The Annapolis Center
For Science-Based Public Policy

"Our greatest responsibility is to be good ancestors."
…Jonas Salk

Providing Health Care to the Aging Baby Boomers

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Executive Summary

The United States will experience a tremendous increase in its elderly population during the next thirty years. By 2030, more than one-fifth of the population will be age 65 or older. Older adults are the demographic group that suffer the most from chronic health conditions and require expensive treatment. This paper:

- Examines the demographics of a growing elderly population;
- Considers the health needs of this aging population including common chronic conditions and leading causes of death;
- Discusses the roles that Medicare, Medicaid, supplemental insurance, the Department of Veterans Affairs and the Department of Defense health care programs play in financing health care for the elderly; and,
- Considers the gaps in coverage and the future needs of the population

As health care costs continue to rise, governments and employers are finding their budgets for providing health care becoming tighter: A clear need for health care finance reform is emerging. The Baby Boom population is quickly approaching retirement age, creating a need for policymakers to develop an infrastructure to deliver the health care, prescription drug assistance, and long-term care that this demographic group will require.

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Providing Health Care to the Aging Baby Boomers

The Baby Boom population, the cohort of Americans born 1946 –1964, is rapidly approaching retirement age, posing a challenge to policymakers and health providers to ensure adequate health care for a much larger and longer-living elderly. The U.S. General Accounting Office (GAO) projects that 76 million adults will reach age 65 between 2011 and 2029, at least doubling the costs of Medicare, Medicaid and Social Security

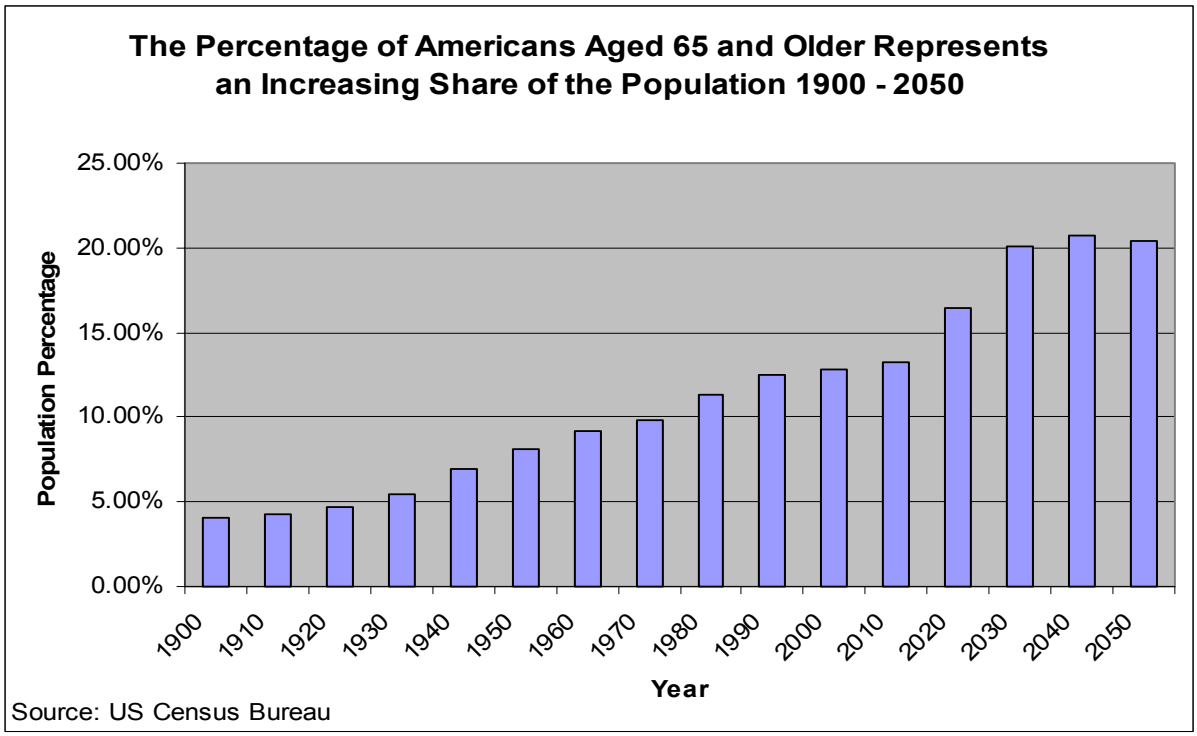
The over-65 age group is projected to increase by 54 percent between 2000 and 2020, adding 19 million people to the group that is most likely to require health care for treatment of chronic conditions.[i] Increases in the elderly population will dramatically increase the need for health care services. This paper reviews the demographics of the current and projected elderly population, common health care needs of the elderly, and the current sources of health care financing.

Demographics

As health care has improved, Americans have enjoyed longer life expectancies. Demographic changes have led to an increase in the adult population that will soon become elderly. Thus, the older population is experiencing front-end growth as more Americans reach old age and back-end growth as current seniors live longer than previous generations.

The under-65 population increased by 13.3 percent in the ten year period from 1990 – 2000, largely driven by the 34 percent increase in the 45-64 cohort.[ii] This cohort, the Baby Boom generation, will reach retirement during the next twenty years, significantly increasing the size of America's older population.

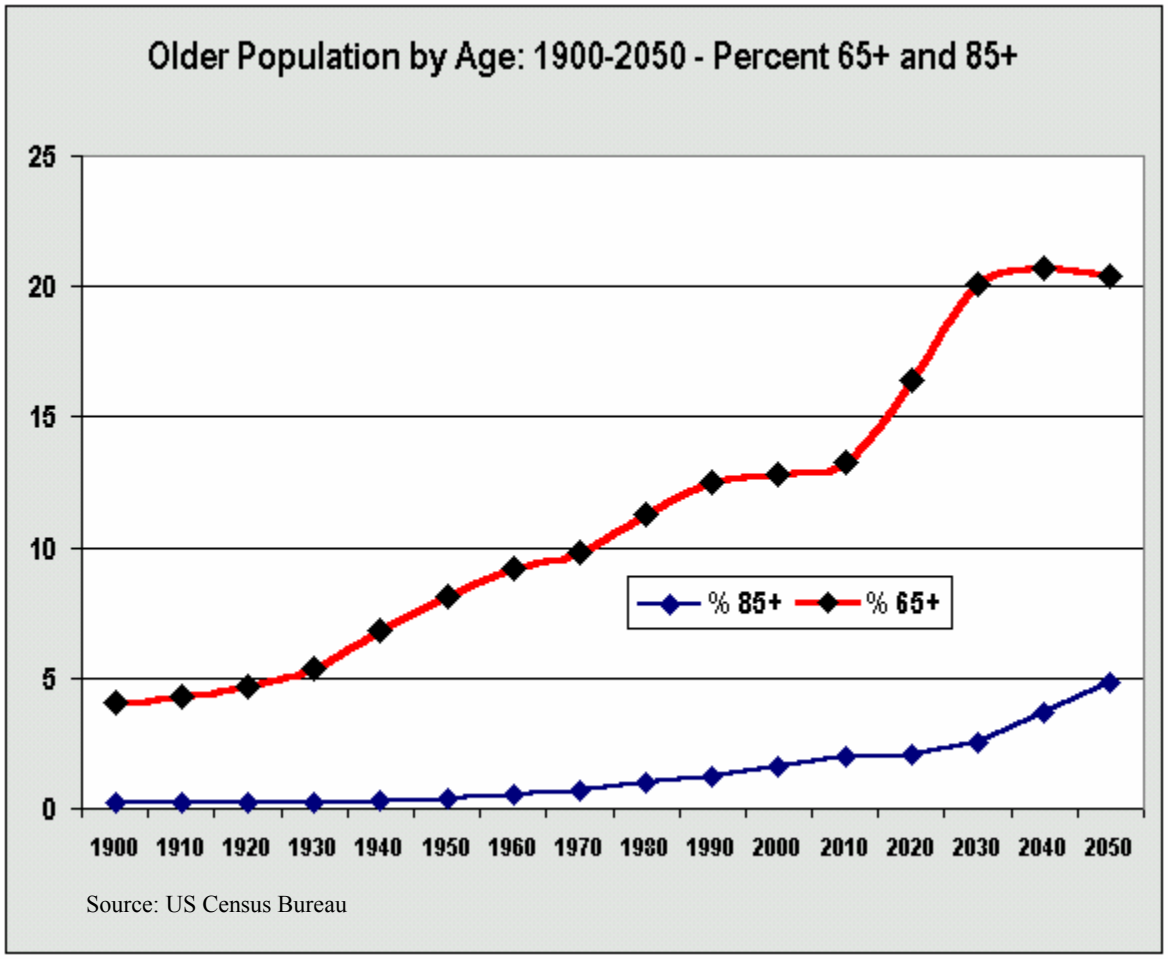
Figure 1



Projections indicate that those over 65 will represent more than one-fifth of the total population by 2030. Note the dramatic increase in the elderly population between 1900 and 2050.

The oldest of the elderly population, aged 85 and older, represent the most rapidly growing segment of the population. This group accounted for only 4.3 percent of the population in 2000, but is projected to swell to 14.3 percent by 2040, more than tripling in a forty-year period.[iii] The oldest of the elderly, are most likely to need long-term care services for multiple health concerns.[iv] This suggests that national health expenditures for long-term care and supportive services may increase around 2030, coinciding with the expansion of the oldest of the elderly cohort.

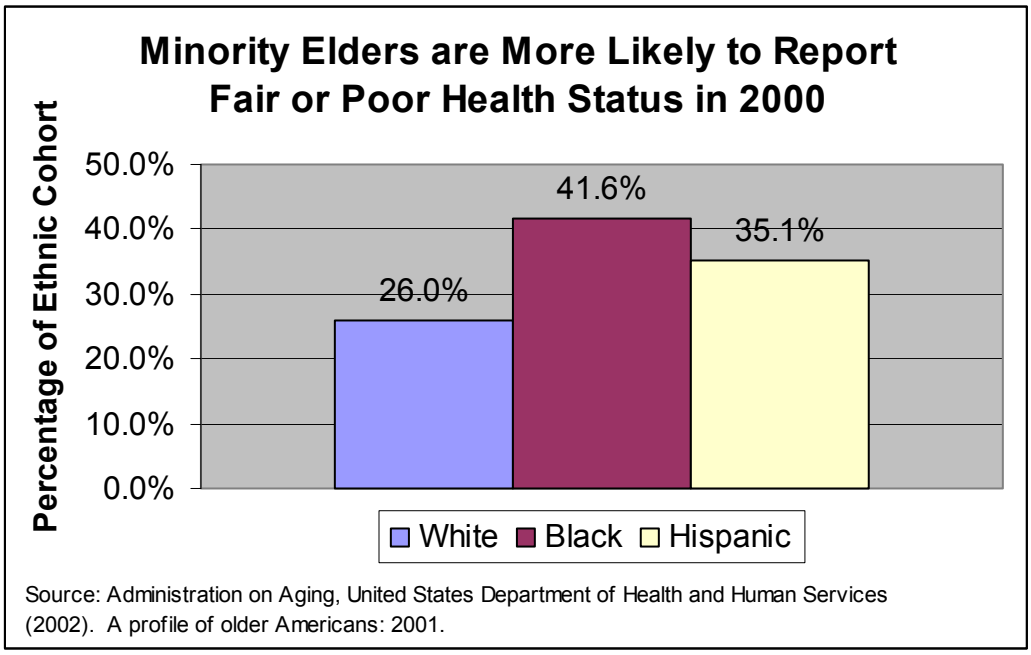
Figure 2



Women comprise a disproportionate share of the elderly population. Women who live to age 65 can expect to live another 19 years on average, while men reaching 65 can expect to live another 15 years on average.[v] The 2000 Census reported 20.6 million older female adults and 14.4 million older men.[vi] The gender imbalance increases with age; in 2000 there were 245 women to every 100 men in the 85-and-older group.[vii] Though this imbalance is projected to decrease slightly over time as mortality rates converge, females will continue to outlive men and dominate sex ratios amongst the older cohorts.[viii]

As the Baby Boomers age, the older population is becoming increasingly diverse. In 2000, the 65+ population was 88.9 percent White, 8.3 percent Black, 2.8 percent Other; fully 5.4 percent of the total was of Hispanic origin.[ix] Minority groups will represent increasingly large proportions of the older population over time. Notable is the change in ethnic background of the elderly, particularly the growth in the Hispanic population. Minority groups face increased likelihood of chronic conditions, also indicating greater health care needs in the future. In 2000, Minority elders were much more likely than White seniors to report that their health was only fair or poor.

Figure 3



Source: Administration on Aging, United States Department of Health and Human Services (2002). A profile of older Americans: 2001.

Health Status of the Elderly

As people age, the likelihood increases of having one or more chronic health conditions which limit daily activities. Chronic conditions cannot be cured, though many can be controlled through drugs and lifestyle modifications. About 45% of adults age 65-69 reported a disability in 1997 (8.1 percent of which were severe enough to require assistance). Nearly 74% percent of the population 80 and above reports at least one disability, with the majority of responders indicating that their disability was severe.[x]

Elderly Americans suffer from a variety of chronic health conditions including arthritis, high blood pressure, heart disease, and limitations of vision and sight. The prevalence rates of the most common chronic conditions are shown below. Many elderly suffer from more than one chronic condition.

Figure 4

Common Chronic Conditions Afflicting the Non-Institutionalized Elderly Population		
	65-74 Year Olds	75+ Year Olds
Arthritis	45.3%	52.4%
Hypertension	39.2%	42.0%
Hearing Impairment	25.5%	37.0%
Heart Disease	26.8%	36.4%
Vision Impairment	19.9%	27.1%
Orthopedic Impairment	7.0%	10.4%
Diabetes	17.5%	13.4%
Arteriosclerosis	13.3%	11.7%
Varicose Veins	7.7%	8.7%
Cerebrovascular Disease	5.2%	9.9%
Chronic Sinusitis	15.7%	14.9%
Emphysema/Chronic Bronchitis	10.1%	9.3%

Chronic health conditions can interfere with activities of daily living including eating, toileting, grooming, walking and grocery shopping.[xi] ADLs (Activities of Daily Living) can make it more difficult for older adults to live independently. Independent living is also difficult for a senior whose physical or mental condition limits one's ability to do housework, remember to take medication and manage personal finances.[xii] Nearly half of all Americans who reach age 65 can expect to spend part of their lives in a nursing home.[xiii]

Chronic conditions contribute to premature mortality and increased morbidity in the older population. As the following charts indicate, cancer and heart disease account for more than 50% of all older adult deaths. High prevalence rates of mortality from chronic conditions highlight the need for early and on-going medical management including maintenance drugs.

Figure 5

Leading Causes of Death for Young-Old Americans, Ages 55 – 74

Rank	Cause	Percent of Deaths 55-64	65-74
1	Cancer	37.0%	34.0%
2	Heart Disease	26.3%	27.7%
3	Chronic Lower Respiratory Disease	4.5%	7.1%
4	Cerbreovascular Disease	4.1%	5.4%
5	Diabetes	3.8%	3.8%

Leading Causes of Death for Elderly Americans Aged 75 - 84

Cause	75-84
Heart Disease	31.4%
Cancer	26.3%
Cerbreovascular Disease	8.1%
Chronic Lower Respiratory Disease	6.8%
Diabetes	3.2%

Figure 6

Leading Causes of Death Among the Oldest-Old, Americans Age 85+

1	Heart Disease	38.2%
2	Cancer	11.7%
3	Cerbrovascular Disease	10.2%
4	Influenza/Pneumonia	4.8%
5	Alzheimer's Disease	4.3%

Source: National Center for Health Statistics, 2002.

Note the change in risk of mortality from a particular disease that an older adult faces as one ages. Conditions such as Alzheimer's disease and Pneumonia become leading causes of death for the oldest of the elderly. This group is most likely to require home or institutional care for one or more of these conditions including: rehabilitation for orthopedic problems; supervision for those with Alzheimer's disease or cognitive impairments; and, assistance for those whose chronic conditions interfere with the activities of daily living.

Current research suggests that medical advances and improved quality of life may result in lower disability levels for older adults in the future.[xiv] However, improved health will not be uniformly experienced by all seniors. Minorities and low-income elders are more likely to suffer from chronic conditions, particularly those that require expensive or complex treatment.[xv] The growth of the older minority population suggests a particular need for treatment of conditions that disproportionately impact minority elders. Projections of lower disability rates in the future help to mitigate concern about financing and providing long-term care for the aging Baby Boomers. Researchers advocate using the next twenty years to improve our long-term care service delivery so we are prepared to meet the Boomers' needs.

The GAO estimates that the rates of disability amongst older Americans may increase by 200 to 400 percent in the next 40 years. However, as the number of Americans aged 85 and older increases, there is considerable uncertainty surrounding this projection.[xvi] The rise of the assisted living industry, which provides ADL assistance in a home-like setting, and increased availability of home health care, may reduce reliance on nursing home care for the disabled elderly.

Paying for Health Care

Health care for older Americans is paid for by a variety of sources. America does not have a single payer health care financing system that provides standard health insurance benefits to all seniors. Currently, care is financed through a combination of: Medicare, the Federal health insurance program for adults aged 65 and above; private supplemental insurance, including employer-sponsored plans and Medigap policies; Medicaid, the social assistance program for low-income Americans; and other sources. Most notable are the Veterans Administration which funds health care for veterans and the Department of Defense which funds care for military

retirees and their dependants. An overview of these various programs is presented in the following discussion.

Medicare

More than 39 million Americans receive health insurance through the Medicare program.[xvii] Medicare is a social insurance program financed through a payroll tax that is shared by employers and employees. Contributions from workers pay for the premiums for the 65+ year old adults, who typically qualify for Medicare if they are eligible for Social Security. All beneficiaries receive Medicare Part A hospital insurance. Most (greater than 95 percent) opt to purchase Part B, the supplemental medical insurance that pays doctors bills and for a variety of outpatient services. Part B premiums pay for 25 percent of Medicare part B services; the rest are paid for from general revenues.[xviii]

Medicare is not a comprehensive insurance program. In 2000, Medicare covered 51.4 percent of total personal health care expenditures for seniors on Medicare.[xix] Traditional Fee for Service Medicare does not cover prescription drugs or most long-term care services, which are both large health care expenses the elderly face. A prescription drug benefit program is currently a major policy issue under discussion because many seniors do not have access to supplemental health plans that provide prescription drugs. In the Fall of 1999, 37.7 percent of Medicare beneficiaries lacked drug coverage.[xx] This figure may be even higher in 2003 as many Medicare+Choice plans have either left the market or reduced drug benefits.[xxi] Many beneficiaries resort to splitting pills or leaving prescriptions unfilled.

Many, but not all, seniors have access to Medicare+Choice plans; Medicare managed care plans that offer additional benefits such as prescription drug coverage and preventative services. Presently, about 13 percent of beneficiaries have elected to enroll in these plans.[xxii] Most seniors rely on other forms of insurance to supplement their Medicare benefits. In 1998, 76.7% of noninstitutionalized Medicare beneficiaries relied on supplemental health insurance including Medicaid, employer-sponsored, public programs (including VA and DoD), and individually purchased coverage.[xxiii]

When Medicare began in 1965, it was designed to meet the needs of the older population that had a much shorter life expectancy than today and was more reliant on hospital care than today's older adults. Now that Americans are leading longer, healthier lives, there are new demands on Medicare causing considerable concern for its future. Initially, a high ratio of workers to retired beneficiaries generated an excess of funds compared to the costs of care. Thus, a "trust fund" for Medicare Part A was created. The government spent these excess collections on other programs, and thus the "trust fund" is only a government IOU. All of the IOU's in the "trust fund" are projected to be depleted by 2030 as costs outpace future payroll tax revenues. Furthermore, Part B costs, 75% of which are already paid from general revenues, will require increasing amounts of Federal revenues.[xxiv] As program spending increases, the need for a revised Medicare benefit package is becoming increasing clear.

President Bush underscored the importance of a Medicare program that provides all seniors access to prescription drug plans in his 2003 State of the Union address. He proposed to

meet this need through private health plans, similar to the Federal Employees Health Benefits Program.[xxv] This will probably require seniors to join health maintenance organizations (HMOs), which restrict choice in exchange for increased benefits like prescription drug coverage.

The Medicare+Choice program gives seniors the option of receiving care from an HMO rather than fee-for-service Medicare in order to gain additional benefits. This experiment has not been entirely successful. Some plans have had to reduce benefits, increase co-payments, or pull out of some service areas because they were unable to maintain profitability at the low levels of reimbursement.[xxvi] The President and Congress are trying to find an affordable way to provide a drug benefit for Medicare beneficiaries.[xxvii]

Medicare reform has important implications, not only for a drug benefit, but for physician reimbursement levels. In an attempt to restrain rising health care costs, payments to Medicare providers were to decrease by 4.4% in 2003.[xxviii] This created an access problem for elderly Americans as physicians became reluctant to accept additional Medicare patients. In February of 2003, Congress passed legislation reversing the programmed decrease in provider payments. This will improve access for elderly patients, but it will also increase the nation's health care costs and budget deficits.

Supplemental Insurance

Medicare supplemental insurance, referred to as Medigap, is regulated. Private insurers can sell ten different products that pay for health care services not covered by Medicare. However, only three of these products include prescription drug coverage. These policies can be quite expensive because insurers are allowed to prescreen applicants for existing health conditions and increase premium rates as policy holders age. These characteristics make Medigap a viable alternative predominantly for more affluent seniors.

Retirees with employer-sponsored health insurance benefits that accompany pension packages use this coverage as a Medicare supplement. Rising health care costs and slowed economic growth have led many companies to reduce retiree health benefits as they struggle to meet the costs of retirement benefits for an aging workforce.[xxix] A 2002 survey found that 50 percent of large employers, 30 percent of mid-sized and only 5 percent of small firms were offering retiree health benefits.[xxx] This number is likely to decrease in the future, and many firms that will be able to continue offering coverage will increase premiums or cost-sharing to beneficiaries.

Insurance characteristics of the near-old, adults ages 50-64, provide clues to that cohort's insurance status as it becomes the next generation of older Americans. Approximately 13 percent of this group was uninsured in 2000.[xxxi] The uninsured in this group were likely to be lower-income earners who do not receive insurance from their employers and cannot readily afford private policies.

Department of Veterans Affairs (VA)

The Department of Veterans Affairs provides comprehensive health care including inpatient, outpatient, preventative services and prescription drugs to veterans of the U.S. Armed Forces.[xxxii] These services are provided according to a veterans' priority, which is based on the veteran's disability and income level. Veterans with service-connected disabilities and those with very low incomes have the highest priority and receive care at no cost. VA care is provided at approximately 1,300 facilities nationwide.[xxxiii] Currently about 5 million veterans use VA medical services and the annual VA health care Budget is approximately $25 million. VA facilities fill an important void for many elderly veterans who rely on their VA benefits to provide pharmaceuticals and preventive care not covered by Medicare.

The demand for VA care has become so great that the administration recently suspended enrollment for the lowest priority group of veterans in order to ensure that the population with the greatest need receives required care. Priority 8 veterans, the group affected by the ruling, have annual incomes in excess of $30,000 and no service connected disabilities.[xxxiv] This decision typifies the kind of choices that may need to be made as the nation tries to care for a growing elderly population. Proposals to increase payments by those in low priority groups will enable the VA system to reduce wait times at primary care clinics and more efficiently serve the sickest veterans.[xxxv] The U.S. GAO attributes the majority of the recent increase in VA patient workload to rapidly increasing enrollment of veterans age 65 and older.[xxxvi]

Department of Defense (DOD)

Military retirees over age 65 and their Medicare-eligible spouses are eligible for TRICARE for Life (TFL) in addition to Medicare. TFL serves as a Medicare supplemental policy and pays nearly all of the patient's Medicare co-pays. Retirees and their spouses must subscribe to Medicare part B to be eligible for TFL. TFL provides all services covered in the TRICARE program in addition to those provided by Medicare, including a very generous prescription drug benefit. Long-term care is one of the few services that TFL does not cover.

Medicaid

Medicaid is another part of America's social safety net, designed to provide health care to the aged, blind, disabled, as well as children and pregnant women living in poverty. Medicaid is financed jointly by general revenues from Federal and State governments. Low income seniors can either qualify for a full Medicaid benefit or for a partial Medicaid benefit program to supplement Medicare. Elderly long-term care users are sometimes impoverished by their costs of care and qualify for Medicaid by spending down their income and assets to the poverty level.

The poorest seniors, those living below the Federal poverty level (FPL) with limited assets, are eligible for comprehensive Medicaid benefits. Seniors with incomes 175 percent below the FPL and low asset levels, qualify for assistance with Medicare cost sharing. The assistance ranges from complete payment of premiums and cost-sharing charges, to a partial reimbursement of Part B premiums for those with higher income and asset levels.[xxxvii] For 2003,

the FPL is $8,980 for a single person household and $12,120 for a couple[xxxviii]. Individuals with high health care expenditures can qualify for Medicaid medically needy programs to meet catastrophic care expenses such as those associated with long-term care.

In 2000, Medicaid was the largest payer of long-term care in the United States, paying 46 percent of the cost.[xxxix] Many patients enter long-term care facilities as Medicaid patients; these tend to be older, sicker seniors living on very low incomes. Others spend down to Medicaid-qualifying levels, since long-term care stays can cost $60,000 a year. Many people prefer to receive long-term care in their homes so that they can retain more of their independence.[xl] Many states have developed Medicaid programs that provide home and community-based long-term care, which are more cost-effective and user-friendly. However, since each state designs its own Medicaid programs, there is considerable variation in service availability.[xli]

Many states are currently making difficult financing decisions in light of looming budget deficits. Medicaid expenses are amongst the largest budget items for many states. Forty-nine states already have, or plan to address, shortfalls by restricting Medicaid eligibility and/or trimming benefits, making Medicaid another area where access to health care for the elderly is threatened.

Conclusion

America will see a dramatic increase in the older population, as the Baby Boomers move into their retirement years. The increase in the nation's elderly population will initially consist of younger, healthier elders who may not have immediate high cost health care needs. Improved socioeconomic status and advances in health care delivery may limit the rate of increase of their needs for long-term care services. However, there is a clear need for revisions to Medicare, the basic health care financing system for the elderly. Some Medicare beneficiaries need help paying for their prescription drugs and are unable to access the treatment they need. Medicare should be modernized to reflect the changing needs of our aging population in collaboration with doctors, health plans, and pharmaceutical companies, to create a sustainable delivery system. Though the steepest increases in the number of elderly are still a few years away, policymakers should act now to ensure that the necessary infrastructure is in place by the time the greatest impact of aging is felt.

The financial burden the aging population will place on our public health and medical care systems can be lowered through appropriate application of government and private sector resources. For this to work, quality health care should include clinical preventive services and therapeutic medical care. Health care errors are made - by omission and by commission. Several issues that should be considered for the future, include:

- Encourage a strong national leadership position regarding health problems related to aging
- Set standards for comprehensive geriatric care including access to preventative and home-based care
- Provide reimbursement for evidence based preventive services for seniors

- Establish standardized health care performance measures and quality indicators
- Encourage comparative quality reporting to the public for in-patient and out-patient care
- Encourage government and private sector cooperation in developing information technology infrastructure
- Develop a health services research agenda including a focus on geriatric epidemiology
- Support measures aimed at improving senior care provider competencies

APPENDIX A

Major Sources of Financing Offer Older Americans Different Benefits

	Medicare	Medicaid	Veterans Affairs	Private Insurance
Eligibility (for older Americans)	Americans 65+ with qualifying SS participation	Low-income: 100% FPL for full benefits, up to 175% FPL for partial coverage	Previous service in the U.S. Armed Forces	Some receive coverage from employer-sponsored retirement benefits, anyone with sufficient income can purchase MediGap or other private policies- these tend to be expensive
Preventative Care	Not under Part A, with Part B Annual physical exams are not covered, Medicare pays 80% of many diagnostic tests/screenings M+C beneficiaries in some plans may have additional benefits.	Covered	Covered	Varies by plan
Prescription Drugs	Very limited. Part B covers a few drugs including most injectibles for people with certain chronic conditions.	Typically covered with limits on brand-name usage and total monthly dollar amounts. Programs vary by state.	Covered. Veterans with higher incomes and no service-related disabilities may face higher co-payments.	Varies by plan. Only 4 Medigap plans include drug coverage.
Long-Term Care (nursing home)	Limited coverage- Part B covers the first 100 days in a skilled nursing facility, high copays after day 21.	Covered, this is a mandated benefit.	Covered, but veterans must apply individually.	Varies, long-term care services are generally not covered under traditional health insurance and require separate LTC insurance.
Long-Term Care (home care)	Not covered.	Differs by state, patients typically face co-pays of $0.50 - $3.00/visit.	Covered, this is part of the Medical Benefits Package available to all veterans.	Varies, LTC services are generally not covered under traditional health insurance and require separate LTC insurance.
Hospital Services	Covered under Part A. Deductible of $840 for first 60 days, high copays for days 61+. ER care is covered if it leads to admission, otherwise you face Part B deductibles.	Inpatient and outpatient services covered.	Covered, mostly at VA hospitals except when unavailable.	Varies, Medigap plans generally cover Medicare copays and deductibles.
Cost to Participate	Most beneficiaries do not pay for Part A. Part	Minimal cost to beneficiary. Some	Required to enroll in Medicare Parts A	Premiums vary by coverage,

	B premiums are $58.70 in 2003. M+C premiums can be an additional $0-$100+/mo.	services require low co-payments.	and B. Some priority groups will have to make modest co-payments.	policyholder's age and health. Employer-sponsored plans differ by firm. Medigap policies for a healthy 65 year old cost $407-$8,074/yr.

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