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ISSUE BRIEF

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Key Issues in Understanding the Economic and Health Security of Current and Future Generations of Seniors

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INTRODUCTION

Concerted attention by policymakers to the nation's budget deficit and debt has spurred several deficit- and debt-reduction proposals, which typically include changes to the nation's three major entitlement programs – Medicare, Medicaid, and Social Security. Some reforms that have been proposed include: raising the age of eligibility for Medicare from 65 to 67; requiring higher-income Medicare beneficiaries to contribute more to the cost of Medicare coverage than they currently do; providing block grants to states to pay the federal share of their Medicaid program expenses; and using the chained consumer price index to determine the growth in Social Security benefit payments, which would slow their growth over time. If implemented, such changes could significantly affect the economic and health security of current and future generations of seniors in their retirement years.

Policy options affecting health care programs and Social Security are often discussed separately from one another. But policy choices in each area – health care and retirement income – interact in their effect on the economic security and well-being of seniors. For example, increasing how much seniors have to pay out of pocket for premiums or cost-sharing amounts would result in health care expenses absorbing a larger share of retirees' income and savings, putting more seniors – especially those living on limited incomes – at greater risk of financial insecurity. Similarly, constraining the growth in annual increases in Social Security payments would result in less income available to pay for rising health care costs.

This brief examines key issues to help bridge policy discussions related to the economic and health security of seniors, drawing from recent data and research and a discussion among experts from the income, retirement security, and health policy fields at a roundtable convened by the Kaiser Family Foundation in 2011. The goal of the roundtable was to develop a more integrated understanding of the economic and health security issues facing seniors, and of the role that Medicare, Medicaid, and Social Security play in ensuring seniors' financial security (notwithstanding the important role these programs play for other populations, including nonelderly people with disabilities). These facts and findings have important implications for understanding the effects of proposed changes to Medicare, Medicaid and Social Security.

KEY ISSUES

1 Economic and health security are interrelated and many seniors face significant vulnerability in both areas; a relatively small share of seniors have high incomes

In current deficit-reduction discussions, there has been some interest in policies that would require wealthy seniors to pay a larger share of their health care expenses than they currently do. However, estimates indicate that wealth among seniors is highly concentrated. In 2010, the top 10 percent of Medicare beneficiaries ages 65 and older had annual incomes of $65,000 or greater, while the top 5 percent had annual incomes of $86,100 or greater.[1]

Most seniors live on low or modest incomes. Nearly 1 in 10 seniors had family income below the federal poverty threshold ($10,458 for single individuals age 65 or older and $13,194 for senior couples) in 2010, and over one-third (35 percent) had incomes less than twice the poverty threshold.[2,3] This amount – just over $26,000 for senior couples – is about the same as a recent estimate of the average income required by seniors to meet their basic living expenses without financial assistance.[4] This amount is also well above the income eligibility thresholds of most programs that provide assistance to seniors, including the Supplemental Security Income (SSI) program, Medicaid, and the low-income subsidy (LIS) program under the Medicare Part D prescription drug benefit.

The official measure of poverty, however, does not take into account medical costs and certain other expenses that reduce disposable income, nor does it factor in the value of in-kind benefits that households can use to meet their basic needs (such as housing or energy subsidies). Medical expenses represent a particular burden for senior households compared to younger households.[5] While the vast majority of seniors have Medicare coverage to help pay for the cost of hospitalizations, physician visits, and other medical services, most also face sizable out-of-pocket health care expenses, in the form of premiums, deductibles and other cost-sharing requirements, and for services not covered by Medicare, such as dental and long-term care, as described in more detail in the following section.

When out-of-pocket medical expenses and other factors are taken into account, the share of seniors living in poverty in 2010 increases from 9.0 percent to 15.9 percent, and nearly half (49.0 percent) have incomes less than twice the poverty threshold, according to an alternative measure of poverty developed by the Census Bureau.[6] This increase primarily reflects the burden of health care costs among seniors, underscoring the effects of health expenses on their financial security. With many seniors having limited financial resources, some choose to delay or forego needed health care because they cannot afford the out-of-pocket expenses, and some have to choose between paying for medicines and other health care costs or paying for food, rent, and utility bills.[7]

2 Even with Medicare coverage, medical costs are a significant portion of seniors' budgets

Medicare currently provides health insurance to more than 40 million people age 65 and older and more than 8 million younger people with permanent disabilities, and helps to cover the cost of hospitalizations, physician visits, and other health care services.[8] Given that health care needs tend to increase with age, it is not surprising that many seniors have multiple chronic conditions and relatively extensive medical needs. Nearly half (46 percent) of seniors covered by Medicare have three or more chronic conditions and nearly one-fourth (23 percent) are in fair or poor health.[9] In 2008, 73 percent of seniors had one or more physician visits, 16 percent received inpatient hospital services, 8 percent used home health care services, and 4 percent received post-acute care in a skilled nursing facility.[10]

While Medicare provides access to a variety of medical services, including inpatient and outpatient medical care, a prescription drug benefit, post-acute care, and preventive and diagnostic services, these services are not provided at no cost to beneficiaries. For 2012, the Part A deductible for inpatient hospital services is $1,156; the standard monthly premium for Part B, which covers physician and most other outpatient services, is $99.90 and the Part B deductible is $140[11]; and the monthly premium for Part D prescription drug coverage (which varies depending on which drug plan is chosen) averages about $40.[12] For the year, the standard Part B premium and an average-priced drug plan total about $1,700 for an individual or about $3,400 for a couple.

For low-income seniors, state Medicaid programs provide important benefits and financial protections, including helping to pay for Medicare's premiums and cost sharing and – for those who qualify for full Medicaid coverage – benefits not covered by Medicare, such as dental care and long-term care.[13] But not all seniors with low incomes are eligible for or covered by Medicaid, such as those who have savings and assets too high to qualify.[14]

To help pay for Medicare cost-sharing requirements and cover gaps in the Medicare benefit package, a majority of seniors covered by Medicare (91 percent in 2009) have some form of supplemental insurance, including employer-sponsored retiree health coverage, Medigap, Medicare Advantage, and Medicaid.[15] Yet despite widespread supplemental insurance coverage, most seniors spend substantial amounts out of pocket on health care expenses, including premiums for Medicare Part B and Part D, premiums for supplemental insurance, cost sharing for Medicare-covered services, and expenses for services not covered by Medicare. Premiums alone (for both Medicare and supplemental insurance) account for the largest share of Medicare beneficiaries' out-of-pocket health spending, and more than 4 in 10 seniors covered by Medicare spent more than 10 percent of their income on premiums alone in 2006.[16] And many seniors, even those with supplemental insurance, do not have any coverage for long-term care, meaning that these services are unaffordable or that paying for them requires large out-of-pocket expenditures. This may be a particular concern for older seniors (those ages 85 and older) who are most likely to need long-term services and supports such as nursing home care, and who devote a much larger share of their incomes to health and long-term care expenses than younger seniors.[17]

Not surprisingly, seniors with more financial resources at their disposal are better able to absorb the cost of medical care. Seniors with incomes over 400 percent of the federal poverty level ($44,680 for an individual in 2012) – a group which includes those with middle incomes up to the very well-off – spent 8 percent of their incomes on health care expenses in 2006, at the median.[18] In contrast, median out-of-pocket health care spending as a share of income was three times greater (25 percent) among seniors with incomes between 100 and 200 percent of poverty.

3 Seniors typically rely on Social Security for most of their income, including the income they need to pay for health care expenses

People ages 62 and older are eligible for Social Security benefits based on their own work history; or as the spouse, widow or widower, or divorced former spouse (of a marriage of 10 or more years) of a worker; or a combination of both. Among people ages 65 and older, 88 percent have household income from Social Security benefits.[19] Nearly two in three of those ages 65 and older received more than half of their income in the form of Social Security benefits, and for one in three senior households receiving Social Security, nearly all of their income—90 percent or more—is from Social Security benefits.[20]

Among people ages 65 and older, 53 percent had household income from a private or public pension other than Social Security in 2008.[21] Unmarried seniors (those who are widowed, divorced, or never married) are less likely to have income from pensions other than Social Security—35 percent of unmarried seniors, compared with 49 percent of married seniors, have this type of income.[22] At older ages, when seniors are more likely to have the greatest health care expenses, they tend to be even more reliant on Social Security income, as savings are depleted and other sources of income decline.

With Medicare premiums and other health care costs on the rise, the amount of Social Security income available for other uses decreases. Over the past two decades, Medicare premiums have risen considerably faster than the cost-of-living increases in Social Security benefits in percentage terms.[23,24] In most years, a significant share of the cost-of-living adjustment (COLA) received by Social Security recipients has gone to paying for increased Part B and (since 2006) Part D premiums.[25] (Medicare Part B and Part D premiums are typically deducted from most beneficiaries' Social Security payments.) As a result, the remaining portion of the yearly cost-of-living increase generally has not been large enough to keep up with inflation in other basic living expenses or with the rising cost of medical care services, including services Medicare does not cover.

While Social Security recipients generally receive an annual cost-of-living increase that reflects higher costs associated with inflation in prices, there was no COLA in 2010 and 2011 due to negative or relatively low inflation. When there is no COLA or when the Social Security COLA is insufficient to cover the amount of the Medicare Part B premium increase for an individual, the law prohibits a reduction in that individual's monthly Social Security payment that would otherwise result from an increase in the Part B premium.[26] This is known as the "hold-harmless" provision. This provision can prevent Medicare beneficiaries from paying any increase in Part B premiums if there is no COLA, but it does not apply to Medicare Part D drug plan premiums. Thus, Medicare beneficiaries who receive a zero percent cost-of-living increase and who are enrolled in Part D plans could see a reduction in their Social Security payments if their monthly Part D plan premium increases.

With no COLA in 2010 and 2011, the majority of Medicare beneficiaries paid a monthly Part B premium of $96.40 (the standard Part B premium amount in 2009) during those years. For 2012, Social Security recipients received a 3.6 percent COLA, which meant that Medicare beneficiaries once again experienced an increase in their Part B premiums – for most, an increase of just over $3, from $96.40 per month in 2011 to $99.90 per month in 2012.

4 Many seniors are not financially well-prepared for retirement and the outlook is especially uncertain for people with low incomes

While some seniors are well-prepared financially for their retirement years, most have limited savings and modest resources in retirement accounts and home equity. The top five percent of Medicare beneficiaries ages 65 and older have retirement savings and financial assets totaling over $1.1 million dollars, but most have considerably less.[27] Median savings (retirement accounts and other financial assets) among seniors was nearly $66,900 in 2010. One-fourth of seniors had savings of less than $11,800. Among the 81 percent of seniors with home equity, the average amount was just over $136,000 in 2010, but half had less than $94,000.[28]

Research indicates that the median level of savings cited above may be insufficient to cover health care expenses in retirement for many seniors. For example, one study estimates that for people with median drug expenses who purchase both Medigap and Part D drug coverage, a man would need $124,000 and a woman would need $152,000 in savings at age 65 to have a 90 percent chance of having enough money to cover insurance premiums and other health care expenses in retirement (not including long-term care expenses).[29]

Indicators of "retirement readiness" suggest that future cohorts of seniors may not be better positioned financially for retirement than the current generation, which has implications for reform options that would place a greater health care cost burden on many seniors, such as raising the age of Medicare eligibility or placing restrictions on the generosity of Medigap policies. One measure suggests that just under one half (47 percent) of people ages 56-62 are at risk of not being able to cover basic expenses and uncovered health care costs, and only somewhat smaller shares of younger cohorts are similarly at risk.[30] Retirees' own perceptions of how well they are prepared for retirement is at an all-time low,[31] and the retirement outlook is especially troubling for people with low incomes, because they typically have low levels of savings and other assets.[32] A recent study estimates that low-income seniors (those in the bottom one-fifth of the income distribution) will largely exhaust their assets by the time they reach older ages, leaving them solely reliant on Social Security income and, for the minority who have it, other pension income.[33]

5 Problems with medical bills and medical debt are a concern for many low- and middle-income seniors

Concerns about paying medical bills and the accumulation of medical debt play a significant role in the financial lives of many seniors. Debt related to health care is an indicator of the difficulty some seniors have in paying their out-of-pocket health care expenses. For some, the financial strains from medical bills or medical debt mean they are not able to meet other basic living expenses, such as paying for rent or utilities.

Results of a national survey indicate that nearly one in five seniors had problems with medical bills or medical debt in 2007.[34] About 16 percent reported medical bill problems in the past year, including problems paying bills, being contacted by a collection agency, or having to change their way of life to pay bills. One in ten seniors reported that they had medical debt or bills that they were paying off over time. Among seniors with medical bill or medical debt problems, roughly one-third (or 6 percent of seniors overall) reported that because of medical bills, they were unable to fully pay for basic necessities such as food, utilities, and rent. For more than one-third, medical bills resulted in exhausting all of their savings. Medical bills also led people to take on credit card debt (22 percent of those with medical bill or debt problems) and take out mortgages or loans (8 percent). Among low- and middle-income seniors with credit card debt for medical expenses, the average debt related to medical expenses was nearly $4,000 in 2008.[35]

Moreover, limited financial resources among many seniors means that some choose to delay or forego needed health care, such as medications and dental care, because they cannot afford the out-of-pocket expenses.[36] In 2008, 16 percent of Medicare beneficiaries ages 65 and older reported delaying care in the previous 12 months due to cost concerns, and among those who delayed care due to costs, some reported experiencing adverse consequences as a result, including stress and anxiety (40 percent), physical pain (26 percent), and a worsening of their existing medical conditions (21 percent).[37] Reduced use of medical care due to cost is particularly troubling among low-income people, who are more likely to experience negative health outcomes as a result.[38] Moreover, seniors with low and moderate incomes often face trade-offs between paying for medicines and other health care costs or paying for food, rent, and utility bills.

6 The need for long-term services and supports and the lack of long-term care insurance or the ability to pay for it are major risks to economic security in retirement

Few people have insurance that protects them against the potential costs of long-term services and supports, such as personal assistance at home, assisted living services, or nursing home care. Medicare covers short-term post-acute care, but does not pay for long-term stays in a nursing home or other facility. Medicaid benefits include long-term services and supports, but only for people with low financial resources, including those who have exhausted their resources paying for medical care and long-term services and supports. Moreover, Medicaid eligibility rules and benefits vary widely among states, especially for services delivered at home and in community settings, such as assisted living facilities. Private long-term care insurance is designed to pay for long-term care services, but only about 10 percent of seniors have this type of

insurance.[39] The cost of long-term care insurance is a significant barrier to take-up, with a typical premium for a couple (both age 60) around $3,000 per year and rising considerably with age.[40]

Despite low rates of long-term care coverage, the chances of needing long-term care in one's retirement years are not insignificant. Among people age 65, two-thirds are projected to need some long-term services and supports during their lifetimes, and an estimated 18 percent will use more than one year of nursing home care during the remainder of their lives.[41] But, far from being predictable, the need for long-term services and supports is uncertain and varies widely among individuals. Some seniors will have no long-term service and support expenses—they will not need this type of support during their lives, or they will rely entirely on unpaid assistance from family and friends.[42] Others, however, will need extensive support of a type or amount beyond what unpaid caregivers can provide. When extensive services in a nursing home or assisted living facility or at-home care are needed, they can quickly exhaust savings. The annual cost of nursing home care, for example, averaged about $78,000 nationwide in 2011 for a semi-private room, and over $100,000 annually in several of the most expensive markets – well in excess of the median savings of $66,900 in 2010.[43] Because the cost of these services can add up quickly, low- and middle-income seniors with extensive long-term care needs often deplete their savings paying for care and many become eligible for Medicaid coverage. About one-third of Medicaid spending covers long-term services and supports.[44]

7 Disparities in economic and health security in retirement exist between seniors of color and white seniors

In looking at the economic and health security of communities of color, it is especially important to recognize the interrelated nature of race/ethnicity, income, and health status. People of color, who disproportionately have lower earnings during their working years and are less likely to have pensions for retirement income, also face a higher incidence of chronic disease. The result is that seniors in racial/ethnic minority groups have, on average, greater health care needs and fewer financial resources to cover the associated costs.

Poverty rates among black and Hispanic seniors are more than twice as high as among white seniors. In 2010, 18 percent of African American and 18 percent of Hispanic adults ages 65 and older had household income below the federal poverty level, compared with 7 percent of white non-Hispanic adults ages 65 and older.[45] As with income, there are striking disparities in savings and home equity. Among Medicare beneficiaries ages 65 and older, the median level of savings (retirement accounts and other financial assets) is nearly $66,900 overall, but the median is substantially higher among white seniors than among black and Hispanic seniors – with median levels of $88,100, $9,700, and $9,800, respectively, and averaging $314,200 in 2010 among white seniors, compared with $58,400 among black seniors and $98,000 among Hispanic seniors.[46] Among seniors with home equity, average home equity of beneficiaries ages 65 and older is also higher among white beneficiaries ages 65 and older ($140,800 in 2010) than among black and Hispanic seniors (on average, $86,800 and $113,200, respectively).[47]

The incidence of chronic health problems and disability is greater among people of color than among whites, resulting in both lower income and a lesser ability to save during pre-retirement years and higher total health care expenses during retirement for people of color than for whites. Among men ages 62 to 64 (the years just before reaching the age of Medicare eligibility for most), 41 percent of black men and 33 percent of Hispanic men report health problems that affect their ability to work, compared with 26 percent of white men.[48] A similar pattern was observed among women ages 62 to 64: 49 percent of black women and 32 percent of Hispanic women report health problems or disabilities that prevent them from working or limit the kind or type of work they can do, compared with 25 percent of white women.

Compounding the problem of greater health care needs among people of color than among whites, more than one-third of black and Hispanic senior households are at risk of financial instability based on their current health care expenses.[49] And yet, while having lower incomes and higher incidence of chronic conditions puts seniors in racial and ethnic minority groups at greater risk of financial insecurity in retirement than white seniors, they are also more likely than white seniors to benefit from the financial protections that Medicaid offers Medicare beneficiaries who quality for coverage because of their low incomes. In 2008, 15 percent of seniors covered by Medicare overall had Medicaid coverage, but a smaller share of whites (10 percent) than blacks and Hispanics (35 percent and 39 percent, respectively).[50] To some degree, this coverage helps shields seniors in racial and ethnic minority groups from the burden of health care spending as a share of income because Medicaid helps pay the cost of Medicare cost sharing and premiums. In 2008, the median amount of income spent on health care costs (including premiums) was 18 percent for white seniors with Medicare, compared to 14 percent and 15 percent for black and Hispanic seniors, respectively.[51]

8 Women are at greater risk of financial insecurity in retirement than men

Among those ages 65 and older, women are more likely to have income below the poverty level than men. In 2010, 11 percent of senior women had incomes below the federal poverty level compared with 7 percent of senior men.[52] Unmarried senior women (widowed, divorced, or never married) are at greater risk of poverty than married senior women as well as unmarried senior men. Among senior women who live alone, one in six (17 percent) had income below poverty in 2010, compared to 13.5 percent of senior men who live alone.

While many factors contribute to the pattern of lower incomes for senior women, an important reason for those who marry is the drop in household income from Social Security and pensions that usually occurs when a husband dies – typically falling by between one-third and one-half.[53] While some household expenses also decline, the drop in income exceeds the drop in financial needs because household expenses such as mortgage or rent and utilities do not decline proportionally.[54] For widowed women, another important cause of financial insecurity and reduced income is the use of resources to pay for a husband's health care needs before his death.[55]

Although the retirement picture is expected to be somewhat better for future generations, women will continue to be significantly less prepared for retirement than men. Women in the baby boomer generation (people born between 1946 and 1965) are expected to have higher incomes in retirement than women currently of retirement age because both Social Security benefits and savings in retirement accounts tend to rise with increased lifetime earnings, and because baby boomer women have entered and remained in the workforce at higher rates than previous generations.[56] Yet women's earnings continue to be significantly lower than men's, which means they will have, on average, lower Social Security and pension benefits and less savings in retirement accounts than their male counterparts.[57] At the same time, women will continue to have longer average life expectancy than men and will need to finance a longer retirement period, on average. These trends mean that women of retirement age in the future will be at a significantly greater risk of financial insecurity in retirement than men, as they are today – and especially so for senior women in communities of color.

9 Only a subset of the next generation can expect to have substantially higher incomes and assets than the current generation of seniors

While it is important to examine the potential impact of changes to entitlement programs on the current generation of seniors, examining the long-term impact on future generations is also crucial, as policymakers consider some options for controlling the federal deficit and debt that would impact only new beneficiaries of entitlement programs. While future generations of seniors can expect to see some increase in income and assets, on average, as compared with current beneficiaries, only a small portion of the next generation of seniors will have significantly higher incomes and assets. Much of this growth is projected to occur among those with the highest incomes, and racial and ethnic disparities are expected to persist.[58]

Although average incomes of future retirees will be higher than for current retirees, the gains will not be evenly distributed across income groups. Gains in income for low- and middle-income groups will be more modest than gains for the highest-income group, which will result in widening income inequality among seniors.[59] For example, among "leading boomers" (those born between 1946 and 1955), median annual incomes at age 67 for people in the bottom three quartiles of the income distribution are projected to be about $1,000 to $3,000 higher (in 2011 dollars) than for their counterparts in the generation born a decade earlier (between 1936 and 1945). In contrast, "leading boomers" in the highest-income quintile are projected to have median income at age 67 about $8,000 higher than their counterparts in the older cohort. Furthermore, while per capita income of Medicare beneficiaries is expected to rise overall by 2030, those increases will occur primarily among those with higher incomes, and greater gains are projected to occur among whites than among black or Hispanic beneficiaries.[60]

Estimates of financial security among future generations of retirees indicate that a large proportion is at risk of not being able to sustain their pre-retirement standard of living. According to recent projections, an estimated two in five baby boomers will not be able to replace more than three-quarters of their pre-retirement earnings, a common benchmark of adequate retirement income.[61] And nearly one in five (17 percent) will not be able to replace more than half of their pre-retirement earnings.

With minimal appreciable growth in assets and savings, the next generation of seniors will not have substantially greater capacity than the current generation to tap into savings to cover medical expenses, including long-term care. Furthermore, future cohorts of retirees will face increased risks associated with the changing retirement landscape, including the shift from "defined benefit" pensions to a growing reliance on "defined contribution" retirement accounts that individuals typically must manage themselves.[62] Defined benefit plans are pension plans sponsored by employers that typically provide retirees with a lifelong annuity—that is, a specified and usually fixed income, typically based on a person's length of employment and annual wages (although some retirees opt to take all or some of their pension as a lump-sum payment). Defined contribution plans, in contrast, are individual retirement savings accounts funded by contributions from the employee and sometimes also by the employer.

Although defined contribution plans can be beneficial because of their transportability and flexibility,[63] a major concern is that they can create more risk for individuals in retirement than traditional pension plans. With defined contribution plans, individuals must figure out on their own how much to contribute to the plan during their working years and where to invest those funds, and then at what rate to draw from the funds during retirement. As a result, individuals can accumulate insufficient funds during their working years to cover their expenses during retirement, and funds can be depleted before the end of the person's life. Although people could opt to buy an annuity with the funds, very few people choose to do this.[64]

10 In the future, insurance premiums and out-of-pocket health care expenses can be expected to be a major use of retirement income

For seniors today and in the future, out-of-pocket expenses for health and long-term care will likely continue to be a major expense and a major source of financial risk in retirement. Seniors' out-of-pocket health expenses are likely to be affected by several trends:

- National trends in health care spending affect Medicare beneficiaries' out-of-pocket expenses for premiums, cost sharing, and services not covered by Medicare. The Patient Protection and Affordable Care Act of 2010 has initiated a number of strategies to slow the growth of Medicare spending. Reflecting these changes, projections by the Centers for Medicare and Medicaid Services indicate that average Medicare spending per beneficiary is expected to increase an average of 3.5 percent annually between 2010 and 2019, assuming no physician payment cuts, a rate of growth similar to the projected rise in gross domestic product (GDP) per capita.[65] Cost-of-living increases in Social Security benefits may not be as high: annual cost-of-living increases for 2013-2020 period are projected to average less than 3 percent.[66] As a result of these trends, seniors' out-of-pocket health care costs are likely to increase and may rise faster than incomes, leaving a smaller share of retirement income available for other purposes.
- Retiree health benefits are likely to decrease for future cohorts of seniors, which could increase out-of-pocket spending.[67] With private employers and state and local governments cutting back on these offerings, more seniors may look to purchase supplemental insurance in the individual Medigap market, enroll in Medicare Advantage plans, or choose to go without supplemental insurance in the future.
- States are currently facing tight budgets and many are considering ways to reduce Medicaid spending.[68] These efforts may lead to reduced coverage of services, such as dental care and long-term services and supports, which could result in higher out-of-pocket costs and more people unable to get needed care.
- Many seniors will continue to face a risk of financially catastrophic long-term care costs. If current trends continue, most seniors in the future will not be insured for long-term care costs and face the risk of high out-of-pocket costs and unmet needs. The number of people with private long-term care insurance has shown low growth in recent years.[69] Although the Affordable Care Act included a new public insurance program—Community Living Assistance Services and Supports (CLASS) program—to provide a foundation of coverage for long-term services and supports for voluntary participants meeting certain requirements, the Department of Health and Human Services announced that it will not pursue implementation of CLASS after determining that it cannot design a program that satisfies the law's requirements.[70]
- Ongoing discussions about spending growth for entitlement programs could result in reforms that limit the federal government's future contributions and shift costs onto beneficiaries. For example, raising the age of eligibility for Medicare from 65 to 67 would reduce Medicare spending, but would increase costs for other payers, including employers offering health benefits to retirees and current workers, state Medicaid programs covering low-income individuals, and individuals who would lose access to Medicare and pay higher premiums for other sources of coverage.[71]

CONCLUSION

Policymakers are considering a range of proposals in an attempt to address the nation's debt and deficit, many of which could have significant implications for seniors because they involve reforms of the three major entitlement programs: Medicare, Medicaid, and Social Security. Considering the interconnected nature of economic and health security among seniors allows for a more informed view of policy options under discussion. These proposals could greatly affect the level and generosity of medical coverage and income supports available to current and future generations of seniors, as well as their ability to pay for health care expenses and other needs in retirement. While a small share of seniors can and will be able to afford to pay a greater share of their health care expenses, as some policymakers have proposed, most seniors face a greater level of financial insecurity in the future.

Proposals to change Medicare, Medicaid, and Social Security are usually considered separately from one another, even though they would affect many of the same individuals. Given the significant degree of overlap between the populations served by these programs, changes under consideration in each program that could weaken the level of protection it provides should be evaluated not solely on their effects on the federal budget, but in the fuller context of the economic and health security of the individuals who rely on these programs. As policymakers consider options for decreasing spending on entitlement programs, it is important to consider the overall and interrelated effects of policy proposals on seniors' ability to pay for needed health care and essential living expenses. Especially important is recognition of the health and economic vulnerabilities faced by a sizable share of seniors—now and among future generations—and the potential for policy changes to increase the disparities between better-off seniors and those facing the greatest levels of economic and health insecurity.

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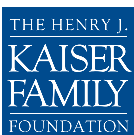

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