

# The Silver Tsunami

States have a fairly long to-do list to get ready for the health care needs of an aging America.

BY MEGAN COMLOSSY AND  
JACOB WALDEN

**A**mericans lucky enough to be growing old in the 21st century are living longer than ever before. Thanks in part to advances in medicine, more Americans not only will reach retirement age, they'll spend several years there. Those who live to age 65 can expect to live another 19 years, according to the U.S. Department of Health and Human Services' Administration on Aging. That's nearly five years longer than people who turned 65 in 1965, the year Congress created Medicare and Medicaid.

"The good news is that we're living longer," says Washington Representative Steve Tharinger (D), "but are we ready for the wave that's coming?"

Compared to Japan and Europe, the U.S. population is relatively young. But our adolescent



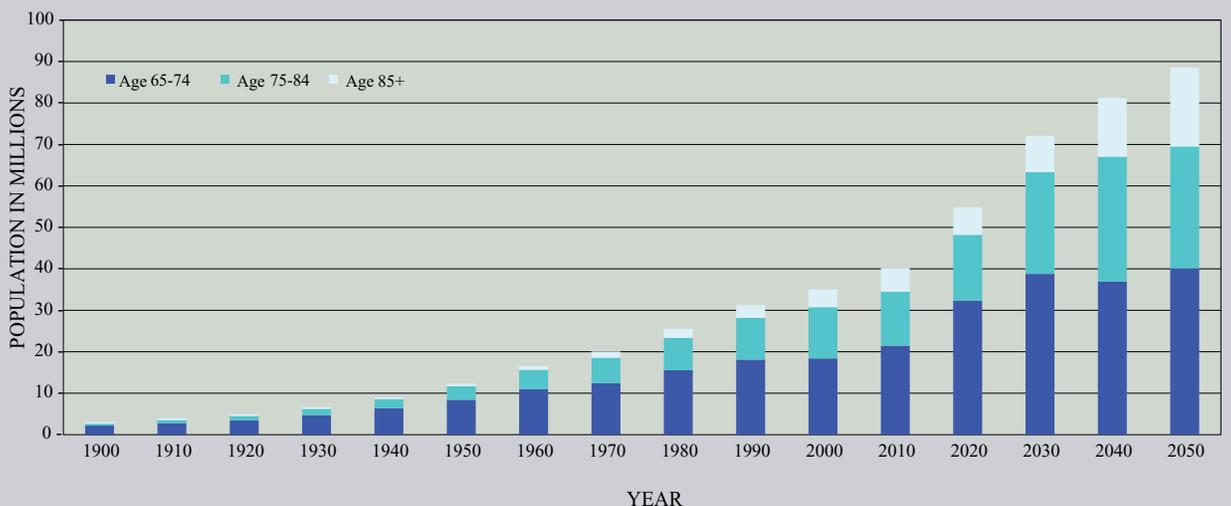
Representative Steve

Tharinger (D) Washington

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## America Is Aging

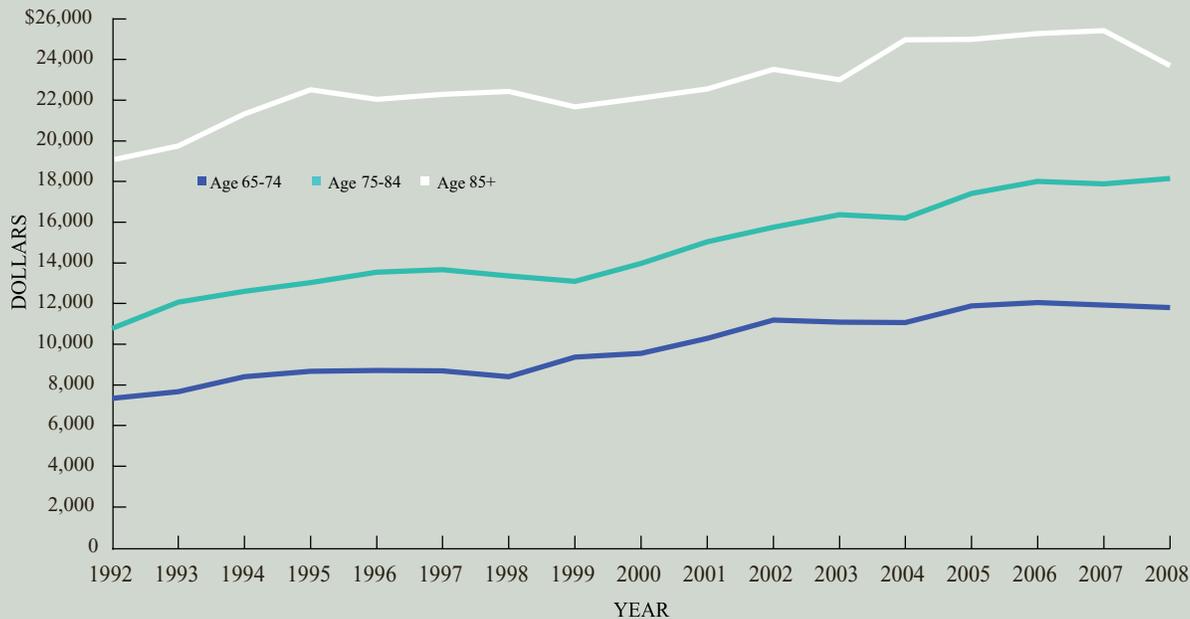
Since 1900, the number of Americans 65 and older has swelled and will continue to do so as baby boomers age.



Source: U.S. Census Bureau

## Aging Costs

The average annual health care costs for Medicare enrollees increase with age.



Note: Costs include both out-of-pocket and insurance covered expenses and are inflation-adjusted to 2008.

Source: Center for Medicare and Medicaid Services, Medicare Current Beneficiary Survey.

country will be catching up soon as baby boomers—those born between 1946 and 1964—grow older. More than one in eight, about 41 million people, in the United States today are over age 65. By 2030, that number is expected to increase to 72 million, boosting the elderly population from 13 percent to 20 percent, according to the Administration on Aging.

The addition of 31 million seniors will strain the U.S. health care system as never before. A long life often comes at a cost, as the aches, pains and chronic afflictions of old age require more and more expensive care. Medicare and Medicaid will assume increasing responsibility for this growing population's health—providing care for their complex, costly, chronic conditions and other long-term care needs. "I'm not sure that we've planned—as states, communities or individuals—especially for the financial part," says Tharinger.

In 2012, the public cost of Medicaid and Medicare was at least \$997 billion, according to the Centers for Medicare and Medicaid Services. By 2022, the total public cost of these programs is expected to reach \$1.96 trillion. The federal government is primarily responsible for funding Medicare, to the tune of \$580 billion in 2012. The cost of Medicaid, however, is shared by states and the federal government.

Faced with the health care needs of graying baby boomers, state lawmakers will be asked not only to ensure health care providers receive proper geriatric medical training, but also to support innovative ways of improving the quality of care for aging Americans at a lower cost. How best to prepare for this silver tsunami will be debated and decided in legislatures in the years to come.

### Racially and Ethnically Diverse

America's future elderly will be more racially and ethnically diverse than ever before. Today, 21 percent of Americans over age 65 are from racial or ethnic minorities, groups that historically have experienced poorer health than their white counterparts. By 2050, it is estimated they will comprise 42 percent of the elderly. As people age, differences in life expectancy rates among races disappear.

The health care industry and state and federal governments will need to become more adept at providing relevant care to diverse groups, which often hold different values and beliefs about aging and caring for the elderly. Addressing the need for more primary care doctors with cross-cultural training and language skills is critical. Hiring a more diverse health care workforce, expanding the use of community health workers, and supporting community- and family-based care also have helped bridge current cultural gaps in health care and may be useful with the incoming wave of aging boomers as well.

Lawmakers will continue to debate whether to offer loan repayments and other incentives to encourage providers to practice in underserved areas; how to support culturally competent health-care teams—such as those in community health centers; and the value of having cultural competency guidelines for health care providers.

### Medical Home-Sweet-Home?

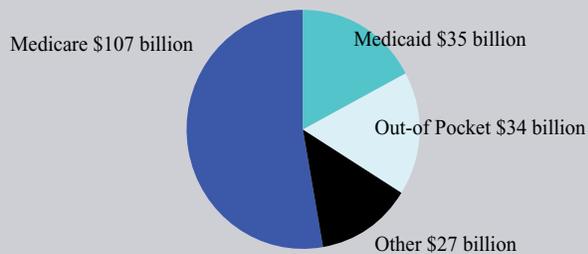
About 80 percent of the elderly have at least one chronic condition; around 69 percent have two or more. No wonder chronic conditions such as high blood pressure, heart disease, cancer,

## Alzheimer's Disease and Dementia

It's hard to discuss an aging America without mentioning Alzheimer's disease, the fifth-leading killer of older Americans. It destroys brain cells and affects the memory, language, reasoning and behavior of more than 5 million older Americans every year. As baby boomers age, the incidence of Alzheimer's is expected to nearly triple—to as high as 13.8 million by 2050—unless more effective prevention and treatment methods are found. That's why at least 30 state legislatures have established a state plan or task force to address the disease. "We're being proactive here in Connecticut," says Representative Joseph Serra (D), co-chair of the state's newly established Task Force on Alzheimer's Disease and Dementia. "I believe we need to get a handle on it before it's an even bigger problem. We're going to need caregivers with expertise in this area." According to the Alzheimer's Association, more than 15 million friends and family members provide 17.5 billion hours of unpaid care for loved ones with the disease each year. "Our task force is looking into workforce education and training ... preparing for what will happen in the not-so-distant future."

### A Killer of a Disease

The estimated direct costs of caring for Alzheimer's patients will total \$203 billion this year.



Source: Alzheimer's Association, Oct. 15, 2013

lung disease, Alzheimer's and diabetes in older adults account for 66 percent of all medical costs.

Navigating the complicated, often uncoordinated, U.S. health care system is difficult for anyone, much less an elderly person with several ailments. Often, they must wend their way through health care settings, providers and medications, and may receive conflicting medical advice, unnecessary or duplicative tests, or experience harmful drug interactions.

To better coordinate care and control costs, most states are increasing the use of a team-based approach to health care. The patient-centered medical home is one model that relies upon a team of health care professionals to provide coordinated, comprehensive services—especially for high-cost patients and those with complex health needs. In addition to common health care services, medical homes provide and coordinate a wide-range of services, including behavioral, community-based and long-term services.

For example, a diabetic who has high blood pressure and is fighting depression used to have to make several trips to various doctors to manage the different conditions. Once connected with a medical home, however, the patient can see his or her primary care doctor, a therapist and a nutritionist in the same visit.

Medical homes typically involve partnerships among public payers, such as Medicaid or Medicare, private health plans, and community agencies. The model has achieved widespread support in states. As of mid-2013, 43 states used medical homes to provide services to certain high-cost Medicaid enrollees, such as those with congestive heart failure, diabetes or mental illness. Increasingly, states are developing pilot programs to implement medical homes for older adults with complex needs, such as those who are eligible for both Medicaid and Medicare. Many states also are adjusting financial incentives to reward health care providers who use a team-based approach or who offer care coordination services.

Switching to a medical home model can be costly initially and complicated for providers. Studies have shown, however, that medical homes can improve patient care and, in the long run, reduce costs. In North Carolina, a peer-reviewed study of a large medical home system for Medicaid beneficiaries (including the elderly) found cost savings of \$63 to \$190 per member per month between 2007 and 2011—totalling \$184 million over that period. In addition, the study found that even as the program expanded to a sicker population, hospital admissions and emergency department use declined.

### Long-Term Planning

In 2009, the life expectancy for a woman who reached 85 was seven more years, and for men nearly six. More than two-thirds of older Americans will eventually need some kind of long-term care, such as skilled nursing, yet neither basic private health insurance policies nor Medicare cover these services. Stand-alone private, long-term care insurance has been available since the 1980s but, according to the Congressional Research Service, only a little over 10 percent of Americans over age 55 purchase it. Nationwide, 41 percent of long-term care costs are paid through Medicaid, and it isn't cheap.

In an effort to improve quality of life and contain costs, states are turning to models that rely on home- and community-based services, and managed care programs, rather than the traditional fee-for-service system, for long-term care.

"Helping seniors stay in their homes as long as possible, with assistance from state programs, is good for families and good for our state," says Connecticut Representative Joseph Serra (D). This not only gives elderly Americans more choices in where they live and receive health care—be it nursing homes or their own homes (preferred by most) or something else—it can save money. In FY 2011, Connecticut's Home Care Program for Elders saved the state \$109 million in Medicaid costs by reducing the use of nursing homes. Many states have seen similar results. AARP reviewed evaluations of the cost-effectiveness of home- and community-based services in 25 states and found that allowing people to "age in place" instead of moving to a nursing facility helped slow the rate of spending growth.

At least 16 states currently provide long-term services through Medicaid managed care programs—networks of health care providers that receive a capitated (typically per member per month)



Representative Joseph Serra (D) Connecticut

## What is Dual Eligibility?

About 9 million Americans qualify, or are “dually eligible,” for both Medicare and Medicaid. These beneficiaries are typically among the poorest and sickest covered by either program, and are among the most costly. Medicare typically covers acute and hospital care while Medicaid covers most long-term care services. They also account for a disproportionate share of spending. Under the Affordable Care Act, 15 states have received federal demonstration grants to develop innovative strategies to meet the complex needs of dually eligible enrollees at a lower cost. Many are integrating care through comprehensive coordination and long-term supports and services.

payment in exchange for providing health care services to a specific group of patients. States are increasingly using this model as a strategy to expand home- and community-based services, especially for high-needs (and high-cost) patients, such as those who are eligible for both Medicare and Medicaid. By 2014, 26 states are expected to offer long-term services and supports for Medicaid beneficiaries under a managed care model. According to the Center for Health Care Strategies, with careful oversight and proper incentives, managed care provides high-quality, patient-centered and cost-effective care.

Exploring various housing and care options is “crucial if we want to keep up with the growing aging population” says Texas Representative Elliott Naishtat (D). He chaired the Joint Legislative Committee on Aging, which took an in-depth look at innovative long-term alternatives during the last interim. Committee recommendations led the Legislature to increase the base Medicaid reimbursement rate for nursing home care—long among the lowest in the country according to Naishtat—and to encourage development of small-group nursing homes as an alternative to traditional skilled nursing facilities. These mini-nursing homes, limited to between 10 and 12 elderly people, provide personalized long-term care in a home-like setting.



Representative  
Elliott  
Naishtat (D)  
Texas

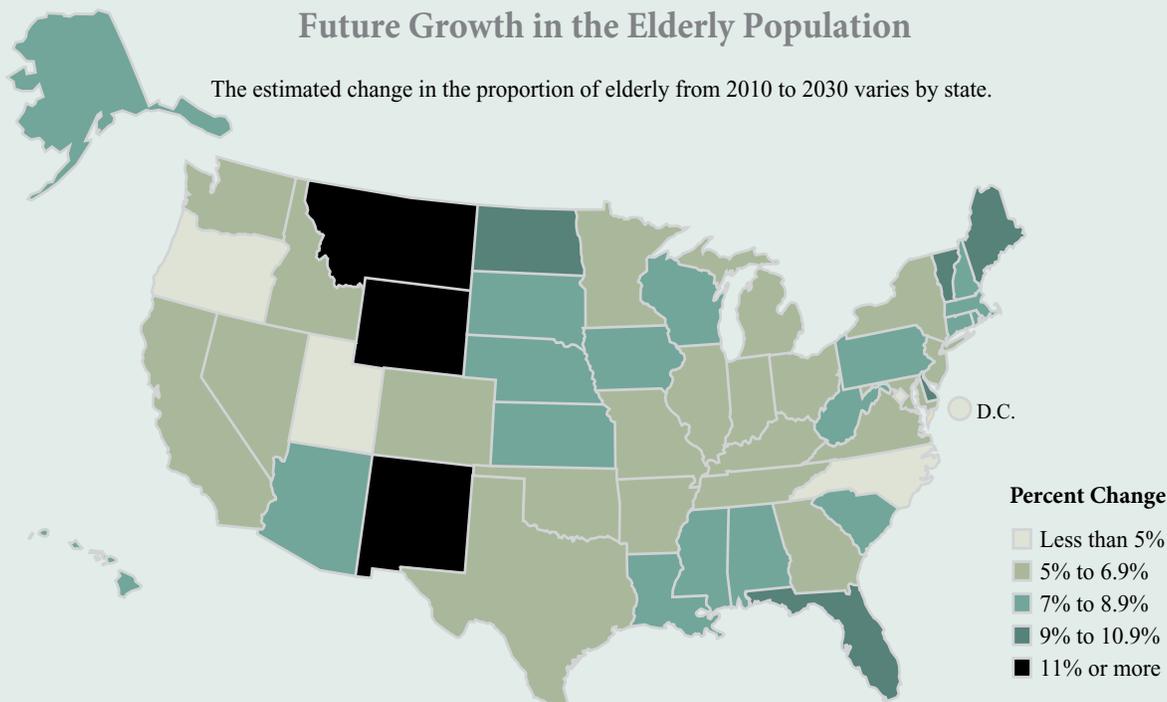
“We wanted to look for ways to create a more efficient system that would reward performance and serve the aging population in the least restrictive environment,” he says. Also important was an environment that would promote seniors’ “quality of life and overall well-being.” Similar small-group nursing home initiatives are underway in 31 other states.

### Workers Needed

Another need is to attract and retain high-quality personal care attendants. “In order to ensure that our aging population is receiving the best possible quality of care, the state must invest in the workforce that cares for residents on a daily basis,” says Naishtat. Based on the Joint Legislative Committee on Aging’s recommendations, the Legislature adopted a base wage increase for direct care workers earlier this year. Such workers have long been exempted from minimum wage and overtime requirements, but this is starting to change. Fifteen states extend state minimum wage and overtime protections to direct care workers and this September, the U.S. Department of Labor issued new rules

## Future Growth in the Elderly Population

The estimated change in the proportion of elderly from 2010 to 2030 varies by state.



Source: U.S. Census Bureau

Note: Data are not available for Puerto Rico and U.S. Virgin Islands

requiring these workers to receive federal minimum wage and overtime pay beginning in 2015.

Although many believe that long-term care should be provided and funded by patients, family and friends, not the government, “there’s no real mechanism for individuals to save for long-term care,” says Tharinger. Wider use of private, long-term care insurance could alleviate some of the spending pressure on Medicaid, but few buy it.

“The bottom line is that it costs too much,” says Enid Kassner, a director at AARP’s Public Policy Institute. For an average 55-year-old today, that’s around \$2,065 a year, though costs vary widely depending on a person’s age at the time of purchase, amount of coverage and other policy characteristics. Many long-term care insurance policies limit how much or how long they will pay. They were never meant “to solve the nation’s problem for financing long-term care, because most people can’t afford it and very few insurers even find it profitable,” says Kassner.

### Preparing for the End

Although medical technology has discovered many ways to lengthen life, it hasn’t yet defeated death. Lawmakers continue to look for the most appropriate, cost effective ways to help constituents near the end of their lives. Beginning in the 1970s, that meant supporting people’s rights to choose whether they wanted life-extending treatments down the road. These “advanced directives,” for example, allow people to express their wishes on future care and to designate a representative who will speak for them if they can no longer speak for themselves. Such arrangements give doctors and family members some direction, but allow flexibility in reconsidering choices.

Forty state legislatures have passed laws that allow people to designate an official durable power of attorney for their future health-care decisions. Forty-four states have laws addressing who to designate when the patient has not named a representative. Without such a surrogacy law, “it’s a real problem if a patient is incapacitated, and hasn’t designated a proxy or indicated their wishes,” says New Hampshire Senator John Reagan (R). “It’s a major issue we’re addressing in our state.” And, to simplify and clarify the legal choices available when planning end-of-life decisions, at least 26 states have merged several related statutes.

When the decision comes to end any further disease-fighting or life-preserving care, palliative and hospice services can help. They offer comforting care, often at home, meeting “patients’ physical, psychological, emotional, social and spiritual needs—helping those near the end of life live comfortably,” says New Hampshire’s Reagan. Funded by a variety of payers, including nearly all state Medicaid programs, Medicare, private insurance plans and private payers, these end-of-life options are a growing choice for many.

Not many health care providers specialize in end-of-life care,



Senator  
John Reagan (R)  
New Hampshire

## A Seat at the Table

The first state Silver-Haired Legislature was organized in Missouri in 1973. Since then, at least 30 states have established their own nonpartisan, nonprofit model legislatures of citizen volunteers age 60 and over. Silver-haired legislatures typically mirror state legislatures, with members formally elected from across the state to represent the interests of older adults and to debate issues, such as health care, that affect them. Most meet annually—often at the state capitol when the legislature is out of session—and develop legislative agendas. In 2009, for example, the Texas Silver-Haired Legislature played an integral role in advocating for establishment of the state’s Joint Legislative Committee on Aging.

and when they do, they often face complications when they apply for reimbursement from Medicaid and Medicare. Nevertheless, Reagan says the benefits are tremendous, and that’s why he co-sponsored legislation this year to study the issue further in New Hampshire. “Often, as soon as you transition a terminal patient to palliative care, and away from a ‘cure at any cost’ mentality, their quality of life improves, and they live longer,” he says. As a consumer-driven service, Reagan believes that as baby boomers learn about this option, they’ll be asking for it more often.

### Wellness and Prevention

Some of the improvement to life spans can be attributed to changes in lifestyle. Americans are smoking less, exercising more and breathing cleaner air. On the other hand, Americans are eating more and growing fatter. Obese men, only a quarter of the elderly population in 1992, now comprise 42 percent. The changes in the older female population are similar—the proportion of obese women has increased from 27 percent to 45 percent. Extra weight is linked to various chronic conditions, many of which now top the list of causes of death among older Americans. Heart disease remains the leading cause of death, followed by cancer, chronic lower respiratory diseases, stroke, Alzheimer’s disease and diabetes.

Poor health and chronic disease are not an inevitable part of aging, however. Eating well and staying active can prevent some chronic health problems. But what role should government play in promoting healthy behavior?

Smoking bans, financial incentives to buy healthy local produce, development of walkable communities—all these and other policies have both pros and cons and upfront costs. Even the Silver Sneakers Fitness program to keep seniors active and social has a price tag. Some wince at the cost of these programs, arguing they are unlikely to make a difference and are a waste of money. Others decry a nanny state that tells them what to eat, how much to exercise and how to die. They contend the government should stay out of personal decisions—and many state legislatures do.

With state governments often left with the health care tab for citizens’ poor decisions, however, this debate will likely not only continue, but intensify. And with 10,000 baby boomers turning 65 every day, lawmakers have little choice but to try and prepare, somehow, for the changes that are coming. Spending time, money and effort now may pay off down the road as the silver wave of aging Americans swells.