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Getting Older, Staying Healthier: The Demographics of Health Care

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Mr. Chairman, members of the Committee, I'm pleased to have the opportunity to testify before you today on future policy toward the growing elderly population. My focus will be on long-term care—specifically, on the implications of growing numbers of elderly for public policy toward long-term care financing. My testimony will reflect more than twenty-five years of research experience in long-term care, at Georgetown University and, before that, the Urban Institute. Based on that research, my policy conclusions are the following:

- In contrast to policies toward income and health security (Social Security and Medicare), the nation lacks a policy that assures people of all ages access to quality long-term care when they need it, without risk of impoverishment.

- The need for long-term care is unpredictable and, when extensive service is required, financially catastrophic—best dealt with through insurance, rather than personal savings. But neither Medicare nor private insurance provides that insurance protection.

- The federal-state Medicaid program provides invaluable support to those who need long-term care, but only when and if they're impoverished. Its protections vary substantially across states, and, in most states, fail to assure access to quality care, especially in people's homes.

- A much larger elderly population—the aging of the baby boom—is likely to substantially increase the **numbers** of people who need long-term care, even if the **proportion** of elderly who need it declines. The result will be greater demand on an already significantly stressed Medicaid program, squeezing out states' ability to meet other needs and, at the same time, likely reducing equity and adequacy across states.

- Although private insurance and certainly private resources can contribute to financing, long-term care security—throughout the nation— requires new federal policy and a significant investment of federal funds.

The following will lay out inadequacies in current long-term care financing; the implications of growth in the elderly population for future inadequacies; and the importance of federal policy to sustain and improve long-term care protection. Unless otherwise noted, I am drawing on research from the Georgetown Long-term Care

Financing Project, funded by the Robert Wood Johnson Foundation, and available at our web site: **ltc.georgetown.edu.** The opinions I present are, of course, only my own.

People who need extensive assistance with basic tasks of living (like bathing, dressing and eating) face the risk of catastrophic costs and inadequate care. Today, almost 10 million people of all ages need long-term care. Only 1.6 million are in nursing homes. Most people needing long-term, especially younger people, live in the community. Among people not in nursing homes, fully three quarters rely solely on family and friends to provide the assistance they require. The range of needs is considerable—with some people requiring only occasional assistance and others needing a great deal**.** Intensive family care-giving comes at considerable cost—in employment, health status and quality of life—and may fail to meet care needs. Nationally, one in five people with long-term care needs who are not in nursing homes report "unmet" need, frequently resulting in significant consequences—falling, soiling oneself, or inability to bathe or eat. The cost of paid care exceeds most families' ability to pay. In 2002, the average annual cost of nursing home care exceeded $50,000 and 4 hours per day of home care over a year were estimated to cost $26,000. Clearly, the need for extensive paid long-term care constitutes a catastrophic expense.

The likelihood of needing long-term care is also unpredictable. Although the likelihood increases with age, close to 40 percent of people with long-term care needs are under the age of 65. And the need for care among the elderly varies considerably. Over a lifetime, projections of people currently retiring indicate that 30 percent are likely to die without

ever needing long-term care; fewer than 10 percent are likely to need less than a year of care, and about 20 percent are likely to need care for five years or more.

Given the reality that long-term care is an unpredictable need for a potentially catastrophic expense, insurance makes sense. Reliance on savings alone is inefficient and ineffective. People will either save too much or too little to cover expenses. But few people have adequate long-term care insurance. Although sales of private long-term care insurance are growing (the number of policies ever sold more than tripled over the 1990s), only about 6 million people are estimated to currently hold any type of private long-term care insurance. Although there is potential for substantial expansion of that market, private long-term care insurance policies offer a limited means to spread long-term care risk: they are not available to those who already have long-term care needs; are not even advocated as a means of protecting young people against the risk of disability; offer benefits limited to fixed dollar amounts rather than to the cost of needed services; and are acknowledged to be unaffordable or insufficient to protect the substantial segment of elderly persons, now and in the future, with low and modest incomes. We need only look at experience in health insurance to recognize that reliance on the individual market—plagued by risk selection, high marketing costs, benefit exclusions, and other problems—for long-term care will be grossly inadequate to assure adequate protection.

Current public policy also falls far short of assuring insurance protection. Medicare, which provides health insurance to many who need long-term care, covers very little

long-term care. Its financing for nursing home care and home care is closely tied to the need for acute care and is available for personal care only if skilled services—like nursing and rehabilitation therapy—are also required. It is Medicaid that provides the nation's long-term care safety net. But Medicaid protections differ considerably from what we think of as "insurance". Medicaid provides invaluable coverage of long-term care expenses, but only after people have exhausted virtually all of their own resources. As a result, Medicaid does not protect against financial catastrophe; it finances services only after catastrophe strikes.

Further, Medicaid's benefits focus overwhelmingly on nursing home care—an important service for some, but not the home care services preferred by people of all ages. In the last decade, Medicaid home care spending has increased from 14% to 29% of Medicaid's total long-term care spending. But nursing homes still absorb the lion's share of Medicaid's support for long-term care.

Medicaid protection also varies considerably from state to state. As a federal-state matching program, Medicaid gives states the primary role in defining the scope of eligibility and benefits. A recent Urban Institute analysis emphasized the resulting variation across states in service availability as a source of both inequity and inadequacy in our financing system. In an examination of 1998 spending in 13 states, long-term care dollars per aged, blind, or disabled enrollee in the highest spending states (New York and Minnesota) were more than 4 times greater than in the lowest (Alabama, Mississippi)—a

differential even greater than that found for Medicaid's health insurance spending for low income people.

Both our own research and that conducted by the General Accounting Office (now the Government Accountability Office) tells us that differences in state policies have enormous consequences for people who need long-term care. Studies comparing access for individuals with very similar needs in different communities show that people served in one community get little or no service in another. Georgetown research finds that the same person found financially eligible or sufficiently impaired to receive Medicaid services in one state might not be eligible for Medicaid in another—and, if found eligible, might receive a very different mix or frequency of service. And research (in progress) comparing use of paid services in 6 states finds almost twice the incidence of unmet need (56%) in the state with the smallest share of people likely to receive paid services as in the state with the largest (31 %).

This variation—as well as ups and downs in the availability of benefits over time—undoubtedly reflects variation in states' willingness and ability to finance costly long-term care services. The recent recession demonstrated the impact on states of changes in their economies and the vulnerability of Medicaid recipients to states' reactions. In 2001, Medicaid accounted for 15 % of state spending, with long-term care responsible for 35% of the total. Virtually all states were cutting their Medicaid spending as budget pressures struck, endangering access either for low income people needing health insurance, older or disabled people needing long-term care, or both.

In sum, under current policy, neither public nor private insurance protects people against the risk of long-term care. Despite Medicaid's important role as a safety net, the overall result for people who need care is catastrophic expenses, limited access to service, and care needs going unmet.

Given inequities and inadequacies in our current approach for long-term care, it is no wonder that we are concerned about the future, when a far larger proportion of the nation's population will be over age 65 than are today. Experts disagree on whether disability rates among older people in the future will be the same as or lower than they are today. But even if the proportion of older people with disabilities declines, the larger number of older people will likely mean a larger number of older people will need long-term care in the future than need it today. The population aged 85 and older, who are most likely to have long-term care needs, will double by 2030 and quadruple by 2050.

States will vary in the aging of their populations—with resulting differences in the demand for long-term care and the ability of their working-aged population to support it. To identify future demands on Medicaid, forthcoming Georgetown analysis presents census data on the ratio of elderly people to working-age adults between 2002 and 2025. Nationally, this ratio changes from about one to five (one person over age 65 for every 5.2 people of working age) in 2002 to one to three—an increase of about 66 percent. But the changes differ across states, with some states well below the national average (e.g. California, Connecticut, D.C., Massachusetts) and others, far above. In many states, the

ratio increases by more than three quarters and in a few (e.g. Colorado, Utah, and Oregon), it more than doubles. All states will be challenged to meet increased long-term care needs.

States are already struggling with Medicaid's fiscal demands, which challenge their ability to meet equally pressing needs in education and other areas. And state revenue capacity varies considerably. If current policies persist, pressure to make difficult tradeoffs will only get stronger. In the future, states with bigger increases in the elderly-to-worker ratio will face the greatest pressure. And, since many of the states with the most dramatic changes are currently spending the least on Medicaid long-term care, there is a strong likelihood that in the future, long-term care financing will be even less equitable and less adequate across the nation than it is today.

What's needed for a different future is public policy action. Essentially, the nation faces a choice: do we want to live in a society in which we assure access to affordable quality long-term care for people who need it or in a society in which we leave people in need to manage as best they can on their own? A recent CBO report emphasizes the latter approach—a combination of cutbacks in already inadequate Medicaid protection aimed essentially at forcing people to purchase private insurance and tax preferences to reduce the costs—and thereby promote the purchase—of private long-term care insurance. In my view, Medicaid cuts constitute cruel and unusual punishment for people truly unable to cope by themselves. Some people simply cannot afford insurance. And, as CBO recognizes, given the limited benefits of private long-term care insurance (relative to the

potential cost of care), even those who purchase insurance may face catastrophic costs. Further, proposed tax preferences clearly favor the better off over those in greatest need. Experience with health insurance tells us that such credits are likely to primarily benefit those who would have purchased long-term care insurance even in the absence of credits—substituting public for private dollars—and, as currently proposed, are not even designed to reach the substantial portion of older and younger Americans with low and modest incomes.

The right way to address both current and future long-term care needs requires a commitment of public resources—and, to be adequate and effective in all states—federal resources. Expanded public financing for long-term care could take a variety of forms and by no means need eliminate private contributions. One option, modeled on Social Security, would be to provide everyone access to a "basic" or "limited" long-term care benefit, supplemented by private insurance purchases for the better-off and enhanced public protection for the low income population. Another option would be establishment of a public "floor" of asset protection—a national program assuring everyone access to affordable quality long-term care—at home as well as in the nursing home—without having to give up all their life savings as Medicaid requires today. The asset floor could be set to allow people who worked hard all their lives to keep their homes and modest assets, while allowing the better off to purchase private long-term care insurance to protect greater assets. Either public/private combination could not only better protect people in need; it could also provide substantial relief to states to focus on health insurance, education and other pressing needs—relief that governors have explicitly

requested by calling on the federal government to bear the costs of Medicare/Medicaid "dual eligibles". My highest priority for expenditure of the next federal dollar would be responding to this call (along with supporting more home care and better quality care) with more federal dollars to Medicaid.

Some will undoubtedly characterize proposals like these as "unaffordable", given the fiscal demands of Medicare and Social Security and the current federal budget deficit. But that deficit reflects policy choices. And I would far rather see expenditure of the next federal dollar devoted to enhanced Medicaid long-term care financing than to tax credits for long-term care or tax cuts in general. Indeed, the estate tax is especially appropriate for long-term care financing: taxing everyone's estate at certain levels, to provide reasonable estate protection for those unlucky enough to need long-term care.

As we look to the future, examination of the choices being made by other nations of the world is instructive. Analysis by the Organization for Economic Cooperation and Development (OECD) of long-term care policy in 19 OECD countries (presented at the June research meeting of AcademyHealth) found that the number of countries with universal public protection for long-term care (Germany, Japan and others) is growing. Public protection, they report, does not imply the absence of private obligations (cost sharing and out-of-pocket spending), nor does it imply unlimited service or exploding costs. Rather, in general, it reflects a "fairer" balance between public and private financing—relating personal contributions to ability to pay and targeting benefits to the population in greatest need. Many of these nations have substantially larger proportions

of elderly than the U.S. does today and therefore can be instructive to us as we adjust to an aging society.

Clearly, we will face choices in that adjustment. If we are to be the caring society I believe we wish ourselves to be, we too will move in the direction of greater risk-sharing and equity by adopting the national policy and committing the federal resources which that will require.