



“Ensuring Sustainable Financing of Long Term Care Systems”

Cross Atlantic Exchange to Advance Long Term Care
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Remarks by Senator Richard T. Moore of Massachusetts
Senate Chairman, Massachusetts Legislature’s Committee on Health Care Financing
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“We face a threat more grave and certain than those posed by chemical weapons, nuclear proliferation, or ethnic strife: the ‘age wave’,” states Peter G. Peterson, the author of “Gray Dawn: How the Coming Age Wave Will Transform America-and the World” In a 1999 article appearing in the journal Foreign Affairs, Peterson explained that, “the effects of this demographic shift will be staggering” with a whopping price tag placing a massive burden on an ever-smaller working-age population.”

Most policy makers and population experts agree that global aging will be a significant, perhaps even the transcendent, issue of the 21st Century. The United States and Europe are already beginning to see the early effects of “global aging.” In the next forty-five years both regions will see their population of senior citizens grow from about twenty percent today, to over thirty-two percent in 2050. All agree that sustainable solutions must be found if we are to care for our growing senior population who, by the way, continue to be voters.

We know that health care costs are increasing:

- **Employer-Sponsored Health Coverage Premiums Have Risen 73% Since 2000.** Since 2000, employer-sponsored health coverage premiums have increased by 73%, outpacing overall inflation and increases in worker's wages. [Health Affairs, September, 2005 - October, 2005]
- **Health Care Costs Reached \$1.7 Trillion in 2003.** Expenditures in the United States on health care were nearly \$1.7 trillion in 2003, almost 2 and a half times

the \$696 billion spent in 1990, and almost 7 times the \$246 billion spent in 1980. [Kaiser Family Foundation, Background Brief available at www.kaiseredu.org]

We also know that elderly represent between 50-60 % of the total cost of health care:

- Seniomag noted that: “Seniors account for 60% of all healthcare spending. They purchase 74% of all prescription drugs and buy 51% of all over-the counter Drugs.”
- United Press International reported recently that 50% of healthcare spending is spent on the elderly. “Meanwhile, nearly half of any wealthy nation's healthcare spending is placed on the over-65 year olds, and their per capita healthcare costs run up to five times that of those under that age.”

Everywhere there is mounting evidence that the “age wave” is really a sociological tidal wave as increasing numbers of elderly are living longer and have more complex health needs. This tidal wave will surely wash ashore as the cost of care rises much faster than the rates of inflation and as the proportion of those who work and pay taxes declines. Just as the buildings along the Gulf Coast of the United States were devastated and washed away by the storm surge from Hurricane Katrina one year ago, the present system of long term care will be equally unsustainable. Clearly, a strategy is needed to meet the long term health care needs of our population in the United States and Europe.

However, in the United States, the federal government seems unable to implement a strategy for confronting the implications of a graying America. If the complex, confusing and potentially unsustainable Medicare Part D drug assistance program is indicative of federal commitment, we need to look beyond the “Washington beltway” for affordable, effective solutions. Certainly, one direction could be to look to our friends in the European Community, who are facing the same enormous challenge, for “best practices” that can be replicated or refined for use in America. There is much that we can learn from each other.

We should also look to the state legislatures, the “laboratories of democracy,” as Justice Louis D. Brandeis once called them. State governments are developing innovative and financially sustainable programs for their growing senior populations.

Several years ago, long before the federal government established a prescription drug benefit (Medicare Part D) to help seniors with the cost of medications, Massachusetts established its own prescription drug assistance program called *Prescription Advantage*. This is a drug insurance program that, for low income seniors, is funded by state government, and for seniors with financial means, it is a subsidized drug insurance plan. Even with the new Medicare Part D drug benefit, *Prescription Advantage* continues to supplement gaps in the federal drug plan. A number of other states also established various forms of drug assistance.

At the same time, the Legislature established a prescription drug information and referral service called *MassMedLine* – a public/private partnership between Massachusetts state government, pharmaceutical manufacturers' community benefit programs for free or discounted drugs, and the private, non-profit Massachusetts College of Pharmacy and Health Sciences. By guiding seniors and disabled through the maze of pharmaceutical assistance plans, the program has saved seniors over \$14 million in the past five years. *MassMedLine* has also helped seniors by providing pharmacists to answer questions about medications by phone and Internet and helping seniors to understand and enroll in the new Medicare Part D drug benefit.

In Massachusetts, as in other states, long term care has since World War II been primarily focused on institutional nursing homes that are managed in a variety of methods. Some nursing homes are run as not-for-profit entities, some are for-profit either as single entities or as part of a chain involving several facilities under the same ownership, a few – like the Soldiers Homes in Chelsea and Holyoke – are state facilities for elderly military veterans. These are licensed by the state department of public health as skilled nursing facilities.

Some of these nursing homes provide rehabilitation services for mostly elderly individuals who are recovering from surgery or an accident. They do not require the acute level of care provided in hospitals, but they are too frail to go directly home. In many cases, these individuals return home, but a certain percentage ultimately transfer over from rehabilitative to residential care because they cannot recover sufficiently to live on their own or their may not be adequate support services in their homes.

Many of the better skilled nursing facilities also operate units called day health care. The facility sends a bus to the homes of individuals who don't need 24-hour care, but who can benefit from the socialization and the health check as well as the day time meals that are provided, and brings them to the facility for the day several days per week.

Skilled nursing facilities are financed by individuals who can afford to pay for their care, by the Medicaid program (funded equally by the national and state government), and by the state through a per bed assessment that is then matched with federal Medicaid funds and the bulk of the revenue is returned to the nursing homes in the form of higher Medicaid reimbursements. It is a mechanism used in many states to maximize federal reimbursement, but it is a burden on the small percentage of relatively wealthy nursing home residents who pay for their own care since their care doesn't qualify for Medicaid reimbursement.

In the continuum of long term care, there are Assisted Living Facilities, licensed by the Department of Elder Affairs. These facilities provide limited health care services for elderly residents with a reasonable degree of independence. Most of the funding to support this program comes from the individual directly or through long term care insurance policies. There may be some limited public funding attached to some of the Assisted Living residents. Another residential program that provides essentially no

health care services, to its residents - but is a step above a boarding house, is called a rest home. Residents in these facilities often receive public assistance.

About thirty percent of elderly who are supported by Medicaid receive home care services in their own homes. These services could entail visits by a visiting nurse, hot meals, rehabilitation services and other forms of assistance.

In 2004, Massachusetts established *Senior Care Options (SCO)*, a partnership between MassHealth (Medicaid) and Medicare, which provides a complete package of needed health care and social services for low-income, frail seniors. This voluntary program helps those who would have been institutionalized for care in years past remain in their home at less cost to taxpayers. As of August 1, 2006 there have been 5,394 seniors have enrolled in the SCO program. Since many, of not all, of these seniors would have probably had to be placed in a nursing home, the savings to taxpayers and the benefit to the quality of life of seniors are clear.

Recently, Massachusetts followed the lead of Oregon, Vermont, and several other states in adopting "*Equal Choice*." The policy **offers low income seniors and disabled citizens a genuine opportunity to remain in their home** (estimated annual per person cost of \$28,000) as their care needs become more complex, rather than be forced to enter a nursing home (estimated annual per person cost of \$51,500). Federal Medicaid dollars and state matching funds will now more easily follow the person to the most appropriate, least restrictive care setting.

As public subsidies for long term living are focused on allowing the dramatically growing population of seniors to remain in their homes, there will be a reduction in the need for more expanding the infrastructure for expensive institutional care. Some high quality nursing homes will be needed as part of the continuum of care as long as we have to deal with illnesses such as dementia and Alzheimer's disease. However, we can, we should, in fact, we must be focus on quality care in these remaining institutional settings.

While there is a clear responsibility on the part of government to assist our citizens with the affordability of the cost of daily living whether in their homes, assisted living or nursing home settings, citizens share a part of that responsibility based on ability to pay.

Clearly, those who can afford to put money aside to share the cost of their long term care with the federal and state governments should be provided incentives by both levels of government to invest in themselves in the form of federal and state tax credits to purchase long term care insurance to offset part of the future costs of long term care. An equally important role for state governments, in their traditional regulation of insurance, is to guarantee quality and flexibility in the long term care insurance products available to the residents of their respective states. Here, again, state governments are taking the lead in helping to make long term care sustainable by sharing the costs with seniors themselves. Regrettably, my own state of Massachusetts is one of only four states in the country that have, so far, failed to pass a law mandating minimum standards for long term care insurance. However, I am pleased to report that the state senate has approved legislation

that, if enacted into law, would help address that glaring hole in our regulatory structure. I am also pleased to be able to say that the bill that passed the Senate is based on three related bills that I sponsored or co-sponsored in the current term.

Since current estimates are that one in five people who reach the age of 65 will spend more than 2 years in a nursing home, and at the current cost of about \$50,000 U.S. dollars per person per year, that cost is exorbitant. Three in five people who reach the age of 65 will require some form of long term care for some period of time.

Massachusetts also has one of the highest percentages of residents receiving treatment in nursing homes and other long term care facilities. Despite our passage of the “Equal Choice” law, it will take time for the senior population to shift to a majority receiving home and community based care. One result of this combination is that payments to long term care facilities currently account for the largest single percentage of Medicaid’s fee-for-service payments. Even with our efforts to shift care to home and community based settings, sustaining long term care in the community, while less expensive on a per capita basis than institutional care, will still be expensive given the growing numbers of elderly. It is no exaggeration to describe this combination of facts as a fiscal time bomb.

This bill, passed by the Massachusetts Senate, and awaiting action by the House, makes three changes to try to encourage Massachusetts residents to purchase long-term care insurance policies.

- First, the bill requires the Massachusetts Group Insurance Commission, the agency responsible for public employee health insurance, to devise a long term care insurance plan for state employees. Under that plan, the Group Insurance Commission would assemble a package of approved long term care insurance products that state employees could purchase.
- Second, the bill would create a tax exemption for long term care insurance premiums. The exemption would have a ceiling of up to \$5,000 in the annual premiums paid for long term care insurance policies approved for sale in the Commonwealth.
- Third, the bill would institute the long-term care model law promulgated by the National Association of Insurance Commissioners. Insurers and consumers in other states that have passed this law have grown increasingly comfortable with it, even as the insurance product itself is evolving. It outlines basic disclosure and performance standards for the insurance companies.

We have to act responsibly now to address the stark fiscal realities that demographically we cannot avoid in the future. The legislation could be expected to reduce Medicaid costs in future years resulting from the increased access to long-term care insurance policies.

Sustainability of long term care cannot be based on affordability alone. The *quality of care* provided to seniors and the disabled must be an essential link with affordability – or cost-effectiveness of long term care. Ensuring that nursing homes and home-based care are delivered in safe, high quality settings by well-trained staff will be increasingly challenging as the number of seniors increase.

In testimony presented to the United States Congress last year, Herb Kuhn, Director of the Center for Medicare Management in the federal Centers for Medicare and Medicaid Services, noted:

- *Pay for performance* is in the early stages of development and a great deal more work still needs to be done to develop a full set of widely applicable quality performance measures. But that...
- Inefficient health care is costly to the patient and to the government;
- Small percentages in financial incentives can encourage provider interest in quality, while keeping the payment system predictable for health care providers;
- Patients with chronic conditions often require care across several settings of care...pay for performance initiatives need to support improved coordination of care.

Clearly, mechanisms focusing on pay for performance in long term care settings are in early stages of development to serve as both carrot and stick to encourage providers of care to maintain and improve quality of care, yet early pilot projects are a promising direction for ensuring sustainable long term care.

Every state has a program that provides *long term care ombudsman* services as authorized by the Older Americans Act of 1965 and its subsequent reauthorizations. While there are some variations among the states as to where the ombudsman function is administratively placed, the intent of to provide elders and their families with a complaint department to promote improved care and quality of life. In Massachusetts, the Department of Elder Affairs administers the Long Term Care Ombudsman program and the Division of Health Care Quality of the Department of Public Health licenses and inspects nursing homes. As the state shifts its long term care emphasis to home care settings, the challenge will be to provide effective mechanisms for monitoring the quality of care just as is now done through the nursing home survey.

Another program that is being employed in about forty states in the United States (but, regrettably, not yet in Massachusetts) is known as *Collaborative Drug Therapy Management (CDTM)*. In this program, a physician voluntarily partners with a pharmacist to manage the health care of patients – especially those who are seniors with chronic disease. This professional partnership has been demonstrated to improve the quality of care and limit costly waste and medication error.

In addition to sharing with the government the responsibility of funding long term care, individuals can help to reduce their need for long term care services by adopting healthy lifestyles and behaviors. The government's part in this is to promote public policies that provide incentives and penalties – carrots and sticks – to promote healthy aging. After all, if you don't need health care services, you and the government can save money, and you will enjoy long term living, rather than long term care.

The national and state governments ***must set goals for healthy aging*** and adopt policies that support efforts by citizens to achieve those goals. Our U. S. Centers for Disease Control and Prevention have identified fifteen indicators related to older adult health status, behaviors, preventive care and screening, and injuries and they have begun measuring those indicators on a state specific basis. [See Appendix.]

Beyond policies that provide adequate funding for long term care that promote more cost-effective services at home rather than in more expensive nursing facilities, providing opportunities such as through long term care insurance so that those who can afford to help finance their own care do so, and promoting policies that encourage health life styles, another method of ensuring sustainability of long term care is to improve access to health care through ***telehealth technologies***.

As Albert Einstein once said, “We cannot solve our problems with the same thinking we used when we created them.” The supply of health care providers, even with a concerted effort to assist and encourage more people to enter these professions, is projected to be inadequate to serve the needs of the growing elderly population. Consequently, we need to use those resources we have, or are able to develop, more effectively. Through the use of new technologies it is possible for a physician or nurse to check on the health status of many elderly each day rather than just a few. States, and the national government, are working to increase the availability to telehealth technology at the community level.

Home monitoring devices, as part of our “equal choice” program of long term care, can be ideal of chronic disease patients with congestive health failure and diabetes, especially when 78% of health care dollars are currently spent on chronic disease. Savings in managing chronic disease can help to make long term care sustainable for the future. In home monitoring devices can report weight and temperature, pulse and heart rate, blood sugars and peak flow. This data can be relayed to nursing staff and physicians and questions for the patient for individualized care can be asked in a multitude of languages to minimize health disparities. The use of e-Health initiatives can also promote patient safety and cost reduction in a variety of areas such as computerized physician order entry systems (CPOE) and electronic medical records.

Let me summarize the steps that, I believe, are important to ensuring that our society can financially sustain the cost of long term care for the dramatically increasing number of senior citizens:

- Promote home care as a viable alternative to institutional care by providing an adequate system of quality services in the person's own home or with a family member to limit the number of new nursing home beds that may be needed.

- Promote reserving nursing home beds for those who are too frail to function in their home or have diseases such as Alzheimer's that render seniors unable to be served effectively in their home.
- Promote telemedicine to maximize the effectiveness of medical personnel who are needed to maintain seniors in their home or community setting at a reasonable cost.
- Promote public/private partnerships with pharmaceutical manufacturers and schools of medicine, pharmacy and nursing to maximize non-government supported benefits.
- Promote healthy lifestyles with proper nutrition and exercise as well as prevention (including aggressive efforts to reduce infections and falls) throughout life, but especially after age 50.
- Promote the purchase of long term care insurance to share the cost of long term living between the public treasury and individuals.
- Promote managed care – especially through mechanisms such as senior care options for frail, low-income seniors, and collaborative drug therapy management for seniors with chronic health conditions.
- Promote quality in long term care, including pay for performance standards for cost-effective care that helps patients and taxpayers.

Thank you.

APPENDIX

GOALS FOR HEALTHY AGING (CDC)

Indicator 1: Physically unhealthy days – defined as the overall number of days during the previous 30 days when the respondent to the survey reported that his/her physical health (including illness and injury) was not good. Factors associated with fewer unhealthy days included having a college degree, being employed, having never smoked, and having some level of physical activity. Action items include moderate physical activity such as walking or exercise, not smoking, eating healthy, getting preventive care, managing chronic diseases.

Indicator 2: Frequency of mental distress – defined as the number of days during the previous 30 days when the respondent reported that their mental health was not good because of stress, depression and problems with emotions. Those reporting 14 or more days of poor mental health are defined as having frequent mental distress. Action items include providing support groups or counseling.

Indicator 3: Oral health: Complete tooth loss – the degree of tooth loss is often defined by socio-economic, racial/ethnic and health characteristics including annual income below \$15,000 US, having less than a high school education, having diabetes, and being a non-Hispanic Black. Action items include drinking fluoridated water or using fluoridated toothpaste, practicing good oral hygiene, avoiding tobacco, limiting alcohol, etc.

Indicator 4: Disability – limitations of activities because of physical, mental, or emotional problems. Action items include regular medical care, medication, supports such as wheelchair, special bed, etc.

Indicator 5: Physical Activity – few factors contribute as much to successful aging as having a physically active lifestyle. Action items include daily walking, gardening, etc.

Indicator 6: Eating five or more fruits and vegetables daily – eating a diet rich in fruits and vegetables helps reduce risk of some cancers and chronic conditions such as diabetes and cardiovascular disease.

Indicator 7: Obesity – Maintaining a healthy body weight is important to older adults. People over age 65 have increased prevalence for obesity. Individual body mass (BMI) below 30kg/m² is the goal. Action items are diet and exercise.

Indicator 8: Current Smoking – Cigarette smoking is responsible for 440,000 premature deaths in the US. This behavior results in premature death or disability. Action items include stopping smoking, counseling and medication to help with addiction.

Indicator 9: Flu Vaccine in past year.

Indicator 10: Ever had pneumonia vaccine – although influenza and pneumonia can be prevented through vaccination, 90% of the deaths are among those 65 and over. Action item – promote vaccination, especially among health workers who work with those in nursing homes or hospitals.

Indicator 11: Mammogram within last two years – mammography is best way to detect breast cancer in women when it is most treatable. Action item is to get more women into timely screening after age 50, and especially after age 65.

Indicator 12: Colorectal Cancer Screening – colon cancer is the second leading cause of cancer deaths in the U.S. Early detection through screening is very effective. Action items include annual fecal occult blood test, a flexible sigmoidoscopy every five years, a double-contrast barium enema every 5 years, and a colonoscopy every ten years.

Indicator 13: Up to date on select preventive services – older adults need all of 9 through 12. New Medicare law provides these services, but elderly need to be encouraged to take advantage.

Indicator 14: Cholesterol Screening – because high serum cholesterol is a major risk factor in coronary disease and the leading cause of illness in older men and women periodic screening and medication and/or diet are important steps in prevention. Lowering cholesterol levels can prolong and improve quality of life.

Indicator 15: Hip fracture hospitalizations – the most serious type of fall related fracture is a leading contributor to death and disability and reduced quality of life in older adults. It is also a very expensive problem. Exercise and diet are effective measures in prevention as well as surveying home and other areas for potential causes of accidents. A national state by state falls prevention program is a critical need for addressing this issue. A summit is scheduled to develop a plan to prevent falls and related injuries and to work with older adults to make sure they benefit.