston, Dallas, San Antonio,

Fort Worth, and Arlington, Texas.

So it is the perfect storm.

And I don't think we're doing the right kind of lifestyles to accomplish what we need to.

Now, the other target was tobacco prevention, because we felt that obviously this could probably have the most impact.

So monies were placed into this tobacco initiative, and because of the large number of effects, and of the fact that it's preventable.

So what are our successes?

Well, I'd like to highlight the fact that we've had some major successes in the area of trends in prevalence of smoking cessation.

And one of the problems that we have, as all states have, is we have little funds. In fact, through our last session and the reorganization, we didn't even know if the Health Disparities Task Force would actually survive, and our budget was cut down to about 20 percent of what it was.

Along with that, of course, that meant that the Regions received very few funds at all, and what little funds they had -- we wanted to know what the Regions were -- how they were going to address all the problems with such little money.

And one of the things we learned is that people can get very ingenious, especially if they have a lot of passion, and as long as also you have their support, and they have maybe a real clear focus.

So we decided maybe the Regions should focus only on one area of concern, with that little funds.

And the next slide, what it does, it highlights a pilot initiative for East Texas counties: Jefferson, Harris, Fort Bend, and Montgomery.

And it was quite amazing what they were able to accomplish. After the first two years of implementation, they had 36 percent reduction in 6th to 12th Grade tobacco users in East Texas. Fifty-five fewer 6th to 12th graders using tobacco products, and 18.6 reduction in adult smoking rates, which translated to about 90,000 fewer adult smokers in the area. So it's exceedingly successful.

So I'd to now focus on the Hispanic health disparities. Now mind you, then, all these other issues that I've talked about are pretty generic. They cross all boundaries.

On education, I found that to be one of the most severely lacking, as far as underrepresentation of Hispanics. There's a tremendously high dropout rate, poor SAT scores, and very poor enrollment in early childhood

education.

Hispanics and blacks are also disproportionately underrepresented in virtually all the health professions, and this includes academia, research fields, and post-bachelor degrees.

The major disparity, though, in my mind, is in decision-making positions in the health professions, in state and national bodies, business sector, educational sector, and governmental sectors.

In Texas, Hispanics are disproportionately uninsured, and underinsured, and the problem is greater among Hispanics in the Southwest and even greater among my area, which is South Texas, along the Border.

And this is really already a wrong slide, because it's up to about 29 percent of Texans are uninsured. And I want to focus on the fact that most of the uninsured are employed, so most of the Hispanics are working. They're the working poor.

Texas ranks second among states in the percentage of children who do not have public or private health insurance, and 44 percent of the uninsured children are Hispanic.

Migrant children, even though they do have coverage under the Texas Medicaid program, unfortunately many of them can't take that with them across states.

Lack of insurance also affects not only poor health, but higher hospitalization rates and more advanced disease, as stated here in this slide.

Hispanics also have lower utilization rates of healthcare. Some of it is culture. As you all know, we believe in a lot of home remedies, we rely a lot on our *abuelita* or grandmother to help us out when we're not feeling well. And we're reactive, versus proactive.

And women set the health agenda in the household, and that's very important to know, because if you want to affect the family, you need to affect the women in the household, and this is particularly true in the Hispanic population.

Of concern is that only 13 percent of the state's 13,000 Primary Care physicians are Hispanic. That's significant, because language and cultural barriers are significant as they are, period.

As far as diabetes, we do have a higher rate of diabetes in Hispanics, a much higher rate of complications, and much higher death rates.

Homicide is also one of the things that sometimes is not spoke of, but the homicide rate for Hispanics, in males, is about two to four times higher than that for Anglo males in Texas in 1990 and 2000.

And let me just say that I'm a past

Commissioner of Jail Standards, and you also find the fact that you also have a lot more Hispanics, young Hispanics, in jail.

The adjusted death rate from cervical cancer is also higher in Hispanic females. The screening for breast cancer is much lower, and breast examinations by clinical physicians. Rates of mammography, also, are lowest in Hispanic females.

And as you well know, teenage pregnancy rates are exceedingly high, with also percent unmarried, two-thirds of teenage pregnancies, and rates overall basically have been stable, though.

Obesity, as I mentioned before, is disproportionately increasing in Hispanics, and we're finding more and more in the middle-age group, and I do have -- you know, I didn't know how much time I had, but I do have a whole series of slides of that, and information on the youth, and the obesity is happening in Elementary School age children.

There needs to be more frequent assessment of mental health, because obviously diabetes and depression go hand-in-hand. About 85 percent of depression is associated also with a chronic illness, so we really need to focus on that one.

Summary: we have rapidly growing numbers,

increased undereducation, low income, language barriers, greater lack of access, underutilization, and greater uninsured and underinsured.

The policy implications have to do with expansion of health insurance, increased inclusion of Latinos in medical health research as consumers and researchers, and increased numbers of Latinos and blacks in academic health institutions. Enhancement of early educational opportunities, with a dramatic focus needed in elimination of disparities with access to care, utilization of care, and preventive services.

The challenges obviously, as you well know, are increased healthcare costs, lack of societal mandate, increased expectations as far as technology, and improving healthcare requires education, employment, and decision-making capacity in a variety of community and organizational sectors.

The summary then is, we do have major underrepresentation in all areas, and we definitely have a great number of health disparities, and very few resources.

So I was asked to think outside the box when I was in health disparity, so I thought this is a oxymoron where you're in a state institution, but I figured, well, let's give it a try.

So we were -- lessons learned. Well, some new initiatives that we thought of are that there are definitely some state program initiatives, regional initiatives, and the initiation of Texas State Health Strategic Partnership.

Let me focus a little bit on that one. That is 100 organizations that have been put together by the then Commission of Health, now Commissioner of DSHS, Dr. Sanchez, and I want to commend him for that, that brings in a great number of private organizations and public organizations and academic centers, trying to focus on some major goals that hopefully will help the state of Texas.

Go ahead.

Strategies obviously to look at eliminating health disparities as an overall theme, but looking at the fact that there's certainly a great need for research, because there's a lot of unknowns out there.

There's a lot of unknowns as to why things are happening. We definitely need some research.

But the strategies include improved access, enhanced public information, community partnerships, and realignment of funding priorities.

And we knew that there's a lot of causes of disparity. We're trying to focus on them.

So small steps and big impact is what we're looking for.

So we were linking to external partners, we're looking for, you know, obviously, a lot of public, community, and private sectors.

And then we asked the Region, and I said before, you know, What are you doing right? You know, what is going on?

So these are the different Regions that I'm talking about, and each Region actually presented to the Health Disparity Task Force their focus area.

And one of the biggest areas where we really see a great amount of improvement, and really culturally sensitive, and culturally appropriate, is through the Promotora community outreach projects. And there are many.

They're poorly funded, but I can tell you there's a lot of passion there, and a lot of desire to help.

One of the other areas that I was fortunate, I went to a minority health conference here in Texas, and UTMB is looking at a 3-Share program for the uninsured, and that includes premium sharing between the employer, employee, and the government.

At Texas Instruments, too, in a national

meeting, had a different focus in trying to alleviate, obviously, there costs, but in doing so I think they did some very wonderful things.

The designed disease management programs that are relevant to the employee, they collaborated with a national committee and national research agency, and they were working to influence the local business community to increase their awareness of the healthcare disparities.

And what they wanted to accomplish is to have a diversity of networks, cultural proficiency in delivery of healthcare, and data tracking of disease outcomes.

And I can't overemphasize data and accountability. It's hard to fight and to argue over data.

So TI, I think, is in the right track of trying to deliver basically culturally appropriate healthcare that makes sense, and is effective as far as cost-cutting, as well.

So basically what they're looking and helping to increase the awareness and the need for cultural competency for healthcare providers, ensuring health plan physician panels have a diversity population, encouraging healthcare plan carriers to diversify.

I wanted to just to focus again on the Texas State Strategic Healthcare Partnership goals. There are

nine major goals, six of them are dealing with major healthcare issues. And if you look at the fact that these are under organizations and what their focusing on is really primary, very core preventive measures, like health nutrition, health choices, mental health, health stress environmental, and reducing infectious diseases. So they're very, very broad.

The rest, the other three, we're dealing with infrastructure of the system itself.

So you see that you're talking about public health services, governmental agencies, and community -- Texas community infrastructure.

And I want to focus also on the fact that we have been very blessed in also having some very national initiatives being focused in this area, and just to highlight, the Presidential Advisory Commission on Educational Excellence for Hispanic Americans.

I guess my three major areas, focuses, points that I'd like to make are that there needs to be cooperation, collaboration, focus, and focus on high-yield practice with a lot of data and accountability.

And communicate, communicate, communicate.

I'd like to end this with a little video clip. In East Texas, they used their monies that we had for them in many creative ways.

One was to collaborate with an academic center and a public health sector in coming with these very culturally appropriate videos.

So I'd like to end my discussion with that.

MS. PEREZ: Dr. Valdez, I'm so sorry. We were not able to bring up the video clip. There were technical difficulties bringing that, so I apologize for that.

But we can make it available to the committee members, and we do have a web site. We can also make it available on there.

DR. VALDEZ: It's very impressive. The public service announcements media is really underutilized. A lot of the studies that we did in South Texas really proved that radio and the media are one of the -- in fact, probably number one source of information for a lot of our clients, and the second is physicians, but the first is media.

So I would very much encourage you to use that media as well.

Thank you.

CHAIR JOHNSON: I think you have a commitment from us that we will get that when we get it.

Thank you very much.

Is Karl Eschbach here?

MR. ESCHBACH: Yes, I am.

CHAIR JOHNSON: Okay. Would you like to join us at the head table? And we'd like to welcome you, Karl.

Dr. Eschbach is Associate Professor in the Department of Internal Medicine, Division of Geriatrics and the University of Texas in Galveston, and what we're going to do, if this works for you, is ask you to make your presentation of 10 to 12 minutes, and then we'll open the Working Group to questions for you, if you may, and if we may, and we're able to go until about 9:15 in total, so, if you take 12 minutes or so for formal presentation, then we'll open our discussion.

MR. ESCHBACH: Okay.

CHAIR JOHNSON: Welcome.

MR. ESCHBACH: I want to talk about Hispanic health and healthcare issues in Texas and the United States.

The purpose of the presentation -- next slide -- is to give a context to understanding healthcare accessibility issues for Hispanics in Texas and the other states.

As you mentioned, I'm at the University of Texas Medical Branch in with the Department of Internal Medicine, but my training and background is as a demographer. So those are the issues I'm going to talk about.

In particular, I'm going to talk about population growth, composition of the Hispanic population, health status of Hispanics, healthcare access, the Regional burden in Texas, and the undocumented population and its needs.

The next slide shows you the rapid growth, which I'm sure everyone here is familiar with, of Hispanics as a percentage of the United States population, from about 1.4 percent of the U.S. population in 1940 up to 41.3 million people and 14.1 percent of the population in 2004.

In Texas, the population was estimated in 2003, the latest Census Bureau estimates 7.6 million is now 34.2 percent of the population, and the projected growth of the Hispanic population from the Census Bureau and the Texas State Data Center are respectively to, in 2040, 22 percent of the population, in the state of Texas, of course, we don't know exactly what's going to happen, but up to 19 million persons, and over half the population by 2040.

These projections are based on trends before 2000, and so far, since 2000, we've been pretty much on track.

86 percent of Texas Hispanics are of Mexican origin. 31 percent of Texas Hispanics are immigrants. It's a little lower than for the United States as a whole,

and I won't belabor the point, but of course as we all know, the Hispanic -- on average, although there's a great diversity in the population, have lower average education, and concentration in service work, precision production, craft, repair, construction, and transportation industries, which is important in terms of looking at healthcare access.

Now I want to talk a couple minutes, and, you know, I may a little bit -- you know, I came in a little late, and seems to contradict Dr. Valdez a little bit, but I think not really, but I want to talk about the Hispanic paradox, which 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 disadvantage of the Hispanics.

The standard citation to this fact is a JAMA article from 1993 that showed that the standardized mortality rate ratio for Hispanics compared to non-Hispanic whites was .74 for men and .82 for women. The Hispanics have lower heart disease and cancer mortality, the birth outcomes are similar to whites, and another aspect of the paradox that's important is that the Hispanic advantage is larger for immigrants than it is for natives.

Now what's the cause of the mortality

advantage? Well, that's a matter of debate, and we can't go through everything here, but one cause seems to be the better health behaviors of Hispanic populations on average, particularly immigrants, in terms of diet and lower smoking rates.

If you look at mortality rates for younger adults, you find much lower suicide rates for Hispanics. Now, believe it or not, much lower rates of death from drug abuse and from STDs. I mean, a point important to emphasize, because it's often overlooked.

And the other important reason is health selected migration. The idea here is, and it's a world-wide phenomenon, is that healthier people are more likely to move long distances, more likely to cross international borders. Economists, you know, in short, explain that that happens because people are moving largely for economic reasons, and if they're doing so, people who expect a greater return are more likely to move.

And, you know, for that reason, the people who come to the United States are more likely to be in good health.

So what is the implication of this, is, a point that I want to emphasize, is that if you look at statistics nationwide, Hispanics do not impose an excessive healthcare burden because of poor health habits,

and extra burden of illness, or higher use of medical care.

Now, you know, I want to say in saying this, and I do not want to minimize and overlook the fact that there are many disadvantages. There are higher rates of diabetes, hypertension, higher rates of risks like obesity and low rates of physical activity in leisure time.

All of these things are true. Nonetheless, there are counterbalancing advantages with respect to this population, which means that it is not particularly overburdening our healthcare system with respect to poor health.

But I think the major issue, and the one, you know, that I choose to focus on, is the limited access to health insurance coverage of the Hispanic population, because, as I mentioned before, of the concentration in industries and occupations with limited insurance -- employer-based insurance coverage. And also because unauthorized immigration status limits accessibility to public programs.

So if we look at the next slide, this shows the health insurance rates for the Hispanic population in 2003. This is national data from the National Health Interview Survey, and it's broken down by age.

And you see here that the rate of no insurance

for children is 22 percent; for working age adults it's 46 percent; even for elders, in spite of the Social Security program, it's still 7 percent.

And you'll also see relatively low rates of employment-based health insurance, so you can break this down further, and the next slide is showing the percent with no health insurance for Hispanic immigrants versus U.S.-born, and you'll see here that immigrant children, 65 percent of children under 18 have no health insurance coverage whatsoever, as defined in the National Health Interview Survey. This is a point estimate for the point in time at the time of the survey.

And again, among immigrants, 13 percent, even at older ages, despite Social Security, have no health insurance. For the U.S.-born, rates are much lower, but as you can see, compared to the last column, they are still much higher that those for non-Hispanic whites.

So what are the health implications of lower insurance rates? Well, lower rates of healthcare utilization, lower screening and immunization, less likely to have a regular provider of care, shorter survival time after diagnosis, and, you know, a burden to seek healthcare in informal sectors by crossing the border.

My chief of my division, Geriatrics, at UTMB, is a Mexican physician. He says that he is very aware

that many of his patients that he sees even in Galveston, that he's writing a prescription for them and they're getting it filled in Monterrey, and seeing a physician in Monterrey, Mexico, because they may not have the access they need in the United States.

Now, as I said, I wanted to touch briefly on unauthorized immigrant populations. This is an important issue. Estimates are that 80 percent of recent Mexican immigrants to the United States are unauthorized. There is an estimated undocumented population of 1.4 million in Texas and 10 million in the United States. And these estimates are from Jeffrey Passel, a recent study done that the Pew Hispanic Center.

You know, these are a considerable portion of the population. In fact, if you looked at the Houston/Harris County area, the undocumented population is perhaps -- now the estimates show clearly more than 10 percent of the population, and a greater portion of the labor force, because they tend to be concentrated in working ages, instead of as children and of older ages.

So I think the important point that I want to take out of that is that if we move on and look at implications, is that Texas and the United States are depending on immigrant labor. Right. We've got a system where a large portion of our labor supply comes from

undocumented migrants. And this symposium is not about migration policy, and I don't intend to talk about that.

But I observe as a demographer the structural fact that we've got a large portion of our population, and neither employers or the federal or state government wants to take responsibility for paying for their medical care. Right.

So I come back to the fact that I said before, you often hear about the burden of Hispanic health, and, you know, some people construe that of, Oh, it's a distressed population with higher rates of illness, but I would suggest that basically what's going on is that because we have this stable system, where are taking labor without making a provision to pay for healthcare, that we're putting a burden on local hospital districts and other providers to supply this care. And we're putting the burden on the immigrants themselves.

Now I set aside one point on the last slide that I want to go back to, which was another factoid that Jeff Passel brought out in his report, and that's that the linkings between undocumented, documented, undocumented migrants and U.S. citizens is very complex. In fact 31 percent of all undocumented households include at least one citizen child. Right? So that the limitations of healthcare access to immigrant parents, because of their

status, also fall on their citizen children.

Now finally let's move on -- this slide is simply showing you, giving you an idea of what I call the regional burden, showing you where there are large concentrations of Hispanic populations in Texas. I didn't label it, but I think most people there can pick out the concentration in Harris County, and the Metroplex, Tarrant and Dallas Counties, and Bexar County, and in a lesser extent in Travis, and then along the Border.

I also show you, you know, important facts that a lot of the burden that I've referred to of unfunded immigrant care is going on in the interior cities.

The Border is a special region that has more native populations. Again, the Border regions do have immigrant Hispanic populations, but they are not principal destinations, because they do not have the employment opportunities other places do.

So what one finds in the Border regions is large U.S. citizen populations -- Hispanic populations, with very low rates of health insurance coverage. In areas where the high degree of poverty, low degree of infrastructure, does create for native populations an extra health burden.

What I said about the Hispanic paradox does not apply to the Border regions, which are areas of special

need.

So the implication of regional concentration is that there are local concentrations of uninsured immigrant populations in major metropolitan centers, and these burden local hospital districts, and the South Texas Border communities have low coverage rates despite more native presence.

So to conclude my remarks, you know, with the points to see up there: Hispanics are a rapidly growing population, Hispanics are according to the statistics, relatively healthy population, however their health insurance rates are far lower. Their healthcare access is impaired, there's a large burden placed on local providers, and finally and sadly, every demographic expectation is that these trends will magnify if they are not addressed.

CHAIR JOHNSON: Thank you very much, Karl. Your presentation -- both of your presentations are very informative and we certainly appreciate them.

I'd like to start a question with you, if I may, Adela, and that is, if you were to make a recommendation to the President or Congress about the opportunities for improving healthcare for Hispanics, what would be the one thing that you would make a recommendation on, that would best use the available

dollars, would bring the best return on investment of dollars to help healthcare for the Hispanic population?

DR. VALDEZ: For me it's a personal bias, I guess, because I have seen what education can do. And the best focus would be to provide the best educational opportunities at a very early age.

You can pour a lot of money into a lot of things, and healthcare can be one where you can pour a lot it and it be very useful, but I think for long-term gain, I would say education, and started very early with exceedingly high expectations of anybody who has anything to do with a child.

CHAIR JOHNSON: Are you referring to education regarding health or general education for all?

DR. VALDEZ: General education, expectations of everybody getting a very solid, good educational background from the get-go, so that opportunities are there. I think that is life-changing. It did for me, and having had an education really changed not only myself, but my entire family, and the expectations of the future, so -- and obviously the more educated you are, the more likely you have insurance and have access to care. I think that would be more profound an effect.

VICE CHAIR McLAUGHLIN: I'd like to follow up on that comment just a little bit that, as you said,

clearly having a better education increases the likelihood that you'll be able to get a job in the workplace that brings with it health insurance, and also the more educated you are, the better a consumer you are of healthcare services, and there's literature for both of that.

I wonder, though, given some of the comments you made about obesity and nutrition and exercise, how you would weigh those two for the Hispanic population, because the return to education research has not been based on solely the Hispanic population, that's been based on the overall population, and I'm wondering, given your comments about obesity and diabetes, whether for the Hispanic population that, if you had only the certain dollars, as Randy was saying, that would be the biggest kick.

In part I say this, given the -- a report a number of years ago, an article in the Wall Street Journal, that some new schools in Atlanta weren't even having playgrounds or gyms put into them, because they say, We just don't have the money, and we'd rather spend the money on computer labs and other things to make our students better educated to enter the labor force. How does that fit? I mean, I --

DR. VALDEZ: There's always a balance. I don't think you can -- he asked me for what I thought would be

the more long-lasting, and it doesn't have to be health, but if you were to say, Health, that's why, you know, in dealing with the two other issues, tobacco cessation was very high on the list, and the second was actually physical activity, nutrition, because that has also very life-changing events --

VICE CHAIR McLAUGHLIN: Right.

DR. VALDEZ: -- and I agree with. You know, I'm not trying to dispute that. I think the school systems, though, in the state of Texas, have been trying to work towards that. I don't think as effectively as they should, with CATCH programs and others.

But -- and that's one avenue is to do it through the school systems. Obviously educating the community through the schools.

So it could still function in that manner. Again, I would still focus on -- having seen what I have seen in South Texas, and what I have seen happen when the type of schools that we need have been developed. When children of all economic levels have access to excellent schools, and seeing them go to major Ivy League universities and come back, is very rewarding to the entire community.

You know, again, we are working in South Texas, we have actually a Hispanic nutrition center that just

about started. We have a $1 million foundation for that. So we are going to be looking at how to best approach the kinds of issues that you were talking about, so that part of the research will be happening, and I do understand the focus on that and the importance of that.

VICE CHAIR McLAUGHLIN: I just mean, we don't have good research, and Karl the demographer, I think would agree, on the Hispanic population *per se*, of what the trade-off is between better education, better development of human capital, to then be able to enter the workplace, and, you know, the exercise and nutrition, because it does seem as though the diabetes and obesity problems, and the mental health problems and tying to substance abuse and risky sexual behavior, all of those things wound up together, it's really hard to know, I think, for this particular population, where to put our energies.

And I think that was the heart of Randy's question, that we're being asked to come up with some recommendations, and, you know, you don't want to put all your eggs in one basket, but --

DR. VALDEZ: Well, if I had to, that's exactly what I'd still do, knowing all the facts and having seen a lot of that being a physician, and having dealt with those issues, having to try and find access to care issues.

Things certainly are very different for those populations that actually get educated. And I think the literacy level is such where I think -- and they can better understand -- the family can better understand, the issues at hand.

But as you can tell, diabetes and obesity are not just a Hispanic issue. It's a national issue. And you're talking about people who are exceedingly well educated in which this is happening as well.

CHAIR JOHNSON: Go ahead.

MR. CONLAN: Dr. Valdez, I want to thank you. You said so many things that were of interest to me. I --

DR. VALDEZ: Well, thank you.

MS. CONLAN: -- was writing them down. Maybe I'll have time to have questions, or maybe we can talk later.

I'm a former elementary school teacher, and I have worked with my students in tobacco prevention and some health issues, and so I agree with you.

And I think empowerment and community development is really important to bring to this problem.

But I read an article in my newspaper recently about the correlation between Mexican-American obesity and the shift to white tortillas, away from the corn tortillas. And so, you know, they're very convenient, and

they roll up easily, so that -- I've noticed in my own grocery store I can't even find corn tortillas any more.

I was wondering, is that too simplistic or is there something there?

DR. VALDEZ: As far as diet, I do believe that some of the paradigm that was mentioned before was because of the fact that the new immigrants are having better nutrition, and they do have better resources, like for example the corn products, and the corn tortillas.

As you become more Americanized, you definitely change your dietary habits significantly, and flour tortillas are very much staple of Northern Mexico. And they're now becoming, like you said -- in fact, when I was a child, I went to school with a tortilla, you know, you were felt to be embarrassed, and now it's a common, you know, kind of nice thing to have is a, you know, roll up, or whatever they call it.

But I think the dietary changes have been significant. Most people -- you know, most kids don't even know what a vegetable really is, so.

MS. CONLAN: So could there be a simple nutritional campaign of, you know, glorifying the corn tortilla for, you know, to --

DR. VALDEZ: Well, I think definitely has deficits in nutrition. Education needs to happen. I

think far most we need the research. We really need to focus in those areas, because before we can advise somebody as to, you know, the real things that would be impactful, I think we need to be assured that we're giving them correct advice.

And that's why really looking forward to the Hispanic nutrition center getting started. It's the only one of its kind in the nation, and it will be doing those kinds of researches, asking those kinds of questions, so. I think once that has been accomplished, I think I would feel a lot more comfortable with any advice that comes forward.

MS. BAZOS: Dr. Valdez, thank you for your presentation.

During your presentation you talked a little bit about the fact that immigrants who had Medicaid are not able to take that insurance with them when they cross to other states.

So when someone comes here to Texas, are they very mobile or -- do immigrants move? I think you were talking about the migrant workers --

DR. VALDEZ: The migrant workers.

MS. BAZOS: -- who were on Medicaid. Is there any policy, national or state level, to look at that and negotiate something between states, so that?

DR. VALDEZ: I know that was being looked at. I wouldn't be able to give you specifics on that.

MS. BAZOS: Would that be something that would protect the migrant worker population from losing their insurance? I mean, what kind of burden is that?

DR. VALDEZ: What happens is I think they get to reapply wherever they go, and then that causes the delay in getting some services.

I think definitely it would be a good focus. I would say that that is really a very highly needed for that population. But I think the migrant population is about half a million, overall. The last numbers that I saw.

Do you know what the data shows on the population of migrants right now? I think half a million?

MR. ESCHBACH: Population of migrants in Texas? It's over 2 million.

DR. VALDEZ: Two million.

MS. BAZOS: Two million. So when they leave their jobs in Texas, they lose Medicaid --

MR. ESCHBACH: Again, you're referring to migrant workers?

DR. VALDEZ: Migrant workers.

MR. ESCHBACH: Okay. That was -- no. I'm sorry. I misspoke.

DR. VALDEZ: Migrant workers. Okay.

MS. BAZOS: I was going to say that that was a disturbing fact, about the change in the coverage, but it also makes me wonder about some of the emphasis on communities.

You know, our current President has a big interest in community health centers as a solution, and a part of that comes from his experience as Governor of Texas, that Texas had a history of relying on community health centers.

I did a project in Austin, Texas, that involved the community health centers there as well as the health system there, and they were saying that because of growth, that the community health system in Texas just can't keep up.

DR. VALDEZ: There's no way.

MS. BAZOS: There's just not enough of them. And so while the President, when he was Governor of Texas, maybe it was working all right. Now it's just not working at all.

And so I wonder, too, about, you know, issues of cultural competence, issues of understanding this population, being able to communicate with them, getting them to come in the door and take care of these problems earlier. Do you see that as something to put investment

in, and particularly given the migratory patterns of some of these people, is that a solution? I mean, you can't carry the community health center across the Border either. I mean --

DR. VALDEZ: Well, let me just say that I'm biased towards community health centers, having been a former patient of one.

And the largest community health center is in Harlingen. It's got over 100,000 visits. It has three sites. And the problems, though, are immense. Sometimes the waiting list for any new patient is over three months. Once they do get there, they are provided with a full range of services, which, you know, I don't think in other centers you could provide all the social services and nutrition and the medications all in one package.

So I think providing more resources to those areas and providing a home.

Now, electronic medical records, I think, would be very helpful in really leading into a proper home or a maybe, like say for example, somebody is in Michigan and then they go to South Texas, the EMRs would be a nice way.

Now, seamless care would also require obviously seamless resources, but with community health centers they're not turned away because they don't have funds. So their mission is to take care of those.

As far as cultural appropriateness and sensitivity, it's built into their guidelines. I see it every day as being very caring, very wonderful physicians, who are very culturally sensitive, even though they're not or maybe, many of them are not, basically, Hispanic.

So I find that yes, that works. Unfortunately we don't have enough of them. The population is overall -- the needy is just too great. There needs to be other resources. But I think that one area, I can tell you, it's exceedingly over-taxed.

MS. BAZOS: Would you encourage us to recommend more federal funds towards the development of community centers?

DR. VALDEZ: Definitely, and let me tell you, though, a lot of their time and effort, unfortunately, is trying to keep up with a lot of federal and other state guidelines.

So the technology right now is not very good in a lot of the community health centers, and that technological infrastructure is very much needed so they use their resources for patients instead of trying to, you know, put on all these numbers that they have to, because I've seen that happen.

But yes, definitely, I think putting in much more resources for community health centers would be very

helpful.

MS. BAZOS: Thank you.

MS. HUGHES: Dr. Valdez, Therese Hughes. I was curious about two things. The first is that when -- I'm from Venice, California, and the clinic that I work at -- well, actually, in California as a whole, part of the problem we have is that we have people crossing state lines, but our county lines are more descriptive or in terms of the people that cross county lines for different reasons, and we -- do you not -- I mean, our Medicaid program is sectioned into counties. Does that not -- so we're trying to work at the state level to get a card for all Medicaid patients to go across county lines, and you're emphasizing state lines.

Do you not have the problem going across county lines here?

DR. VALDEZ: Well, I -- they're -- Medicaid, if you're talking about being able to take their Medicaid to another site, or if they have Medicaid --

MS. HUGHES: Right.

DR. VALDEZ: -- or they have other resources, that doesn't seem to be a problem.

MS. HUGHES: Wow.

MS. PEREZ: But, let me just add --

DR. VALDEZ: Not within counties.

MS. PEREZ: Yes, but we have county hospitals that only want to see the county residents. So like here in Harris County, you have the Harris County Hospital District. They don't want to see the residents from Montgomery County --

DR. VALDEZ: Anywhere else.

MS. PEREZ: -- or anywhere else. So that becomes an issue, but then those facilities don't exist in those counties, so -- then of course Karl's over at UTMB in Galveston, and he gets them all, you know, so.

MS. HUGHES: We have that problem with the hospitals, as well, but what if also had the problems where the counties refuse to -- I mean, if the patients come across, we have county line problems, I guess.

CHAIR JOHNSON: Karl, if I can follow up: Earlier we asked Adela her thoughts regarding best opportunity to invest in healthcare, and she shared her thoughts on education. If we were to ask you a similar question, based on your exposure and your experience, what would be some of your thoughts?

MR. ESCHBACH: One follow up point that I want to make is I think it's always important when talking about this issue to distinguish native and foreign born. And they really have quite different needs, and the remarks that I made about overall statistics pertained to

an advantage that was almost entirely a foreign born advantage.

Now I think then, and that comes back to the -- one thing we're focusing on, we have a disparity center that I work with at UTMB that focuses on Hispanic populations, and we have framed the question, you know, what are the immigrants doing right that the native born are doing not.

And when I spoke about those advantages -- statistical advantages, in terms of young adult behaviors, such as lower suicide rates, lower rates of death from alcoholism and drug abuse, sadly those advantages do not persist in the native born population, and I think, you know, for that reason I think I would whole-heartedly agree with the need to, you know, to address those needs and, you know, to figure out, essentially, what's going wrong with acculturation. Right? To figure out what we can do to address those needs.

You know, maybe to have some of the advantages that come with acculturation without the deterioration of some of the behaviors that are advantageous for immigrants, and I think that should be an important focus.

But I also come back to, you know, my sense that with the current structural situation, we can't really address all of these needs with respect to the

immigrants themselves.

They are coming. The efforts at border control, all of the studies, you know, have suggested -- have not really lowered the migration flows or, you know, they may have, against some standard of other, increase that would otherwise would have happened, but the raw numbers are still increasing.

And those are populations for which I come to that until we've figured a way to get medical care resources to this population, rather than, or, you know, if you want to stop it, stop it, I don't know, but, you know, but again, coming in as a demographer, I'm a little bit skeptical of the structural situation that, you know, employers have got used to hiring people, and consumers have got used to, you know, low health prices that, you know, are on the backs of undercompensated immigrant workers for whom healthcare is not provided by the employer or anyone else, and I think until you address that structural situation on the immigrant side of things, you're not going to solve problems.

So I think you've got to have different solutions for immigrants and for the native born. And for the immigrants it's, you know, funding healthcare, and for the native born it's trying to prevent some of the erosion, you know, of behavioral standards in the native

populations.

CHAIR JOHNSON: Could we assume -- go ahead, Catherine, and I'll pick up a little bit later.

VICE CHAIR McLAUGHLIN: Oh, well, I just -- one -- two comments before I follow up on that. One is that we now have a third person at the table with a Wisconsin connection, Randy. If you noticed that Karl, also, was at the University of Wisconsin, so, we both received degrees there, so. Way to go.

CHAIR JOHNSON: We all had to come to Texas to get smart, though, you noticed that.

VICE CHAIR McLAUGHLIN: And the second sort of somewhat flippant comment is that my husband is an immigrant from Mexico, and he just says that Mexicans are reclaiming Texas. That it was their territory to begin with and they're just reclaiming it, so he certainly doesn't think we're going to stop it, Karl, that -- your comment.

The acculturation issue. I just thought I'd point out to you one interesting study that was done a few years ago by someone at Michigan, which is where I am now.

The demographer, who was very interested in this paradigm of low birth weight babies and infant mortality, that immigrants tended to have a very good statistic for that, mimicking those of white Americans,

whereas non-immigrant, U.S. born Hispanics, it's the worst figure of any population in the United States, and so a lot of researchers have, in fact, looked at this acculturation issue, and the fact that the women here who are U.S. born were smoking and not eating correctly, and some of the things you were talking about.

She got interested in this from research she'd done, a dissertation, looking at Mexicans and did a detailed study of women in Detroit who were Mexican immigrants, but they came from two very distinct populations in Mexico, and found that there was a very large difference.

We have this image that immigrants are coming, eating corn tortillas and not smoking and not drinking and not engaging in risky sexual behavior, having, you know, the family structure and being very religious, and that's the difference. And they come to the wicked U.S. and learn all kinds of awful behavior.

But what she found is that that is changing, and that we have to change our view of the cultures from which they are coming, and that from one population group they were arriving already smoking, already drinking, already eating flour instead of corn tortillas, and not eating well, because the cultures in Mexico are changing as well.

So I think that that acculturation bias is going to go away to some degree, as we witness that kind of change.

MR. ESCHBACH: I agree there's certainly a potential that the world never stands still, and the migration flows are changing their composition, and I think that's very plausible.

DR. VALDEZ: Let me mention something else as well. When you look at the Mexican media and you look at what they're advertising and how the focus is on -- even how the women dress in the Mexican media now, is exceedingly different.

When you go to major cities, you can't tell them from an American city. There's McDonald's, there's, you know, every other kind of eatery place is there.

So yes, I think that acculturation is also happening across the border in multiple methods and medias.

CHAIR JOHNSON: Let me try a different subject, if I might, and that is employer-sponsored healthcare.

My sense, but I don't want to assume without hearing more from you, my sense is that you -- neither of you would place a lot of value in trying to improve for the Hispanic population in this area, opportunities for an employer-sponsored healthcare system.

To what extent am I correct? And if I'm not

correct, what would you think could be done to help enhance the opportunities for, and likelihood of employers providing healthcare coverage?

DR. VALDEZ: Want to tackle that one? I have my --

MR. ESCHBACH: Okay, I don't know the specifics of our 3-Share program at UTMB, which is an attempt to do just that. I mean, I think, you know, my --

DR. VALDEZ: I did show the slide on the 3-Share program.

MR. ESCHBACH: Right. You had mentioned the 3-Share program, and it is an issue that if it gets approved, essentially, I think UTMB's perspective, or one of its perspectives on the situation is that it is paying for healthcare anyway, for populations in its community that have no coverage, so essentially if it can contribute one of those funding shares, essentially, it might be able to leverage employer and federal contributions to help.

You know, sure, I think that's, you know, those kinds of approaches, you know, something that, you know, that say leverages opportunities in the private market and brings in resources to encourage more employer-sponsored healthcare, but -- you know, certainly could help the situation.

Whether it's practical to think that that will

be the solution, or that there's going to be enough commitment from private employers, you know, that's another matter.

DR. VALDEZ: There had been some legislation, I think, initially attempted, or some health policies, some time back, in which, at least per state contracts, it was going to be required that their employees be -- have some kind of insurance. That never passed, and I foresee that, even though I think it would be a wonderful thing to have at least more access, maybe they'll still be underinsured, but they'd have some insurance, that would be a wonderful resource.

The problem is, I think, that small businesses are very concerned about being able to keep abreast of their business with that kind of model.

But I would very much like to see maybe a collaborative effort between -- very much like the 3-Share plan be developed.

CHAIR JOHNSON: Any further questions or -- go ahead, Montye.

MS. CONLAN: I wanted to pursue this education theme, and since we have someone from a university in Texas, maybe we can plant the seed.

I was involved in a program that was sponsored by a Catholic University in Washington, D.C. The goal was

to attract more minorities to medical school -- to apply to medical school.

So the objective became to train teachers and actually in molecular biology and immunology, and allow them to work with their students and bring them to Catholic University for these very meaningful laboratory experiences.

I was involved with that project for about four years. By the end of the four years, they were starting to see applications to medical school, and I think that was a wonderful project that worked through the public schools in the District of Columbia.

So perhaps maybe we can plant the seed, and maybe there is a university in Texas that would be interested in a project like that.

But do you think that would be helpful in?

DR. VALDEZ: Actually, there are some programs such as that. Baylor College of Medicine has a program such as that. UT San Antonio has one such as that, and I'm sure other universities have similar programs.

The problem that we find, though, is that there's several layers to dealing with Hispanic populations, and one of them, obviously, is that by the time they're identified, they really need to have the basic sciences, and sometimes that lacking.

But the other -- and I'm finding that a lot in South Texas, at least, is that the nuclear family or the -- it's very strong. There's a lot of fear in leaving the area where they grew up. It's much more stronger than one would think, and therefore these programs try and encourage -- at least summer programs, at least even two weeks out of the whole -- anything that would encourage them to move on forward.

That's why, you know, I am very pleased that we have the types of schools that we have now: the Magnet schools that are there, and which the medical schools, then, or other types of resources, come to those schools. Med ed programs, mini medical school programs, all those that help open up the doors and the opportunities, and even just being -- having a role model is very important.

But I think the more opportunities there are, I think yes, definitely, the more you get them involved in the science.

The one thing that though we found out in admissions, is that the more they're qualified in the grammatical and language skills, the more likely they are to succeed in medical school.

So it's not just, you know, the math and the science.

CHAIR JOHNSON: Well, we want to thank you very

much for your time this morning. We will get our hands on the video that you talked about earlier, and look at that, and review your presentation, as well.

We found -- I'm sure others did as I -- found a lot of good practical comments and suggestions, so thank you very much --

DR. VALDEZ: Well, I could have talked for two hours, I tell you. It was very difficult to try and put everything that I wanted to say in 15 minutes, but thank you for having me here. I appreciate it.

CHAIR JOHNSON: Thank you, Karl.

Okay, we'll adjourn this section of our hearing, and in three minutes begin to discuss rural health.

(Whereupon, a recess was taken.)

CHAIR JOHNSON: Okay, I think we'll begin. I'd like to welcome you back to the second phase of our hearing today. And in this phase we're going to focus on rural health.

Patti Patterson is the Vice President for Rural and Community Health at Texas Tech University Health Sciences Center, and she oversees policy and development for the Rural and Community Health Programs, serves as Research and Education, and serves as Medical Director for the telemedicine and telehealth program.

Rachel Gonzales-Hanson is a lifetime resident of Uvalde, Texas and currently serves as Chief Executive Officer of Community Health Development, Inc, which was incorporated in 1983. It's a non-profit community based healthcare agency, serving rural counties in Texas Wintergarden area, Uvalde, Real, Edwards, and parts of Zavala.

And Ernie Parisi is the Administrator and Chief Executive Officer of the East Texas Medical Center at Quitman, a non-profit hospital with 30 acute care beds.

So we'd like to welcome you, and our agenda has Patti listed first, so we'll ask Patti to go first, and then Ernie and then Rachel, in that order.

But what we'd like to ask you to do is take no more than 12 minutes, and we have to be prompt, because of the end of the session we'd like you to be willing to take some questions if you would.

So when we've gone 10 minutes, I'll just put my name tag up like that, to kind of give you an alert, and then at the end of the time when we're approaching 5 minutes left in our time together I'll just put this up so you can see that we've got 5 minutes left in the overall hour and 15 minutes that we have, okay?

So welcome, and Patti would you start please?

DR. PATTERSON: Thanks. This is all working?

Okay. My expertise in rural health comes from growing up in a town of 2,000 people, also being Commissioner of Health for the State of Texas, and have been working on rural issues at Texas Tech for about five or six years.

Go head. We'll rocket through these.

Whoa, come back, come on back. My dad was an auctioneer, but I can't do it like that. Go back to -- go down to number 3. Okay, this will work.

FEMALE VOICE: Right here?

DR. PATTERSON: Yes.

This is a sign that was on my hometown hospital, okay? "Closed. Call 9-1-1." The trick is, you call 9-1-1, nothing happens.

Next. Okay. I'm going to talk about what I know about, and then extrapolate that to the country overall, and it does fit.

We're in West Texas. Basically, at Texas Tech -- there are eight medical schools in Texas, and Texas Tech is the only one west of I-35. We have campuses in Amarillo, Lubbock, Midland, Odessa, a Residency in Abilene, and a campus in El Paso.

This shows that Texas is a fairly rural state.

Next. Okay. That showed much of the state to be rural. This shows actual population density in the state. I'll show you that as it fits with the country in

a moment. Basically you see the white -- that's counties with zero to ten people per square mile, and it being very sparsely populated, are in the western half of the state.

That's important, because you can't just say, Rural is rural. Being right outside of Austin or right outside of Houston is very different than being 300 miles from anything, and we have a lot of 300 miles from anything places.

Next. Okay. This is how it fits with the United States. You go up the entire middle of the country, have a lot of the same thing.

Next. Okay. Population change, and this is between '90 and 2000, in the parts of the country where everything -- well, Houston, Dallas, those kinds of places, were exploding, we were experiencing a population decline. We also had a decline in per capita income in most of those counties. Okay?

And how does that fit with the rest of the country? The same way through the Great Plains. Why is that important? Well, what's out there? We've already established not many people. Food, fuel, fiber is out there.

So much of what makes this country work is out there where there aren't many people.

Next. Just very quickly, we don't have a very

high African-American population in West Texas. There's much more in East Texas, as well as in the South.

Next. Next. This is Hispanic population, though, and it's interesting that when you start talking about Border health, you really can't separate Border health and rural health in Texas.

And the maps are all wrong. Mexico's influence starts a long way north of the Rio Grande.

So this just shows the percent Hispanic population: 50 to 98 percent, obviously on the Border, but also West Texas and up.

We have an interesting component that we're part of migrant home bases and part of the migrant stream.

Next. To talk about elderly.

Next. The fastest growing population in West Texas is the people over 85. This shows the percentage increase in people over 65. Again, a West Texas phenomenon is young people migrate to the East.

Next. Okay. If you have a whole lot of old people, what do you need? Lots of healthcare. What do we not have? Lots of healthcare.

These, the reddest counties, are those with zero physicians in them. The pink or whatever color that is, is one to three. One to three might be the perfect number, but it does show a paucity of healthcare in those

same areas.

This map shows how far you have to go to primary care. Those red spots are more than 20 miles to primary care, and that middle kind of spot out there is gone, now. That fellow left.

Next.

FEMALE VOICE: Did he die, Patti?

DR. PATTERSON: No, he left.

FEMALE VOICE: Oh, he did?

DR. PATTERSON: At least partly because of Medicaid managed care. It's a long, nasty story.

Same thing, access to prenatal care. Lots of places that it's lots of miles to prenatal care. Is that important?

Next. Duh. Yes. I love this picture, because it's going to take a whole lot of those dollar bills to take care of that baby. We know that people who don't get prenatal care are more likely to have premature babies. That's the big March of Dimes push right now.

There's also a very strong correlation with sexually transmitted diseases, particularly Chlamydia. Those rates are very high out there, too.

Next. One of the important things about this slide is that for counties with small populations, the data is "Not Recorded." That doesn't mean there weren't

any deaths. There's just a number below which you don't report because of privacy issues. So one of the things about rural: it's very hard to get data, sometimes, because it's so hard to get it aggregated, you have to go knock on doors a lot, to try to get anything.

The trauma and death rates, though, in rural areas, are twice as high as urban. Which makes a lot of sense, because it's just a lot of miles.

Next. And this -- I like this one. It's the Golden Hour, basically. The outside circle is 90 miles to a Level I Trauma Center. There are other Trauma Centers out there, but these are the ones that are established by the state as Level I, and obviously there are lots of places along I-10, as it goes from San Antonio to El Paso, that are way past the Golden Hour.

Next. Another just monster issue for us is mental health services. Just like much of other rural parts of the country, we're having a lot of issues with meth labs and kids. A new growth industry, I guess. The farmers don't like it when their anhydrous tanks get stolen, but that's the industry that's going on right now.

Again, and this is just a psychologist. A Pedi Psychiatrist, forget it. And there's not that many in the whole state, but there certainly aren't many in our half.

So lots of gaps there. Is that important?

Next slide. This is the national data on suicide rates, an area I'm pretty interested in. And it's split up by population density. And you see those peaks on the right, on every one -- all in the men? Those rates are highest in isolated areas. Why? I don't know -- maybe it's lack of services, maybe it's culture.

And economy's got to have something to do with it. That's been very bad in a lot of years lately.

Next. Dental services. We all know that there's a shortage of dentists throughout the country. I have trouble getting in to a dentist and have insurance.

But you have lots of places where you just can't get kids in. Plus the ramifications of the Medicaid reimbursement schedules.

I've talked a lot about need for work for us, there are some things that work. Schools that have a mission for putting practitioners into rural areas.

Next. People who have a rural background. It does not work to transplant people from Houston into Muleshoe, Texas. It works for a little while, but pretty much they don't stay. To say generally it doesn't work is probably an overstatement, but it just doesn't work very well. What works is home grown people, and we've got several cases of that where we have large practices in some of these places, they pick kids out of high school,

and mentor them through.

Training in rural sites has been shown to help. Family Medicine, especially. Everybody else just can't cover for each other very well.

Having your family -- grandmothers, is what I call this one. Somebody to babysit?

Good schools. That's a huge problem. You can't really separate the education system from the healthcare system.

Favorable practice environment. They will want to pay -- buy shoes for their children and to send them to college.

One of the important things from a rural perspective, is we know that rural people are more likely to be poor than the population as a whole, more likely to be uninsured, and more likely to be dependent on government funding sources.

So what happens is changes in, for instance, Medicare, will impact rural more quickly, because they're more dependent on that in the rural hospitals.

This is Hart, Texas, one of the places we're working trying to get kids in schools interested in health careers.

Next. One of the programs that I think is making a difference for us is Area Health Education

Centers. This is Title VII funding, which was zeroed out by the Administration, zeroed out by the House, and the Senate is putting it back in, and we'll see what happens in Congress.

Through this program, we have staff in Plainview, which is north of Lubbock, Amarillo, Abilene, Midland, and the goal is to put it as well in El Paso.

There are four folks in each of those places. They cover about 26 counties. Their feet are in schools, clinics, hospitals, every single day. It's a connection between the Health Science Center and those small communities.

You can't do it from Lubbock. You've got to have people out there and you have to have trust and relationships with people, so that's what we're trying to develop.

A lot of the emphasis is workforce, another part of the emphasis is health education in those communities.

Next. One of the things that we've been working on for well over a decade at Texas Tech is trying to overcome distances. A lot of these places are never going to have a practitioner out there. It's just not big enough to support it.

This is our Burn Clinic in El Paso. The lady

on the left here. The people on the right are in Lubbock.

We have the only Burn Center between Lubbock and Phoenix, and Oklahoma City and Mexico City.

So, about half of that population comes from El Paso. Well, these people were driving five or six, seven hours, sitting waiting for Dr. Griswold, seeing him for 30 minutes, driving back.

He asked if we could help. But being the nice guy he is, he also started flying to El Paso.

Well, we can make this cash flow in no time to have a surgeon in the operating room, instead of in Love Field waiting for the plane to El Paso.

It works extremely well. When we do the follow up visits, we're also looking at putting a unit in the Thomason Emergency Room to help manage some people, perhaps not even have to have them sent to the burn unit.

You don't to have to avert too many air transports to make this thing pay for itself.

Next. Another area is nursing homes. Our big business is prison system. But there are a lot of things that are similar between prison systems and nursing homes. Neither of those populations do you want to be moving around the state, for very different reasons. I think it's just mean to move old people around when you don't have to.

This is in the Carillon. And this is close. And if you can do it close, you can do it anywhere.

This woman on the right is 100. She went on a hot air balloon ride on her 100th birthday.

And they're just, you know, connecting and following this lady up.

The policy issue here: Medicare will not pay for telecare that originates from nursing homes. I jump up about that one.

Okay. Next. Another one we're doing is telepharmacy. Working beautifully. A private doc out of Plainview, Texas, was doing a clinic in Turkey, Texas. It's about 75 miles from anywhere. And he was seeing patients and great idea, except it's still 75 miles to get your meds.

So our pharmacy program put together the formulary and the dispensing mechanisms and so forth. That one's working well. We're looking at putting another one in Earth, Texas, if y'all remember the old Dairy Queen ads. That Dairy Queen's closed now, by the way.

Next. It's a lot more than just access to care.

Next. Lots of interest: bioterrorism, rural, agri-terrorism, lots and lots and lots of our cattle production, pork, chicken, is in rural areas, as well as the food supply.

Next. Again, diabetes death rates. The death rates isn't the story there.

Next. Obesity's the story there. If any of y'all are in these pictures, I'm sorry. These were taken at the South Plains Fair.

Next. Surely you guys have seen this. If you haven't, somebody's not doing their job. As far as obesity rates, 90.

Next. Quick. It gets worse, it gets worse.

Now go forward.

Okay, next. That's in '95. You have to add another color.

2000, you add another color, or 20 percent of the adults, and then in 2001 you add in another color where it's over 25 percent of the people in Mississippi.

Okay, does that vary by rural/urban? Looks like it does.

In all these, all men and women, the most isolated are the most obese. Suburbans with Gold's Gym, I guess, are the least. And bagels and tofu and stuff. We don't do bagels and tofu in my home town.

Okay, next. It does vary some across the Regions, the South and Northeast being the highest.

Next. Okay. Things I've learned in five and a half years of working at Texas Tech in Rural Health, and

12 years of working in public health: Rural solutions are going to have to be created. You can't just take urban things and smash them -- make them small and smash them down there. It just will not work.

I can give you a whole list of things that are good examples of that.

It's got to be practical, it's got to be built on relationships, it's got to be built on trust, or they just throw you out.

I mean, literally, talking to the County Judges, my number one credential is I'm from Hale Center, Texas. It doesn't matter I've been Commissioner of Health and have a Masters in Public Health in all that other stuff. They don't care.

And the other is beware of unintended consequences. Very often our policies that we implement, we don't think it through all the way to rural, and then there's a whiplash out there.

Next. Okay. I guess we'll do questions all together later.

CHAIR JOHNSON: Yes.

(Pause.)

MR. PARISI: I couldn't have said it better. Dr. Patterson and I have had an opportunity to be in other programs at other times.

And I'm going to give you a perspective of rural Texas from a rural hospital perspective. It's also from the formation of rural health clinics in Texas, and what the impact is out there.

I'm the administrator of a 30 bed acute care hospital, in Northeast Texas. I'm part of a system that has 10 rural hospitals attached to it, and I'm just one of those 10. We're a Joint Commission accredited hospital.

We serve a population of about 35,000 in my community. The town itself is only 2,000.

Our county is a medically underserved area, and we also have medically underserved areas in neighboring counties, in which we have some rural health clients.

But we have four rural health clinics within our hospital that we provide, and I might add it's been said -- at least I've been credited with establishing the first provider-based rural health clinic in the state of Texas, and that was in 1990.

So, rural health clinics have a definite thing in Texas. It is a primary source of care in Texas.

In our particular hospital, we also provide for four women and children's clinics throughout four different counties, and they're located in Daingerfield, Gilmer, Quitman, and Canton, Texas.

We also have a grant from the state to provide

for primary healthcare, and we also have grants for Title V grants for maternal, children, and planning.

I give you this background because I'm going to reference these as I go through this presentation.

So today what I'm going to talk about is rural versus urban, and I could have the same slide presentation, literally, that Dr. Patterson has had, because it does illustrate the point that we face in rural Texas, and particularly in rural America.

I'm going to talk about access to care. Again, Dr. Patterson eloquently provided for that, and then I'm going to talk about the Texas rural route, so you can really understand how rural Texas is, and how it relates to the access to care.

And I also will talk about the infrastructures issues that Dr. Patterson alluded to, as well.

Hospital volumes are lower, and Medicare and Medicaid utilization is higher in rural America, and specifically in rural Texas.

There are 2,166 rural hospitals in the country, which represents 45 percent of all hospitals in the country. In Texas, there are 185 rural hospitals, 35 percent of those representative in Texas hospitals, of all Texas hospitals.

Sixty-two percent of the hospitals in Texas are

under 50 beds. That's licensed. That doesn't necessarily mean what their occupied rate is. Most of them are below 20. Some of them are in threes and twos.

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. That's the things that Dr. Patterson talks about the county judges and talks about the involvement of county government.

Medicare/Medicaid, and underinsured inpatient utilization in rural Texas runs about 70 percent of inpatient utilization.

In Quitman, using that as an example, although I consider our facility probably a larger survivor than some of the smaller places that are out, particularly in West Texas, we have 80 percent Medicare/Medicaid, and we also provide for 11 percent for charity and bad debt.

That doesn't give you a large margin for private pay insurances within a community.

Total Quitman outpatient utilization runs around 76 percent. In the U.S. rural hospital admissions have declined by 40 percent.

The U.S. 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, 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, shift 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, that's what you're talking about.

Texas rural populations are older and poorer. Texas is 9.9 percent is over age 65. In Texas rural, there's 30 percent over age 65.

In Wood County, which is where my hospital is, we're 20 percent over the age of 65. And I'm one of those. I just got my Medicare card this week, and I call it my extended warranty.

There's a great dependence on Medicare in rural hospitals. Twenty percent are covered by Medicaid, 25 percent have no health insurance.

Now our response to that, how do we as a small community hospital respond to that?

Our hospital charity care being at 8 percent,

which is about $2.6 million in gross revenues.

We have a county indigent care program, as all counties in Texas must participate in, and whether it's funded or not or the money's expended or not remains another issue, which is a local Texas issue, but generally speaking it's 8 to 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. For that $252,000, we have received this grant money. In FY 2004, we provided for over 2,800 primary care visits, a total of 930 patients, unduplicated patients, as we call them. About 1,800 lab and x-ray visits, including CT and ultrasound procedures out of this grant funding, and $647,000 in prescription patient assistance.

Now, we had a person on to provide that prescription assistance. We actually spent ourselves, out of our grant money, which is not a requirement of the grant, of about $30,000 in raw costs for prescription services to those primary healthcare clinics.

Our Title V -- we have a Title V grant. We've received a total of $40,000 for maternal and child health and family planning.

In our four rural health clinics, we have four

med 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 crisis in this state for mental health, period. And I don't think there's anyone at this table that would deny that. Or that's from Texas.

We are projected to see this year 26,000 patients through those four rural health clinics.

We have four women, infant, and children's clinics. We have 411 unduplicated clients. We 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 eligible that we can find into those programs. We have an extremely well-orchestrated 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.

Now, 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.

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

The rural hospital Medicare margins are lower versus urban. In the Med Pac report, the rural margin was negative 3.9 percent, and the urban is 2.3 percent.

I can tell you that most of the hospitals in the state of Texas, in our rural Texas, who are subsidized by tax dollars, are running negative margins. It's only the tax subsidy that's been able to keep them open.

Thirty-four percent of all rural hospitals have a negative total margins, and in Texas, 75 percent of Texas rural hospitals are tax supported.

Texas non-metro hospitals generated 10 percent of the total net Medicare revenue, whereas 70.8 percent of total net revenue generated by all Texas hospitals.

And my point is, where 10 percent of the dollars are being spent on the Medicare program in the state of Texas, that's going to the rurals. And we call

it "pennies on the dollar."

It's pennies on the dollar for the infrastructures issues that are necessary in support of rural, our rural communities. There are access to care issues, limiting care, and we talk about physician issues, as Dr. Patterson talked about physician issues and the disparity. There're issues about physician recruitment, and recruiting for mid-levels in the rural areas.

And the program, the Medicare program itself, which we are largely -- rural hospitals are largely dependent on, does not allow that as a cost of doing business to recruit physicians to their community, does that really make good public sense, good public policy? It does not.

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. Our host is having that same issue in urban Texas: capital dollars.

And in rurals, that is essential to have capital dollars. Most of the facilities in rural Texas were built under the old Hilburton funds. Most of them are aged and having to be replaced.

Workforce issues. Shortages. I'm telling you, nursing, radiology, social workers, ultrasound

technicians, you try to find one out in West Texas. To find an ultrasound technician that can do carotids. You can't. Where do they go? They have to go to Lubbock. They have to go to El Paso.

Salaries are lower in rural Texas, although we're finding that's not really -- in some cases it's an issue, from a nursing perspective, but if you're going to be aggressive, you're going to have to move, and you have to pay the dollars.

These are some stabilizing factors that we have in rural areas. Critical access hospitals. And nationally there're 1,122 critical access hospitals. In Texas, 65 plus. The last count I heard, it was actually closer to 70 critical access hospitals that are being approved.

These are cost-based activities, and not all of the have positive margins yet, and -- because that's not the answer for every hospital.

The rural health clinics, there are 3,400 rural health clinics in Texas. Fifty-one percent of those are provider based. Excuse me: 3,400 in the U.S. In Texas there's 333 in Texas, and 53 percent of those are provider based.

And I gave you on a handout a figure that I think was important. In balancing the budget in 1998,

there was a significant reduction in the amount of rural health clinic operations.

What about some stabilizing, other possible stabilizing factors? And one of the things of public policy that's out there right now is, they call the Rural Community Hospital Demonstration Project.

14 hospitals are in that project, but they were only given to six states with low density issues. Alaska, Utah, Nevada, Montana, South Dakota, and New Mexico.

And the thing about Rural Community Health Hospital Demonstration Projects, that demonstration projects is essential, we think, for the survivability of rural hospitals within the United States.

There should be another stabilizing factor is the FUAC Rural Health Clinic Collaboration. And we think that with the emphasis by the Administration on community health centers and trying to provide those, that if you'll look at the demographics of Texas, you have more rural health clinics out in the rural Texas than you have community health centers.

That doesn't make sense. Take some of that money and put it out there where the people are being treated, and maybe change the law to how to make it work, or do some sort of arrangement with community health centers so that can happen.

Of the 133 counties that are rural, 47 percent do not have a hospital in Texas. Sixty-four counties are considered "frontier," which is seven people per square mile.

And I like to always use the example, there's one hospital in West Texas that serves the combined square mileages of Rhode Island, Massachusetts, Vermont, and Connecticut. That's rural. When you think about that. The economic impact of rural hospital, in Texas, and across the country, you'll find this, is they're either the number one or the number two largest employer in that community. It's the anchor for other healthcare services, pharmacies, and physicians. Without a hospital, most physicians will leave.

The Office of Rural Community Affairs encourages the use of local 4(b) sales taxes used by communities for economic development, including healthcare facilities.

And there's one demonstration project that was used for that, was at St. Joseph's Hospital, which is in Navasota, it was in Grimes County, and that was used as a demonstration for that.

In Quitman, so you can understand the impact, financial impact, we have 207 employees, we have a payroll of $5.5 million. We're the largest employer in Wood

County. We have seven independent physicians and specialists in the community. We have one independent pharmacy, we have one pharmacy through a grocery chain. And we don't have a Wal-Mart.

And that's sort of a measurement: If you've been successful in your community, you've got to have a Wal-Mart. The nearest Wal-Mart for us is 8 miles away.

I can continue to talk about infrastructure, but as mentioned with bioterrorism and so on and so forth, we're the last bastion. Where are those people going to go if we're not there?

I hope the information I've provided has been of help to you, and Dr. Patterson, I could have taken your slides and put them in my presentation, and they would have just perfectly matched.

Appreciate it very much.

CHAIR JOHNSON: Thank you, Ernie. Next we'll ask Rachel Gonzales-Hanson for her comments.

MS. GONZALES-HANSON: Buenos dias. Thank you, Mr. Chairman and members of the Working Group, for inviting me to speak with you today.

Community Health Development is a community migrant health center or an FQHC in Uvalde, Texas.

I had the privilege of serving as President of the Texas Association of Community Health Centers from

1992 to 1994, and currently serve on its board of directors. Additionally, I was honored to serve as the Chair of the board for the National Association of Community Health Centers in 1998, and also served on HHS's National Advisory Committee on Rural Health from 1999 to 2003.

In 2004, CHDI served almost one-third of our entire service area population, and by the way, our service area actually is the size of the state of Rhode Island.

And our patient demographics are similar to other community migrant health centers in rural Texas: A disproportionate share of uninsured; a high incidence rate of teen pregnancies; and a significant number of geriatrics with multiple chronic conditions and polypharmacy.

And while several of you are very familiar with the operations of FQHC, I would like to take a moment to review the unique requirements and the history of the health center program, before I go into a bit more detail on some specific rural issues.

This year celebrates the 40th anniversary of the health center program, which began as a demonstration project for migrant farm workers in 1965, and before I go any further, I would like to just distinguish between

migrant and immigrant.

Migrant seasonal farm workers are those that work in the fields and deal with crops, not to necessarily be equated with immigrants. I just wanted to make that clear.

The program was really started by Drs. Jack Geiger and Count Gibson as a mechanism to improve health and empower the community. That overarching goal still exists today.

Every health center is governed by a board of directors that comprises a majority of its members from patients of the center. In other words, I, as CEO, answer to the board directly, and therefore the patients themselves.

This is not a top-down approach to healthcare, common across the country. Indeed, it is a bottom-up, locally controlled approach that succeeds in communities of all sizes and of all colors.

The federal law governing health centers carries with it four main ingredients or requirements: governance from 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 center, and therefore, of course, to the patients. This empowers the community to improve their access to care and addresses health issues in such a way that makes sense for the community. That is exactly the way it was originally designed.

Unfortunately, not all federal programs are as clear in their purpose yet flexible in their local design. We have literally hundreds of healthcare programs in the country, some overlapping, some completely disjointed, yet every one is well-intentioned.

I was very encouraged by the recent HHS initiative to improve coordination among various programs, and believe more should be done to ensure that our federal efforts are coordinated in their management and design.

This is not to say that all programs should be rolled up into one insurance program, or one access program. Rather, tremendous progress can be made just through coordination of existing programs.

This would save the health center time, and also the federal government resources.

I also want to touch on a couple of concerns regarding the availability of care in rural areas. Health centers wholeheartedly support the expansion of health insurance to more individuals across the country. To put it simply, insurance matters.

However, even with an insurance card, as everyone knows, it is hard to obtain healthcare in rural areas, and more often that is the major hurdle.

Let me share with you a true story that is unfortunately not an isolated case. One of our patients was diagnosed with cancer, and the closest treatment center was a five hour drive away. When the treatment center was contacted by our staff, we were informed that there was a waiting list for referred cancer patients, especially if they were not from the area, and they had no resources.

Can you imagine having to tell the patient that they were on a waiting list? And as if that wasn't enough, this patient had lost his wife to cancer just two months prior to his own diagnosis.

So put yourself in their shoes. What would you have done?

This family actually did travel the five hours to the treatment center, and found a creative way to get into their system. And that's a little sad.

And then there was the patient that had diabetes, high blood pressure, congestive heart failure, and the doctor realized the patient was 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 card, and the next available appointment was four months away.

By the way, the elderly patient had no transportation, and absolutely no support system.

So along with the challenges a rural population faces in accessing primary care, the challenges of accessing specialty care are even greater.

While getting the patients to healthcare services is truly a tremendous challenge for us in rural areas, the ability to recruit and retain medical, dental, mental health professionals, and administrative staff is also a struggle, as you've heard throughout the presentations.

Therefore, as you examine insurance coverage options, I urge you to ensure that payments for providers such as health centers, but all providers, are adequate to recruit and retain providers, even under private coverage. The problem for us is if a newly insured patient comes to us for care, that their coverage is incomplete or inadequate, we will still provide the services necessary to that individual. It is our primary mission.

However, we'll be forced to subsidize that care by using our federal grant dollars that should focus on

caring for the uninsured in our community.

And unless you can guarantee that everyone will be insured, health centers are still going to be the safety net providers in their communities for the uninsured, and therefore adequate reimbursement for all the services provided by FQHCs is critical.

In 1993, Congress recognized this by enacting the FQHC payment rates under Medicare and Medicaid for health centers, although the health center Medicaid rate was restructured in '97, and again in 2000.

Today health centers are reimbursed adequately under a specific prospective payment system that ensures federal grant dollars are not subsidizing publicly insured Medicaid patients.

I urge this Working Group to ensure that payments to safety net providers are adequate, especially in rural areas where no other provider may exist.

It is noteworthy to state that health centers are one of the lowest cost providers in the country, averaging $450 per patient per year.

Each Medicaid patient served by a health center saves 30 percent on overall healthcare costs for that patient. This clearly speaks to the importance of access, and to the quality of care.

And let me be clear about another important

point. It is a fallacy that is cheaper to provide healthcare in rural areas than in urban areas. An office visit in a rural area is just as costly as one in an urban area, and in fact, recruiting costs, coupled with compensation packages, puts us even to a more expensive rate than in urban settings, and any reimbursement methodology must keep this in mind.

Another recruitment/retention tool that we use, in fact, for healthcare professionals at health centers, is the Federal Tort Claims Act, which provides coverage for medical malpractice. It is estimated that health centers save nearly $200 million each year on insurance premiums. However, not everyone is entitled to FTCA or can use the FTCA coverage, so therefore you must also consider the rising cost of medical malpractice and incorporate that cost into a rural payment mechanism.

Ensuring insurance coverage in rural areas is a very difficult task. It is my hope that you find effective solutions. I ask that you remember that insurance coverage should be shaped in a way that encourages access to primary care, preventive services, and specialty care as needed, while not creating additional barriers.

This will take careful examination of what comprehensive primary care services should be

accommodated, and I would encourage you to look at the health center law as a good starting point for such discussions.

Section 330 of the Public Health Service Act lays out mandatory services that must be provided on site or by referral. It also lists additional services that centers may choose to perform, based on the local needs and its capacity.

If an insurance package pays for all these services adequately, the providers will follow. If it doesn't, rural areas will suffer the most.

It should also be noted that in rural areas like mine, where we have migrant seasonal farm workers, the health concerns are compounded.

At CHDI we see a large number of migrant and seasonal farm workers who have very different healthcare needs than one might see in other rural areas of the country, like the coast of Oregon, or in New England.

I know that HHS is finalizing a study on farm worker health needs, and I encourage the Working Group to examine that report once it becomes available. Hopefully it will analyze the growing problem of Medicaid coverage for farm workers who leave the state periodically but require access to healthcare in another state.

As a state-run program, Medicaid is facing the

growing challenge of portability, since it is not in any state's interest to cover healthcare costs outside its borders. Indeed, this problem discourages migrant farm workers and their families from signing up for Medicaid in any state, since they know that they'll be moving to another state soon, and the coverage would not apply. Addressing this issue is critical.

I know I have taken quite a bit of your time, and I am grateful for you listening to the concerns of a health center in rural parts of Texas.

We have coordination issues, recruitment issues, retention issues, reimbursement issues, portability issues, and access issues, all rolled into one.

But none of these is irreconcilable, and all must be overcome if we are to succeed in expanding health insurance coverage and thereby access to care for millions of people who do not have it today.

It is costing our system too much, and straining the safety net in ways unimaginable to the point of jeopardizing them from when our systems were created.

I would offer a couple of solutions that are at least starting points, and do not require any waivers or changing of laws. It is as simple as overcoming administrative barriers.

For example, creating an expedited eligibility process for special populations, including but not limited to migrant seasonal farm workers. States have this flexibility now, and for migrant farm workers that cross state lines quicker than paperwork is processed in the local Medicaid offices, this would result in a dramatic increase in access to care for this historically ignored population.

Another example is that states currently have the option to allow for presumptive eligibility for special populations. That is to say that if a migrant farm worker from Texas, that is qualified for Medicaid, migrates to another state, the state could allow for presumptive eligibility during the period of time the farm worker is going through the eligibility process in that state.

One more example is developing uniformity and consistency in the Medicaid program throughout the various states, specifically reimbursement rates. They should not vary as much as they do from state to state. This would go far to encourage more healthcare professionals to participate as Medicaid providers, and reduce one of the recruitment barriers that we experience, especially in Texas.

Finally, establishing 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.

This would have a positive impact on the negative attitude that some state and local offices exhibit. You see, they see their role as that of keeping the number of Medicaid clients as low as possible. This attitude and subsequent behavior conflict with the main purpose of the Medicaid program.

Again, I thank you for listening, and please know that I along with my health center colleagues stand ready to help in any way we can, and we'd be happy to answer any questions. Thank you.

CHAIR JOHNSON: Well, thank you very much. As you started your discussion, I was reflecting on my own background, because I come from a rural area, and I went to a grade school that had two classrooms. We had the big room and the little room, and I was in the little room. We had 16 in my classroom and four in my class.

But I think you've out-smalled me in many respects, and the issues that you're dealing with are certainly serious, and I know that we all take that understanding away: the seriousness of your tones and your data, that facts that you presented and so forth. So we really do appreciate your input.

A question, Patti, to you first, and the others, both of you can join her in your response if you wish.

You've got some background in telemedicine. To what extent are you seeing telemedicine, and define that as broadly as you wish, as a significant part of the answer, and to what extent would be helpful if Medicare and Medicaid would be reimbursing more and more telemedicine processes and procedures?

DR. PATTERSON: I think we have to be really smart about how we do this. You know, the last thing we want is somebody going through a nursing home with a video recorder and billing Medicare for it.

But I do think there are ways that it can be very helpful, and it needs to be done wisely and with integrity, because there are people out there who don't fit those categories.

I think the limitations aren't the technology. I think the limitations are the ways we've figured out to use them. We're working on some ideas right now for chronic disease monitoring that won't even be the video thing, you can keep up with somebody with chronic pulmonary disease with their oxygen levels in their blood. You can keep up with a diabetic's glucose and so forth.

There are some really smart people in the

industry now starting to get interested in that, so I think there's going to be ways that we can look at some of that.

I think we've been kind of very confined in the way that we're doing it so far. It depends on how smart we are.

MS. GONZALES-HANSON: Can I add something to that, please? I think the other challenge, especially in rural Texas, is the infrastructure to support that technology. Because I know in our area, in our three counties that we serve, up until recently we didn't have T-1 access for two of those counties. We could not get phone companies that deal with those at that point. It was the phone company, wouldn't even install T-1 lines.

So it is about, you know, what is it that we can do for the infrastructure as far as, what is it that's possible to do with infrastructure.

MS. WRIGHT: Mr. Parisi, I'd like to -- I'm sure there's a question someplace, but a little bit of comments, also, for rural areas. What level of involvement do you have specialists directly come to your areas versus your having to send the patients out to that specialist, versus -- are the specialists doing a lot of outreach to your community? Right now I'm sitting in the state of South Dakota, and the physicians -- some of

the -- most of the physicians refuse to do any type of outreach to the communities, because they may go to a community and spending a day away from their office, seeing a patient, and they're seeing that patient that afternoon, and they're saying, Oh, by the way, I'm coming to the city this evening to go to the theater or a movie or see the ophthalmologist, so they're saying, I could be back in my office seeing the 30 patients when I'm just seeing five in outreach.

Also, what part do mobile vans play, as far as MRIs, PETs, mammographies, getting to these areas, and also the use of mid-level practitioners?

Again, depending geographically, we have docs arguing that they don't want those mid-level practitioners out there doing those things, when I think it could be easily handled by them and an extension of their arm to get those medical services out there to the people that need it.

MR. PARISI: Well, there's no doubt that specialist standpoint, there's some reluctance in going out to the rural areas, because of the very reasons that you cite. Because they do lose four hours traveling time, and I'm losing that ability to see patients during that four hour travel time.

You know, part of the solution is telemedicine,

and that's one of the true benefits, I think, of telemedicine, and I think in some special areas where that can be done.

In my particular case, in my particular hospital, I do have some rotating specialties coming into my facility. Fortunately for me, I'm relatively close to an urban facility, where it's reasonable. But you get up to West Texas, and it's not reasonable. And you're just not going to see that.

And as far as mid-levels are concerned, you're still going to have that bias from mid-level that I think in the establishment of rural health clinics certainly will save Texas with as many of them as there were at one time, now are starting to come back. I mean, that was the only primary healthcare source in a lot of rural Texas towns, specifically in West Texas, and how do you overcome that bias? I really don't know, except through education. I think the younger physicians are more attuned to it than the older physicians are, just by virtue of the fact of their training.

And as far as mobile is concerned, mobile is an answer. You know, in some cases technology, specifically when it comes to rurals, not everybody can have an MRI period. The cost is too large.

In my facility, I use an MRI. I have an MRI

that comes out once a month. I mean, excuse me, once a week.

And but other technologies, mammographies, you can do it on a mobile basis, and there are services out there that do it. It becomes a volume issue. It becomes a reimbursement issue.

Many facilities will not go ahead and buy that type of technology because, either one, the volume does not have versus including and plus the reimbursement does not pay for the technology itself to be out there.

A mammography, even though it seems like a simple procedure, from a technology standpoint, from a quality, and from a dollar standpoint, to maintain that equipment, and maintain the quality assurances requirement for mammography, is probably one of the most rigorous and most expensive of all the technologies in radiology and in a hospital setting. Just by virtue of that, because of the training and everything that goes on. Yet the reimbursement is the lowest.

And so what you have in cases like that is you have healthcare facilities are refusing to do it.

So what do you have? You have a lack -- access to care issue.

MS. WRIGHT: You know, I'd just like to add, and I'd like to know if you, or any of you, know the

statistics for that, again in South Dakota, because of that ruralness that we have, we had until a couple of years ago a high rate of mastectomies versus lumpectomies. Number one because it was access, number two it was access to care afterwards. You know, that women did not want to come back every day for six weeks for radiation oncology, they just said, Give me the total mastectomy, I'll be back on the farm on my land, you know, in a week. And it's true, we did have one of the highest rates.

MR. PARISI: I don't have the statistic.

DR. PATTERSON: I don't have the stats, but we see it. It happens, and we did run a mobile mammography unit in the far West Texas down along Alpine and so forth, and can't make it cash flow. There is also the issue of the potential liability, just keeping the technology going, keeping the tech up to date; you got to have a driver. It's extremely difficult.

So what we did was help the Alpine hospital get into that business.

MS. HUGHES: This is Therese Hughes. It's more a general comment. A couple years back, probably five years back, I read Robert Caro's books about LBJ, all three of them, and the first two of them spoke about West Texas, and the ruralness of it, and how at the time there wasn't electricity or running water.

And I find the lack of healthcare to be equivalent to the lack of electricity and running water back in the days when LBJ was a young man, and I, actually sitting here, feel that it's frightening.

Certainly the issues of access greet us at all areas of our, you know, of our nation, but I'm becoming slowly aware of the absolute lack of access in rural areas, and I hope that as we go forward we will hear from more people and y'all hit into our web site with ideas on how to improve the care for, and you know, new ideas that you have, because I think it would be frightening to be in your shoes.

I thank you for doing what you do, because, you know, juggling one life over another is always a difficult issue, but when you have no access, period, the juggling is even, in my opinion, just horrific.

So thank you very much for what you do. And I hope that together we can come up with some ideas that can reduce disparities, because it seems that, like I said, this many years later, healthcare has replaced electricity and running water as a need.

MR. PARISI: I think, my biggest concern is public policy, and as mentioned, you know, one size doesn't fit all, in particularly rural areas. One size does not fit all in rural areas. And my extreme concern

is that in rural areas, we depend heavily on the Medicare dollar, because that's the population we take care of.

And when you have a change in Medicare reimbursement policy, it has an extreme ripple effect to the rural areas, and a devastating rural effect. And we can go back to when PBS came into effect in 1984, and we lost close to 200 hospitals in Texas because of that change alone. I mean, you think about that, you know.

Well, you know, you can't have a hospital on every corner, and I've heard people in the Beltway tell me that, that we're not here to ensure that you have a hospital on every corner. Well, we're not expecting that, but, you know, the citizens of rural America should have access to healthcare.

And that hospital, that physician's office, that health center, we are that infrastructure to that community. We're the only health infrastructure that's there, and if you can't have adequate reimbursement to operate those things, you're not going to have access to care, period.

DR. PATTERSON: Another classic, on the policy, and I talked about it in terms of consequences, is mail order pharmacy. Sounds like a great idea. But if it undermines your one pharmacist and they leave, then you're toast.

The other thing that I want to make really clear is three points: prevention, prevention, prevention. Most of the diseases -- chronic diseases, have their etiology in behavior now. And that's why I was showing the things on obesity. It's the second largest healthcare cost driver now, second only to tobacco.

And the incidence of obesity and prevalence of obesity in 6- to 11-year-olds has tripled in the last 30 years.

So that is something we have got to get ahead of or there's no system that's going to take care of it.

CHAIR JOHNSON: Ernie, you and Rachel have been singing a similar song in terms of the Medicare reimbursement rate needing to be addressed and so forth.

A final question if I might, for the three of you, just quickly, would be a similar question to what I asked the first panel, and that is: What's the biggest opportunity for us, in terms of a recommendation to deal with the issues that you're dealing with?

Is it the Medicare reimbursement rate, or is it something else that you think would bring about a greater opportunity, because as you're talking, Ernie, and you're suggesting most of the patients are Medicare patients, that would indicate to me that in these areas the population's going to become even sparser in the future.

MR. PARISI: Well, obviously the demographics are there, indicating we have a very aged population in the rural areas, and as a result of that, they have significant levels of Medicaid because of that. Because we have aged and poor populations in our communities.

And the thing about I guess my view about Medicare, when you look at the total dollars that are spent on programs, across the country, and the amount of dollars that go to the rural segment, those are cheap dollars. Spend them for infrastructure, because without those dollars, that infrastructure's going to go away, and you cannot replicate it without millions and billions of dollars of grant funds. You just cannot do it.

And I think all of us, who provide for healthcare in rural America, and I sit as the Chairman of the Rural Hospitals Issues Group for the Rural Policy and Research Institute, and we have 18 rural hospital administrators from across the country, that we meet twice a year to talk about issues facing the infrastructure of rural hospitals, and rural hospitals, you know, that are in the rural infrastructure, and we all -- South Dakota -- we all talked about these issues.

It's not just a Texas issue. This is a national issue, as far as rural health is concerned, because we're all faced with the same issues. And you

know, I would say that if you, if, from a policy perspective, if when the Fed makes a decision on Medicare policy, they need to look at how it ratchets us all out, particularly into the rural areas, because they get that piece, because they look at economies, and they look at volumes, in doing this, they look at data that's, generally speaking, when they make these decisions, four years old. Has no relevance to what's actually occurring in our communities now.

CHAIR JOHNSON: Let me ask, I'm going to ask the question just a little bit differently. Say this is Senator Kay Bailey Hutchison, or Senator John Cornyn. They've come to be with you today. You have one chance to make one recommendation to help your situation. What's your recommendation, both of the two of you?

MS. GONZALES-HANSON: Do you want to go first?

DR. PATTERSON: We always talk about looking at the big picture. I say look at the little picture. And let's find ways to make normal systems work. I mean, it's great that federally qualified health centers get additional reimbursement rates, it's great that rural health clinics can get cost-based reimbursement or whatever the thing is.

Those can be across the street for a private practitioner who can't get that rate. And so it

undermines a private solution.

CHAIR JOHNSON: Okay, so what I'm hearing you say is, ensure your public solutions don't undermine your private solutions, as well.

DR. PATTERSON: Excellent. Yes.

MS. GONZALES-HANSON: And I think the other piece to that is again it's as simple as having the private sector receive a fair reimbursement rate. And that's the bottom line --

DR. PATTERSON: Right.

MS. GONZALES-HANSON: -- because we have different array of services that are provided through rural health clinics and through FQHCs, but the private sector is definitely a partner in that community.

We're not the sole solutions, neither are rural health clinics. The private sector is crucial, and being able to have everybody be on an even scale, when it comes to fair reimbursement, is important. I think your question, Mr. Chairman, though, unfortunately, is unfair, because there isn't just one answer. Right? There's not one thing we could do. It's a multifaceted approach --

DR. PATTERSON: You have 30 seconds to think about it.

MS. GONZALES-HANSON: I have 30 seconds to think about it? As I was thinking about it and I was back

there, and the first panel was going on, I thought that, That's not fair! I still don't have, I think, just one answer, but I would say, I sort of, I want to piggy-back what Patti said, and so I won't elaborate on that, but earlier you were talking, I think the other panel was talking about "growing our own."

There are a lot of projects that are going on in Texas. They do partner with health centers -- I'm sorry -- with universities, to grow our own healthcare professionals. They are based on the community, so the ones that run it are the communities themselves. That is what makes that pipeline, growing our own makes that pipeline more effective, versus coming from universities and coming in.

Our communities designed those projects, and then they partner with colleges and universities and, you know, health education centers, or academic centers, to try to make sure that we bring back. It's a long-term approach, but there's no other way to do it.

CHAIR JOHNSON: Well, thank you very much. I would -- last comment? Go ahead.

MS. CONLAN: I wanted to thank you for speaking about Medicaid. I am a Medicaid beneficiary, and sometimes I wonder, traveling with this group, what would happen to me if I had an accident, because my Medicaid

doesn't carry with me. And I thank you for speaking not only on behalf of Medicaid providers, but also the Medicaid beneficiaries, and their treatment, sometimes, because I've experienced that myself, from the gatekeepers that are trying to preserve the state treasury.

But I'm wondering with the transportation issues you've mentioned, in terms of receiving healthcare, what about even applying for Medicaid? Is there a problem there? I know in Florida they're closing satellite offices again to save money.

MS. GONZALES-HANSON: And in Texas, we're closing satellite offices, and we're developing call centers.

By the way, and this was when I was at our TACHC conference earlier this year, and I don't know if it's changed or not, because, you know, wait around long enough in Texas and something will change. But actually the contract was already let out for who would be manning the call centers to the Bahamas, is what I was told, and I'm waiting for my people to be able to talk to people in the Bahamas and understand each other. That's going to be really good.

So definite problems.

Now, one of the things that's really helpful, and I don't know how they do that in other states, I know

in Texas we have outstationed eligibility workers that could be based in hospitals and community health centers, where basically we share the cost with the state for half the salary. So we have somebody there that -- onsite that will actually be, and those will not be replaced, that can actually process the patient so it's faster, and they're right there onsite.

There are a limited number. I understand that they will allow for that through the state, number one. And number two, they also don't necessarily -- well, they don't encourage them to be proactive in trying to process as many as possible, so basically I understand that the con to that is, historically if they're not a person with a heart, then they process maybe three or four a day, they're okay. Three or four applications.

CHAIR JOHNSON: Well, thank you very much for your time this morning. We appreciate your comments, and I'd like to echo Therese's perspective as well, or thank you for the contribution that you make in behalf of your patients and clients and people who live in your regions.

And we will take your comments this morning back and include them in part of our evaluation.

I think we'll take a ten minute break right now, and we'll reconvene at 10:45.

(Whereupon, a recess was taken.)

CHAIR JOHNSON: I'd like to welcome to the next phase of our hearing today Nancy Wilson and Lanette Gonzales are here to talk about opportunities and issues with respect to long-term care.

Nancy is with the Huffington Center on Aging at Baylor College of Medicine. Lanette is with Sheltering Arms in Houston, and ladies we're really delighted you're here today. This is our fourth in a series of hearings on healthcare, and we're looking forward to your comments.

So this is your presentation, Nancy, so we'll assume that you're going to go first. And we're looking, again, to your comments. If you'd prefer to use the microphone on the platform, you can, but if you'd prefer to sit there, that's fine too.

MS. WILSON: Well, thank you, Mr. Johnson. Good morning. *Buenos dias*, *bien venidos a* Houston. We're very pleased and honored to have this issue on the agenda and to have you here today to have us talk about it.

Just briefly, my background is in Social Work and Public Health. I've kind of grown up in the field of aging, having come to Houston in 1974 with solid plans to stay for two years and then move on. And I'm somewhat past that time-frame.

But part of that has been the privilege and opportunity to work in a diverse community and a diverse

state, and more recently we have come together as part of a partnership that's a private/public partnership. You have some information about that in handouts that you were given called, "Care for Elders."

Lanette and I are both part of this partnership. We've come together to address what we think is the concern of the 21st Century, and that is the growing aging population and the need for assistance and attention to vulnerable older adults and caregivers, as well as other old adults coping with disabilities.

In Harris County, we are coming together across funding streams, across auspices, non-profit, private, public, as well as other key stake holders in terms of funding, corporations and media.

And our mission really is to do the same thing I think you're trying to do for the country, only we're only going to look at it for the county.

So I commend your reach, and I'd like to inform that effort, but I'm glad -- we think that 7,800 square miles is as big a territory as we'd like to focus on, although I do remind all of us when we get struggling with issues of access, that we're as big as the state of Rhode Island, so it should be challenging to look at these issues in our county.

The brochure that you were given is a bit of a

summary of our initial road map of the strategic plan that was developed, and I want to acknowledge that our partnership is supported through the Robert Wood Johnson Foundation, Community Partnerships for Older Adults Program.

We are one of eight programs around the country that have been funded to implement plans, and there are another 13 communities in the pipeline to develop plans and compete for implementation funding.

Robert Wood Johnson is joined in funding through local foundation support, as well as our United Way organization. As I say, we have significant in-kind contributions from partners across the spectrum within our community.

We are concerned with a lot of the themes that have already been addressed this morning: access to needed services for older adults who need to know where to call, family member who gets a call, Mom's in the hospital, has fractured her hip, can't go home. Where do I start, what do I do?

We are concerned with issues of availability of affordable services, not only in terms of whether or not the individual can come to the service, if they happen to live outside of the Transit routes in our community, but also whether he or she is physically capable of enduring

the ride on the transit to get to the service, or whether he or she has the funds to pay for the help that's needed, and we'll talk some more about that.

Lanette's going to talk about issues of quality of care and the workforce. Again, this is a theme across healthcare, but it's certainly a theme in long-term care, in terms of the quality of care, and also the ability and the adequacy of our workforce to address these issues.

And then we recognize that one of our missions as a community is to not just think about what the systems and providers can do, but also how we can help individuals and families prepare for what we know is a significant risk of needing long-term care, but also prepare for the highest quality of life in the longevity that we find ourselves enjoying increasingly in our country.

And also how organizations can prepare for the long-term care needs, both in terms of workforce, and in terms of approaches, in terms of creative use of technology and such.

And then how our community can think about the physical and social environment, because oftentimes it's not just the limitations an individual has, but it's how adequate the housing structure is, the transportation patterns, the neighborhoods are, in terms of allowing older people to live successfully with fewer limitations

into later life.

So today I'm going to talk about this -- the broad scope of the population that needs long-term care, but I just want to acknowledge a limitation, not the fact that I have a couple of broken fingers, but the fact that my experience focuses primarily on older adults, however, as I think about these issues and work on these issues, I just wanted to tell you I'm always thinking about three -- really four categories of people.

I'm thinking about my brother-in-law who at four years old was bit by a mosquito, developed encephalitis, has struggled with mobility and function issues his entire life, but was able to be successfully employed, and thanks to the Metro of Washington, D.C., is still ambulatory by virtue of an electric wheelchair and adequate transportation system, and careful planning on the part of a number of individuals in his family, for whom he's been a beneficiary of lots of financial trusts and other things, so that he can continue to function.

He's fiercely independent, living in his own apartment, and is a big volunteer with a national institute.

My neighbors. I have lovely neighbors in an older neighborhood of Houston, but people who are often on my heart are Mrs. H., who's 81. She has congestive heart

failure, she has chronic obstructive pulmonary disease, regretfully she had a fall about 15 years ago that left her with a closed head injury which limits her cognitive ability but not entirely, she is able to enjoy a lot of life, and able to do some things.

She'd like to remain at home, and her very dedicated spouse would like her to remain at home as long as possible until her death.

But they have lots of issues around these medical care issues, but also just day-to-day dependence and the need for ability.

And he's facing surgery soon, as her only primary caregiver. Both kids live out of town. So they're going to need lots of assistance.

And then I have a niece -- and so that's part of the long-term care population. I have a niece who's 22 years old. She developed mental retardation at the time of her birth due to complications. She has autism, she is heavily dependent on family assistance, and the family would like for her to stay at home as long as possible, with supervised help.

All of these are individuals that fall into this category of needing long-term care assistance. They have functional limitations that, the things that you and I did every day to get here, get up, as I told the medical

students, brush our teeth, comb our hair, fix our food, all those sorts of issues, they cannot count on being able to do. They have to rely on other people.

So this is what long-term care is about.

And then obviously the fact that everybody I talked about who is still at home, which is their preference, is because of heroic family measures: spouses, parents, siblings. And so we have to kind of be mindful of all these individuals and the effect of their heroics on the workplace, and what does it mean in terms of their lost productivity and their distraction when they're getting calls and other needs, need to be available.

Long-term care among all the services is one of the few areas of healthcare that we define based on a population, not on a discrete list of services. No one will ever say, this is everything that long-term care is, because we always talk about it as, whatever people who have functional limitations who need assistance over time, need, and that's one of the challenges, I think, that we face, and our partnership and the panel faces.

And there are a lot of not rigid boundaries. If someone needs help following a medication regime that they were given in the hospital in order to maintain their successful acute care plan, you know, that's an issue

that's part of long-term care.

We also tend to confuse -- in many areas we can talk about the settings of service as this is what this service is. Well, long-term care you have maybe people who are getting acute care in a nursing home, nursing homes are thought of as long-term care settings, they're reimbursed as long-term care settings, but they are providing acute care.

Same thing with home health care: it's delivering medical treatment into the home environment. So we have a lot of challenges.

And so one of the themes that I want to strike today is that obviously as you begin to struggle with issues around healthcare access, that they have huge impact on long-term care impact as well.

I liked Robyn Stone's kind of four-bulleted summary about things we have 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, and all other populations with disability.

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.

However, increasingly, as y'all were talking about earlier with other panels, people are discharged into the community with complex medical needs, they're going to need long-term care and assistance, but their needs are complex.

And that's services and housing, and housing and shelter is a component of this service, unlike other services, that we have to think about, and how that interacts.

So the key issue in long-term care obviously is that, why do people need long-term care? They have a chronic illness. I think that, again, looking at our county, we're not unique, we have a significant minority population which increases, perhaps, the percentage of older adults reporting disabilities, but in our community alone, over half of people have two or more disabilities and over 60,000 people need help with basic daily living tasks, on a regular basis.

So the settings in which long-term care gets delivered, as we know, is not just nursing homes, but it can be anything from someone who can help modify their home, so that they can get in and out with a wheelchair, to making sure that there's a meal at home for someone who's no longer able to prepare that.

This past week, as I've been struggling with an acute-care injury with this, I've come to recognize the joy of being able to wash your own hair, or the lack of being able to do that, and I started training my daughter as a future caregiver to help me with that task, and that's one of the realities that we often find, is that we turn to women for this role.

I don't want to overstate long-term care, though, and I think one of the challenges we've had on the national policy side is people talk about the huge risk of long-term care, and so we get afraid to do anything about it because, oh, it's just too expensive; we can't deal with it. And I want to be real clear, I line up with Bill Scanlon on this, is that the risk of nursing home placement, while it increases with age, many of us, about one in two, will spend some time in a nursing home, but not necessarily a long period of time. And so it's a risk, it's not a guarantee, in terms of need for assistance.

But we do know that risk increases with age, as represented by the percentage of people who enter nursing homes in later life or who need other assistance. Most people with long-term care needs, by preference and by practice live in their own homes.

And I think what's really striking and

compelling to me is only 8 percent of those people -- this is a national statistic -- rely upon paid health exclusively. So most of us rely upon family.

So the implications for that in terms of long-term care is what happens to the age pyramid, going forward, in terms of the availability of caregivers, what happens to the employment needs within our community to keep the economic boat floating, has huge implications in terms of what's going to be existing in terms of long-term care.

Caroline and Rosie asked me to talk about costs, and I want to try to give you what I think is some of the best information that's been available coming out of the Georgetown Long-Term Financing Project.

First, in terms of nursing home costs, the average annual cost in 2002 was $51,000 for a shared room, for a semi-private room, and $61,000 for a private room. Well, those can obviously be adjusted up for inflation.

Lanette's going to talk about home care, but if you annualized four hours of home care, and imagine what needs to be done in four hours. I can tell you that the couple I talked about earlier needs more than four hours of assistance on a daily basis.

Paying for that out of pocket is $26,000 a year, for just four hours. So if you need more than that

assistance, if you need stand-by assistance to be able to go to the bathroom, which is more than four hours -- it's difficult to schedule toileting -- you're going to be well in excess of that amount of money.

Assisted living has become an option that combines housing and services, and it's become a very popular option. It's become, I think, one of the biggest boom industries here in Houston, and the cost can range from $10,000 a year to well more than $50,000; in excess of that if you go into very luxurious situations.

Most of that cost is borne by individual expense, so we have to recognize that only a portion of people can afford to live in assisted living, which is marketed as one of the best options of assistance.

And to kind of put some reality around this, here's a table that shows the household income, and I want you to go back to that statistic about the annual cost of nursing home care, what it costs to live in assisted living, and look at our population in Harris County, and see that a significant percentage of individuals, if they gave all their income, could not begin to pay for even four hours of assistance at home.

So long-term care is very expensive. It can be a catastrophic healthcare cost for individuals who need assistance over time.

CHAIR JOHNSON: Nancy, is this per person or --

MS. WILSON: Yes. This is --

CHAIR JOHNSON: -- if they're --

MS. WILSON: -- I mean, no this is household. Yes, thank you. So it's individuals and -- thank you for that clarification. This is household income of people 65 and older.

Now, significant numbers of those are individual women living alone, because that's the most represented category in later life, but this is household income.

So imagine that one person has to enter an assisted living or a nursing home, and you're splitting the income, and people managing on much less cost.

Another cost issue, in terms of the expense of long-term care, I think is reflected in the fact that, again, these heroic family caregivers often are well exceeding what we're investing in terms of care, and this is one effort to kind of show that.

If you can go back one, can -- oh, I'm sorry; maybe that's not -- maybe that was in there as a -- I guess it's the next one after that. So skip two. I'm sorry, Kim. Go to the next one.

Okay, this is the value of family caregiver services, the HCFA CMS estimate from 2002. This is what

family and friends are investing, compared with what's being paid for nursing home care and home health care, and you see the investment.

Now what that translates into in terms of cost to family members, is we have caregivers who are foregoing retirement security and other income as part of being available to perform this care, and I do have some quantitative numbers I can give you around that.

Okay, so Kim, if you can go back one. I'm sorry; yes, one more.

This shows the overall kind of how long-term care is funded, and as you can see, the public concern and I know what you're concerned with is a significant portion of what pays for long-term care, but we have to also remember that we have significant number of people who aren't getting anything.

Out of pocket can be both individual older adults as well as family members. Private insurance is still only 9 percent, although that's a growing market, but it's been demonstrated that even the most modest long-term care insurance products, when purchased early, are not necessarily within everybody's economic reach. But that is an option we have to look at.

Other private, if there are any corporate, or philanthropic benefits, and then other public services are

things like the VA, and then Medicare, which is primarily post-acute care in nursing homes and home healthcare, and then Medicaid.

And I had indicated that in the absence of other speakers I'd say a little bit about Medicaid, because it is the dominant public long-term care source. All states -- it's a federal-state program, all states, the Medicaid program finances long-term care for people who have limited resources, however there's huge variability, because states have, within federal frameworks, can really define which lists of services they're going to provide within federal guidelines for which populations.

And so what this means is, and they've done actual tests to look at this, is that depending upon where you live in the community and in the country, your access to whether or not you're going to get personal care assistance, adult day health service, nursing home care, is going to vary greatly. And so there are a lot of issues of equity that we have in existing with Medicaid financing.

Even within states, this is true. Separate and apart from rural and urban, you have individual availability issues and financing differences.

States can develop waiver programs, which means

we're going to change the rules of what we provide for this population, and which leaves some people getting services and some people not.

So we know that there's great concern about what's going to happen to the shaded portion of financing going forward as we have, the aging population and growing numbers of people needing assistance.

So I want to talk to you a little bit about, I was asked to address what are some best practices approaches with some potential to reduce or at least not increase long-term care costs as we have the increasing population of people who need assistance.

Well, one thing I think we have to be clear about, is that right now all of our care is kind of financed in very discrete silos, so there is Medicare medical services, and there's a little bit of funding for long-term care services, and then there's some funding within Medicaid for various services, and there's also a huge schism between what people can get in terms of acute care and what they can get in terms of long-term care, and so what that might mean is if I, as an individual, have a chronic illness, and my acute care provider says what I need for this illness is medication management, assistance with doing this exercise program, all these other things, that will not be addressed if there isn't long-term care

support available to do that.

And the communication systems both in terms of the health information systems and other things are not integrated, so there's not a lot of flexibility around that.

One of the few shining lights, in terms of looking at integration of care for individuals has been the PACE program. I don't know if this is something that the panel are individually or collectively are familiar with, but the program of all-inclusive care for the elderly, focuses on the 55 and older Medicare and Medicaid population, it's built of services where it takes all the -- I always describe it as you take all the funding and put it in a brown paper bag, and an interdisciplinary team of individuals can determine what level of assistance to support this person in need.

You don't have to decide, is this part of their acute care benefit or their long-term benefit, this is what they need to function.

And the eligibility, they have to qualify for nursing home care to participate in the program, so they're not increasing individuals who would otherwise not have been the responsibility of the state.

So that's one model I think that we should look at. It's available on a very limited basis. Here in the

whole state of Texas we have only two PACE programs functioning, and we'd like to see more. And it is part of Medicare provisions that needs to be looked at.

Another model that I think has had some impact in terms of cost and benefit as been providing integrated care within nursing home settings. EverCare has taken an approach where they use mid-level practitioners to do care in nursing homes, as opposed to having transport, transferring people from the nursing home setting to the hospital setting.

There's huge relocation problems. Lots of errors around medication, other issues, when people have to be hospitalized.

So that's a model I think we need to look at: How can we streamline the provision of acute care services to older adults who may be in congruent care living environments.

Right now it's very, very difficult for facilities to accomplish that, because of how the rigid financing, categorical financing is in place in many areas.

Another model with some promise, I think, is the work that's been done both by the Robert Wood Johnson Foundation, but also supported by the Department of Health and Human Services, around looking at the power of

consumer-directed services. Some of you may have heard of it as the cash and counseling demonstration.

And this is the notion that individuals can participate in determining how their benefits, how their Medicaid benefits get used on their behalf.

If I'm living at home and I need a certain level of assistance that my niece can provide me in and around her work schedule and I need to modify my bathroom or my residence, instead of having to say, Okay, I qualify for a home health provider who comes into my home to do this, but I can't get Medicaid financing for these home modifications because that's not in the state plan, it allows me to take my Medicaid funding and direct it, and perhaps even participate in directly interviewing and hiring and supervising the individual.

This is a program that has been greatly fueled by individuals within the adult disabled population, but I think we've been very paternalistic about not using with older adults, but we're finding that it's been effective in some other states across both aged and non-aged recipients. I commend it to the panel to look at in terms of something that we would like to see more expanded.

And then I think, going back to this concept of long-term care, it's expensive, it's not, I think, something we can expect people to save for.

In my age cohort, being the solidly middle aged person that I am, we tend to split our conversations these days between talking about where our kids are going to go to college and how to pay for that, and where our older relatives are going to find themselves in their later years.

Those are two very different issues. College has a very defined period of time. We can probably get arms -- I can't say we can pay for it, but we can get some arms around estimating the cost. Long-term care, it's an indefinite period of time. It's an uncertain risk, and it can be exorbitantly expensive, well exceeding college costs, for a prolong period of time.

If I am taking care of someone with a dementia illness who might have a life-course of 20 years, and I'm going to be expected to spend $60,000 a year, that's not something I think that we expect people to be able to pay for.

Private insurance is one mechanism to look at that, but I think many people can say that we haven't done a good job of making sure that the plans that are in place or available to people are well-marketed, but they're also well-structured, so that when people are investing money in private plans, that they're going to get value for their dollar.

That's something I think we need to look at.

CHAIR JOHNSON: Nancy --

MS. WILSON: Yes.

CHAIR JOHNSON: We're going to have to ask you to --

MS. WILSON: Wrap up.

CHAIR JOHNSON: -- wrap up in about three minutes.

MS. WILSON: Okay, that's fine. Okay, so let me --

CHAIR JOHNSON: And you'll have time at the end of Lanette's discussion to respond to questions.

MS. WILSON: Wonderful. Okay. So let me say another thing I think we need to think about in terms of approaches is recognize that we have to be prepared to have a smaller population of people who are vulnerable.

If you can kind of flip through the next two things. We've taken the same approach in medical care to people with chronic illness in later life that we've taken to every other age group, which is let's treat to cure, and not necessarily think about the goals and the quality issues, and I think this is one of the things we have to focus on, and particularly we need to think about how to address the threats to disability that we can do something about.

And so as we think about long-term care, I want to make sure that we focus on prevention. You have a panel member who's well-represented to talk about these issues, Rosie Perez, because she's involved with a local project that's one of three in Texas that's part of a national initiative on looking at evidence-based health promotion programs.

And Kim, you can just kind of keep cycling through.

Things like falls, prevention, physical activity, addressing depression, addressing the lack of attention to medication management, are things that need to be thought about as ways of preventing disability, and preventing the need for long-term care assistance.

There's very little support for this right now, and there's very little attention to how this can be delivered in the least cost-effective setting, which is typically the community, and as I said, Rosie can tell you about work that's going on here in physical activity. We're doing work on depression. There's work going on nationally in falls prevention.

We have to recognize the threats to health and well being for older adults are not necessarily blood pressure control, hepatitis level, there's a lot of other things that are bigger threats to well being, and we

oftentimes focus on paying for acute care and don't prevent disability when we can.

So I thank you for your time and attention. I think that I'm particularly pleased that long-term care made it on the agenda as we talk about what's important, because it often is not talked about.

CHAIR JOHNSON: Thank you, Nancy.

And Lanette, what I neglected to say at the start of our discussion was we'd like to ask you to speak for about 12 minutes or so --

MS. GONZALES: Okay.

CHAIR JOHNSON: -- and then we'll take questions when you're done, okay?

MS. GONZALES: Okay. Very good. Thank you, Mr. Chairman, Mr. Johnson, and the panel.

I appreciate the opportunity to talk about one community agency's approach to providing good long-term care services to the elderly, and you may already have heard some of these statistics, but in Harris County we have a little over 252,000 residents that are over the age of 65 years old.

And about 28 percent of these -- that age group increased about 28 percent. And then also the residents older than 85 years old increased by 52 percent in the last decade.

So we have a pretty diverse, when we talk about our older population from 65 to 85 years old, but those individuals requiring and needing long-term care services.

The median household income of these individuals is about $33,000, so you can see that the challenge of paying for long-term care services is very difficult, as Nancy has already talked about.

Particularly even as you look at those individuals that are 75 years of age and older, the income goes down. It is a little over $25,000 annually, and here in Harris County only about 15 percent of seniors can actually afford, have incomes that would enable them to pay, for let's say, in-home care services if they needed it.

So the need here is great, as I'm sure you've heard in other areas.

Individuals who are age 85 years old and older are some of the largest risk factors for long-term care needs, and those individuals have multiple chronic health conditions. We find that even here in Harris County.

Our most vulnerable older adults who are 75 years of age or older have things like arthritis and hypertension and heart disease, hearing impairment, cancer, stroke victims, and again diabetes.

So these individuals also have cognitive and

multiple functional impairments, again requiring long-term care services, that are not going to go away.

What we found in our agency is these individuals can require -- or need services for as long as 20 years. And when you talk about a population who also cannot afford that care, it becomes the responsibility of Medicaid if they have it, or other entities to help support that cost.

When we look at some of the risk factors, primarily these individuals are living alone, they have limited to no support systems, they're living at or near poverty, they are women, because women -- statistics tell us women tend to live longer than men, and they are primarily minorities, so those are the individuals who are at highest risk factors.

Kim, I'm sorry; I'm moving ahead to keep within my twelve minutes.

FEMALE VOICE: I'm sorry. Go ahead.

MS. GONZALES: But do go to the next slide.

FEMALE VOICE: Sure.

MS. GONZALES: Okay. Some of the providers of long-term care or, as Nancy already talked about, primarily family caregivers, individuals, the female, and female Baby Boomers right now are a growing population.

They work full-time. On average the annual

household income is $35,000 a year. Those individuals provide, what the studies have told us, an average of 18 hours per week of care, and as an adult child who is taking care of an aging parent, I can tell you that 18 hours is just a small portion of what that care responsibility is.

Other support systems in terms of providers for long-term care is community organizations and agencies, which is why I'm here today, to talk about Sheltering Arms Senior Services and what we do to help support the long-term care needs of our community.

One of the challenges that we face in our community is limited funding. As you have well heard I'm sure in other communities that you've talked to, limited funding, long waiting lists for services, and shortage of direct care workers.

And I do want to spend a few minutes talking about the shortage of the direct care workforce, because again, they're going to be critical to us being able to continue to provide good long-term care services to the elderly.

When we talk about limited funding, we do have, again, major public and non-profit sources of funding, Medicaid, the block grant, funds, the Older Americans Act funding that comes through the Area Agency on Aging, which

is significant and critical to being able to provide services.

For us, our United Way, which gives an average of $5 million a year to help support these services, and then local foundation support.

The reality of it is for those individuals who are having to pay out of pocket for services, it can often be cost prohibitive. The cost for home care services alone, as Nancy has already talked about, could run as much as $15 per hour, up to $125.

And for the individuals who receive private pay services from our organization, they pay as much as $11,000 a month for home care services on a 24 hour basis, so it is again very expensive, and unfortunately what we are finding in the communities is there are individuals who are qualified by the Medicaid services, there are few individuals who at 15 percent can afford to pay out of pocket for services.

But there's a huge gap in the individuals who are just beyond that level, and they cannot afford to pay the $15 an hour that I've just talked about. So what happens to those individuals? And we'll talk about those in a little bit.

What is also critical for the elderly is finding individuals who can provide good, quality care,

and so with a shortage of our direct care workers and those shortages being from low wages and benefits, those shortages coming from hard working conditions.

It is often easier, we understand from individuals because of focus groups that we've held, it is easier for them to go and work for the local Jack in the Box than to go into a home and provide quality care for seniors.

The heavy work loads, the lifting, the transferring, the ambulating of seniors. And then the stigma that's related to providing that type of work. Often times people feel like -- the direct care workforce feel like they are not valued or recognized for what they provide to the community.

And then of course there is low to no recognition for those services. Agencies often fail to give the pat on the back to say you're doing a good job, or to recognize the efforts of the direct care workforce, and so there are some strategies that need to be developed, in terms of retaining -- recruiting and retaining high quality direct care workers.

When you look at even the Welfare to Work Program, the Welfare to Work Program does not look at home care service provision as an option of good employment for individuals. That is a problem. It is indeed, and a lot

of it has to do with the low wages.

It is indeed a disservice to this community when we're going to have a shortage of direct care workers, not just in Harris County, not just in Texas, but nationwide, and the statistics tell us that.

We need to increase the wages, and provide fringe benefits such as health insurance and the payments for such.

We need to increase and improve training requirements. These individuals want to know, they want the knowledge and the skills to do a good job, and they want to provide good quality care for our seniors.

And then we need to create opportunities for them to move up within this industry, for them to not only begin providing personal care assistance, but for them to go on and get their Certified Nurse Aide, so that they can go into an assisted living facility or in a nursing home and go on to provide good, quality care.

So we need to provide opportunities for that.

With care for elders, as Nancy talked about, there is an initiative here in Harris County that is focused on the quality and workforce issues that I've just talked about, and that partnership established back in 2001, and we are collaborating with other direct care service providers in this city, to again bring about some

of the changes that I've just talked about.

And so part of our solutions will include improving recruitment by promoting the direct care workforce. There will be a recruitment campaign that will be designed to attract people to this workforce. There will be enhanced screening opportunities, so that we can identify that we're indeed attracting the individuals who are appropriate for providing good, quality care.

So many -- what we heard in our focus groups with seniors is they are fearful of individuals coming into their home. They're fearful that they're going to be robbed, they can't depend on the person to show up on time, et cetera, and we are going to have enhanced screening opportunities or efforts that will identify individuals who are again, appropriate for the care.

And we also know that there are some CMS demonstrations out there that are looking at this same thing, and I hope that those demonstration efforts will continue.

We want to increase retention through orientation, training, and recognition opportunities, and then we're going to pilot a wage supplementation program, that will allow individuals to earn a higher wage, a higher salary, hourly wage, so that then they can meet the needs of their family, they can participate in insurance

programs, so that they themselves can have good healthcare. The can be able to pay for good housing for their family members.

And so care for elders is just one effort, but I want to take a few minutes and talk about Sheltering Arms Senior Services, and what we have been doing.

I can talk about the strategies and the initiatives and the solutions that you've just heard about care for the elders, because we've been doing that same thing at Sheltering Arms.

Sheltering Arms has been around since 1893. It is a United Way agency. We receive about $2 million from United Way to provide services for those individuals that are, again, just above the poverty guideline, so they do not qualify for Medicaid services, yet they cannot afford to pay full fee for services out of pocket.

We are a state licensed and Medicare certified agency. We have over 200 employees providing care. Our employees are bonded and insured, and last year we served over 79,000 seniors and caregivers in our community through our programs, so we're not a small agency by any means.

Sheltering Arms is also the fiscal agent for Care for Elders.

And if you will, Kim, go to the next slide and

then stop there, I'll talk about the programs from there.

Some of the programs that we are providing in this community through our safety and protection programs, and I want to just touch on a couple of those. Lifeline is an emergency response service, and we talk a lot about seniors who are at risk for falls. What we know about that service is, with a press of a personal health button, a senior can receive immediate assistance, which may get them to the hospital, get them the treatment they need, so that they can return back to their home environment. It's an out of pocket cost. It is not funded by Medicare. It is in some cases funded by a Medicaid program, but it is a service that has been known to save lives of our seniors, and also reduce some of the costs that can be associated with long-term acute care.

Also, going on to our home management services, I talked about, or we talked about individuals needing care in the home. That is often times the first line of care that a senior will need, someone to come in, do light house cleaning, prepare meals for them, make sure that they're taking their medications, often times that's the beginning.

And then as we work with that senior, the longer we're in that home we find out that they will need personal care assistance. Someone to come in and help

them with a bath, someone to help get them dressed, someone to help ambulate and transfer them.

And we're talking about individuals who do not need to go into a nursing home. They are still able to live within their own home, with just a little bit of assistance.

And then under our specialized care, we also have an effort where we work directly with individuals that have some form of dementia, so instead of that individual having to go into a nursing home, we can provide a trained staff member to go into the home, who knows how to calm that person down, who knows how to work with that individual, and make sure that they have a good day so that their caregiver can go to work.

We also provide the skill services which are Medicare certified, our home healthcare with the skilled nursing, physical therapy, occupational therapy services, so that when that person is released from the hospital, and we know that that is happening more and more often, they're being released sooner, we can put the nursing staff in and provide the disease management programs that will get that person to meet goals within that 60 day time period, so they can, again, remain independent within their own home.

Our other services that we provide, if you look

under the blue category, our Eldercare Counseling and Referral Services, our critical services for caregivers who are having to find out who provides good, quality care, whether it's here in Harris County, or if it's in the state of New York, or any other area, because so many of our -- of adult children are living out of areas, out of state from Mom and Dad, we can help adult children find services for their aging parents.

And in our case management program, our case management program are where our case managers or social workers are doing some of the grass roots work with individuals who are truly low income, they're going in, they're completing forms, they are helping to arrange services, they stay with that person, meet with them on a regular basis, make sure services are in place, until that person, again, can go on and live quality of life in their own home environment.

And if it turns out that the social worker is not able to remove themselves from that person, then they continue to work with them for as long as they're needed. And again, that can go on for 20 years.

Kim, if you will move forward to the other, I've already talked about those, so jump ahead, forward three slides, please. Four. Four slides.

In the final analysis, just in closing, what

I'd like to say is that, you know, the average life expectancy is 87 years old, and the number of people purchasing care for relatives to place more demands our form of long-term care system.

We've talked about the Baby Boomers, and they're soon going to be aging and needing services.

Personal and home care assistance is projected to be the fourth fastest growing occupation in the nation. It's going to be tremendous. And if we don't impact, if we don't do something now to generate good, quality workforce to meet those needs, then we're going to have a huge problem on our hands.

The reductions in Medicare payments may diminish the future growth rate of healthcare jobs available, and then there's a smaller pool of middle-aged women available to provide low skill basic services, and that smaller pool, what we found out is that smaller pool is going to be more diverse, and that's going to create a problem in itself.

So the challenges are great for this committee, as you go forward and we would ask you that you move forward in continuing the Medicare and Medicaid funding, because they are major sources of funding for healthcare, that the reimbursement policy plays a substantial role in determining workers wages, benefits, and training

opportunities, and that really needs to be a part of the initiatives and part of the effort.

And then lastly that we maintain the payment rates to keep up with the true cost of providing services, because when you do that, you give organizations the opportunity to offer competitive wages and benefits, which then support the direct care workforce.

Thank you.

CHAIR JOHNSON: Thank you very much. Could I ask that you put that continuum --

MS. GONZALES: Yes.

CHAIR JOHNSON: -- slide back on the screen, at your convenience, and Lanette, I have a question for you.

MS. GONZALES: Okay.

CHAIR JOHNSON: Let's say, well, the background is that it seems that the data is showing and personal anecdote experience is showing that people who are reaching their 60's and 65 year old age ranges, are gradually coming to a conclusion that they don't have enough money to retire.

And the data shows, I think, that people who keep active physically and mentally are going to be healthier than those who just "retire" and do very little of anything --

MS. GONZALES: Absolutely.

CHAIR JOHNSON: -- so let's give that, let's assume that for a second, and let's say that my wife and I are in that category. The data also shows that as you pointed out, that we're going to have more and more Baby Boomers are going to come, and even if we had the money, we may not have the caregivers.

MS. GONZALES: Right.

CHAIR JOHNSON: So let's say I come to you and my wife comes to you. I'm an accountant, let's say, and my wife's a teacher, and we say, we'd like to be employed by Sheltering Arms.

What kind of training will you give us to be potentially employees of your organization, and is there a place for us in your organization?

MS. GONZALES: There's a place for you in our organization, and it will depend on the type of care that you want to provide. If you want to provide hands-on care through the Care for Elders Effort, we have developed a 16 hour orientation program that gives you the basic foundation on how to provide care to an older adult.

And it doesn't matter that you're an accountant or that I'm an administrator. In an agency, we all need the basic skill level on how to transfer an individual. We all need to know what the physical problems are, the emotional problems associated with, providing care to the

elderly.

And then we're going to offer you some continuing education, training so that you can continue to enhance those skills, and then we will place you in an employment providing that hands-on care, and at Sheltering Arms, the average wage that you will earn right now would be anywhere from $7 an hour to $12.50 an hour, and any other organization it would be minimum wage, or $6.00 an hour.

VICE CHAIR McLAUGHLIN: I have a question. I could really identify with Nancy's comment about those of us who are looking at children and parents at the same time.

I have in-laws who are in a graduated living facility. My mother has decided she can no longer live in her home, and has to go into, you know, one of these retirement homes that does have assisted living, and yet it wasn't that long ago that my children stopped going to childcare.

So I really do feel this. And that's part of my question. I look at this long-term care continuum, and Shakespeare, I think, was the first person who really pointed out that we end up where we started, and I do look at some of these services, and it looks like what I had to do for my children, when they were quite young, and what I

had to pay someone to do for my children.

Now obviously the difference is with children you hope the movement is the other direction, instead of functional decline, it's functional acquisition.

But it does make me wonder, from your perspective, what is the difference? We don't think of childcare in this country as healthcare. We don't expect healthcare insurance or providers or government programs to pay for it. Why are cooking meals and some of the things you talked about, why do you think -- what's the difference?

I mean, I know for those of us who were working parents and had small children, we either hired someone to come to our home, and then there's that same fear, of, you know, can you trust the person? What are they going to do to my child? What are they going to do to our home?

Same fear as what you were talking about.

Or we put them in a childcare group arrangement, where maybe the efficiency is a little bit better, the workers got paid more, a little bit safer. What is the difference?

MS. GONZALES: I think the differences are a couple of things. With our children, I think you, and you touched on that. With our children, we know that that childcare is short term, and at some point they're going

to grow up, they're going to go on and be well educated, and, we hope, good, responsible adults.

With our aging parents, they, you know, often times by the time they get to an agency like Sheltering Arms, they have two or more functional limitations, and then that just gets worse. They're not going to get better.

They already have limited resources, because wages were not what they are now, they were not that well back then, so they only saved a little, and for some of our elderly population, they didn't have the opportunity to earn a higher wage, so there was not much money to be saved. It was all about just maintaining the day-to-day and taking care of the household.

So you have a population who, first of all, doesn't have the resources, the functional decline is going to get worse, and for somebody to come in and provide meal preparation and house cleaning assistance means the difference between that person trying to wheel that chair up to the stove and trying to prepare a meal for themselves, which I've actually visualized where they have a pot in their lap and they're trying to stir, which, itself, can be another threat, or the difference between someone who has pulmonary disease and trying to dust their own furniture, which is going to make the situation worse.

So we do have a situation where older adults need more care in the home, and daycare is not always an option for them. First of all, daycare is limited. Second of all, it too is costly, so it's not always an option for older adults.

VICE CHAIR McLAUGHLIN: Well, that was actually one of the questions I was going to ask. You didn't give us any costs, any dollar amounts for that, but I wondered at what point, because with childcare we certainly investigated this, and I wondered at what point do those two curves cross? I mean, there are some what we call economies of scale in a group situation, and as I said, we certainly found, for the childcare issue, that in a childcare center, the workers did have health insurance in some cases, they had higher wages, there was less turnover, so it was better for the workers --

MS. GONZALES: You're absolutely right.

VICE CHAIR McLAUGHLIN: -- than going to someone's home, and that's why I was wondering why, in your opinions, both of you, do we not see more daycare centers for elderly people that could result in a better set of labor force conditions, one of your concerns, which as I said is mimicked in the childcare labor force. Those workers also are often underpaid and exploited.

Do you have any data on where the cutoff is?

MS. WILSON: Well, I think a couple things. One is, in terms of adult daycare, one of the biggest challenges around that, in contrast to children's care, is the capital expenditures necessary to have a facility that can be a licensed adult daycare facility pale -- I mean, what you need to do to accommodate -- you know, in my local church community, our church area can function, you know, Monday through Friday as a pre-school environment, and then on Sunday do church school.

Well, you cannot accommodate the range of disabilities and needs that would result in the need for adult daycare within that sort of thing. So one thing to recognize. And we've done virtually nothing to help subsidize the development of adult daycare on the capital expenditure side. So that's one reality there.

I think secondly that there are, in terms of cost for care, you're going to find a pretty big range. I would say on average in our community, adult daycare can be as high as $70 a day, so you're right, you can compare that. It depends on what hour of the day. If it's 12 hours, 10 hours, 8 hours, whatever, there are some economies of scale.

And I think that in terms of subsidized housing, those exist, too. But again, until recently, now there are, the Center for Medicare Services has initiated

some demonstrations around reimbursing adult daycare, but Medicare as the only universal financing mechanism has not supported adult daycare, and so there haven't been any encouragements around that.

And on the Medicaid side, very limited. Not all states have that as an option on their menu.

VICE CHAIR McLAUGHLIN: Well, one of our jobs -- sorry.

MS. WILSON: I'm sorry.

VICE CHAIR McLAUGHLIN: I was just saying, one of our jobs is to come up with some recommendations from the community, things we've heard, and Randy usually asks this question, but what I'm trying to get at is if we are going to make recommendations that the federal government subsidize something to create an environment or a continual subsidy, where do you think we'd get our better return: subsidizing home healthcare workers or subsidizing the capital resources necessary to develop a good system of daycare facilities?

MS. GONZALES: I would say, Nancy, I'm going to let you respond, and I'm going to respond this way, and say that the subsidy of the need for direct care workers is critical, because I know what the cost of adult daycare is, and I know just what it costs Sheltering Arms to provide this specialized dementia daycare center, and

without the funding that we get from foundations and some client fees, we would not be able to maintain that facility.

We recently closed a facility back in, I guess a little more than a year ago, because it was just too cost prohibitive.

When you talk about -- there's also huge transportation issues related to trying to get people to a daycare setting, so then you not only have to subsidize the cost of the daycare, but also the transportation for getting them there and back home.

Then it becomes more cost-effective, possibly, to subsidize or even provide the financial support for training people to provide good, quality care to seniors who are in their community, because they then have the opportunity to not only serve one individual, but they can serve two or three in a day, and each of those seniors be able to get good, quality care.

Nancy?

MS. WILSON: Well, I think that the reality is you have to have a certain concentration of people with need to justify the availability of any daycare, whether it's children's care or adult daycare, so I think we may think about what are the flexibilities across the 50 states, and my response would be that I agree with you, I

think that where individuals have the ability to prepare and plan and pay, and have the means to do so, I think we need to think about that, which is why when you look at private long-term care options -- but I also think that the prohibitive nature of very expensive care that's needed, we as a society typically said, We want to have a safety net in place, and we want to think of -- and I think of long-term care as much more along the lines of retirement options, as maybe there's a way to have some social insurance mechanism, not as extensive as, you know, retirement options.

And people have advocated, right now, people tend to not invest in long-term care because they say, Oh, I'll use Medicaid when I need it, or I'll spend down or I'll transfer assets, or I'll do all this.

And people who are wiser than I am, because I'm not an economist, have said, let's think about a limited social insurance benefit that comes in front of long-term care insurance, and then perhaps motivate the market. So I think we need to think creatively about how to couple individual responsibility with societal responsibility, and a safety net that has more flexibility and more equity than what Medicaid has currently across the states.

CHAIR JOHNSON: Dotty?

MS. BAZOS: I'm just wondering if there's data

to suggest or do you know, have you see in your practice that being enrolled in long-term care actually slows down functional decline of folks who need those services?

And in addition, how does being in a long-term care program compare to just being in a nursing home? I mean, some people are in nursing homes because they don't have any type of system like this, so what would be the cost-benefit for developing a system like this versus people staying in their homes?

MS. GONZALES: Well, I think the cost of a nursing home can easily be as, as Nancy has already shown, $40- to $50,000 a year. The cost of having someone in their home -- first if all, individuals in a nursing home need 24-hour care. Individuals who are living in their homes that only have two functional declines don't necessarily need 24-hour care, and so it can be more cost-effective to keep them in their home, particularly if they have services on a regular basis.

They have meals to ensure that their dietary needs are met; they maintain their nutrition; somebody's checking on their medication, making sure that they're managing their medication, and making sure that their personal care needs are met so they can have improved health. So again it can be more cost-effective to keep that individual in their home, because --

MS. BAZOS: Do you think it slows down their functional decline so that they --

MS. WILSON: Well, I think what's implied in your question is that we have integrated programs, and right now we tend to have discrete services, where you have lots of different providers doing this.

Now, Sheltering Arms may coordinate a range of things, but even there they don't have the full scope of assistance that someone might need, I mean, in other words, we don't have something that's equivalent. The closest thing to equivalent, I'd say, is the PACE program, that does do a whole range of services for someone who can still be in a housing situation or an independent living situation, and then you look at all costs.

But that's part of the challenge right now, is people who are in long-term care have incredible acute care costs, and we're looking at all that separately, and I would say to the panel, and, you know, I don't know if you've thought of this, unless we look at chronic care across the board, in terms of how to help people prevent disability, but also what are the total costs of care, you're not getting a real picture for what the cost comparisons are, I guess.

MS. CONLAN: I want to thank you, Nancy, for introducing a topic that's near and dear to my heart: the

role of volunteers. And I do believe that it's underestimated the current role in reducing the costs of healthcare, the part of the family caring for their family members, churches, and other social organizations.

And I have to mention on a personal note, I was a volunteer coordinator at the National Zoo for about 10 years, so I'm really glad to hear about your brother. You know, the Friends of the National Zoo does a wonderful job, a big job, and they certainly know how to motivate their volunteers and provide incentives.

In working in this project, I have often thought, what if there was a call to action? You know, in the '60's there was a call to action, for the Peace Corps and for VISTA. What if we had a new call to action, a healthcare volunteer program, and I think it would help to remove the stigma for the paid workers, and kind of invigorate some of these problems, and turn it into a more positive movement.

And so I just welcome thoughts on that.

MS. WILSON: Well, as I was cover two things I wasn't mindful of my time. I apologize. But one of the things I wanted to mention is, I think we have to recognize that we do have some of that going on with the increasing emphasis on self-care management and chronic disease self-management, and I'm sure you're all familiar

with the Stanford initiative around chronic disease self-management.

These are programs that focus on people with chronic disease in a group model that are peer led. They're trained peer leaders, often individuals who are coping themselves with a chronic illness.

And this program has shown great benefit in terms of helping people reduce their acute care cost, but more importantly improve outcomes and improve function and improved satisfaction.

And where I was going with all that is that the Administration on Aging in concert with the National Council on Aging, is talking about developing lots of approaches where we try to train maybe early retirees and other older adults who themselves are healthy and able to contribute to well-being to be involved in functioning as lay leaders and coaches, because a lot of these healthy aging programs, which can have a huge impact across all ages, I mean, I can be in a wheelchair in a nursing home and benefit from physical activity, need social support, need encouragement, need the volunteer roles.

So I do think we have great capability here, and I see in our local community the impact of the community service requirement for high school students. A lot of those students are coming into adult daycare and

other environments where they can really be of service, so I applaud, you know, that way of thinking.

But I also think that we have to recognize that helping older adults and families understand more about chronic illnesses is an imperative across the healthcare system, but it's really seen in long-term care.

CHAIR JOHNSON: It seems that -- well, we have had long-term care insurance offered as an alternative in my company, and probably 3 percent of our people signed up for it. Very low percentage, and that's not uncommon among other companies who have offered it. And what I'm hearing you suggest is that the likelihood of us, as a population, funding long-term care, and to the extent that the cost would be met by individuals, it's not very high.

And so I'm kind of led to believe that we have to find some alternatives to that and maybe the -- my esteemed colleague's on to something here that we could consider.

And then a related question. We know, based on what we've heard in our hearings and what we've read, the significant portion of our cost for health care itself, not nursing home care, but health care, is incurred in the last six months of life.

And one of the things that we're charged to do is evaluate the trade-offs. What are we willing to give

up, and one of the questions that some of us informally have had is, Are we willing to come to the -- toward the end of our lives and say, you know, I would prefer to have palliative care, as opposed to heroic care.

And I think one of the things we're going to have to talk about, as we get into this further, is to what extent do we talk about that as a Working Group and dialog with the American public on that.

What trends are you seeing, both of you, in terms of the acceptance of palliative care, and choice of palliative care instead of heroic care? Are you seeing any trends? Or are you reading about any trends in that area?

MS. WILSON: Well, I think you've touched on a theme that's kind of near and dear to my heart, as someone who's part of my life is involved in medical education, and that is, we have to start with thinking about kind of the values and the orientation of our healthcare system, and start with the settings of care and the professionals, and the administrative folks who work in those settings.

Right now, in some respects, there are disincentives to focus on some of less attractive options in terms of care like palliative care. I mean, I think we tend to -- we get in, we have a problem, we want to diagnose it, treat it, we want to get every sub-specialist

involved in looking at it.

And then the idea that everybody needs to be prepared to have the palliative care discussion has not been, you know, well embraced.

So one of the encouraging trends is, we do have within that field of medical training and medical education, increasing attention to palliative care as a mandated requirement activity, and we have, you know, board certified people who are going to be involved in leading some of that.

And I think that is going to help, because frankly, having the benefits and the services of hospice care, one of the challenges we've gotten to with hospice care is we haven't raised reimbursement rates in that arena for a long time. And so that's also a limit. Sometimes people say, Well, what are my options? And if my options don't sound very good then no, I think I stick with what I know, so that's one challenge.

But I do think that, you know, witness events of recent months and years, we have a lot more conversations going on, and I do think we need to have more public dialog around what are choices and decisions around that, and so I applaud the panel's, you know, thinking about that.

But I also think that we have to embed those

values and that processes in medical education -- the training of all health professionals, and all providers, because often times they have to be the ones who are going to be prepared to say, It's time to have this conversation.

MS. GONZALES: I think you're right, Nancy. It is so hard for families to hear that perhaps it's time for hospice services, and particularly when you look at the minority populations. There's not been a lot of conversation about palliative care, and particularly around hospice services.

And so there is a need to educate the community about the benefits of those services, and to begin to have more conversations about that.

And then, as you look at Sheltering Arms long-term care continuum chart, you do see hospice services at the end of that chart, and that is because we do try and have those conversations when we are counseling with caregivers and seniors, and even Sheltering Arms, itself, is planning to open a hospice next year, as we take the year now to look at the feasibility of how we can provide that service, and so we do recognize that it is indeed an option for families, and one that should be considered.

MS. WILSON: Let me just add one P.S.: If you ever get a chance to talk to people who work in PACE, the

stories they tell about people dying outside of the hospital setting, with great peace and planning and consideration, are pretty powerful --

MS. GONZALES: Absolutely.

MS. WILSON: -- and I think one of the things that happens right now is, people heroically manage at home for a period of time, and then something happens and someone's having agonal breathing difficulties or something else, and the next thing you know, it's 9-1-1, we're in the hospital, and the sequelae come from there.

And I think there is a huge community education effort, but people need options. They need to feel that, if I don't pursue this, I'm not going to be abandoned --

MS. GONZALES: Right.

MS. WILSON: -- in a situation that I can't manage.

CHAIR JOHNSON: Well, you're -- actually, this would be a great topic to consider over a lunchtime discussion and further, but we're not going to be able to do that, unfortunately.

We appreciate your time this morning, and sharing your expertise with us.

We'll adjourn this section of our hearing, and we've been informed that we have a mobile health clinic that's available.

MS. PEREZ: Yes, Randy, if I may just provide a little bit of information. Lunch is here, and I'd like to just make a general announcement that the lunch order is for the Committee members and that staff that is working for the hearings today. There is a cafeteria down on the ground floor of this building that the public is welcome to go down and grab something.

We will be starting back at 1:00.

And the mobile clinic is available, and we also have a press event scheduled.

CHAIR JOHNSON: Okay. My suggestion, if it's okay with the rest of the Working Group is we do the mobile clinic first, and that should take about 20 minutes or so, and then we can come back, and if it takes longer than that for lunch, we can just continue eating until the start of our next session, but we must start at 1:00, no later than that, so we ask each of the Working Group members to be back by 12:55 or so, so we're ready to go. Okay?

Thank you very much. We'll adjourn until 1:00, but we'll go -- Rosie would you like to take us to where

we should be going?

(Whereupon, a recess was taken.)

CHAIR JOHNSON: Okay, I think we're going to begin, and we'd like to welcome you to our panel this afternoon. We're pleased to have Paul Dennett, Gerry Smolka, and Marshall Bolyard with us to talk about retiree healthcare.

Paul Dennett comes from the American Benefits Council where he serves as Vice-President of Healthcare Policy, and the American Benefits Council is an association of a couple of hundred employers and service providers and so forth.

Gerry Smolka is from AARP. I have my card in my wallet. I am 50 years old, plus a few. And AARP has certainly been a voice for your members, and especially in the recent last few years in healthcare, and certainly you're going to have a voice in response to some of the challenges we have today, and we're looking forward to hearing that.

Marshall Bolyard is retired from the military service as a Lieutenant Colonel, and is Executive Director of the U.S. Family Health Plan for Christus Health, where he directs a network of healthcare providers of more than 100 primary care physicians and 400 specialists, and hospitals and so forth.

So you each come with a different perspective, and we're looking forward to hearing that perspective. You know a little bit about the Working Group, so we won't get into introducing ourselves.

Just briefly, what we ask you to do, and we'll start with you, Paul, and then you, Gerry, and then you, Marshall. We'd like for you to speak for about 12 minutes or so, and if I put my thing up, that means -- my table tent -- then you've gone beyond your 12 minutes, and we'd urge you to kind of wrap up your comments.

And the reason for that is that it's not that we don't want to hear any more from you, but our Working Group has found the richest experience to be when we can dialog with you based on what you've said, and the need for information that we have.

So that's how we'll do that. And we are committed to adjourning on time, as well, and so with five minutes left in our session, I'll just put this up again. Okay?

So Paul, would you like to begin?

MR. DENNETT: Thank you very much, Mr. Chairman, and also thank all of you as members of the Working Group and the staff. I'm one of the people that actually read through your statutory charter shortly after the Medicare Modernization Act was enacted, and I thought,

This is great that a group like this is going to get together, because this will be one stop shopping for those of us who care about healthcare policy, because we're looking forward to the recommendations to wrap it all together. You have a formidable charge.

I'm going to spend just a short amount of time talking about two basic issues. One is what have been some of the contributory causes for the decline in retiree health coverage, and I think perhaps maybe even more so than the last panel you heard from, that the sources for the decline, and the coverage and the challenge, I think in retiree health are fairly well understood at this point.

And then the other thing that I'd like to do is talk about what are some possible solutions that you should consider as you go about your work.

So first of all, just in terms of overview of the problem for retiree health, and clearly the central problem is that there's simply a declining number of Americans with retiree health coverage, and unlike the general trend for the decline of the uninsured for active employees -- or, individuals, the decline in retiree health has been quite persistent and quite precipitous.

There's also an increasing share of the cost of the coverage for retiree health being borne by individuals

themselves, and inadequate savings, as a result, for individuals for their retirement needs, including for their need for healthcare in retirement.

And then finally, you know, we'll talk about this a little bit, as well, the inadequate savings vehicles for individuals to turn to if they retire without health benefits from prior employment.

In terms of declining coverage, as I mentioned, there's been a persistent decline in the number of firms offering retiree healthcare. For most of us who are used to having healthcare through employment, it's not at all uncommon now, even in firms that have traditionally retiree health, for new or more recent hires to find that there is either no retiree health benefit through employment offered to new employees, or a significant increase in the number of years in service that you would have to work for a firm before you would have that benefit.

So conditions have clearly changed. From 1988, when there were 66 percent of firms that were 200 or larger, in terms of the number of employees, offered retiree health coverage, to where we are now, in the most recent survey -- and much of the data that I'll cite is from the annual Kaiser Family Foundation and Hewitt Associate Survey that comes out each December -- to now 36

percent of the same sized firms that offer retiree health benefits.

And just to put that into perspective, for firms of all sizes, for active employees, it's more like two-thirds to 70 percent, depending on which surveys you look at, that offer health coverage to active workers, and obviously that percentage increases significantly by the size of the firm. Obviously, smaller firms tend to have less incidence of coverage and larger firms more.

But in the retiree health area, because of the fact that the commitment has significantly changed for newer hires, the number will significantly decline. It's predictable that it will decline even further from the levels that we can see today.

In terms of the causes for the decline, as I mentioned at the outset, they're fairly well understood, but overwhelmingly, like many of the problems in healthcare, it begins with cost.

For 2004 the average cost for retiree health coverage was just under 13 percent. That's slightly higher than the cost in 2004 for coverage for active workers, but there's a significant difference in this area, and that largely has to do with competitiveness pressures that many employers face in providing or continuing to provide retiree health benefits when many of

their competitors increasingly in a global economy don't provide that benefit.

There's also, in the early 1990's, a significant change in the federal accounting standards, the so-called FAS-106 standards, which basically means that healthcare for retirement has to be accounted for by employers on an accrued liability basis, not just on the amount of money that is spent from year to year, the actual dollars that are spent in, say, 2005, but have to be accounted for all of the future commitments that an employer has made for their retirees, and then brought back on a present value basis to the costs of the year in which it's being computed.

So that's an enormous liability for firms that provide retiree health, and significantly changed employers' behavior starting in the early- to mid-1990's.

The most common response that many employers made at that time was to place caps on their contributions to the premiums for retiree health coverage. And those can take many forms. In some cases they were set by companies to say after whatever number of years it may take for us to be spending two times or three times what we are spending today, either retirees will pick up increased portions of the cost from that point forward, or in the most significant settings for caps, it sometimes

meant that that would be the end of any employer contribution, and all further costs would be paid entirely by the retirees.

Another major cause for decline in coverage is the changing ratio of retirees to active employees. That's something we're all familiar with, in terms of the coming wave of those of us in the Baby Boom generation, but it simply makes it very difficult on a public policy basis for Medicare and for Social Security, who face much the same problems, as well as for employers to support the kinds of retiree health cost commitments that they had in the past.

I've already mentioned the global competitiveness pressures that's often cited by many employers as a concern, that they provide a retiree health benefit and their competitors do not, and still needing to compete in a global economy.

And then finally, there's the difficulty of what individuals do in the individual market, and the lack of many affordable products in that market.

In terms of employer cost concerns, this -- in terms of a recent survey of CEO attitudes, of those that provide retiree health, either -- 90 percent said that they were either very concerned or at least somewhat concerned about retiree health costs, but it's almost in

all cases, I mean just anecdotally, among either senior level executives or CEO's of companies that provide retiree health, is either their number one or number two benefit concern, is what do we do about retiree healthcare commitments.

And for those that are providing it, it ranges to about a little more than a quarter of the firms total healthcare costs, which obviously means that it's a significant item in terms of what they've committed to.

From the retiree concern, the average premiums now, for pre-65 retirees, which clearly, where there's no Medicare that has started yet, for those retirees it's a more expensive proposition to provide retiree health benefits, costs just under $500 a month on average. Less for those over 65, where retiree health is typically supplementing the coverage provided by Medicare.

Nearly half, however, of retirees with coverage, pay at least 40 percent, 40 percent or more of their total premium, which is significantly higher than the average amount of premium that's paid by those of us in the active workforce with healthcare coverage, depending again on firm size. It could be anywhere as small as 5 or 10 percent to maybe 20 to 25 percent of total premium, but on average retirees pay a much higher share of their total costs, and one in five retirees, or

about 20 percent, pay the entire amount of the premium, so basically the benefit that they're receiving is the benefit of a negotiated group rate for the cost of their coverage, but they're paying that entire group rate themselves.

And as I've already mentioned, new and recent hires are far less likely to have the benefit at all.

There's also very much a need for stronger savings incentives and vehicles to address retiree health needs. It starts with the fact that very few of us, very few Americans, save adequately now for their retirement income needs, and many don't at all, consider as part of that, nor do their financial advisors and planners, the need to save additionally for healthcare needs in retirement.

The estimates from the Employee Benefit Research Institute, a private, non-profit group that does research on benefits issues, say that for coverage needs beyond Medicare, that over your lifetime that that would cost on average about $200,000 for retirees. That's in addition to Medicare coverage.

401(k)s and IRAs could be one potential source for adequate savings, but many of us don't even max out on the amount of money that we possibly could, or could make available through the employer match for the savings

vehicles in retirement, but there's another problem, even if we did participate fully in those, and that is that the dollars that come out at distribution, at retirement, from the saving instruments that are available under law, are then taxed, including for when you use those dollars for healthcare needs, whether they're acute care needs for a hospital or physician or other services, or long-term care needs.

This is partially addressed by health savings accounts, which are just established by the same law that established your panel, but health savings accounts which would allow for savings for healthcare needs and then can be spent on a pre-tax basis, a non-tax basis, so long as they're used for that purpose, have strict limits on the amount you can contribute to them.

I have two more slides and I'll wrap up here.

There have been improvements in Medicare. Medicare's biggest improvement is obviously the addition of prescription drug coverage, and as part of that it also provides new financial incentives, we can discuss, if you like, for employers to provide prescription drug coverage to retirees, which was a major retiree need, for healthcare.

Further reforms are also needed beyond those that have been addressed by Medicare. The most important

of those would be public and private purchasing initiatives to make healthcare both more efficiently provided and higher quality, and I understand you've already had a hearing on that in Salt Lake, so you know about some of the initiatives in that area.

We would also suggest that you consider allowing funds coming out of 401(k)s or IRAs to be used on a tax-free basis when used for healthcare needs in retirement, and to establish new vehicles that individuals could use during their working years to save solely for retiree health needs, with health savings accounts, to allow those to build up with increased savings if individuals participate in health savings accounts over the course of their working years, again for retiree health needs.

And I think, since time is up, I'll skip the summing-up slide, and just save any of that if we'd like to talk further, after the panel's finished.

Thank you.

CHAIR JOHNSON: Thank you, Paul.

Gerry?

MS. SMOLKA: I'm very happy to be here today. Retiree health, as you can imagine, is an issue that's near and dear to the hearts of people in my organization. It's central to older people who are retired to have

adequate health coverage.

It's the fourth leg of what used to be the three-legged stool for retirement security. You have Social Security, pensions and savings, and earnings are the basis of financial security but the final element of security in your older years is having adequate health coverage.

The issues related to health coverage are somewhat different for early retirees than they are for retirees once they become eligible for Medicare. We know that as we get older, we tend to have more health problems; some people more so than others. Because of this, health insurance provides security that we'll have access to health care that we need when we're older without, hopefully, exhausting savings that we've built up for retirement. We don't want to spend all our savings and other resources on health care, or then we're going to face other budget decisions and trade-offs for which we hadn't planned.

In many respects, the issue of healthcare costs for retirees is the same issue that people of all ages face, that of growing healthcare costs. The difference, really, as Paul noted, is that for most of us prior to age 65, our employer is the source of our health insurance.

And so as we transition out of the workforce,

very often, changes occur, related to health coverage. The challenge of how to keep coverage may be prime among them for many people.

As you see in the graphic, which I've provided, 70 percent of the 50- to 64-year-old population has coverage through an employer. And, 7 percent of the population 50 to 64 buys their own insurance.

What's also notable in the pie chart is that, if you don't have employer insurance, the second largest slice of the pie is the uninsured. This is not a segment where we want to see growth.

There were 6.4 million people ages 50 to 64 who were uninsured in 2003. One million of them were retired. The number of uninsured retirees actually grew 19 percent between 2000 and 2003.

So, this is a worrisome situation.

As you can see in the table on slide 6, the pattern of where people get their health coverage changes among those who retire before age 65. Employer coverage drops about 13 percent. Most notably, people lose coverage in their own name in significant numbers. Some of those people may never have had a promise of retiree health benefits, others just may not have qualified for them, or may not be able to afford them. There's a slight uptick in the number of people who have coverage as

dependents on a spouse's policy.

There's also a big jump in the number of people who buy their own coverage. And there is a 5 percent increase in the number of people who get coverage through public programs, which in this age group is most often associated with disability.

I think many people don't understand that among those ages 50 to 64, Medicaid is generally not going to be an option for coverage. The idea that public programs provide fall-back coverage is mistaken unless someone is disabled or has very costly health needs and happens to live in a state with a program for the medically needy. Otherwise, Medicaid is probably not going to be of any assistance to older adults.

The alternative for the early retiree who doesn't have a retiree health benefit, is the individual market. And, it can be a tricky place to buy health insurance in your 50'sand early 60's, particularly if you have a history of any health conditions. You may be turned down in many instances. Or, you may have the specific disease that you want covered excluded, either temporarily or permanently. If your insurance application is accepted, the rates are likely to be sizeable; you may find you are offered coverage with premiums that remind you of your mortgage payments.

For interest, I looked at what coverage might cost here in Houston, if you were not offered coverage in the individual market and had to turn to the Texas High Risk Pool, where you are guaranteed you can buy coverage regardless of your health. The 2005 monthly premium for a 62 year-old man who does not smoke, is $1,435 for a policy with a $500 annual deductible. Family coverage is in addition to that. This same man can buy down the monthly premium to $713 by increasing the deductible to $2,500; 42 percent of the risk pool enrollment is at the $2,500 deductible level. If he buys a plan with a $5,000 annual deductible, the monthly premium drops to $572 a month.

This illustration helps you appreciate how difficult the individual market might prove to be for a retiree who has existing health conditions and no retiree coverage.

For early retirees who are fortunate enough to have retiree health benefits, there are also the challenges which Paul has already mentioned. They may be asked to take on an increasing share of their premiums and/or rising deductibles and cost-sharing.

I see correspondence from members of our organization that say, when I retired eight years ago, my monthly premium was $25 a month and now my monthly premium is $1,200 a month. Whether this person hit a cap on his

employer's contribution to retiree benefits or other changes were made in his retiree health benefit, the correspondence doesn't often say and the retiree may not even know. Unfortunately, stories like that don't surprise me any more. But the point is that even if you do have retiree health benefits, they can be costly, and the cost may be more than people ever thought of when they first retired. I know that the fine print in employee benefit plans may say that the plans can be changed at any time, and that language gives employers permission to change. But, just as the employers don't know what's down the road, retirees who are trying to imagine what their premiums and costs are going to be long-term don't really know how to plan either. It's a difficult situation.

The number of early retirees has been declining in recent years. It's a reversal of where the retirement trend had been going. And when several years ago AARP did a survey of people between the ages of 45 and 75 who were still in the workforce, they asked the reasons that they were in the workforce. A significant number of people said they stay in the workforce because they want to stay engaged and involved, et cetera. But among those who said that they wanted to work beyond the normal retirement age or who were working beyond the retirement age, three-quarters said that a major reason they continued to work

was because they needed to earn the money, and nearly two-thirds said that that they continued to work to maintain their health insurance. What I didn't put on the slide was another fifty-some percent said that they needed to work to earn money to help pay family members' health bills.

So clearly, among people who are staying in the workforce, healthcare costs are a major motivator.

But we don't always have a choice about when we leave the workforce. Becoming a retiree may happen by default, as a result of bankruptcy of a corporation or being downsized. You may not really have planned to retire when you left that last job. You may not have been able to get another job.

So when we're talking about health benefits for retirees, there is a range of situations that we're trying to cover.

Medicare eligible retirees at least have the assurance of a basic benefit through Medicare. Because of this, the percentage uninsured in the population age 65 and over drops to 1 percent. But the vast majority of people on Medicare supplement Medicare with something else, because Medicare covers a little less than half the total personal health costs of those in the Medicare program. So, employer-sponsored retiree health benefits

have been a very valuable way for retirees to supplement Medicare. In fact, that is how most retirees have gotten good drug benefits up until now. Drug coverage has been a prime, cherished benefit that retirees got through their retiree health coverage.

But, apart from supplementing Medicare, as you heard this morning, there are also the long-term care needs, which aren't covered by retiree health benefits or by Medicare generally. That's another health care cost that people have to worry about once they're in their later years.

To help put what people over age 65 spend out-of-pocket on healthcare, and this does not include long-term care or home healthcare in perspective, you can look at the graphic which I supplied. It shows the value of employer-sponsored coverage. Out-of-pocket costs for people with employer-sponsored coverage in addition to Medicare represent about 17 percent of their income, on average. Whereas, for people who have to buy their own coverage through Medigap, out-of-pocket spending, on average, is 32 percent of their income. Now, a large share of that is the additional cost of the Medigap premiums.

The average share of income spent on health care by those with supplemental coverage through other

public plans, which could be Tri-Care or Veterans benefits, is 27 percent; the share spent by those with only Medicare was 23 percent.

If you're low-income and qualify for Medicaid, you're in relatively better shape, but because you're low-income, you still are spending a large share of your money on healthcare costs.

The issue for Medicare-eligible retirees is really largely the same as for early retirees with health benefits. It's a question of how to stretch their savings and their Social Security and pensions to cover increased premiums and increased cost sharing.

Some people find that they can no longer afford to keep their retiree health benefit. I talked to a gentleman like that last week in Salt Lake, actually.

And as Paul noted, in the future retirees are less likely to have coverage from their employers.

So it's not surprising that when you ask people about the primary concerns of adults 55 and older, they say one is whether they're going to have enough money to live on. The second concern is whether they're going to be able to afford their healthcare throughout the remainder of their life.

And Paul noted this: There's a slide showing the work that Dallas Salisbury did at EBRI which gives

some idea of what they estimated you need to save to be able to afford health coverage in retirement if you want to get a Medigap Plan F to supplement Medicare, and pay your Medicare Part B and Part D premiums –depending on how long you live. And these are not nice dollar amounts; they are shocking. When Dallas gave this presentation to our policy committee last year, everybody was silent when they saw these six-figure estimates of what people should plan for if they want supplemental coverage in addition to Medicare to help cover their health costs.

The concerns of older adults really are like those for the rest of us. We want to be assured that when we get sick, we can have access to healthcare, and that we're not going to be broken financially and emotionally by these costs.

Individuals are in just as tough a position as employers and governments are in terms of trying to figure out how to be deal with rising healthcare costs. d I wish you well, and I hope that lots of creative thinking goes on in the course of your work. We need to find some ways to address the problem of rising healthcare costs, and to assure people, regardless of their health or age or work situation, that they're going to able to have access to adequate and affordable health coverage, whatever their stage in life.

CHAIR JOHNSON: Okay, thank you, Gerry. And Marshall.

MR. BOLYARD: Well, I want to thank the members of the Working Group, as well, for this opportunity to talk about the U.S. Family Health Plan.

Had I an opportunity to have heard these presentations before, I might have framed my presentation a little differently, because we really come at this quite a bit differently, since we manage and administer a very rich and very affordable entitlement benefit for military families.

And so to kind of help me frame this presentation, I need to go back in history just a little bit. We had our origins in 1981, when Congress authorized the transfer of ten public health service hospitals to private, not-for-profit healthcare entities.

And Congress required that these facilities, when they were transferred, continue to be used for healthcare purposes. Later that year, Congress designated these facilities as treatment facilities of the uniformed services. Their title was Uniformed Services Treatment Facilities. This meant that military families who were entitled to healthcare in military hospitals, including the over-age-65 population, were now entitled to another option, and that was care at our USTF.

In 1989 DOD and USTF worked together to develop a new managed care delivery and reimbursement model that could be used as a template for future DOD managed care initiatives. We developed what became known as the U.S. Family Health Plan. And we implemented in October, 1993.

Then in 1997, after the introduction of Tri-Care, we changed our name from USTF to Tri-Care Designated Providers, and they made us a permanent part of the military health system.

We currently have, in the entire alliance of six designated providers, 90,000-plus uniformed service beneficiaries, so we're a small program in the context of DOD overall care.

We provide this program at six locations throughout the United States. It covers about 14 states, and they are, as you see on the slide, at Johns Hopkins in Baltimore, CHRISTUS Health here in Houston, Brighton Marine in Boston, PacMed in Seattle, St. Vincent's Catholic Medical Center in New York City, and Martin's Point Healthcare in Portland, Maine.

We are a fully at-risk managed care program that receives payment from the Department of Defense on a capitated basis. Our capitation can not exceed what the government would otherwise pay for services that we provide to these military families if US Family Health

Plan did not exist. It is codified in law, and this rate is commonly referred to as the government ceiling rate, and it's recalculated annually for the government, by DOD. As a result, we represent for the DOD a fixed annual budget, which varies only by the number and the demographics of our enrolled population.

The Tri-Care benefit which we provide is a very rich benefit with no premium, and minimal or no copay, depending on the status of the sponsor. Forty-two percent of our membership is over the age of 65. They must commit to not using Medicare while they're enrolled in our program. They have no copays other than a negligible $3 for generic and $9 for brand-name pharmaceuticals. Active duty families make up a very small portion of our under age 65 membership, less than 10 percent--they also have no deductibles, no premiums, and no copay. The bulk of our under-age-65 members, however, are retired members and their family members, and they do pay an annual enrollment fee of $230 per member, $460 for family. They also have copays, which average about $12 for an outpatient service, and $11 per day for inpatient care. They have the same pharmacy benefit, and they have a catastrophic cap of $3,000 per year. The average age of our members is around 54, and that's a much older population than most managed care plans, commercial plans, that we see. We've

consequently had to develop some special expertise in addressing the healthcare needs of this segment of the beneficiary population.

One of our really unique features is that as far as we can determine, we're the only DOD-contracted provider operating outpatient pharmacies that are authorized to purchase pharmaceuticals at the federal fee schedule--at government prices. This is statutory authority derived from our enabling legislation, and it's a breakthrough that really benefits the government, the health plan, and the plan members. Needless to say, this doesn't make us real popular with big Pharma.

A major measure of our success has been our ability to maintain a consistently high level of patient satisfaction. In our last survey, 87 percent of those surveyed rated us 8 or higher on a 10 point scale with 10 being the highest or best. In comparison, the national average was only 62 percent. As you can see from the slide, US Family Health Plan has consistently scored 25 to 30 points higher than the average commercial plan. And not only that, but we average about 15 points higher than the 90th percentile for commercial managed care plans. For the years showing up there, the 90th percentile score varied between approximately 70 and 72.

Certain aspects of our program stand out as

being principal contributors to our success. We feel that the key is our ability to offer population-based care at its best. We believe that in many ways the US Family Health Plan can serve as a model for delivery of care to an enrolled population whether younger than 65 or 65 and older.

We've identified six factors that have been prime contributors to our high rate of acceptance: The first is population-based care. We're sponsored by integrated healthcare management organizations that provide population-based care. The overall management of the care of a population allows us to develop and implement innovative care delivery models that keep the patient foremost in our focus. The six sponsoring organizations regularly share information on these models and we continuously strive toward "best practices".

Secondly, we're operated by local or regional not-for-profit healthcare systems that are provider-based. We approach care from a provider perspective, not from that of a payer or an insurer.

We've accepted full risk for care. We believe we're the only program in the military health system where full risk is taken for the care of uniformed services beneficiaries. This commitment requires us to develop and implement accurate measures of outcome, both clinical and

financial, and continuously monitor and improve the care of our enrollees. Being clinical enterprises, we have learned that clinical management is essential for quality and economy. Being fully at risk, we necessarily focus financial and human resources on the health needs and requirements of our enrollees in a structured care environment. In addition, our financial model, where all of the TRICARE Prime benefits are paid on a strict capitation basis, provides DOD with fixed predictable costs, with no retroactive adjustments, as well as access to data on a controlled normative population.

Care Management and Disease Management -- we maintain a strong emphasis on both of those. At Christus Health, we introduced a medical management model that utilizes triple boarded hospitalists to take care of our hospitalized patients. This results in more efficient care utilizing evidence-based medicine, helps prevent medical errors, and provides more cost-effective medicine and better outcomes. We also use risk-stratification protocols to identify high-risk patients with chronic medical conditions like CAD, COPD, CHF, diabetes, and asthma and enroll them in intensive disease management clinics and programs.

The primary care manager is at the center of our management model, and they manage and coordinate the

care of those individual who have selected them. PCM, by name, has been in effect throughout the US Family Healh Plan for many years.

And then finally is Customer Focus. We have patient advocates on-site in each of our hospitals, because as an enrolled program we have learned the following:

We must compete every day in the marketplace for the loyalty of our enrollees. They have other options.

We need to maintain a strong emphasis on responsiveness to patient concerns, needs, and demands.

We must be committed to a member services function that addresses these concerns, needs, and demands in a timely manner.

Telephones must be answered and appointments must be available and timely.

And finally, physicians and support staff must be attentive and caring, and the quality of care must be both the best and recognized as such. That's our challenge.

I think this model has some benefit for you for consideration, and so in summary, I'll just mention this quickly, as I'm running out of time.

Intimacy between the patient and the provider.

The American healthcare system is so large and fragmented and pulled by so many special interests that the patient has gotten lost in the crowd, in my belief. Our program, by its nature, is focused on a tightly bound population. The very model promotes the integration of the provider, the patient, and the administration. The notion of creating locally managed, smaller groups of members, tightly bound to dedicated groups of providers, helps to align incentives to keep the patient the primary focus.

Focus on population health, not fragmented care. The payment structure of capitation provides incentives to focus on the long-term healthcare needs of the population, and it discourages the provision of episodic care.

Patient-centric. The focus on the patient has led us to have arguably, among the highest patient satisfaction scores in the country. By having a tightly bound, manageably sized population, we're better able to understand the members' needs, and hence develop responsive member services, medical services, and clinical delivery.

And then finally, Members for Life. And maybe that's overstating it--we've only been around about 25 years, but in our plan members tend to stay with us for many years. And this allows for continuity, stability,

and administration simplicity, and it provides great comfort and satisfaction for our members. For example, when our members reach age 65, it is a very simple transition. It's transparent to them. They don't know that it's even happening. Because nothing changes, except that their copays decrease.

So in closing, I want to restate that measured by the high level of enrollee satisfaction, we have a very successful program within the military health services. We believe that many of the features of our plan likely are transferable as the government continues to look at more effective ways to provide high quality care, to manage that care effectively, and to improve the delivery of hard-earned benefits.

I very much appreciate the opportunity to tell you about our program today, and I hope that the information I have provided you will be of some assistance in your extremely difficult and challenging task.

So I thank you and I wish you good luck.

CHAIR JOHNSON: Thank you, Marshall. We appreciate your comments, as well as those of Gerry and Paul.

We will get into the Family Healthcare Program in just a few minutes, I'm sure, but yesterday there were three articles in a couple different papers that I'd like

to just mention, and you probably saw them as well.

The first was actually in the New York Times, an article written by Milt Freudenheim, where he talked about new worry for investors, retiree medical benefits.

And he talked about the fact that some investors were concerned about the businesses that they're investing in because of the obligations of retiree medical coverage. And he went on to talk about that a little bit, and -- in the Wall Street Journal yesterday, there was an article about the United Auto Workers who wanted to get into General Motors' books to feel, to get a sense of whether or not there's really a healthcare issue that General Motors is facing there.

My question to Paul and to Gerry, to start with, is what are your suggestions regarding how do we balance this global competition thing, where an organization like General Motors seems to be, and these would be my words after reading what I've read, in deep trouble because of their legacy costs, and Gerry, your perspective that the retirees also have some issues to face, as well, and some of us would say, some of those retirees have very, very rich healthcare coverage, but many employers don't provide rich healthcare coverage as you pointed out, it's plain coverage, pretty minimal coverage. How do we balance those two? Can I ask both of

you to share your perspective, and maybe Gerry, you go first and then Paul?

MS. SMOLKA: I'm not sure we know how to balance the two yet. Certainly I recognize that employers have their own economic constraints. At an individual level, there is also the question of how you plan for how you're going to support yourself in retirement -- the microeconomics of your family retirement budget.

And yes, it's true that many Americans are not saving at the level that they should to help pay for a variety of costs. But, some of the people on whom costs fall hardest may not have the ability to do save much.

I'm not sure that I know how to balance the business concern about global competition and healthcare costs at the individual level. We talk in my organization about getting people to improve savings and think about their long-term costs. We talk about getting people to think about their own role in their health, and taking more responsibility for adopting healthy behaviors. But those aren't necessarily magic bullets, by themselves. And so, -- we look more broadly to how we can make the healthcare system in this country overall more balanced. If we have a universal system where people are assured that there is basic care that they can get when they need it, then there's a baseline that people know that they can

count on.

The question is going to be how strongly the public supports that notion, and, how the public feels about paying for that notion.

Financing healthcare has to be a combined responsibility of government, the employer, and the individual.

Where the tipping point is, and how much we each have to carry is something that I don't think we've figured out yet.

CHAIR JOHNSON: Thank you.

MR. DENNETT: I wish I could have been with you when you heard from some of the folks in Salt Lake City, like Don Berwick and Jack Wennberg and Peter Lee, because it's not just a message that is about, you know, those of us who are active employees in healthcare. I think that the message that I would assume they told you about is the need to make healthcare both more responsive, in terms of quality and efficiency, is one that translates immediately to the problem for retiree health, and the fundamental problem, whether it's for those of us as individuals or for General Motors or Ford or for -- or government, as purchasers for healthcare services for retirees, is an affordability crisis.

And it would seem that the first thing we need

to do is to make sure that the dollars being spent on healthcare are truly for effective and efficient care, and that we reward people who consistently can provide that product, that service, to individuals, to patients.

And because retirees tend to have even more difficult and complex conditions and be higher utilizers of services, it's even more urgent that that message translate as part of the solution for retiree health.

There are not going to be, as far as I can see, any new startups of retiree health defined benefit plans by companies, and so for the other part of the solution, I think we really need to look at how do we get individuals without this benefit into understanding the importance of long-term, career long savings, which is part of our retiree income challenge generally in this country, but we need to add to that the additional incentive and importance of saving for retiree health need.

And then we need to incent people. We need to give them the vehicles that give them the incentive to do that. We need to have tax advantaged vehicles through the course of your working career that encourage you and your employer to contribute dollars into vehicles that can be there when you retire for your health needs.

VICE CHAIR McLAUGHLIN: It's interesting that you bring up Peter Lee at Salt Lake City. In addition to

hearing from him, we heard from Dave Walker, the Comptroller General of the United States, and both of them in their presentations talked about costs, and this sort of tension.

But both of them mentioned that the health care costs are paid for by employees through lower wage growth. And one of the issues for retirees is that once you're retired, you can't -- and your retiree health benefit is cut, that even though it might have been the fine print, there was an implicit contract, when you were a current employee, with your employer, that you were sacrificing current wages in order to have some kind of security in terms of health benefits as a retiree.

So one of the interesting things, of course, has been that by defaulting, if you will, on that implicit contract, with current retirees, employers may be realizing some improvement in their accounting statement, but that current employees, and we're seeing this in surveys of people in their 20's and 30's, they're saying, I can't count on my employer giving me health insurance when I'm a retiree. Look at what's happened in the last ten years. I'm demanding higher wages now.

So in some ways it's a very short run game, and I think it adds credence to the fact that the only way around this is to try to reduce the healthcare costs

altogether, of the system. That this is really a very short run solution, to default on this implicit contract, because current employees are going to be demanding a different rate of trade. They're going to be demanding a different compensation package.

MR. DENNETT: Yes, and I think I would add to what you said, obviously for younger workers they tend to be very different in terms of their mobility from job to job, so their needs are also different than the types of benefit packages that were structured for our parents' or grandparents' generations, that tend to have a much longer length of service with a particular employer that they start with, and the average worker today moves much more quickly.

And for retirement income purposes, the model for that kind of a worker for retirement income security has been more the 401(k) that's fully portable, and there really is no comparable health vehicle that meets that individual's needs.

That -- and I think that's really what we to fill, which is something that is both affordable for individuals and employers to contribute to, as well as portable for those individuals as they switch jobs.

MS. SMOLKA: You're right. The dilemma for the generation that is finding their benefits changing is that

they did think they had an implicit contract. That's why they're so emotional and why they are so understandably heated about radical changes to their retiree health benefits.

They thought that the benefit was something that they had earned, and which their retirement income calculations took into account. They thought they could rely on the benefit, and they get very upset when it turns out that it isn't something that they can rely on.

And, you know, many people don't realize that, unlike pensions, these aren't prefunded benefits.

And so, if a company is starting to fail, and they're looking to find cash, cutting retiree health expenditures is a place to look.

The other piece of bad news for some is going to be the fact that the accounting rules for public sector employers are going to be changing in the next few years. They didn't change ten years ago. And, retiree health benefits in the public sector have tended to be much stronger than those in the private sector up until now. Accounting for those future benefit costs is going to be an issue that state and local governments are going to be dealing with as well.

We're going to see the issue debated in various places around the country as it comes up, too.

VICE CHAIR McLAUGHLIN: Yes, in Michigan, which is where I'm from, there was, as I'm sure you know, this recent case before the State Supreme Court where they ruled that retiree benefits are not protected.

And the implications are rippling quite quickly through the system, including state employees and local employees, who are saying, well, if our Supreme Court says that these are not protected, then why should we think that they will be for us?

And the thing is that, as I said, those are now demanding higher wages. So it's an illusory savings in some ways.

The only one that's really been solid is military; you know, the military has been really solid. I come from a family filled with military people who did their 20 years or 30 years, and in part made sacrifices all those years, because they wanted the benefits that were guaranteed to them in the military, where it was not an implicit contract; it was an explicit contract.

So I can understand why you'd have such an incentive to try to make -- to honor that contract, but at the same time try to have some kind of financial responsibility. It sounds like you're doing a great job.

MR. BOLYARD: I can tell you that the benefit has been up and down. When we started this program, it

was totally free; nobody paid anything for their care. And the minute DOD started adding some costs, some enrollment fees, some copays, well, we became the enemy, not DOD and not Congress, but rather the health plan.

The psyche of a military beneficiary is "you promised me free care for the rest of my life", and so anything that falls below free care causes some level of dissatisfaction. But the reality is, I think what DOD and Congress have come up with -- and it really did improve the members' perception when they rolled out Tri-Care and they rolled out the U.S. Family Health Plan.

I think it's a fair benefit. It's not free, but it's very affordable.

CHAIR JOHNSON: In a recent discussion with a vice-president at one of the companies with whom I have contact -- he's about 45 years old, and he was asked, Well, what do you think is going to happen for retiree medical coverage? His response was, I'm planning to work until I'm eligible for Medicare, because it's not going to be there for me.

To what extent -- we were talking and you heard us talking about long-term care in the panel before. Is that going to be the way we're going to end up going? That our retirement age is going to change, and we ought to set expectation because of the cost for medical

coverage in the 50s-and-above years, that we should begin, as a population, to begin to think of working longer, in part for medical coverage?

MS. SMOLKA: Well, I think the survey that I mentioned earlier indicates that maintaining health insurance and paying for health expenses are reasons a significant share of older workers give for working. Social Security normal retirement age is rising, already. I'm not sure that people always recognize that. The age of eligibility for Medicare is still 65. But I'm not ready to say that the age of eligibility should change. I think that the surveys show that people realize that they need to stay working, to save or earn more, and, possibly, if they're not yet 65 to hold on to their insurance.

I talk to members all the time who have a spouse who's not yet 65. If the spouse has been a dependent on their coverage, do they stay working beyond 65 until the spouse is also Medicare eligible, at a minimum? You know, there are certainly people that do that.

And there are people who do take jobs well beyond age 65 to help them pay for their premium increases. It's hard, but that's what some people have to do in order to be able to afford their healthcare

coverage.

MR. DENNETT: I think that I would only add to that that as the Baby Boom generation gets into that age cohort, that many more employers are also going to try and encourage longer periods of employment. They will continue to be a very valuable part of the workplace, and that's fairly predictable just because of workforce needs and the fact that there won't be the same size of the entry-level labor force of younger workers to fill employment needs, so there will be a growing trend in all likelihood for there to be more older workers in the workplace.

But in terms of retiree health needs, I think that the recognition of the solution begins I think with just a clear understanding that it is not likely to be a benefit that is offered to an entirely new wave of workers coming into the workplace, so that even the roughly 30 to 35 percent of employers that are providing the benefit today, it's going to significantly decline, the percentage of those with the benefit will significantly decline.

And so that's why I think we need solutions that are more individually based for the future, and incentives for saving for this need, rather than to say, How can we reestablish something that is in all likelihood not likely to get created again. Certainly not in the

same way that it had been provided as a benefit to past generations.

CHAIR JOHNSON: Gerry, Paul talked about those tax incentives, and financial incentives to put money aside. There clearly will be people who will not be able to afford, and some won't feel they can afford, to put extra money aside.

MS. SMOLKA: That's right.

CHAIR JOHNSON: Having said that, is that a tax kind of policy that you think would work for the working public who are not in the lower pay ranges, but above those lower pay ranges? To what extent has AARP contemplated that?

MS. SMOLKA: Well, you're talking to somebody who's on the health team, not on the economics, retirement income, and pension side of the office.

It's certainly something that we've looked at, but I can't speak to it. I know we've been looked at ways to encourage people to save. I don't know what positions we have taken on various tax incentives.

We're also looking at ways to encourage and make opportunities available to older workers, partly because, as Paul said, the demographics are such that there may be a labor shortage, and keeping people in the workforce may prove to be good business for employers, as

well. We all hear about the likely retirement of massive numbers of teachers, nurses, and others, and the concern about how replace their skills.

But any solution that we would be interested in supporting needs to address those people who are not necessarily able to save lots of money. It's a measure of the kind of society we are, in some respects, to make sure that people can get care that they need. And there are challenges, as we all know, with the Medicaid program today.

But then there are those retirees who are just above the Medicaid level, and they, in many respects, have some of the toughest challenges trying to figure out how to meet their various needs.

MR. DENNETT: Could I just jump in on the tax issue? I think, you know, there're basically three tax incentives that you might want to consider in this area, and I think all three of them could play an important role generally.

For higher earners, you need to have a broad deduction for medical expenses in retirement, including for the spending of dollars on retiree health insurance premiums, the same way that there's tax preferred dollars available to individuals when they have active employee provided healthcare.

But for those that have lower or more modest incomes, clearly the deduction isn't going to be as valuable to them. You need to consider tax credits for them.

And for those with the lowest level incomes, who have no tax incidents to credit against, you probably need to consider refundable tax credits for their health insurance needs in retirement.

And you've seen the Administration proposed some of that in -- most recently in the context of trying to create incentives for health savings accounts, but really it -- I mean, the fundamental problem in all of this area for individuals, if you leave employment without a benefit, is that you're spending after-tax dollars for your healthcare needs in retirement, and whatever mechanisms of tax preferences, and those are the three generally available: broad deductions, tax credits, or refundable tax credits, which generally are only considered for lowest income individuals, that that's the direction we need to go, is to create a public policy of tax preferences that rewards people for saving for these needs.

MS. SMOLKA: I guess one point I would like to make to add on to that is that when we talk about these tax policies, we really do have to pay attention to what

it is that we're buying and what the cost of that is for different people.

When the Medicare buy-in proposals were around a couple of years ago, since that proposal was for a self supporting program, the premiums were higher than most people on a modest income would be able to manage without any subsidy

The issue with all of these tax proposals is similar to what we've observed under the Trade Adjustment Act's health coverage tax credits. It's a 35 percent credit towards whatever plan your state allows under the Health Coverage Tax Credit. But, the take-up of the credit has been much lower than people would have liked, because the 35 percent leaves an amount that people still find high when they have a limited income.

So unless it's a very finely tuned tax policy, we may find it is more helpful to those with more resources than those who are at the margin of being able to afford coverage.

CHAIR JOHNSON: Well, thank you very much for your participation this afternoon. Marshall, we didn't ask you too many questions, but you have certainly been able to install some practices and plans that seem to have made sense, and if we could request from you maybe to get a more detailed description of your program, and your

methods of delivery, so it becomes patient-centered, physician-centered, your disease management strategies and approaches and incentives, and so forth, if we would be able to get some access to that, that might be helpful for our consideration.

So, Caroline, if we could coordinate on that, that would be helpful.

And your organization, Gerry, has been collaborating with employers to try to come closer to what Marshall talked about is what they're doing in disclosure and working with CMS, and that kind of partnership in the future is going to be very, very helpful as well. So.

Thank you very much for all of your time this afternoon.

Okay. We're adjourned.

(Whereupon, at 2:15 p.m.the meeting was adjourned.)