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Caring for a Large Geriatric Generation: The Coming Crisis in U.S. Health Care

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The time has more than come to begin planning seriously for the aging of the baby boom generation. The need for planning goes beyond concerns about the solvency of Social Security and Medicare. Another crisis looms in the form of a huge bill for the care of baby boomers who in their old age will need help dressing, eating, taking medication, and performing other daily tasks. Under the current system, most nursing home care is paid for by Medicaid-a program designed primarily to subsidize the acute care of indigent families. This arrangement diverts health care resources from their intended use, thwarts the development of a long-term-care insurance system, and provides meager resources to heavily burdened providers, forcing them to skimp on care needed by a vulnerable population.

RICHARD EASTERLIN, THE EMINENT DEMOGRAPHER, published a book in 1987 entitled Birth and Fortune. In it he put forth a theory as to why generations tend to alternate in size. The theory held that the economy's capital stock, and thus real incomes, rises unusually rapidly when small generations reach working age and labor is scarce. This outcome, Easterlin contended, makes for optimism about the future, an abundance of children, and, thereafter, unusually slow growth in incomes when all of those children enter the labor force. Easterlin's is, in short, a theory that seeks to explain how expectations about living standards affect family size.

This hypothesis may or may not be valid. It is certain, however, that the nation now faces a serious economic problem arising from the aging of the large generation born during the 20 years or so after World War II and the sharp drop in the birth rate that followed. Almost daily, the press and public discussion remind us of the challenge of financing Social Security and Medicare as the ratio of workers to retirees drops to two to one some 30 years from now, from three to one today and from four to one as recently as the early 1970s. Much less is said about what happens when the postwar baby boomers become not golf-playing 65-year-olds sipping chardonnay at the 19th hole, but wheelchair-bound 85-year-olds being fed Ensure through a straw. Unless the medical profession can come up with ways to stave off Alzheimer's disease and deal more successfully with the consequences of stroke and diabetes, the nation will face a crisis for which-now, in any case-it is woefully unprepared.

Coping with the financial stress on Social Security and Medicare will be relatively easy, as well-established financing vehicles are in place. Dealing with the jump in the number of so-called old-old will be much more difficult. Indeed, no mechanism now exists for the financing of long-term care save Medicaid, which, as conceived in the 1960s, was meant to pay for the acute care of the most indigent families, not the long-term care required by the majority of frail elderly residents of nursing homes. The private insurance market, in contrast, fills a tiny fraction of the need. Few families have the resources to finance out of pocket either nursing home care or equivalent at-home care, which in New York State, for example, can easily cost upwards of $100,000 a year (Gregory and Gibson 2002).

The consequences of Medicaid financing are troubling for the frail elderly and for the nation at large. The lack of any serious national debate about those consequences is even more troubling.

In this note I examine these financing problems and reflect on my own experience as the principal caregiver for my mother, who died recently after a six-year battle with Alzheimer's-type dementia.

Whatever professional insight an economist brings to the analysis pales in comparison to the experience itself.

Who Pays the Bill?

The government is the dominant payer of nursing home care, accounting for an estimated 61 percent of expenditures in 2001, the latest year for which figures are available (Levit et al. 2003; see Table 1). Medicaid picks up 47 percentage points of the government's outlay, with Medicare covering most of the rest, although Medicare reimbursement is limited almost exclusively to short-term rehabilitation after a hospital stay, say, for treatment of a stroke. Mainly through Medicare, the government accounts for slightly more than half of the nation's expenditures for home care, which also typically takes the form of rehabilitation following a hospital stay for an acute illness or injury.

Table 1. Long-Term-Care Financing in the United States, 2001

	Billions of dollars	
	Home care	Nursing home care
Private		
Out of pocket[1]	6.3	26.9
Private health insurance[2]	7.0	7.5
Other private payments	1.1	3.7
	14.4	**38.1**
Public		
Medicare	9.9	11.6
Medicaid	7.1	47.0
Other public payments	1.7	2.3
	18.7	**60.9**
Total	**33.2**	**98.9**

Note: Discrepancies in addition are due to rounding.
Source: Levit, et al. (2003)

[1] The out-of-pocket figures include Social Security paid to beneficiaries, then paid back to Medicaid to reduce Medicaid's portion of the cost of a nursing home stay. An estimated 40 percent of out-of-pocket payments are from this source.

[2] This includes the bills paid by ordinary health insurance for the disabled victim of an auto accident, for example. It thus exaggerates the size of the long-term-care insurance market.

The extent to which long-term care is dependent on public financing depends on what is measured, and how. Most important is whether one distinguishes between long-term custodial care, for which Medicaid is the principal payer (not by design, but by default), and short-term rehabilitation, which is financed almost entirely as was intended when Medicare was introduced in the 1960s.

However one defines long-term care, it is clear that Medicaid is the dominant payer. That is certainly true of the portion of nursing home care, almost all of it custodial, for which virtually no private financing mechanism exists. Two out of three nursing home residents receive Medicaid, which pays approximately 80 percent of the cost of care as measured by resident-days (Moses 1999). Thus a large majority of the institutionalized disabled elderly receive care funded by a program intended for welfare

recipients and governed by traditional welfare rules, such as those stipulating asset and income limits. Only about 5 percent of the total cost is paid by insurance; the rest, out of pocket. Medicaid in effect has become a nearly universal form of long-term-care insurance, albeit with strict asset and income limits.

The official figures in the table, it should be noted, exaggerate both private insurance and out-of-pocket payments. The first includes benefits provided by ordinary health insurance coverage for the care of people disabled by automobile accidents, for example. The second includes, for instance, Social Security payments to elderly individuals, which then revert to Medicaid. The key things to keep in mind are that Medicaid pays 80 percent of the bill; few families are sufficiently well-heeled to pay out of pocket; and the insurance market is undeveloped-which comes as no surprise, considering how easy it is to qualify for Medicaid when admitted to a nursing home and how easy it is to find a lawyer who will help accomplish that.

The Consequences of a Welfare Model

The first consequence of this funding system is that almost one-fourth of the Medicaid budget is diverted from the acute-care needs of the indigent population (Levit et al. 2003, 158). Some states provide extensive coverage to the indigent, but this is hardly true of the nation as a whole. In parts of the South and West, the qualifying income levels are especially low. Congress and the states have had the opportunity to raise the standards, to finance both the acute-care needs of the poor and the nursing home care of qualifying frail elderly. However, having the opportunity and taking it are two different things when the nation's accounts tend toward large deficits, as they have except during the late 1990s.

Second, Medicaid financing of long-term care yields two-tier care. Nursing homes are often unwilling to accept Medicaid recipients (or those who are unlikely to remain private payers for long), except when they can bill Medicare for rehabilitation services. The admission process at many of the best-run institutions is grounded not in need, but in the ability to pay. Because of long-standing budget constraints, Medicaid typically pays 20 to 30 percent less than a private-pay resident-and often as much as 50 percent less. It is a simple business decision to accept the private payer, especially since decades of "certificate of need" regulation, an important supply limitation, have kept nursing homes operating at or close to capacity. We all have to be grateful for those religious institutions that do not operate for profit, but even they are hard pressed to accept Medicaid beneficiaries. God, after all, does not pay the utility bill, or meet the payroll at the end of the week.

The problem is not only two-tier care, but also second-rate care. Certainly there are many fine nursing homes, staffed by heroes and saints. But reimbursement rates, even in relatively high-income states like New York, cannot possibly provide for first-rate care. There are too few aides and nurses for too many residents; too few porters for too many residents; and too little physical therapy to accommodate too many residents. Indeed, no physical therapy is offered unless the patient's prognosis points to improvement in the impaired skill. Thus, no reimbursement is available if the aim is merely to prevent the skill-ambulation, for example-from atrophying. So atrophy it does.

Nursing homes strive not to provide first-rate care in any idealized sense, but care that is achievable within the payment limits of the state and federal governments. Such care requires countless compromises: chairs that recline too much for residents to get out of easily (also a threat to ambulation); wheelchairs that, however uncomfortable, are efficient for transporting residents around the building; lift contraptions that, however frightening to residents, ease their transfer from bed to chair. There is only so much even heroes and saints can do on a shift.

The final consequence of a welfare model for long-term care is the creative accounting it encourages. Limits on assets and income, a necessary part of any welfare mechanism, are easily met with the help of elder-care lawyers, who abound in high-income states like New York. How many of us have friends who could not imagine admitting that they cheat on their taxes but who would willingly tell us, "Mom turned over the house and the bank account to me on the advice of a lawyer"? Is this, as the elder-care lawyers claim, perfectly legitimate estate planning? Or is it, as many of the rest of us would claim,

welfare fraud?

In all too many cases, Medicaid has become a guarantee of an inheritance. It is one thing for the elderly to "spend down" their resources and qualify legitimately for welfare funds. It is quite another to transfer assets in order to qualify. Indeed, it is hard to conceive of a system more conducive to abuse of the elderly. Surrendering assets to children robs the elderly not just of their assets, but of financial independence itself. Worse, these machinations lead to undue institutionalization; once their assets are transferred, the elderly are impoverished and thus eligible for Medicaid.

The financial burden that such a system-relying heavily on welfare and on out-of-pocket payments-imposes on a spouse remaining in the community is also unwholesome. To be sure, the income and asset limits for a nursing home resident's spouse are significantly higher than they are for, say, an institutionalized widow or widower (whose monthly allowance barely covers a few magazine subscriptions and a haircut). New York State, for example, allows spouses to keep about $2,200 per month of income; some states, such as Alabama, use the federally mandated minimum spousal income of $1,492 (CMS 2003). Spouses can keep half of a couple's financial assets, up to a maximum of $90,660 (CMS 2003). Even these higher limits, however, make independent living difficult. The caps often lead to "spousal refusal"-a way of getting Medicaid for a spouse in need of nursing home care without meeting the asset and income limits. This is an understandable response-especially for relatively young spouses who are still employed. No such financial responsibility is imposed on a son or daughter, or even on a parent with a disabled adult child. These, however, are ethical issues beyond my brief.

The Impediments to a Solution

One of the most distressing aspects of a welfare model is that it undermines an insurance model for which long-term care is ideally suited. Insurance makes sense for low-probability, high-consequence events. Two out of five people over the age of 65 spend some time in a nursing home, but most of them come and go in a matter of months for rehabilitation or other short-term needs (Kemper and Murtaugh 1991, as cited in Moses 1999). With Medicare the payer in most of those cases, the insurance is already in place. One out of 10 elderly will require at least five years of nursing home care. Few families would be able to meet this expense-the accompanying high-consequence event for which insurance was designed.

Why the insurance market for long-term institutional care has failed to develop is no mystery: Medicaid can be relied on in the vast majority of cases if and when the need arises. The nursing home bills will be paid by government, and the bills will not eat into the elderly person's legacy. So why incur years of premiums for private insurance when, with a bit of planning, government will be the insurer? Moreover, polling data reveal that many people incorrectly believe Medicare extends to long-term care.

The cost of insurance is also higher than it ought to be-another impediment to the growth of the market. Selling costs, in particular, are high, a result of an underdeveloped market and, in a catch-22, a cause of it. What is more, the long-term-care insurance market faces problems common to any insurance system: adverse selection (the tendency of those most apt to call on the insurance to apply) and moral hazard (the temptation to take advantage of coverage once it has been purchased), both of which raise premiums.

The life cycle makes for adverse selection. Long-term-care insurance is naturally at or near the bottom of the priority list for young and even middle-aged people. As a result, the insurance pool is disproportionately drawn from people whose possible need for long-term care is not far over the horizon. Ideally, insurance would draw resources from those who would likely never avail themselves of it.

The decision to enter a nursing home, which is often in the hands of sons and daughters rather than the elderly themselves, introduces moral hazard. With their inheritances at stake, many would not decide to have their parents pay privately for nursing home care, unless insurance proceeds could be tapped.

Clearly, moral hazard is rife in Medicare reimbursement for rehabilitation services at nursing homes. One can predict, to the day, when a patient will return home: the day full out-of-pocket payments must begin.

A subsidiary question is whether the United States should develop a public insurance system, as much of Europe has done. Social insurance has the virtue of low administrative costs; even so, payroll or other taxes would have to rise very sharply to fund a public program. Wiener, Illston, and Hanley (1994) have estimated that meeting long-term-care needs publicly would require an 8 percent payroll tax at the peak of need for the baby boom generation in its old age: half of what Social Security and Medicare together cost today. This levy would come on top of the added payroll taxes both of those social insurance systems need to remain solvent in the face of the coming demographic bulge. A new public insurance system for long-term care, moreover, is unlikely to have priority over extending health insurance to the 40 million Americans now without it.

Private insurance would be similarly costly. The system must become universal to deal effectively with adverse selection, in particular. That, however, would require subsidies to many families. Whatever the split between public and private payments to fund a universal system of long-term care, the overall cost will not be materially different. One way or another, the doubling of the population of over-85-year-olds expected over the next 30 years will be very expensive for society as a whole.

Fixing the System

In an ideal world, the best solution would be to have Medicare pay for the early use of long-term care, extending the principle of Medicare payment for some short-term services. Little distinction of any economic relevance exists between acute care and chronic care, especially for those who suffer from multiple problems of aging.

Longer-term stays in a nursing home would be covered by private insurance, subsidized by tax credits scaled to income to make premiums affordable (Cadette 2000). The same caveat about universal insurance applies here too, however: Long-term-care coverage will remain on the back burner until the nation addresses the issue of the uninsured working poor.

In the meantime, the government should tighten Medicaid eligibility by lengthening the period that applicants must wait for coverage after transferring assets to their heirs. As long as the nation is unwilling to mandate private coverage for long-term care and subsidize it, or unwilling to institute social insurance, any effort to shift to an insurance model will be hamstrung by the ready availability of public aid. The object is not to deny needed support to the disabled elderly, but to make it more costly for people to rely on Medicaid in the first instance.

There is ample time to create a financing structure that is more equitable and efficient than the current system. Costs for long-term care are not projected to rise especially rapidly for quite a few years, and the federal government (ultimately, the taxpayer) is already the major payer. Eventually, though, the nation must be ready to cope with a quantum jump in the demand for long-term care and to finance it in a sensible way.

A Personal Perspective

My interest in this subject, as I mentioned above, is not merely academic. My mother died after spending several years at one of the best nursing homes in the region: Ozanam Hall of Queens, which is run by the Carmelite Sisters. Their commitment to the care of the aged and infirm is as strong as one can find. The staff at the home, for the most part, shares that commitment. Even so, my mother's care was deficient in many ways. The deficiency was in the resources, not in how they were used. How does a nurse's aide bathe, feed, and tidy up (a euphemism if ever there was one) nine or 10 residents with advanced dementia-and hug them too? How do even heroes and saints do a job so demanding?

The other troubling issue is the intersection of dementia and the accompanying illnesses and injuries that require acute care. This combination often entails round-trip after round-trip, from hospital to nursing home and back: To what end? At what cost, not just to society but to my mother herself, whose prognosis was poor from the beginning? I faced a constant struggle to secure palliative care, as opposed to what I viewed as aggressive intervention.

Sheila Hale, the widow of distinguished British historian Sir John Hale, has written a powerful book, The Man Who Lost His Language, about her husband's aphasia following a massive stroke. An aging population, she writes, is being served by a medical profession that is far more comfortable dealing with illnesses that can be easily treated with drugs, technology, or surgery. Speech therapy, she goes on to say, is left to inadequately trained and inexperienced staff, although-for her husband at least-it represented a greater therapeutic challenge.

As Hale reminds us, meeting long-term-care needs will grow even more difficult as the 65-year-olds of the baby boom generation become 85-year-olds. To be sure, Hale was writing about the United Kingdom's National Health Service. Nonetheless, as I see it, the challenge is also unmet here. It was, in my mother's case, left in the hands of Caribbean women who, however lovingly they cared for her, did so with wholly inadequate resources.

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