

MEETING FUTURE HEALTH AND LONG-TERM CARE NEEDS OF AN AGING POPULATION

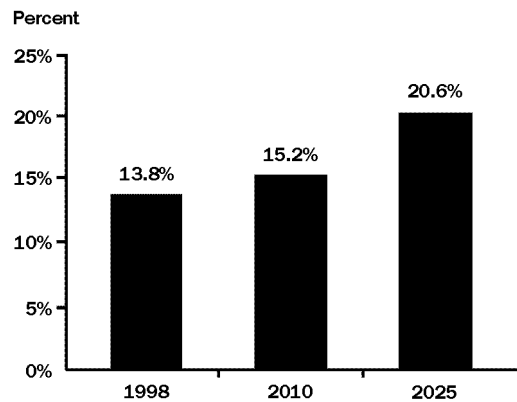
Karen Davis and Susan Raetzman

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ISSUE BRIEF

The United States faces a considerable challenge in providing health care for its elderly and disabled residents in the coming years. With the looming retirement of the baby boom generation, the number of Medicare beneficiaries will increase substantially. The percentage of the population covered by Medicare could increase from about 14 percent today to 20.6 percent by 2025.¹

Medicare Beneficiaries as a Percentage of the Population



Source: Marilyn Moon, *Growth in Medicare Spending: What Will Beneficiaries Pay?* The Commonwealth Fund, May 1999.

Experts predict that in 2025, 5.3 percent of the gross domestic product will be directed toward the Medicare program, compared with 2.7 percent in 1998.² Annual growth in real Medicare spending on a per-beneficiary basis, however, is expected to slow substantially

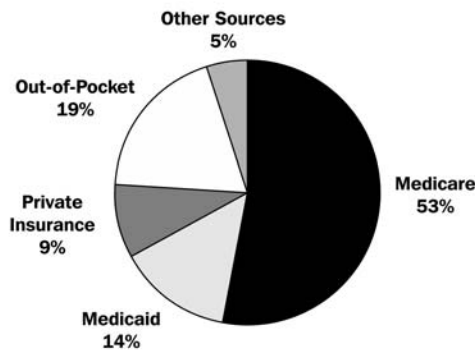
in comparison to the late 1970s, early 1980s, and even recent years.

The most dramatic reduction in spending growth from 1999 to 2002 is an effect of the Balanced Budget Act of 1997 (BBA). The BBA is expected to make a significant downpayment on Medicare's future by achieving \$116 billion in savings from 1998 to 2002 and \$394 billion over the 10-year period from 1998 to 2007. It also extended the projected insolvency of the Medicare Hospital Insurance Trust Fund from 2001 to 2008 and cut the projected deficit in half over 75 years. An even greater slowdown than expected and strong economic growth has pushed the insolvency date back to 2015.³ Approximately three-fourths of the 10-year savings from the BBA are to come from tightening prospective payment rates to health care providers and managed care plans.⁴

Despite slower growth rates, real Medicare spending is projected to rise over the next decade from \$5,953 per beneficiary in 1998 to \$10,235 in 2025 (in 1998 dollars).⁵ Such an increase implies additional burdens on beneficiaries, who contribute through premiums, deductibles, and coinsurance to the cost of covered benefits. Because Medicare's

benefit package is not very generous, beneficiaries must also pay additional expenses for services not covered by the program. Medicare, at present, pays only 53 percent of elderly Americans' health care costs. Growth in Medicare costs also suggests increases in other health care spending, including the 19 percent of health care costs paid by beneficiaries out-of-pocket and the 9 percent paid by private insurance—which has been financed in part (e.g., employer-sponsored retiree benefits) or whole (e.g., Medigap policies) by beneficiaries. Medicaid, which provides low-income Medicare beneficiaries with supplemental coverage and noncovered benefits such as prescription drugs and long-term care, covers 14 percent of costs.

Total Health Care Spending for Medicare Beneficiaries



Source: Medicare Current Beneficiaries Survey, 1994.

A POPULATION IN NEED

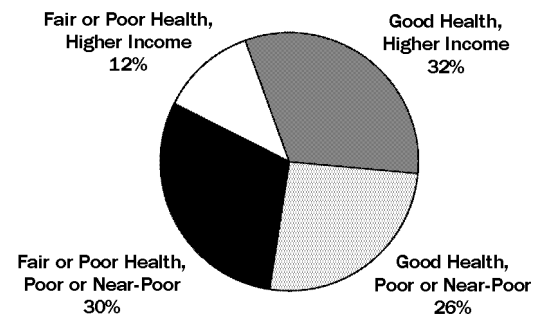
Medicare beneficiaries currently shoulder high health care costs. The BBA included a major increase in the premium for Medicare Part B, which is financed by a combination of beneficiary premiums and general revenues. The annual premium is

now projected to be \$1,084 in 2009, compared with \$546 today.⁶ Combining these premiums with spending for Medicare cost-sharing and services not covered by Medicare, total out-of-pocket spending by elderly beneficiaries who are in traditional fee-for-service and living in the community consumed, on average, 19 percent of their incomes in 1998.⁷ By 2025, this figure is expected to rise to 29 percent of income.

Poor and Sick Beneficiaries

Contrary to popular media images of the wealthy and healthy retiree, two of three Medicare beneficiaries live on relatively low incomes or have health problems. In fact, one of three beneficiaries lives on an income below 200 percent of the poverty level—about \$15,000 annually for an individual—and reports having health problems.⁸

Two of Three Medicare Beneficiaries Have Health Problems* or Live on Low Incomes**



* In fair or poor health, or disabled and under age 65.

** Near-poor include those with incomes between 100% and 199% of the federal poverty level.

Source: The Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries, The Commonwealth Fund, December 1998.

More than 40 percent of the elderly report significant health problems.⁹ Medicare beneficiaries with low incomes are more likely than those with higher incomes to have health problems:

54 percent with incomes below the poverty level perceive themselves to be in fair or poor health, versus 25 percent of those with incomes above 200 percent of the poverty level. Similarly, 26 percent of poor beneficiaries need help with at least one activity of daily living—such as dressing or getting in and out of bed—while only 6 percent of higher-income beneficiaries require this type of help.

Beneficiaries with low incomes or health problems are also at higher risk for experiencing difficulties in gaining access to care. More than one of five (23%) beneficiaries who rate their health as fair or poor and a third (33%) of the under-65 disabled report difficulties getting needed care.¹⁰ By comparison, only 10 percent of those with incomes above 200 percent of poverty have such difficulties.

If Medicare is to continue to provide health and economic security for elderly and disabled beneficiaries, consideration should be given to improving coverage, at least for high-risk beneficiaries. Health care costs are especially burdensome for these low-income and disabled beneficiaries. One of four (27%) Medicare beneficiaries who live below the poverty level, one of four (24%) who are in fair or poor health, and nearly one of three (30%) who are under age 65 and disabled say that paying medical bills is very difficult or that they had spent all their savings.

Long-Term Care Needs

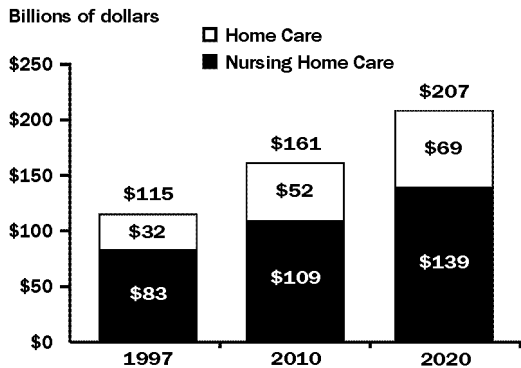
People in need of long-term care services also face potentially great financial risk. Although about 44 percent of the population with long-term care needs is under age 65, the likelihood of needing long-term care is much greater among the elderly.¹¹ Recent estimates indicate that the number of elderly individuals with long-term care needs will rise substantially, from 7.2 million in 1996 to approximately 10 million in 2020.¹² The types of services required are diverse, ranging from care in a nursing home or other facility, to home health care, to personal assistance with basic activities.

Long-term care users of all ages and their families bear a large portion of the costs. Out-of-pocket costs accounted for 28 percent of the nation's \$115 billion in spending on nursing home and home care in 1997, not including informal caregiving.¹³ These costs can be catastrophic: median annual nursing home costs were \$32,000 in 1995, and as high as \$80,000 per year in some states.¹⁴ Private insurance—both medical and long-term care—accounts for another 7 percent of spending. Medicare and Medicaid together account for approximately 58 percent of nursing home and home care spending.

Future projections of national spending on long-term care for the elderly indicate continued growth as more baby boomers reach age 65 and more elderly people live to be 85 years or older. By 2020, total spending is expected to rise to \$207 billion (in 2000

dollars), the majority of which will go toward nursing home care.¹⁵ An increasing share of long-term care services, though, is projected to be delivered in the home; in 2020, home care spending will account for about one-third of long-term care spending.

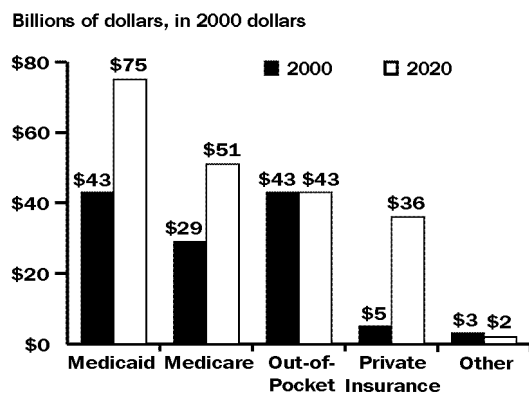
Projected Long-Term Care Expenditures for Elderly People



Note: Amounts are in 2000 dollars, except for 1997; 1997 refers to long-term care spending for all ages. Numbers may not add up due to rounding.
Source: Congressional Budget Office projections, March 1999.

Although Medicare is likely to remain the largest purchaser of home health care, Medicaid, because it currently finances a large share of nursing home care and increasingly covers home- and community-based care, will grow from \$43 billion in 2000 to \$75 billion in 2020. Medicaid will continue to be the

Long-Term Care Projected Expenditure Growth by Payer



Source: Congressional Budget Office projections, March 1999.

largest source of payment for long-term care services for the elderly. Spending by private insurance, small in dollar terms, will grow more than seven-fold from \$5 billion in 2000 to \$36 billion in 2020.

MEDICARE REFORM

The National Bipartisan Commission on the Future of Medicare, created by the BBA, was charged with examining the Medicare program and making recommendations on financing health care for the elderly and disabled in the 21st century. While the 17-member commission did not reach the consensus necessary to issue recommendations as hoped in March 1999, its deliberations included discussion of two broad approaches: major restructuring of Medicare and incremental program reform. Restructuring would transform Medicare into a premium support program, whereby the government would make fixed payments to managed care and other private plans. Incremental reforms would maintain the current program but modernize it.

Premium-Support Approach

Under the premium-support option that continues to be debated, Medicare would be replaced with a system in which the elderly and disabled could choose from an array of private health insurance arrangements and managed care plans. Medicare's payment toward premiums would be set at 88 percent of the national median private plan premium. Beneficiaries would pay the difference between the premium charged by a plan in their local area and the federal

government's contribution. While the government and beneficiaries would share the financial risk of year-to-year premium increases, beneficiaries would not be certain of the health insurance benefits that could be purchased based on the government's contribution and the resulting out-of-pocket costs. The poorest and sickest beneficiaries would be the most vulnerable.

Traditional fee-for-service Medicare, which would be retained as an option under the premium-support approach, should be attractive to beneficiaries because of their familiarity with the program and because of certain economic advantages. Fee-for-service Medicare, for example, has fewer administrative costs than managed care plans, and its prospective payment rates for hospitals and physicians are typically lower than those offered by managed care plans. If, however, sicker beneficiaries select traditional Medicare while healthier beneficiaries join managed care plans—as is the present case—then traditional Medicare premiums could grow faster than private plan premiums. Those enrolled in traditional Medicare would face disproportionately higher costs, making this source of coverage increasingly unaffordable to those who may have few other choices.

The impact of a premium-support approach on future Medicare outlays is likely to be only modest. Because it relies on competition and choice among plans to hold down premiums, the promise of this approach will depend in part on successful implemen-

tation of the Medicare+Choice program. The initial response to Medicare+Choice—which allows beneficiaries to choose among several managed care plans—has, however, fallen short of expectations. Few new private plans have opted to participate, and HMOs have pulled out of Medicare in some areas. Furthermore, no evidence to date proves any Medicare savings from this strategy.

Modernizing Medicare Benefits

An incremental approach to reforming Medicare could entail modernizing the program through multiple changes. Among the possibilities are updating benefits to reflect the state-of-the-art in the private sector—such as adding coverage for prescription drugs—and implementing financial protections for at-risk portions of the elderly population, including low-income beneficiaries and near-elderly individuals who do not have access to affordable coverage in the private sector. Currently, more than three-quarters of the elderly take prescriptions drugs on a regular basis, and 11 percent spend more than \$100 per month for them.¹⁶

Modernization could also involve structural changes, such as improving Medicare's ability to function as a prudent purchaser and further strengthening consumer protections in the Medicare+Choice and Medigap markets. Additional financing sources under consideration include extending BBA provisions to slow increases in provider payments beyond 2002, introducing

income-related premiums, and dedicating part of the federal budget surplus to Medicare.

LONG-TERM CARE REFORM

The inadequacies of the current long-term care system are well known: the elderly who are in need of long-term care services must navigate a fragmented world of financing and delivery that relies primarily on the means-tested Medicaid program, which provides varying degrees of coverage and financial protection, depending on the state. In addition, concerns persist about the quality of care provided by the nation's 16,800 nursing homes, where 1.6 million elderly people reside.¹⁷

Alternatives for improving the financing and delivery of long-term care for older adults include:

- expanding Medicare financing of long-term care services, e.g., home care and nursing facility benefits;
- developing support for family members, friends, and others who struggle to balance the responsibility of informal caregiving with other demands on their time and energies;
- improving implementation and enforcement of quality standards for nursing home care and, eventually, for home health care; and
- continuing to promote the integration of acute and long-term care in the way that the Program of All-Inclusive Care for the Elderly and similar programs already do.

The Clinton Administration has developed two major initiatives to facilitate these goals. First, as part of an ongoing commitment to the nation's nursing home residents, an aggressive strategy announced in July 1998 is aimed at ensuring quality of care. Actions taken to date include strengthening nursing home enforcement and federal oversight, expanding consumer access to information for making educated choices among nursing homes, and increasingly focusing inspections on preventing negative health outcomes.

In January 1999, the President introduced a \$6.2 billion proposal to provide financial and other assistance for people needing long-term care and their families. The main element of the initiative is a \$1,000 tax credit for certain people with long-term care needs or their caregivers. Other provisions would give \$125 million per year to create a National Family Caregiver Support Program, which would offer information, counseling, and respite; establish private long-term care insurance coverage at group rates for federal employees, who may voluntarily purchase it; and educate Medicare beneficiaries about long-term care options. The initiative also includes an expansion of Medicaid coverage for home- and community-based services and competitive grants to convert federally subsidized elderly housing projects into assisted-living facilities.¹⁹

CONCLUSION

Many factors make long-range predictions about spending and alternative programs difficult: the progress of biomedical

research, the health habits of older people, the organization and operation of health care providers and payers, trends in the overall economy. Nevertheless, Americans must continue to face important long-term care issues, and a consensus must be reached on reforms that assure that the United States will provide health and economic security for older and disabled Americans in the 21st century.

NOTES

- ¹ Marilyn Moon, *Growth in Medicare Spending: What Will Beneficiaries Pay?*, The Commonwealth Fund, May 1999.
- ² Ibid.
- ³ *Status of the Social Security and Medicare Programs: A Summary of the 1999 Annual Reports*, Social Security and Medicare Boards of Trustees, March 1999.
- ⁴ Marilyn Moon, Barbara Gage, and Alison Evans, *An Examination of Key Medicare Provisions in the Balanced Budget Act of 1997*, The Commonwealth Fund, September 1997.
- ⁵ Moon, May 1999.
- ⁶ *1999 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund*, March 1999.
- ⁷ Moon et al., September 1997.
- ⁸ Cathy Schoen, Patricia Neuman, Diane Rowland, Karen Davis, Michelle Kitchman, and Drew Altman, *The Kaiser/ Commonwealth 1997 Survey of Medicare Beneficiaries*, The Commonwealth Fund, November 1998.
- ⁹ Ibid.
- ¹⁰ Ibid.
- ¹¹ Harriet L. Komisar and Judith Feder, *The President's Proposed Long-Term Care Initiative: Background and Issues* (policy brief), The Commonwealth Fund, August 1999.
- ¹² Robert Friedland, presentation at *Long-Term Care Options: For Now and the Future*, roundtable sponsored by The Commonwealth Fund, March 26, 1999.

- ¹³ Georgetown University Institute for Health Care Research and Policy analysis using national health expenditures data from Health Care Financing Administration at website: <http://www.hcfa.gov/stats/nhe-oact/tables/tl7.htm> (accessed February 26, 1999).
- ¹⁴ Calculations based on Joann Lamphere, Normandy Brangan, Sharon Bee, and Rafael Semansky, *Reforming the Health Care System: State Profiles 1998*, AARP Public Policy Institute, December 1998.
- ¹⁵ *Projections of Expenditures for Long-Term Care Services for the Elderly*, Congressional Budget Office, March 1999.
- ¹⁶ Schoen et al., November 1998.
- ¹⁷ *Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards*, U.S. General Accounting Office, March 1999.
- ¹⁸ *Budget of the United States Government, Fiscal Year 2000*, Office of Management and Budget, February 1, 1999.



One East 75th Street
New York, NY 10021-2692

Tel: 212.606.3800
Fax: 212.606.3500
E-mail: cmwf@cmwf.org
<http://www.cmwf.org>

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