CARING FOR AN AGING AMERICA

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Invited Testimony
House Appropriations Committee
Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
Hearing on "Health Care Access and the Aging of America"
February 15, 2007

CARING FOR AN AGING AMERICA

Thank you, Mr. Chairman, for this invitation to testify today. My name is Mary Jane Koren and I am an assistant vice president of The Commonwealth Fund and a member of the National Commission for Quality Long-Term Care. I thank Chairman Obey and Ranking Member Walsh—and every member of the House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies—for conducting this hearing on the challenges our nation's health care system faces as society ages, and how, ultimately, we can help strengthen that system for America's seniors.

I doubt that there is anyone present here today who is unfamiliar with the fact that the number of people over the age of 65 is increasing. It is the exponential nature of that growth, as those born between 1946 and 1962 enter "old age," which is staggering. In 1950, there were 16 million people over age 65, about 8 percent of the U.S. population. Today there are about 36 million—roughly 13 percent of the population. Projections to 2020 and 2050 have the proportion of elderly rising to 17 percent and then 20 percent. That is, one of every five people in the United States will be "old" by mid-century. Likewise, looking at the growth rates for the elderly, it is the oldest cohorts—those over 85—that will be growing the fastest. By 2050, this group will represent almost 5 percent of the population, a 10-fold increase from 1950, when it was 0.4 percent.

For the moment, put aside the broader societal consequences of those numbers and instead think about them from the perspective of demand for health services. As people age, progressing from what we geriatricians call "the young old" to "the old old," the following three outcomes can be expected: First, the number of people with chronic illnesses will increase. This has tremendous consequences. Two-thirds of Medicare spending is for beneficiaries with five or more chronic conditions while only 1 percent is for beneficiaries without chronic conditions. In addition to the economic impact, we also know that chronic illnesses have profound functional consequences, which leads to my second point.

As people get older, they will more likely need someone to help them perform basic activities of daily living (e.g., personal functions like bathing, dressing, and toileting; as well as social activities) and independent activities of daily living, like managing money, meal preparation, and transportation. This means that the need for long-term care services will escalate in tandem with the aging of America. Unfortunately,

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the problem of long-term care is the elephant in the room when policymakers and planners gather to talk about the health care system. Everybody knows it's there, but it's too daunting to take it on and simply hasn't been part of the discussion.

Finally, the mortality rate for the human race is 100 percent. Despite the impressive gains in life expectancy made over the past century, old people will die. Our current system has not really come to terms with that fact, creating devastating consequences for patients dying in hospitals rather than at home with their families and the associated costs of futile interventions.

What then, in my view, are the challenges? I would argue that foremost is the need to completely rethink the system we have and create a person-centered health care system. If we segmented the elderly population not by age cohorts or eligibility categories, but rather grouped them according to their health care characteristics (e.g. those dying with a short terminal course or those having limited physiologic reserve who experience acute exacerbations of underlying chronic conditions), our care delivery system would have a very different orientation and our current cost spiral might slow. Dr. Joanne Lynn, from the Center for Medicare and Medicaid Services (CMS), who originated this idea, has developed a very provocative framework that shows us what such a system might look like and what the cost implications might be. Using patients' goals for care to shape the delivery and payment system is a far more sensible and cost-effective way to begin planning for the provision of services for our aging population than our current approach. It would mean that long-term care services and palliative care cease to be the problem no one wants to discuss and, instead, become central to the solution for caring for our aging society.

The second major challenge is helping the long-term care system realize its potential and ready itself to meet the coming demand. The National Commission for Quality Long-Term Care, a non-partisan group of former or current governors, members of Congress, state officials, policy experts, advocates, and others, chaired by former Senator Bob Kerrey and former House Speaker Newt Gingrich, has come together to grapple with the problems and promise of long-term care. The Commission, in its report *Out of Isolation: A Vision for Long-Term Care,* has identified six broad areas of system change: cultural transformation, empowering individuals and families, workforce, technology, regulation, and finance. I would like to address several of those areas here.

First, is the issue of quality: how do we transform the culture of long-term care, making it a high-performance system that delivers the very best quality of care and

quality of life? At the system level, the Nursing Home Quality Campaign: Advancing Excellence for America's Nursing Homes represents an outstanding example of a high level public-private partnership committed to helping nursing homes meet performance targets for specific quality areas. Each of the stakeholders involved—consumers, provider associations, professional organizations, the Agency for Healthcare Research and Quality, and CMS—are using their influence with nursing home providers to measurably improve the quality of care and quality of life for residents. It's a model that could be adapted to take on other seemingly intractable issues or that could be emulated by other parts of the long-term care system. At the practice level, there are a number of promising models that embody the concept of person-centered care. Providing evidence on what works is critically important to enlightened policymaking. To this end, The Commonwealth Fund has provided financial support for an evaluation of Wisconsin's Wellspring Alliance and the Green House model in Tupelo, Mississippi. These evaluations have shown higher quality of life, better or the same clinical outcomes, no higher costs, and lower turnover of certified nurses aides.

Which brings me to a second urgent issue, that of caregivers. How do we ensure adequate numbers of well-trained workers and also support individuals and their families to care for those needing assistance? We face a coming shortage of skilled and trained workers who are empowered to make decisions on the front-lines to ensure the kind of care we all want in our old age—compassionate, competent, and kind. This is not an insurmountable problem as the results of such demonstrations as the Better Jobs/ Better Care initiative, funded by the Robert Wood Johnson Foundation and Atlantic Philanthropies, have shown.

A third issue is technology: How can technologic innovations such as electronic health records and telehealth be used in the long-term care setting to enhance consumer independence, improve service quality and efficiency, and coordinate care? My first recommendation would be to ensure that long-term care is included in the planning and development of health information systems. A second suggestion is to study and learn from some "natural experiments." For example, New York state is about to invest several million dollars to provide health information technology systems in about 20 nursing homes to determine the impact is on workers and residents and ascertain the business case for such facilities. Tracking such initiatives will accelerate their adoption by long-term care providers.

Lastly, there is the issue of paying for long-term care. What should the balance be between public, private, and individual responsibility and how can that be achieved?

Much has been made of projections that show Medicare and Medicaid consuming an ever-greater share of the federal budget and the nation's gross domestic product, nevertheless simply shifting costs onto older people will not make the financial problem disappear. Most older Americans do not have the savings to ensure their own health security during old age, a period which may extend for decades. Perhaps one of the most important first steps toward finding solutions has been taken by the National Commission for Quality Long-Term Care, which is providing a forum for information sharing and open dialogue among the highest levels of elected state and federal officials aided by nationally recognized experts in long-term care policy and finance. As Commissioners, Governor Phil Bredesen from Tennessee, Governor Haley Barbour from Mississippi, and four members of Congress, Representatives Jim McCreary (LA) and Earl Pomeroy (ND) and Senators Gordon Smith and Ron Wyden, both from Oregon, are being afforded an opportunity to share their mutual concerns and look for common ground.

In conclusion, I would make several recommendations at the federal level. First, have the courage to turn our health care system on its head and reorganize it around patients' health-related goals. Second, begin now to ensure that people can enter old age in better health, with their chronic conditions better controlled. Third, support research into new models of care to help people maintain their independence longer and enhance their quality of life and then ensure that federal regulations and reimbursement policies permit those models to thrive. Finally, if real progress is to be made, give long-term care policy a much higher priority in the national debate. Thank you.

Caring for an Aging America

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The Commonwealth Fund
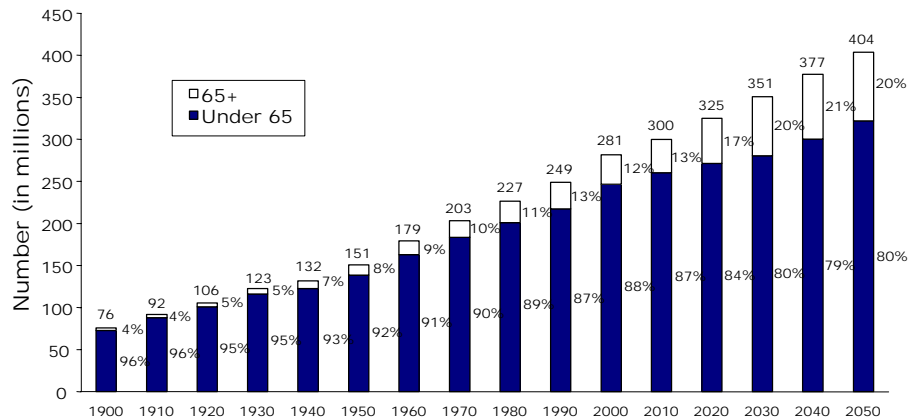**Member, National Commission for Quality Long-Term Care**

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Challenges Ensuring Affordability and Quality of Life for Aging Population

- **Rapid increase in share of the population over age 65 and over age 85**

- **High prevalence of chronic conditions and need for health care**

- **Growing demand for long-term care**

- **Need for culture change to ensure quality of life for frail elders**

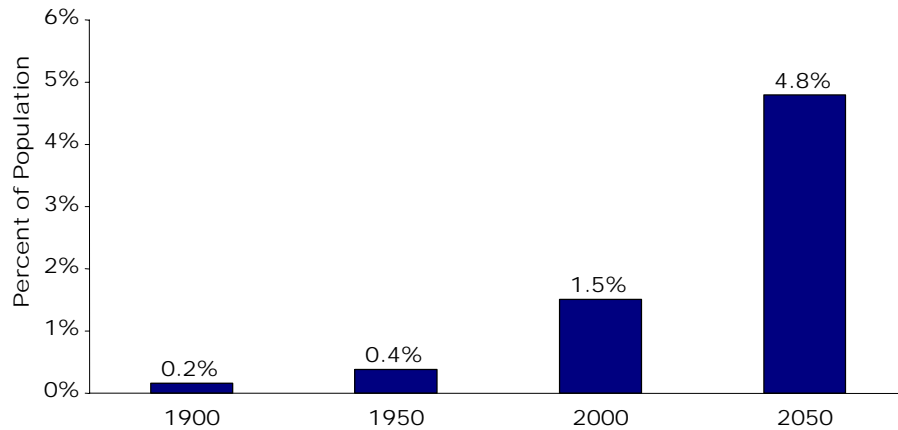## Figure 1. Growth in the Number of People Age 65 and Older

Note: The total population data for 1900 to 2000 include unknown age data. Therefore, the data used to determine the proportion of the population under age 65 and age 65 and older does not sum to equal the total population.

Sources: 1900 to 2000 data are from Hobbs, F., & Stoops, N. (2002). *Demographic Trends in the 20th Century* (Census 2000 Special Reports, CENSR-4). Washington, DC: U.S. Census Bureau. Available at http://www.census.gov/prod/2002pubs/censr-4.pdf. 2010 to 2050 data are from Population Projections Program (2000). *Projections of the Resident Population by Age, Sex, Race, and Hispanic Origin: 1999 to 2100 (Middle Series)*. Washington, DC: U.S. Census Bureau. Available at http://www.census.gov/population/www/projections/natdet.html.
Source: R. Friedland and L. Summer, *Demography Is Not Destiny, Revisited*, The Commonwealth Fund, March 2005.
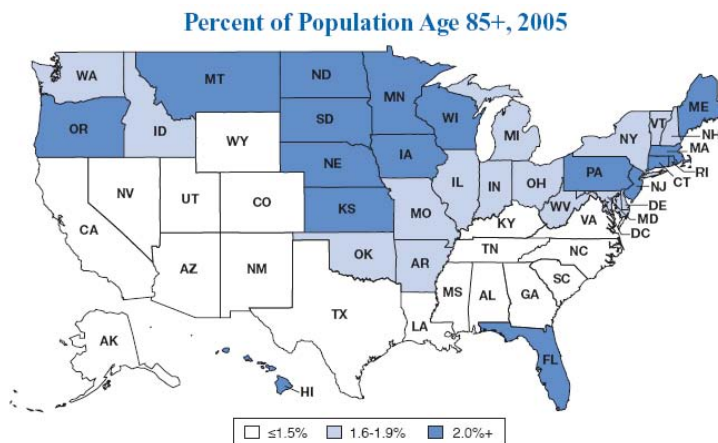
Figure 2. Population Age 85 and Older (%)

Sources: 1900 to 2000 data are from Hobbs, F., & Stoops, N. (2002). *Demographic Trends in the 20th Century* (Census 2000 Special Reports, CENSR-4). Washington, DC: U.S. Census Bureau. Available at http://www.census.gov/prod/2002pubs/censr-4.pdf. 2050 data are from Population Projections Program. (2000). *Projections of the Resident Population by Age, Sex, Race and Hispanic Origin: 1999 to 2100 (Middle Series)*. Washington, DC: U.S. Census Bureau. Available at http://www.census.gov/population/www/projections/natdet.html.
Source: R. Friedland and L. Summer, *Demography Is Not Destiny, Revisited*, The Commonwealth Fund, March 2005.

Figure 3. Percent of Population Age 85 and Older, 2005
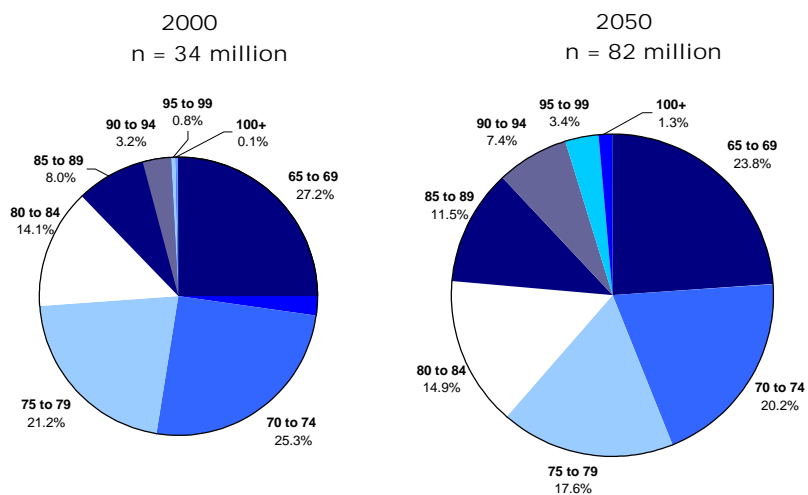
Percent of Population Age 85+, 2005

Legend: ☐ ≤1.5% ☐ 1.6-1.9% ■ 2.0%+

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Figure 4. Older Population by Age

2000
n = 34 million

- 65 to 69 27.2%
- 70 to 74 25.3%
- 75 to 79 21.2%
- 80 to 84 14.1%
- 85 to 89 8.0%
- 90 to 94 3.2%
- 95 to 99 0.8%
- 100+ 0.1%

2050
n = 82 million

- 65 to 69 23.8%
- 70 to 74 20.2%
- 75 to 79 17.6%
- 80 to 84 14.9%
- 85 to 89 11.5%
- 90 to 94 7.4%
- 95 to 99 3.4%
- 100+ 1.3%

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Figure 5. **Population growth**

Number in millions

Total population

65+ years

75+ years

Year

Projected

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SOURCES: Centers for Disease Control and Prevention, National Center for Health Statistics, *Health, United States, 2006*, Figure 1. Data from the U.S. Census Bureau.

Figure 6. Activity limitation among older adults due to chronic conditions, 2003-04

65-74 years

75-84 years

85+ years

- Senility
- Lung
- Diabetes
- Vision
- Hearing
- Heart/circulatory
- Arthritis/musculoskeletal

Number of persons with limitation of activity per 1,000 population

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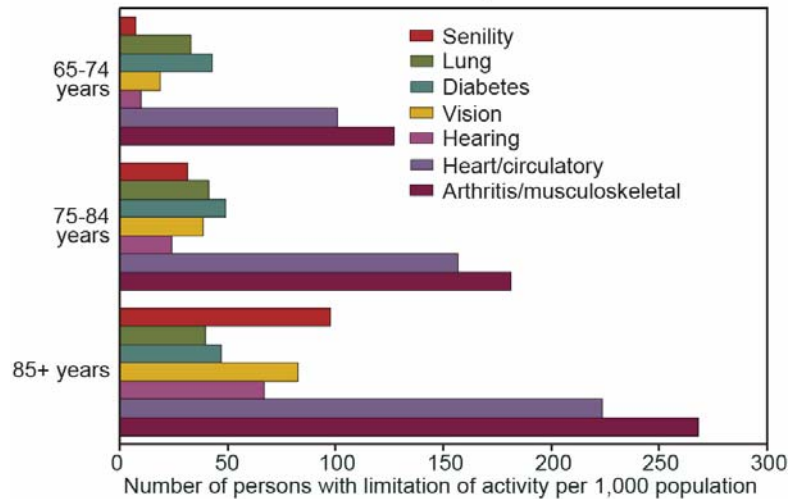
SOURCES: Centers for Disease Control and Prevention, National Center for Health Statistics, *Health, United States, 2006*, Figure 18. Data from the National Health Interview Survey.
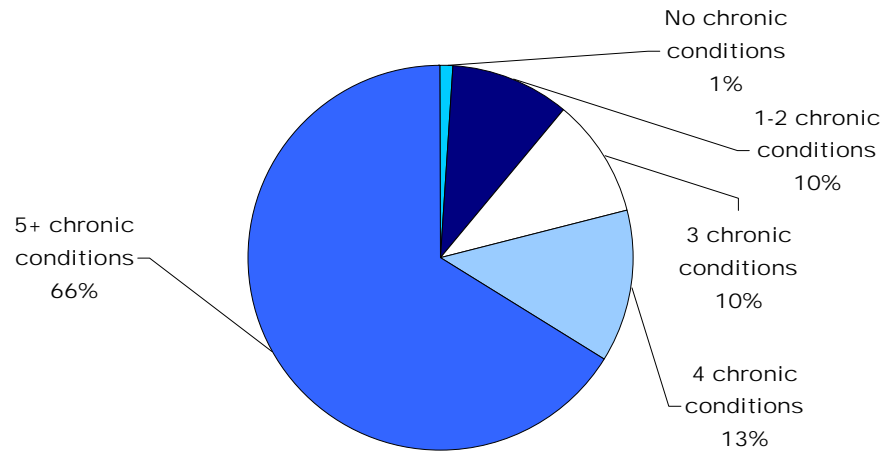
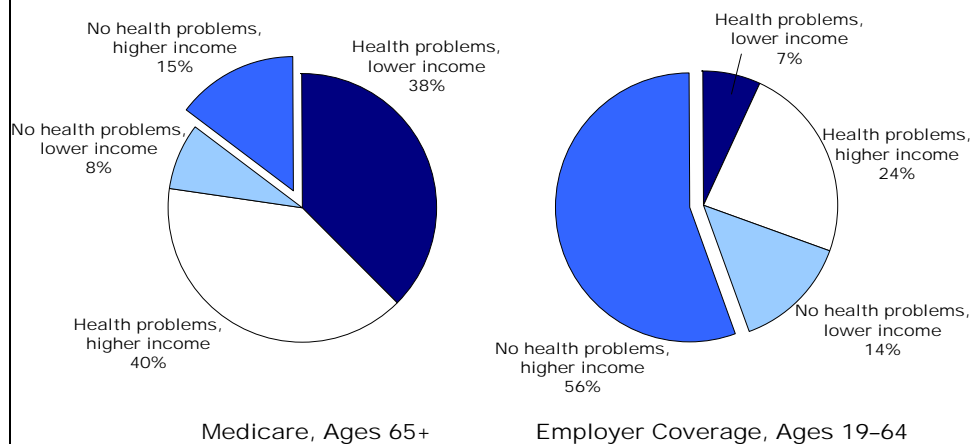**Figure 7. Two-thirds of Medicare Spending is for People with Five or More Chronic Conditions**

No chronic conditions 1%

1-2 chronic conditions 10%

3 chronic conditions 10%

4 chronic conditions 13%

5+ chronic conditions 66%

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Source: G. Anderson and J. Horvath, *Chronic Conditions: Making the Case for Ongoing Care.* Baltimore, MD: Partnership for Solutions, December 2002.

Figure 8. Profile of Medicare Elderly Beneficiaries and Employer Coverage of Nonelderly, by Poverty and Health Problems

No health problems, higher income 15%

Health problems, lower income 38%

No health problems, lower income 8%

Health problems, higher income 40%

Medicare, Ages 65+

Health problems, lower income 7%

Health problems, higher income 24%

No health problems, lower income 14%

No health problems, higher income 56%

Employer Coverage, Ages 19–64

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Note: Respondents with undesignated poverty were not included; lower income defined as ≤200% of poverty; health problems defined as fair or poor health, any chronic condition (cancer, diabetes, heart attack/disease, and arthritis), or disability.
Source: The Commonwealth Fund Biennial Health Insurance Survey, 2003.

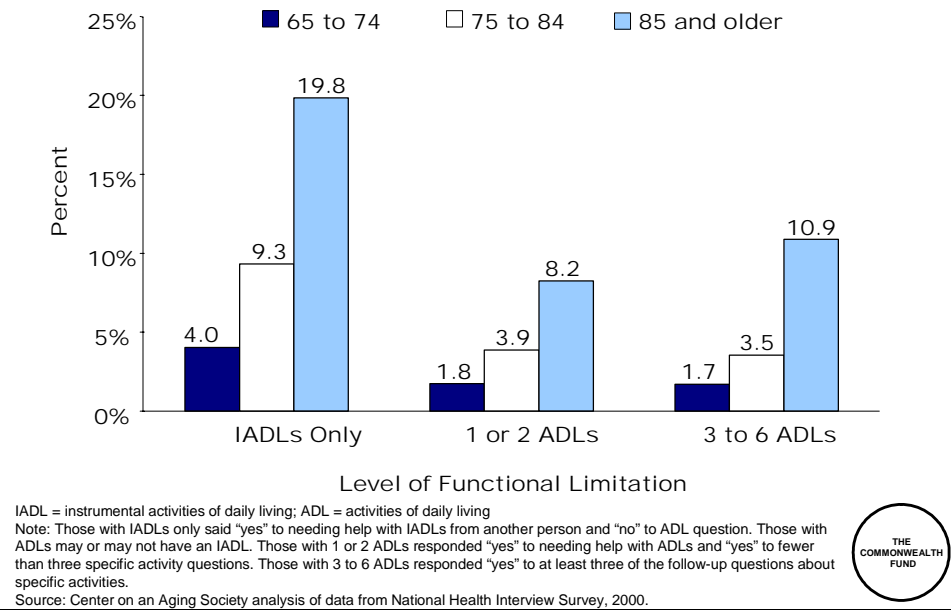**Figure 9. Percentage of Older People with Functional Limitations Who Need Help from Another Person, 2000**

IADL = instrumental activities of daily living; ADL = activities of daily living
Note: Those with IADLs only said "yes" to needing help with IADLs from another person and "no" to ADL question. Those with ADLs may or may not have an IADL. Those with 1 or 2 ADLs responded "yes" to needing help with ADLs and "yes" to fewer than three specific activity questions. Those with 3 to 6 ADLs responded "yes" to at least three of the follow-up questions about specific activities.
Source: Center on an Aging Society analysis of data from National Health Interview Survey, 2000.

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Figure 10. 10 Million Americans Use Long-Term Care

Nursing Home Residents 17%

Community Residents under Age 65 36%

Community Residents Age 65 or Older 47%

Source: Georgetown University 2003b.

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Figure 11. Medicaid's Coverage of Seniors with Alzheimer's Disease

Nursing Homes

Medicare/Other 53%

Medicaid/Medicare 47%

Community

Medicaid/Medicare 24%

Medicare/Other 76%

Note: Includes only Medicare beneficiaries age 65 and older with Alzheimer's disease.
Medicare/Other group includes persons who only have Medicare coverage and persons who have
Medicare with supplemental private coverage. Nursing home group includes beneficiaries who were
in both a nursing home and the community during the year.
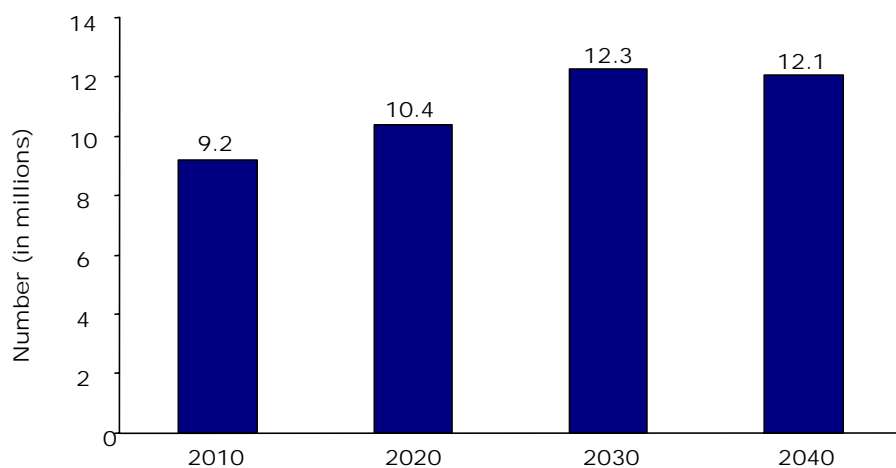Source: Kaiser Family Foundation *Profiles of Medicaid's High Cost Populations*, December 2006.

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Figure 12. Share of People Age 65+ Receiving Long-Term Care Services

Percent

Category	Value
All people Age 65+	15.9
65-69	5.7
70-74	8.8
75-79	13.6
80-84	24.8
85-89	39.8
90-94	59.8
95+	72.1

Note: Receipt of long-term care is defined as receiving human assistance or standby help with at least one of
six activities of daily living or being unable to perform at least one of eight independent activities of daily living
without assistance.
Source: Kaiser Family Foundation "Long Term Care: Understanding Medicaid's Role for the Elderly and
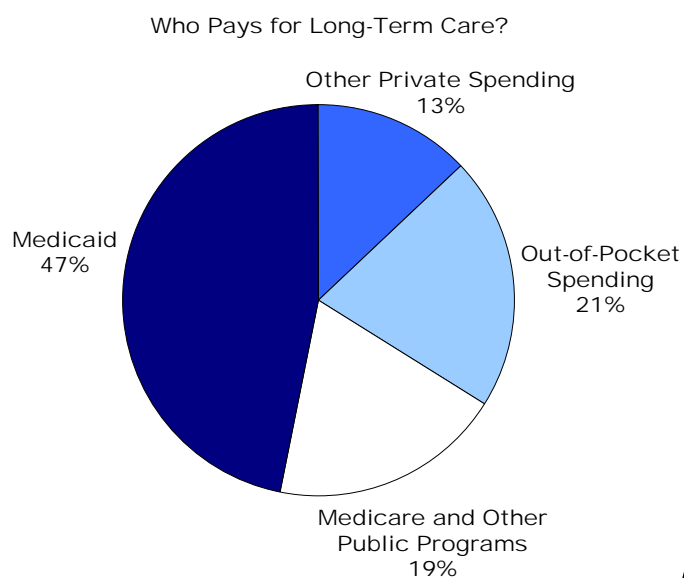Disabled." November 2005.

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Figure 13. Projections of the Number of People Age 65 and Older Who Will Need Long-Term Care

Number (in millions)

Year	Number (in millions)
2010	9.2
2020	10.4
2030	12.3
2040	12.1

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Figure 14. Half of Long-Term Care is Paid by Medicaid

Who Pays for Long-Term Care?

- Other Private Spending 13%
- Out-of-Pocket Spending 21%
- Medicare and Other Public Programs 19%
- Medicaid 47%

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Figure 15. Thirty-five Percent of Medicaid Spending Goes to Long-Term Care

Community-based
9.3%

Nursing Home
20.4%

Non-LTC
Medicaid
65.2%

ICF/MR
5.1%

ICF/MR = intermediate care facilities for the mentally retarded
Source: MEDSTAT HCBS

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Figure 16. National Spending on Long-Term Care, 2003, in Billions

Other Public, $4.6
(2.5%)

Other
Private, $5.4
(3%)

Private Insurance,
$15.7
(8.7%)

Medicaid, $86.3
(47.4%)

Out-of-Pocket,
$37.5
(20.6%)

Medicare, $32.4
(17.8%)

Total = $181.9 billion

Source: Kaiser Family Foundation *Long Term Care: Understanding Medicaid's Role for the Elderly and Disabled*, November 2005.

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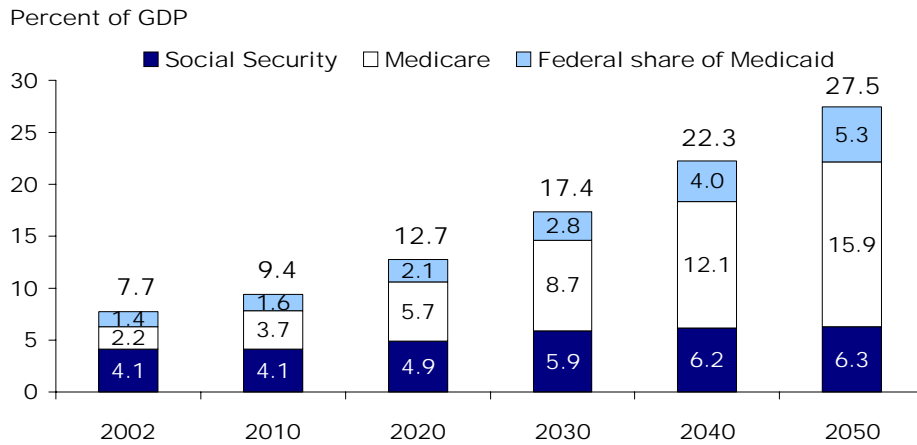FUND

Figure 17. National Nursing Home and Home Care Spending, by Payer, 2004

Nursing Home Spending

- Medicare 14%
- Private Insurance 7%
- Other Private 3%
- Other Public 2%
- Out-of-Pocket 25%
- Medicaid 48%

Total spending: $122 billion

Home Care Spending

- Medicare 26%
- Private Insurance 8%
- Other Private 2%
- Other Public 3%
- Out-of-Pocket 8%
- Medicaid 53%

Total spending: $62 billion

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Figure 18. Projections of Federal Expenditures as a Percentage of GDP

Percent of GDP

Legend: Social Security | Medicare | Federal share of Medicaid

Year	Social Security	Medicare	Federal share of Medicaid	Total
2002	4.1	2.2	1.4	7.7
2010	4.1	3.7	1.6	9.4
2020	4.9	5.7	2.1	12.7
2030	5.9	8.7	2.8	17.4
2040	6.2	12.1	4.0	22.3
2050	6.3	15.9	5.3	27.5

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Figure 19. Wages of the Average Worker Net of Taxes to Finance Social Security, Medicare, and the Disability Insurance Program

Note: Taxes on the average worker assumes *only* workers finance OASI, DI, HI and the general revenues needed for Parts B and D of Medicare.

These calculations assume that the full cost of these programs is financed by workers. Old-Age and Survivors Insurance and Disability Insurance (OASDI) cost rates are from Table VI.B1 and average wages are from Table VI.F7 in the Board of Trustees, Federal OASDI (2004). *The 2004 Annual Report of the Board of Trustees of the OASDI Trust Funds*. Washington, DC: Social Security Administration. Available át http://www.ssa.gov/OACT/TR/TR04/index.html. The Hospital Insurance (HI) cost rate is from Table II.B8 and II.C21 and the cost of Supplemental Medical Insurance (SMI) is based on the estimated Government Contributions in Table II.C5 of the Board of Trustees, Federal HI and Federal SMI Trust Funds (2004). *The 2004 Annual Report of the Board of Trustees of the Federal HI and Federal SMI Trust Funds*. Washington, DC: Centers for Medicare and Medicaid Services. Available at http://www.cms.hhs.gov/publications/trusteesreport/default.asp?. Income tax data is from the Internal Revenue Service (2003). *Internal Revenue Service Data Book, 2002 (Publication No. 55B)*. Available at http://www.irs.gov/taxstats/article/0,,id=102174,00.html. Total income taxes were then increased by the assumed rate of increase in average wages provided in Table VI.F7 of the Board of Trustees, Federal OASDI (2004).

Source: R. Friedland and L. Summer, *Demography Is Not Destiny, Revisited*, The Commonwealth Fund, March 2005.

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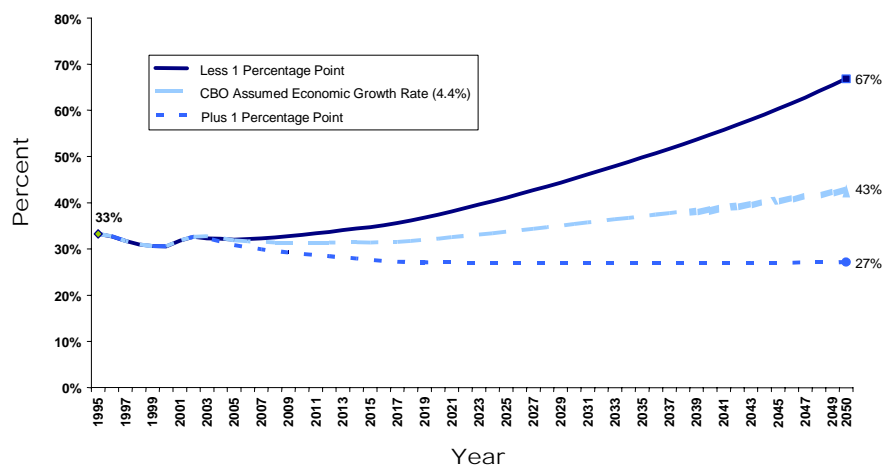## Figure 20. Total Government Spending as a Percentage of GDP, 1995 to 2050

Notes: Historic and projected GDP and Federal expenditure data are from Congressional Budget Office (2003). *Long-Term Budget Outlook: Supplemental Data* retrieved from http://www.cbo.gov. Center on an Aging Society's calculations of projected state and local expenditures are based on data from the U.S. Bureau of Economic Analysis. *National Income Product Accounts Tables (Table 3.3)*. Available at http://www.bea.gov.
Source: R. Friedland and L. Summer, *Demography Is Not Destiny, Revisited*, The Commonwealth Fund, March 2005.

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Figure 21. Two of Five Older Adults Are Not Confident in Their Retirement Security: Older Adults with Low Incomes Are the Least Confident

Percent of adults who are not too or not at all confident they will have enough income and savings to live comfortably in retirement

Legend: ■ Total □ <200% poverty ■ 200% poverty or more

Age group	Total	<200% poverty	200% poverty or more
Ages 50–70	39	64	30
Ages 50–64	41	69	32
Ages 65–70	29	50	15

Source: The Commonwealth Fund Survey of Older Adults, 2004.
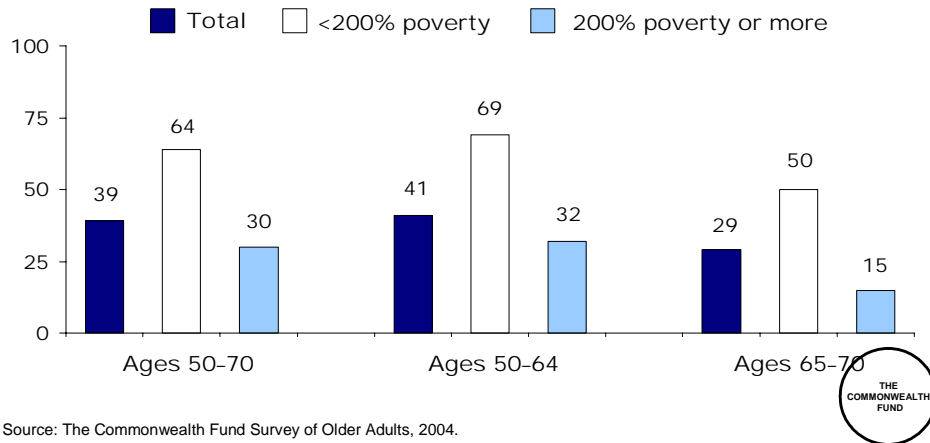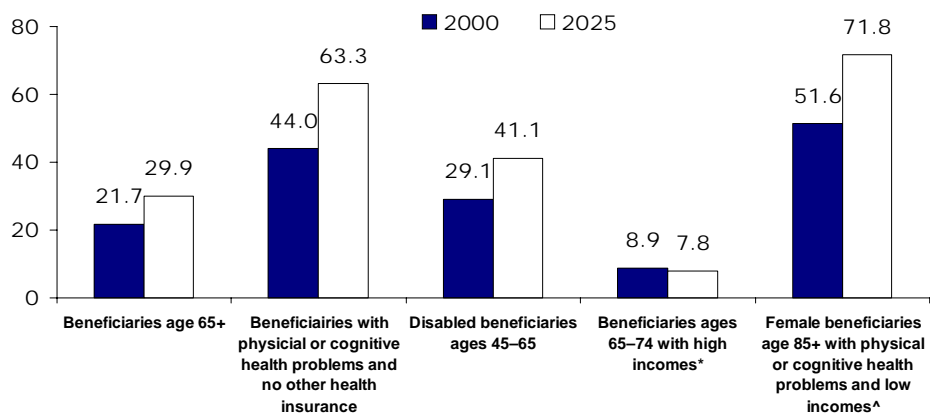
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Figure 22. Projected Out-of-Pocket Spending As a Share of Income Among Groups of Medicare Beneficiaries, 2000 and 2025

Out-of-pocket as percent of income

Legend: ■ 2000 □ 2025

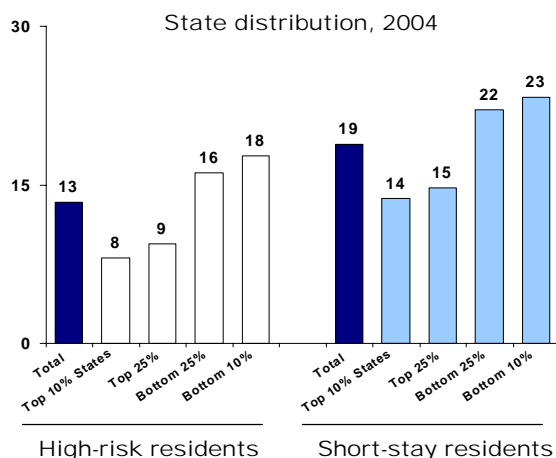| Group	2000	2025
Beneficiaries age 65+	21.7	29.9
Beneficiairies with physical or cognitive health problems and no other health insurance	44.0	63.3
Disabled beneficiaries ages 45–65	29.1	41.1
Beneficiaries ages 65–74 with high incomes*	8.9	7.8
Female beneficiaries age 85+ with physical or cognitive health problems and low incomes^	51.6	71.8

* Annual household incomes of $50,000 or more.

^ Annual household incomes of $5,000 to $20,000.

Source: S. Maxwell, M. Moon, and M. Segal, *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries,* The Commonwealth Fund, January 2001 as reported in R. Friedland and L. Summer, *Demography Is Not Destiny, Revisited*, The Commonwealth Fund, March 2005.

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Figure 23. Pressure Sores Among High-Risk and Short-Stay Residents in Nursing Facilities

Percent of nursing home residents with pressure sores

State distribution, 2004
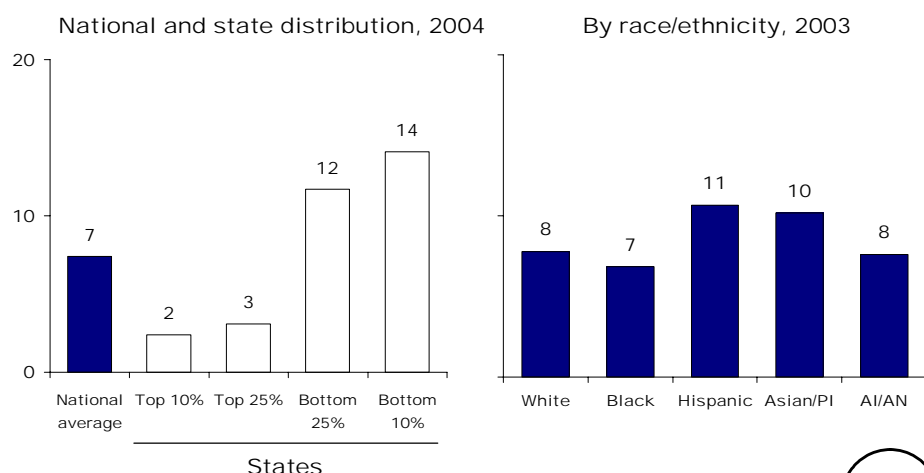
High-risk residents: Total 13, Top 10% States 8, Top 25% 9, Bottom 25% 16, Bottom 10% 18

Short-stay residents: Total 19, Top 10% States 14, Top 25% 15, Bottom 25% 22, Bottom 10% 23

High-risk residents | **Short-stay residents**

By race/ethnicity, 2003

	High-risk residents	Short-stay residents
White	13%	21%
Black	17	26
Hispanic	15	25
Asian	12	22
AI/AN	17	23

AI/AN = American Indian or Alaskan Native.
Data: Nursing Home Minimum Data Set (AHRQ 2005a, 2005b).
Source: Commonwealth Fund Commission on a High Performance Health System.

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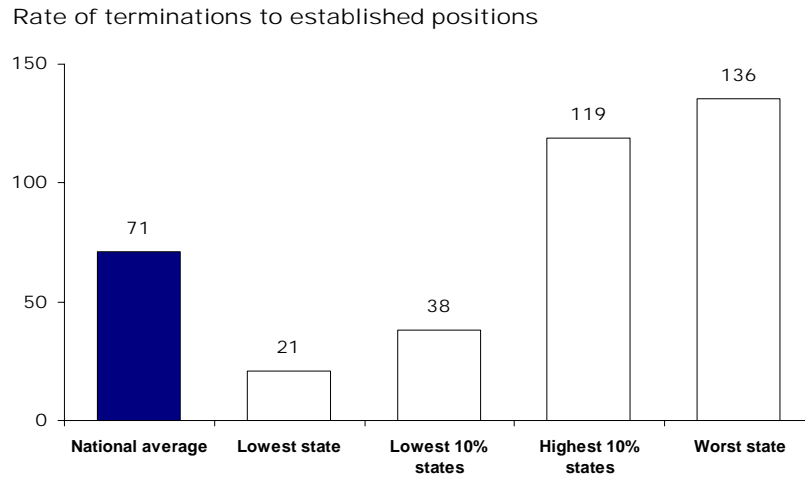**Figure 24. Physical Restraints in Nursing Facilities**

Percent of nursing home residents who were physically restrained

National and state distribution, 2004

National average 7, Top 10% 2, Top 25% 3, Bottom 25% 12, Bottom 10% 14

States

By race/ethnicity, 2003

White 8, Black 7, Hispanic 11, Asian/PI 10, AI/AN 8

PI = Pacific Islander; AI/AN = American Indian or Alaskan Native.
Data: Nursing Home Minimum Data Set (AHRQ 2005a, AHRQ 2005b).
Source: Commonwealth Fund Commission on a High Performance Health System.

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Figure 25. Nursing Homes: Turnover Rates of Certified Nursing Aides in Nursing Homes, 2002

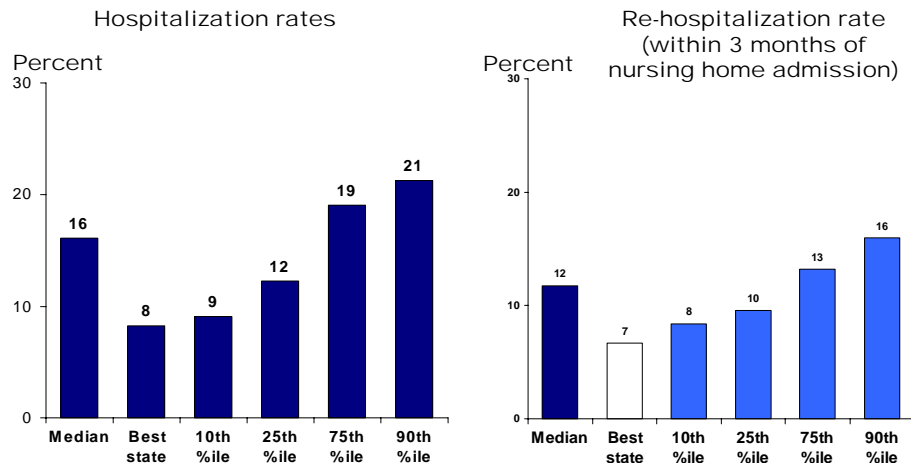**Rate of terminations to established positions**

Data: 2002 American Health Care Association Survey of Nursing Staff Vacancy and Turnover in Nursing Homes (AHCA 2002).

Source: Commonwealth Fund Commission on a High Performance Health System.

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Figure 26. Nursing Homes: Hospital Admission and Readmission Rates Among Nursing Home Residents, per State, 2000

Hospitalization rates

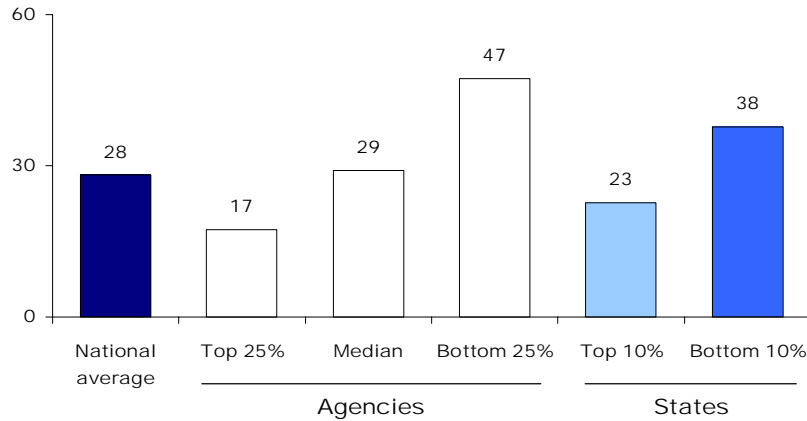**Re-hospitalization rate (within 3 months of nursing home admission)**

Data: V. Mor, Brown University analysis of Medicare enrollment data and Part A claims data for all Medicare beneficiaries who entered a nursing home and had a Minimum Data Set assessment during 2000.

Source: Commonwealth Fund Commission on a High Performance Health System

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**Figure 27. Home Health Care: Hospital Admissions,
by Agencies and States, 2003–2004**

Percent of home health episodes that ended with an acute care hospitalization

National average	Top 25%	Median	Bottom 25%	Top 10%	Bottom 10%
28	17	29	47	23	38

Agencies | States

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Resident-Centered Nursing Home Care for Frail Elders

- **Green House in Tupelo, Mississippi: evaluation supported by Commonwealth Fund finds higher quality of life; 24 sites in development**

- **Wellspring Alliance: started in Wisconsin; evaluation supported by The Commonwealth Fund finds higher quality of life, lower aide turnover, same cost; model spreading to other states**

- **Culture change movement would benefit from:**

  – **QIO technical assistance**

  – **Financial rewards and recognition for high quality of life, low aide turnover**

THE COMMONWEALTH FUND

Advancing Excellence in America's Nursing Homes

A campaign to improve quality of life for residents and staff

www.nhqualitycampaign.org

Through its lead organizations, the campaign represents over:

- 11,000 nursing homes

- 196,000 health care professionals

- 20,000 consumers/ consumer advocates

- Leaders from health care research, academia, and other sectors

  Working on behalf of the 1.5 million Americans cared for each day, and the more than 1 million compassionate long-term caregivers in America's nursing homes

Quality Improvement Goals
1. Reducing high risk pressure ulcers;
2. Reducing the use of daily physical restraints;
3. Improving pain management for longer term nursing home residents;
4. Improving pain management for short stay, post-acute nursing home residents;
5. Establishing individual targets for improving quality;
6. Assessing resident and family satisfaction with the quality of care;
7. Increasing staff retention; and
8. Improving consistent assignment of nursing home staff, so that residents regularly receive care from the same caregivers.

THE COMMONWEALTH FUND

NATIONAL COMMISSION FOR QUALITY LONG-TERM CARE

AN INDEPENDENT COMMISSION AT THE NEW SCHOOL   www.newschool.edu

- Chaired by Former Senator Bob Kerrey and Former Speaker of the House of Representatives Newt Gingrich

- A non-partisan, independent body charged with improving long-term care in America

- Appointed commissioners reflect a diversity of experience in academia, government, quality improvement and long-term care

- www.ncqltc.org

Working to find solutions to the pressing questions facing our aging society, including:

- How do we pay for long-term care and make sure all Americans have choices?

- What will it take to attract and retain the right kind of people to care for us?

- Which approaches hold the most promise for improving and assuring quality?

- Where can Americans get credible information to help them compare options?

THE COMMONWEALTH FUND