APPENDIX B - HEALTH STATUS AND EXPENDITURES OF THE ELDERLY AND BACKGROUND DATA ON LONG-TERM CARE

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HEALTH STATUS

Although the health status of the elderly has improved in recent decades, many elderly persons have conditions that require medical and long-term health care. Most persons 65 years or older have some form of health insurance. About 97 percent are covered by Medicare or Medicaid, and most have supplementary coverage. This appendix reports on the health status, health care expenditures, supplementary insurance, and long-term care insurance of the elderly.

By various measures, the health status of the elderly population has been gradually improving over the years. For example, life expectancy at age 65 has increased from 13.9 years in 1950 to 17.9 years in 2000 (Table B-1). The overall trend since the early 20th century has been an upward one. Improvements in life expectancy, as measured by declines in mortality rates, have been greater for females than for males. Improvements for blacks have been greater than for whites; however, blacks' life expectancy at birth was still almost 6 years less than that for whites in 2000. Some morbidity indicators, such as the prevalence of high blood pressure (hypertension) and high serum cholesterol, improved among those aged 65-74 years in the 1970s, 1980s and early 1990s (Table B-2). However, while serum cholesterol readings have continued their downward trend, the data for 1999-2000 show that the gains have been reversed for hypertension. More than two-thirds of both men and women aged 65-74 have elevated blood pressure. Furthermore, the proportion of overweight seniors has increased markedly. Under the definition for overweight that was adopted in 1998 by the National Institutes of

Health (National Heart, Lung, and Blood Institute, 1998), the proportion of overweight seniors has climbed from about 55 percent in the 1971-74 time period to over 70 percent for females and over 77 percent for males in the 1999-2000 time period. Within that group is a large number of people who are considered obese (33 percent of men and nearly 39 percent of women aged 65-74).

TABLE B-1--LIFE EXPECTANCY AT BIRTH AND AT 65 YEARS OF AGE, BY SEX AND RACE, SELECTED YEARS 1950-2000

[Remaining life expectancy in years]

Year	At Birth					At 65 Years		
	Both Sexes	Male	Female	White	Black	Both Sexes	Male	Female
1950[1]	68.2	65.6	71.1	69.1	60.8	13.9	12.8	15.0
1960[1]	69.7	66.6	73.1	70.6	63.6	14.3	12.8	15.8
1970	70.8	67.1	74.7	71.7	64.1	15.2	13.1	17.0
1980	73.7	70.0	77.4	74.4	68.1	16.4	14.1	18.3
1990	75.4	71.8	78.8	76.1	69.1	17.2	15.1	18.9
1991	75.5	72.0	78.9	76.3	69.3	17.4	15.3	19.1
1992	75.8	72.3	79.1	76.5	69.6	17.5	15.4	19.2
1993	75.5	72.2	78.8	76.3	69.2	17.3	15.3	18.9
1994	75.7	72.4	79.0	76.5	69.5	17.4	15.5	19.0
1995	75.8	72.5	78.9	76.5	69.6	17.4	15.6	18.9
1996	76.1	73.1	79.1	76.8	70.2	17.5	15.7	19.0
1997	76.5	73.6	79.4	77.1	71.1	17.7	15.9	19.2
1998	76.7	73.8	79.5	77.3	71.3	17.8	16.0	19.2
1999	76.7	73.9	79.4	77.3	71.4	17.7	16.1	19.1
2000	76.9	74.1	79.5	77.4	71.7	17.9	16.3	19.2

[1]Includes deaths of nonresidents of the United States in the 1950 and 1960 data.

Source: National Center for Health Statistics (2002a, Table 28).

Among the elderly, the needs for medical and long-term care services are substantial and growing. Many of the elderly have one or more chronic conditions, many of which give rise to the need for continuing health care. Table B-3 shows the prevalence of several common chronic conditions among the elderly. About one-third report having heart disease, nearly 37 percent have arthritis, and 18 percent report some form of cancer. Over 40 percent report trouble with their hearing, and 18 percent have trouble with their vision, even with correction. The prevalence of many chronic conditions is directly related to age and inversely related to financial status. (Cancer and hearing trouble are exceptions, being reported by more people with higher incomes.)

TABLE B-2--SELECTED HEALTH STATUS INDICATORS FOR PERSONS 65-74 YEARS OF AGE, BY SEX, SELECTED PERIODS 1971-2000

[Percent of population]

Health Status Indicator	Male				Female			
	1971-74	1976-80	1988-94	1999-00	1971-74	1976-80	1988-94	1999-00
Hypertension[1]	67.2	67.1	57.3	68.3	78.3	71.8	60.6	73.4
High serum cholesterol	34.7	31.7	21.9	19.2	57.7	51.6	41.3	37.4
(Mean serum cholesterol level,[2] in mg/dL)	226	221	212	210	250	246	233	229
Overweight[3]	54.6	54.2	68.5	77.2	55.9	59.5	60.3	70.1
Obesity[3]	10.9	13.2	24.1	33.4	22.0	21.5	26.9	38.8

[1]Hypertension or elevated blood pressure is defined as either systolic pressure of at least 140 mmHg or diastolic pressure of at least 90 mmHg or both. If the respondent is taking antihypertensive medication, he or she is considered hypertensive.

[2]High serum cholesterol is defined as greater than or equal to 240 mg/dL (6.20 mmol/L). Risk levels were defined by the Second Report of the National Cholesterol Education Program Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults. National Institutes of Health, September 1993.

[3]Overweight is defined as body mass index (BMI) greater than or equal to 25 kilograms/meter, and obesity is defined as BMI greater than or equal to 30 kilograms/meter. The percent of persons with obesity is a subset of the percent who are overweight.

Note-Data are based on measured height and weight of a sample of the civilian, non-institutionalized population.

Source: National Center for Health Statistics (2002a, Tables 68, 69, 70).

Self-assessed health is a common method used to measure health status, with responses ranging from excellent to poor. Over 73 percent of elderly people living in the community describe their health as excellent, very good, or good; only 27 percent report that their health is fair or poor (Table B-4). Men are slightly more likely than women to report very good or excellent health.

Family income is directly related to elderly people's perception of their health. In 1998, about 45 percent of older people with incomes over $20,000 described their health as excellent or very good, while only 27 percent of those with incomes less than $20,000 reported excellent or very good health (National Center for Health Statistics (NCHS), unpublished data).

Surveys on long-term care indicate that rates of chronic disability among the elderly have declined significantly (Manton, 2001). Some demographers, in looking at the reductions in the projected percentage of those 65 and above who are disabled, are predicting that older people will not only have increasing longevity, but less dependency in later life. Others caution, however, that more research is needed to understand the causes of these improvements and the implications for future health care costs and demand for services (Freedman, 2002).

TABLE B-3--SELECTED REPORTED DISEASES AND CONDITIONS AMONG ELDERLY PERSONS, BY AGE AND POVERTY STATUS, 1998

[Percent of population]

Condition	All elderly	Age		Poverty status[2] (65+ years)		
		65-74	75+	Poor	Near poor	Not poor
Heart disease	32.0	28.2	37.0	38.3	34.7	32.3
Stroke	8.3	6.9	10.0	10.9	10.2	7.5
Emphysema	5.1	5.0	5.1	7.1	6.4	4.2
Asthma	7.8	8.3	7.1	11.7	9.3	7.8
Sinusitis	15.4	17.0	13.5	17.5	17.3	14.3
Cancer	17.8	16.5	19.5	14.7	16.2	20.1
Diabetes	13.2	14.3	12.5	20.5	15.3	12.3
Ulcers	13.7	13.1	14.4	17.1	15.8	14.2
Arthritic symptoms	36.8	34.4	40.3	46.5	44.8	35.4
Hearing trouble[3]	41.3	34.1	50.4	40.6	43.4	42.9
Vision trouble[4]	18.0	13.5	23.7	26.3	23.8	15.8

[1]Treatment of unknown values (responses coded as 'refused,' 'don=t know,' or 'not ascertained') for the conditions above: the unknowns are included in the denominators when calculating percents for the AAll elderly@ column, but are not included in the denominators when calculating percents for the AAge@ and APoverty status@ columns. The overall number of unknowns is quite small.

[2]Poverty status is based on family income and family size using the U.S. Census Bureau=s poverty thresholds. APoor@ persons are defined as below the poverty threshold. 'Near poor' persons have incomes of 100 percent to less than 200 percent of the poverty threshold. 'Not poor' persons have incomes that are 200 percent of the poverty threshold or greater.

[3]Respondents were asked about their hearing without a hearing aid (includes those responding 'a little trouble,' 'a lot of trouble,' or 'deaf.')

[4]Respondents were asked if they had trouble seeing even when wearing glasses or contact lenses.

Source: National Center for Health Statistics (2002b, Tables 1-8, pp. 13-28 and Tables 11-12, pp. 33-36).

TABLE B-4--SELF-ASSESSED HEALTH STATUS OF THE ELDERLY, BY SEX, FAMILY INCOME, AND POVERTY STATUS, 1998

[In percent]

Characteristic	Self-assessed health status[1]				
	Excellent	Very good	Good	Fair	Poor
Sex:					
Men	14.8	24.4	34.6	18.4	7.9
Women	13.3	24.2	35.4	19.1	8
All persons 65+ years	13.9	24.3	35.1	18.8	7.9
Family income:					
Less than $20,000	10.3	17.0	36.9	24.6	11.2
$20,000 or more	17.3	27.9	34.9	14.6	5.3

TABLE B-4--SELF-ASSESSED HEALTH STATUS OF THE ELDERLY, BY SEX, FAMILY INCOME, AND POVERTY STATUS, 1998-continued

[In percent]

Characteristic	Self-assessed health status[1]				
	Excellent	Very good	Good	Fair	Poor
Poverty status:[2]					
Poor	7.3	17.4	31.7	28.1	15.6
Near poor	9.7	20.4	31.9	25.1	12.9
Not poor	17.2	28.5	35.7	14.1	4.4

Note-Percentages may not add to 100 percent due to rounding. Data are based on household interviews of the civilian, non-institutionalized population.

[1]The categories related to this concept result from asking the respondent, 'Would you say your general health is excellent, very good, good, fair, or poor?' As such, it is based on the respondent's opinion and not directly on any clinical evidence. Persons who refused to answer or said they did not know are excluded from the calculations.

[2]Poverty status is based on family income and family size using the U.S. Census Bureau=s poverty thresholds. 'Poor' persons are defined as below the poverty threshold. 'Near poor' persons have incomes of 100 percent to less than 200 percent of the poverty threshold. 'Not poor' persons have incomes that are 200 percent of the poverty threshold or greater.

Source: National Center for Health Statistics (unpublished special data run, based on 2002b, Table 21, pp. 57-58).

CAUSES OF DEATH FOR THE ELDERLY

Table B-5 shows the 10 leading causes of death for three subgroups of the older population. In the United States, nearly two-thirds (63 percent) of elderly persons die from heart disease, cancer, or stroke. Heart disease was the major cause of death among the elderly in 1950, and remains so today despite rapid declines in age-adjusted death rates from heart disease that are due to improvements in treatments as well as lifestyle changes. The death rate for cancer among the elderly, however, rose between 1950 and 1995, due especially to increases in lung cancer deaths; since 1995, the rate has decreased slightly (NCHS, 2002a, pp. 52-53, 69). In 2000, heart disease still accounted for 33 percent of all deaths among persons 65 and older, while cancer accounted for 22 percent of all deaths in this age group. The third leading cause of death among the elderlyBstroke (cerebrovascular disease)Bhas been decreasing over the past 40 years. In 2000, cerebrovascular disease accounted for only 8 percent of all deaths in the 65 and older age group.

Alzheimer's disease is now the seventh leading cause of death for older people. Alzheimer's has only been classified as a unique cause of death since 1979. Reported death rates have increased rapidly as the diagnosis has gained more acceptance and as diagnostic procedures changed. Recent large increases in the death rate in the 1998-2000 time period are hard to interpret because of changes to the coding and selection rules under the International Classification of Diseases (NCHS, 2002c). New data indicate that Alzheimer's affects approximately 4.5 million Americans at present, including about 1 in 10 persons over 65 and nearly half of those over age 85 (Alzheimer=s Association, 2003). Death rates from Alzheimer's are also highly age related (NCHS, 2002c). Presence of Alzheimer's

may be masked by inability to confirm the diagnosis except by autopsy of brain tissue, although new diagnostic tools are being developed. Future morbidity and mortality from Alzheimer's disease will increase as the population continues to age unless new treatments or a cure are found. By 2050, an estimated 13.2 million Americans could have the disease (Alzheimer=s Association, 2003).

TABLE B-5--DEATH RATES FOR LEADING CAUSES OF DEATH AMONG OLDER PEOPLE, BY AGE, 2000

[Death rates per 100,000 population in age group]

Rank	Cause of Death	Age			
		65+	65-74	75-84	85+
1	Diseases of the heart	1,707	674	1,787	5,849
2	Malignant neoplasms	1,128	826	1,341	1,796
3	Cerebrovascular diseases	426	130	463	1,568
4	Chronic lower respiratory diseases	306	172	388	640
5	Influenza and pneumonia	168	40	161	734
6	Diabetes mellitus	151	92	180	316
7	Alzheimer's disease	141	19	140	659
8	Nephritis, nephrotic syndrome, nephrosis	90	38	101	274
9	Accidents (unintentional injuries)	89	42	96	270
10	Septicemia	71	31	81	213
All other causes		898	364	951	3,003
All causes		5,175	2,429	5,688	15,322

Source: National Center for Health Statistics (2002d, Table 1, pp. 14-15, and 2002c, Table 11, p. 33).

SUPPLEMENTING MEDICARE COVERAGE

Most beneficiaries depend on some form of private or public coverage to supplement their Medicare coverage (Table B-6). In 2000, only about 13 percent of beneficiaries relied solely on the traditional fee-for-service Medicare program for protection against the costs of care; an additional 13 percent were enrolled in managed care organizations. (See Appendix E for a discussion of Medicare+Choice). The majority of the Medicare population (56 percent in 2000) have private supplemental coverage. This private insurance protection may be obtained through a current or former employer (29 percent in 2000). It may also be obtained through an individually purchased policy, commonly referred to as a "Medigap" policy (23 percent had these plans in 2000). Some persons have both (4 percent in 2000). In addition, a smaller percentage (about 16 percent in 2000) have Medicaid coverage; a small group (2 percent in 2000) have supplemental coverage from one of a variety of other public sources (such as the military).

Employer-Based Policies

Employers may offer their retirees health benefits. Several surveys have attempted to quantify the percentage of employers offering this coverage. Since

each survey uses a different database, the numbers differ somewhat. However, all show that the number offering such plans has declined in recent years.

TABLE B-6--TYPES OF SUPPLEMENTAL HEALTH INSURANCE HELD BY MEDICARE BENEFICIARIES, 2000
[In percent]

Type of Coverage	Percent
Medicare Only	26
Fee-for-Service	13
Managed Care	13
Private Coverage	56
Employer-sponsored	29
Medigap	23
Both	4
Public coverage	18
Medicaid	16
Other	2
Total	100

Note-Medicaid includes qualified Medicare beneficiaries (QMBs) and specified low-income Medicare beneficiaries (SLIMBs).
Source: Centers for Medicare and Medicaid Services. Program Information on Medicare, Medicaid, SCHIP and other programs of the Centers for Medicare and Medicaid Services, chart book, June 2002 edition.

A survey by Mercer shows that over a 10-year period (1993-2002) the number of employers (with over 500 employees) offering health plan coverage to retirees (both current and future retirees) under age 65 fell from 46 percent to 29 percent, while the number providing coverage to Medicare-eligible retirees fell from 40 percent to 23 percent. (Mercer)

A joint study done by The Kaiser Family Foundation and Health Research and Educational Trust (HRET) shows similar trends. From 1998 to 2003, the percentage of large employers (with 200 or more employees) offering coverage to all retirees dropped from 66 percent to 38 percent. Of those offering retiree coverage in 2003, 93 percent offered coverage to early retirees while 78 percent offered coverage to Medicare age retirees. (Kaiser and HRET).

A 2002 survey of private firms with 1,000 or more workers by Kaiser and Hewitt Associates (Kaiser and Hewitt) showed that 91 percent of these employers offered retiree coverage. Of those offering benefits, 74 percent offered new retirees under age 65 (defined as those retiring on or after January 1, 2002) a choice of two or more health plans; 60 percent offered a choice of two or more plans to new retirees age 65 and over. The two most common types of plans offered to pre-65 retirees were preferred provider organizations (PPOs) and health maintenance organizations (HMOs). For age 65 and over retirees, the two most common plan options were indemnity (or managed indemnity) followed by Medicare+Choice/HMO plans. The surveyed firms made substantial changes in recent years in response to rising costs. Forty-four percent increased retiree contributions to premiums, 36 percent increased cost-sharing for retirees; 13 percent

terminated health benefits for future retirees; and 7 percent shifted to a defined contribution approach. Conversely 17 percent reported adding benefits or improving coverage.

Medigap

Beneficiaries with Medigap insurance typically have coverage for Medicare=s deductibles and coinsurance; they may also have coverage for some items and services not covered by Medicare. Individuals who first purchase a Medigap policy on or after July 30, 1992, select from one of 10 basic standardized plans, though not all 10 plans are offered in all states. The 10 plans are known as Plan A through Plan J. Plan A covers a basic package of benefits. Each of the other nine plans includes the basic benefits plus a different combination of additional benefits. Plan J is the most comprehensive. A change authorized by the Balanced Budget Act of 1997 (BBA 97) added two high deductible plans to the list of 10 standardized plans. With the exception of the high deductible feature ($1,650 in 2003), the benefit packages under the high deductible plans are the same as under Plan F or Plan J. Reportedly, few insurers are offering these high deductible plans.

Only three of the standardized plans, Plans H-J, offer prescription drug coverage. All three plans impose a $250 drug deductible. Plans H and I cover 50 percent of the next $2,500 in costs up to a maximum benefit of $1,250 ($2,750 total spending). Plan J covers 50 percent of the next $6,000 in costs up to a maximum benefit of $3,000 ($6,250 total spending). The premiums for these plans are higher than those for the other seven Medigap plans, in large measure due to the drug coverage.

There is wide variation in Medigap premiums for both drug and non-drug policies nationwide. This reflects a number of factors including differences in the benefits of Plan A through Plan J, differences in medical underwriting practices, and differences in pricing structures. Periodically, Weiss Ratings, Inc., under contract with CMS, reports on its inventory of Medigap premiums for 65-year old males (Table B-7). Over the 2-year period 1998-2000, the average premium increases were 15.5 percent for policies without drug coverage compared to 37.2 percent for policies with coverage. The rate slowed substantially in 2002, with only a 2.4 percent increase recorded for all policies over the previous year. For all 3 years, premiums, and premium increases vary greatly by location.

The law contains certain requirements which guarantee the ability of beneficiaries to enroll in Medigap plans under certain specified conditions. These guaranteed issue provisions, outlined below, were significantly expanded by three recent laws: BBA 1997, the Balanced Budget Refinement Act of 1999 (P.L.106-113), and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000, P.L.106-554).

Six-Month Open Enrollment-- Federal law establishes an open enrollment period for the aged. All insurers offering Medigap policies are required to offer open enrollment for 6 months from the date a person first enrolls in Part B (generally when the enrollee turns 65). During this time an insurer cannot deny the issuance, or discriminate in the pricing of a policy because of an individual=s

medical history, health status or claims experience. This requirement is known as guaranteed open enrollment. If an individual applies for a Medigap policy after the open enrollment period, the company is permitted to use medical underwriting. This means that the company can use an individual=s medical history to decide whether or not to accept the application and how much to charge for the policy.

TABLE B-7--AVERAGE NATIONWIDE MEDIGAP PREMIUMS FOR A 65-YEAR OLD MALE, 1998, 2000, AND 2002

Plan	1998 average	2000 average	2002 average
Without drug coverage:			
A	$631	$766	$864
B	875	1,026	1,139
C	1,065	1,239	1,372
D	900	1,050	1,218
E	963	1,107	1,172
F	1,164	1,301	1,432
G	1,071	1,175	1,285
With drug coverage:			
H	1,573	2,347	2,738
I	1,803	2,423	2,734
J	2,408	3,065	3,344

Source: (1) Weiss Ratings, Inc. *Prescription Drug Costs Boost Medigap Premiums Dramatically*. Press Release. March 26, 2001; and (2) Weiss Ratings, Inc. *Rate of Medigap Premiums Slows Dramatically in 2002*. Press Release, August 7, 2002 and information provided by Weiss.

There is no guaranteed open enrollment period for the non-aged disabled population. However, when a disabled person turns 65, that individual has the same open enrollment period as other aged persons.

Guaranteed Issue--The law guarantees issuance of specified Medigap policies (without an exclusion based on a pre-existing condition) for certain persons whose previous supplementary coverage was terminated. Guaranteed issue also applies to certain persons who elect to try out a Medicare+Choice plan. In these cases, individuals are guaranteed issue of specific Medigap plans (generally A, B, C, or F) that are sold to new enrollees by Medigap insurers in the state. The insurer is prohibited from discriminating in the pricing of such a policy on the basis of the individual=s health status, claims experience, receipt of health care or medical condition. This right must be exercised within 63 days of termination of other enrollment. Table B-8 summarizes the guaranteed issue protections of the law. It highlights the event that triggers these protections, the time period during which an affected individual can enroll in a Medigap plan, and the types of Medigap plans that are guaranteed.

TABLE B-8--GUARANTEED ISSUE PROTECTIONS

Current Coverage; Trigger Event	First Day to Apply for Medigap under Guaranteed Issue Provisions	Last Day to Apply for Medigap under Guaranteed Issue Provisions	Medigap Plans Guaranteed
Employee Benefits Plan			
An individual enrolled under a plan that provides benefits supplementing Medicare and the plan terminates or ceases to provide all such supplemental benefits	Date received notice of termination or cessation of benefits (in some cases this could be in a letter saying that a claim has been denied because coverage has ended)	63 days later	A, B, C, or F
Medicare+Choice Plan			
A. Plan Leaves Area or Stops Providing Coverage. An individual enrolled with a Medicare+Choice plan[1] whose enrollment is discontinued because the plan is leaving the Medicare program or is no longer providing coverage in the individual=s service area (See also C and D which may apply in these cases)	Date received termination notice	63 days after coverage ends	A, B, C, or F

TABLE B-8--GUARANTEED ISSUE PROTECTIONS-continued

Current Coverage; Trigger Event	First Day to Apply for Medigap under Guaranteed Issue Provisions	Last Day to Apply for Medigap under Guaranteed Issue Provisions	Medigap Plans Guaranteed
B. Enrollee Moves. The individual moves outside of the entity=s[1] service area	Date received termination notice	63 days after coverage ends	A, B, C, or F
C. Medicare+Choice Trial. An individual was: 1) enrolled in a Medigap policy; 2) subsequently terminated enrollment in that policy and enrolled in a Medicare+Choice organization[1] for the first time; and 3) then terminated enrollment with the Medicare+Choice organization within 12 months[2]	60 days before disenrollment date (except, in cases of involuntary termination, date of receipt of termination notice)	63 days after coverage ends	Former Medigap policy (If the same policy is no longer sold by the insurer, the guarantee is for plans A, B, C, or F)
D. Medicare+Choice Enrollment Upon Turning 65. An individual, upon turning 65 and becoming eligible for Part A, joins a Medicare+Choice plan and subsequently leaves the plan within 1 year[4]	60 days before disenrollment date (except, in cases of involuntary termination, date of receipt of termination notice)	63 days after coverage ends or end of 6-month open enrollment period, whichever is later	Any Medigap policy
E. Entity Fails to Meet Contract Obligations. The individual elects to disenroll with a Medicare+Choice organization[1] due to cause (for example, the marketing materials were misleading or quality standards were not met)	60 days before disenrollment date	63 days after coverage ends	A, B, C, or F

TABLE B-8--GUARANTEED ISSUE PROTECTIONS-continued

Current Coverage; Trigger Event	First Day to Apply for Medigap under Guaranteed Issue Provisions	Last Day to Apply for Medigap under Guaranteed Issue Provisions	Medigap Plans Guaranteed
Medigap			
A. Bankruptcy or Insolvency of Issuer. An individual enrolled under a Medigap policy if enrollment ceases because of the bankruptcy or insolvency of the issuer or because of other involuntary termination of enrollment and there is no provision under state law for continuation of such coverage	Earlier of the date that the notification of termination is received or the date the coverage ends	63 days after coverage ends	A, B, C, or F
B. Cause. The individual disenrolls because the issuer violated a material provision of the policy or materially misrepresented the policy=s provisions	60 days before disenrollment date	63 days after coverage ends	A, B, C, or F

[1] Also applies to 1) Programs of All-Inclusive Care for the Elderly (PACE) program (for persons 65 or older) that covers Medicare benefits and certain long-term care services; 2) Medicare managed care demonstration projects; and 3) Medicare SELECT plans if there is no provision under applicable state law for continuation or conversion of coverage under such policy.
[2] In general, the guarantee only applies if the individual was never previously enrolled in a Medicare+Choice or similar plan. However, special rules apply if an individual enrolls for the first time w.ith a Medicare+Choice organization and was in the plan less than 1 year before the plan left the program or stopped giving care in the area. In this case, the individual may enroll in another Medicare+Choice plan for up to 1 year and still keep the right to return to his or her old Medigap policy.
[3] Also applies to enrollees in a PACE program.
[4] Special rules apply if an individual enrolls with a Medicare+Choice organization and was in the plan less than 1 year before the plan left the program or stopped giving care in the area. In this case, the individual may enroll in another Medicare+Choice plan for up to 1 year and still keep the right to obtain any Medigap policy.
Source: Congressional Research Service.

Pre-Existing Condition Exclusions-- For purposes of Medigap, pre-existing conditions are defined as those diagnosed or treated during the 6 months immediately preceding the start of a Medigap policy. At the time insurers sell a

Medigap policy they are generally permitted to limit or exclude coverage for services related to a preexisting health condition. Such pre-existing condition exclusions cannot be imposed for more than 6 months. However, preexisting limitations may not be imposed at all in the following cases:

- Any individual who falls into one of the qualifying events categories discussed above under "Guaranteed Issue." These include persons whose previous coverage was involuntarily terminated or persons who elect to try out Medicare+Choice.
- During the first 6-month open enrollment period, if on the date of application, the individual had health insurance coverage meeting the definition of "creditable coverage" under the Health Insurance Portability and Accountability Act. (Note that the insurer may impose a pre-existing exclusion limitation if the individual did not have such creditable coverage.)
- An individual who met the pre-existing condition limitation in one Medigap policy. The individual does not have to meet the requirement under a new policy for previously covered benefits; however, an insurer could impose exclusions for newly covered benefits (for example for prescription drugs if not covered under the previous policy).

The prohibition applies to persons who had coverage under a prior policy for at least 6 months. If the individual has less than 6 months prior coverage, the policy must reduce the pre-existing exclusion by the amount of the prior coverage.

Medicaid

Some low-income aged and disabled Medicare beneficiaries are also eligible for full or partial coverage under Medicaid. Medicaid is a federal-state program which provides health insurance coverage to certain low-income individuals. Within broad federal guidelines, each state sets its own eligibility criteria, including income eligibility standards. Persons meeting the state standards are entitled to full coverage under Medicaid. Persons entitled to full Medicaid protection generally have all of their health care expenses met by a combination of Medicare and Medicaid. For these "dual eligibles," Medicare pays first for services both programs cover. Medicaid picks up Medicare cost-sharing charges and provides protection against the costs of services generally not covered by Medicare (such as long-term care). Perhaps the most important service for the majority of dual eligibles is prescription drugs. These dual eligibles typically have comprehensive coverage with only nominal cost-sharing.

Federal law specifies several population groups that are entitled to more limited Medicaid protection. These are qualified Medicare beneficiaries (QMBs), specified low income beneficiaries (SLIMBs), and certain qualified individuals. QMBs and SLIMBs are not entitled to Medicaid=s prescription drug benefit unless they are also entitled to full Medicaid coverage under their state=s Medicaid program. Qualifying individuals are never entitled to Medicaid drug coverage (because, by definition, they are not eligible for full Medicaid benefits).

The following are the three coverage groups:

- *Qualified Medicare Beneficiaries (QMBs)*--QMBs are aged or disabled persons with incomes at or below the federal poverty level. In 2003, the monthly level is $769 for an individual and $1,030 for a couple.[1] They must also have assets below $4,000 for an individual and $6,000 for a couple. QMBs are entitled to have their Medicare cost-sharing charges, including the Part B premium, paid by the federal-state Medicaid program. Medicaid protection is limited to payment of Medicare cost-sharing charges (i.e., the Medicare beneficiary is not entitled to coverage of Medicaid plan services) unless the individual is otherwise entitled to Medicaid.
- *Specified Low-Income Medicare Beneficiaries (SLIMBs)*--These are persons who meet the QMB criteria, except that their income is over the QMB limit. The SLIMB limit is 120 percent of the federal poverty level. In 2003, the monthly income limits are $918 for an individual and $1,232 for a couple.[2] Medicaid protection is limited to payment of the Medicare Part B premium (i.e., the Medicare beneficiary is *not* entitled to coverage of Medicaid plan services) unless the individual is otherwise entitled to Medicaid.
- *Qualifying Individuals (QI-1s)*--These are persons who meet the QMB criteria, except that their income is between 120 percent and 135 percent of poverty; the monthly income limit for QI-1 for an individual is $1,031 and for a couple $1,384. Medicaid protection for these persons is limited to payment of the monthly Medicare Part B premium.[3]

Other Coverage

Some beneficiaries with a military service connection may receive health insurance coverage through Department of Defense or Department of Veterans Affairs programs. P.L.106-398, the Defense department authorization bill for 2000 authorized a permanent comprehensive health care benefit for Medicare-eligible military retirees thereby making all military retirees eligible for health care within TRICARE, the military health care system, effective October 1, 2001. Under the law, Medicare pays first and TRICARE is the secondary payer, subject to a $300

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[1] The annual HHS poverty guidelines for 2003 are $8,980 for an individual and $12,120 for a couple; the monthly figures are $748 for an individual and $1,010 for a couple. The qualifying levels are higher because, by law, $20 per month of unearned income (rounded to the next dollar) is disregarded in the calculation. Sources: Department of Health and Human Services. Annual Update of the HHS Poverty Guidelines. Notice, *Federal Register*, vol. 68, no.26, February 7, 2003; and http://www.cms.hhs.gov/dualeligibles/rate.asp.

[2] This is calculated the same way as the QMB level. See preceding footnote.

[3] In general, Medicaid payments are shared between the federal government and the states according to a matching formula. However, expenditures under the QI-1 program are paid for 100 percent by the Federal government (from the Part B trust fund) up to the State=s allocation level. A State is only required to cover the number of persons which would bring its spending on these population groups in a year up to its allocation level. This temporary program, originally slated to end September 30, 2002, has been extended through March 31, 2004, by P.L.108-89. The program known as QI-2 terminated on September 30, 2002.

deductible. Previously, individuals lost their TRICARE eligibility when they became eligible for Medicare. The law also authorized, effective April 1, 2001, a comprehensive retail and mail order pharmacy benefit and a national mail order pharmacy benefit for all eligible beneficiaries. There are deductibles for use of non-network pharmacies and co-payments for pharmaceuticals received from the National Mail Order Pharmacy and from retail pharmacies.

Drug Coverage

Medicare does not cover most outpatient prescription drugs. Beneficiaries may have access to drug benefits through their managed care plan or supplemental health insurance plan. In 1998, 73 percent of the non-institutionalized Medicare population had drug coverage at some point during the year; the remaining 27 percent had no coverage. The likelihood that a beneficiary has prescription drug coverage varies by the source of coverage. Beneficiaries enrolled in HMOs were the most likely to have drug coverage while those in Medigap plans were the least likely to have such coverage. (See Table B-9.) It should be noted that Table B-9 shows the percentage of beneficiaries who had drug coverage at any point during 1998. Some beneficiaries do not, however, have drug coverage for the entire year. Further, the figures do not reflect the extent and depth of coverage which varies widely by source of coverage.

TABLE B-9--DISTRIBUTION OF NONINSTITUTIONALIZED MEDICARE BENEFICIARIES, BY TYPE OF SUPPLEMENTAL INSURANCE AND PRESENCE OF DRUG COVERAGE, 1998

[In percent]

Type of coverage [1]	With drug coverage	Without drug coverage
All persons	73	27
No supplemental coverage	0	100
Supplemental coverage		
Medicare HMO[2]	92	8
Medicaid[3]	89	11
Employer-sponsored	90	10
Medigap	43	57
All other	89	11

[1] Beneficiaries were classified by their primary health insurance and were counted in only one of the categories (in the hierarchical order as shown in the table for beneficiaries with more than one type).

[2] Includes persons receiving drug coverage through both their basic plans and optional coverage.

[3] The Medicaid number reflects the percentage of all persons on the Medicaid rolls, including the QMB-only and SLIMB-only population (who do not have drug coverage). If just the population with full Medicaid coverage were taken into account, the percentage should be closer to 100 percent.

Source: Poisal, John A., and Lauren Murray. Growing Differences Between Medicare Beneficiaries With and Without Drug Coverage. *Health Affairs*, v. 20, no. 2, March/April 2001.

In 1998, persons in higher income brackets were more likely to have drug coverage. This reflects the fact that these persons were more likely to have drug coverage through a former employer. Persons below poverty had coverage levels slightly higher than persons just above poverty. This reflects the fact that many individuals below poverty were eligible for full Medicaid benefits which include drug benefits. The lowest levels of coverage were for persons between 100 percent and 175 percent of poverty. These persons are the least likely to have access to employer-based coverage or Medicaid. The 1998 number reflects a slight improvement for the low-income population over previous years.

Medicare+Choice (M+C)--The percentage of M+C enrollees with access to prescription drug coverage has declined in recent years. In 1999, 65 percent of the Medicare population had access to at least one M+C coordinated care plan that included prescription drug coverage. In 2003, 50 percent of the Medicare population has access to such a plan. An additional 10 percent have access through preferred provider organizations demonstration projects and private fee-for-service plans. Among persons with access to M+C coordinated care plans, 87 percent in urban counties and 70 percent in rural counties have access to drug coverage. Beneficiaries can get M+C drug coverage through a basic plan or a plan with supplemental benefits. In 1999, 84 percent of M+C enrollees in coordinated care plans had drug coverage through their basic plans; the percentage dropped to 69 percent in 2003.

The scope of coverage available to beneficiaries has been declining. For example, more plans are limiting coverage to generic drugs only. In 2002, 30 percent of those with drug coverage in their basic plan only had coverage for generic drugs; this percentage increased to 44 percent in 2003. One-quarter of those with generic coverage only were subject to an annual cap (CMS, 2003).

Employer-Based Coverage-- Persons with employer-based coverage typically have coverage similar to that offered to current workers. The Kaiser/Hewitt survey of large employers (1,000 or more) showed that the vast majority of employers that offered retiree health benefits for those age 65 and over (96 percent) provided coverage for prescription drugs. Most (80 percent) offered the benefits as part of their retiree health benefits plan, while a small percentage (15 percent) offered coverage through a separate, employer-subsidized stand-alone drug plan. Only one percent offered an unsubsidized drug discount card or other program. The vast majority of those offering drug coverage provided unlimited drug benefits, while 11 percent had a separate drug benefit limit. Of those employers with the largest number of retirees 65 and over, 31 percent had design features specific to the drug benefit, such as a separate deductible or separate out-of-pocket maximum. Ninety-three percent of those large firms offering retiree drug benefits offered both retail and mail order coverage. Only 14 percent with a mail order option required enrollees to use mail order. Sixty-six percent of employers contract directly with a pharmacy benefit manager (PBM) to administer the plan that enrolls the largest number of age 65 and over retirees (Kaiser/Hewitt).

Prescription drug benefits represent a large part of plan expenses for retirees. As a result, many plans are taking actions to contain these costs. These include

imposing either a two-tiered cost-sharing structure (one payment for generic drugs and another for brand name drugs) or three-tiered cost-sharing structure (one payment for generic drugs, another for brand name drugs with no generic substitute and a third for brand-name drugs with a generic substitute).

Medigap--As noted previously, only 3 of the 10 standardized Medigap plans include drug coverage. A number of observers have concluded that only those persons who expect to actually utilize a significant quantity of prescriptions actually purchase such coverage. This is because there is a significant price difference between premiums for policies with drug coverage versus those for policies without drug coverage. This adverse selection tends to further drive up the premium costs.

One analysis of the Medigap market found that about 60 percent of policyholders had no drug coverage. This figure included the 90 percent of beneficiaries purchasing standardized plans (i.e., Plans A- J, first purchased on or after July 30, 1992). Three out of four Medigap policyholders with prescription drug coverage were in prestandard Medigap plans; many of these plans offer coverage that is even less generous than that available under standard plans. As of 2003, enrollees in prestandard plans are at least 76 years old. Since in most states Medigap insurers can deny issuance of Medigap policies after the open enrollment period at age 65, persons with prestandard policies who wish to change plans generally have no alternative except Plan A (if their current carrier is willing to sell them this) or Medicare+Choice (if a M+C plan is available in their area) (Chollet).

Medicaid--As noted previously, persons with full Medicaid coverage generally have access to a prescription drug benefit. However, QMB-only, SLIMB-only, and QI-1 beneficiaries do not have access to drug coverage through the Medicaid program.

State Pharmaceutical Assistance Programs--Some Medicare beneficiaries have coverage through state pharmaceutical assistance programs which provide financial assistance to low-income persons who do not qualify for Medicaid. The National Conference of State Legislatures (NCSL) reports that as of October 2003, 28 states had programs in operation, with some states having more than one program. The state programs vary substantially both in design and coverage. Most states had subsidy programs; while some states operated pharmaceutical discount programs for the purchase of prescription drugs. Virtually all states set income eligibility standards for their subsidy programs. Many subsidy plans required some level of beneficiary financial participation in the form of premiums, deductibles, copayments, or a combination of these. The level of coverage also varied among the States (NCHSL).

MEDICARE REIMBURSEMENT AND OUT-OF-POCKET LIABILITIES OF THE ELDERLY

Tables B-10 through B-12 illustrate for selected years how Medicare reimbursement, acute health care costs, and out-of- pocket liabilities of Medicare enrollees respectively have changed. The years chosen are 1975, 1980, 1985, 1990, 1995, 2000, and 2003. Constant 2003 dollar values were obtained using the

Consumer Price Index for All Urban Consumers (CPI-U). The fastest growing component of Medicare reimbursement is for benefits under the Supplementary Medical Insurance (SMI) Program. For SMI, reimbursements have increased at an average annual rate of 10.7 percent, while the growth in total Medicare costs (including enrollees' share of costs) is 8.7 percent (Table B-10). As a result, the share of SMI costs reimbursed by Medicare increases significantly over the period--from about 63 percent in 1975 to about 76 percent by 2003. The growth in Medicare's share is caused by the declining significance of the SMI deductible, so that more enrollees' costs are eligible for reimbursement.

TABLE B-10 -- REIMBURSEMENTS AND OUT-OF-POCKET COSTS UNDER MEDICARE, SELECTED CALENDAR YEARS 1975-2003

	1975	1980	1985	1990	1995	2000	2003	Annual Growth 1975-2003 (in percent)
[In millions of current dollars]								
Hospital Insurance								
Reimbursement	462	895	1,554	1,963	3,130	3,272	3,739	7.8
Copayments	34	66	118	186	263	290	326	8.4
Total	496	961	1,671	2,149	3,393	3,562	4,065	7.8
Supplementary Medical Insurance								
Reimbursement	180	390	768	1,304	1,823	2,381	3,134	10.7
Copayments	84	137	248	400	659	857	966	9.1
Balance-billing	22	56	87	68	11	6	9	-3.3
Total	286	583	1,104	1,772	2,493	3,244	4,108	10.0
Total Medicare Reimbursements	642	1,285	2,322	3,267	4,953	5,653	6,873	8.8
Total Costs Under Medicare	782	1,545	2,775	3,921	5,886	6,806	8,174	8.7
[In millions of constant 2003 dollars]								
Hospital Insurance								
Reimbursement	1,498	1,978	2,653	2,749	3,772	3,485	3,739	3.3
Copayments	111	146	201	261	317	308	326	3.9
Total	1,609	2,124	2,854	3,010	4,089	3,793	4,065	3.4
Supplementary Medical Insurance								
Reimbursement	583	861	1,312	1,826	2,197	2,536	3,134	6.2
Copayments	271	303	424	560	794	913	966	44.6
Balance-billing	72	125	149	96	13	7	9	-7.3
Total	927	1,289	1,885	2,483	3,004	3,455	4,108	5.5
Total Medicare Reimbursements	2,082	2,839	3,965	4,576	5,969	6,020	6,873	4.4
Total Costs Under Medicare	2,536	3,413	4,738	5,493	7,094	7,248	8,174	4.3
Percent of costs	82.1	83.2	83.7	83.3	84.2	83.1	84.1	0.1

Note- Values after 2000 are projected. The CPI-U was used to get constant dollars.
Source: Congressional Budget Office (2003).

In the Hospital Insurance (HI) Program, by contrast, the rate of growth in reimbursement is roughly comparable to the growth in enrollee's co-payment costs. Consequently, the share of HI costs reimbursed by Medicare was 93 percent in 1975 and 92 percent in 2003 (Table B-10). Overall, the share of costs reimbursed by Medicare has increased slightly. The percentage of costs paid by Medicare for

services covered under Medicare was 82 percent in 1975 and 84 percent in 2003 (Table B-10).

The share of costs paid directly by enrollees is shown in the third panel of Table B-11. Total direct costs (excluding premiums) plus Medicare reimbursement equals the total or 100 percent. In constant dollars, HI co-payments increased the most rapidly between 1975 and 1990. However, between 1990 and 2003, SMI co-payments and premium costs rose the most rapidly. In contrast, the cost to the enrollee from balance billing has decreased significantly since 1985--a direct policy result of the participating physician program and the imposition of lower limits on balance billing (Table B-12 for deductible amounts and monthly premium amounts under Medicare).

Enrollees spend a larger share of their income for Medicare's cost sharing and premium charges than they did in 1975 (Table B-11). In 1975, about 4.3 percent of enrollees' per capita income went to cover their share of acute health care costs under Medicare. By 1995, this figure had risen to 9.0 percent. The percentage declined to 6.6 percent in 2000, but rose to 8.4 percent in 2003.

TABLE B-11 -- ENROLLEE COSTS UNDER MEDICARE, SELECTED CALENDAR YEARS

[Incurred costs per HI or SMI enrollee]

	1975	1980	1985	1990	1995	2000	2003	Annual Growth 1975-2003 (in percent)
[In Current Dollars]								
HI copayments	34	66	118	186	263	290	326	8.4
SMI copayments	84	137	248	400	659	857	966	9.1
Balance-Billing	22	56	87	68	11	6	9	-3.3
Total direct costs	140	260	453	655	933	1,153	1,300	8.3
Premium costs	80	110	186	343	553	546	74	8.1
Total enrollee costs	220	370	639	998	1,486	1,699	2,005	8.2
Enrollee per capita income[1]	5,158	8,431	12,767	15,454	16,460	25,732	23,792	5.6
[In Constant 2003 Dollars]								
HI copayments	111	146	201	261	317	308	326	3.9
SMI copayments	271	303	424	560	794	913	966	4.6
Balance-Billing	72	125	149	96	13	7	6	-7.3
Total direct costs	454	574	773	917	1,124	1,228	1,300	3.8
Premium costs	261	244	318	481	667	581	704	3.6
Total enrollee costs	715	818	1,091	1,398	1,791	1,809	2,005	3.8
Enrollee per capita income[1]	16,721	18,628	21,799	21,646	19,837	27,402	23,792	1.3
[Percent of Costs Under Medicare Paid by Enrollees, by Source of Payment]								
HI copayments	4.4	4.3	4.2	4.7	4.5	4.3	4.0	-0.3
SMI copayments	10.7	8.9	8.9	10.2	11.2	12.6	11.8	0.4
Balance-Billing	2.8	3.7	3.1	1.7	0.2	0.1	0.1	-11.1
Total direct costs	17.9	16.8	16.3	16.7	15.8	16.9	15.9	-0.4
Premium costs	10.3	7.1	6.7	8.8	9.4	8.0	8.6	-0.6

TABLE B-11 -- ENROLLEE COSTS UNDER MEDICARE, SELECTED CALENDAR YEARS-continued

[Incurred costs per HI or SMI enrollee]

	1975	1980	1985	1990	1995	2000	2003	Annual Growth 1975-2003 (in percent)
Total enrollee costs	28.2	24.0	23.0	25.4	25.2	25.0	24.5	-0.5
Enrollee-Paid Costs as a Percent of Enrollee Per Capita Income[1]	4.3	4.4	5.0	6.5	9.0	6.6	8.4	2.5

[1] Tabulated from the Current Population Survey and other statistics of income data.

Note- Values after 2000 are projected. The CPI-U was used to get constant dollars.

Source: Congressional Budget Office (2003).

TABLE B-12 -- COPAYMENT AND PREMIUM VALUES UNDER MEDICARE, SELECTED CALENDAR YEARS 1975-2003

	1975	1980	1985	1990	1995	2000	2003	Annual Growth 1975-2003 (in percent)
[In Current Dollars]								
Hospital Insurance								
Hospital deductible	92	180	400	592	716	776	840	8.2
Supplementary Medical Insurance								
Annual deductible	60	60	75	75	100	100	100	1.8
Monthly premium[1]	6.70	9.20	15.50	28.60	46.10	45.50	58.70	8.1
[In Constant 2003 Dollars]								
Hospital Insurance								
Hospital deductible	298	398	683	829	863	826	840	3.8
Supplementary Medical Insurance								
Annual deductible	195	133	128	105	121	106	100	-2.3
Monthly premium[1]	21.72	20.33	26.46	40.06	55.56	48.45	58.70	3.6

[1] The 1980 SMI monthly premium amount is the average of values for the first and second halves of the year.

Note- Values after 2000 are projected. The CPI-U was used to get constant dollars.

Source: Congressional Budget Office (2003).

HEALTH CARE EXPENDITURES OF MEDICARE BENEFICIARIES

Personal health care spending for Medicare beneficiaries totaled $10,250 per person in 2000 (Table B-13). The figure was higher for the disabled - $13,247 per capita- than for the aged - $9,784 per capita.

Chart B-1 shows that spending by public payers accounted for 63.6 percent of spending for the Medicare population in 2000. Medicare, both fee-for-service and managed care, accounted for 50.3 percent, Medicaid 12.4 percent and the Department of Veterans Affairs 0.9 percent. Private spending accounted for 36.4 percent of total spending. Out-of-pocket spending by beneficiaries represented the

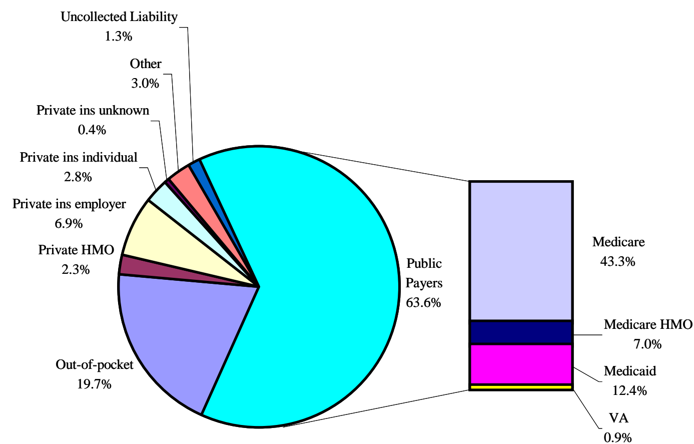
most significant portion of private spending. In fact, out-of-pocket spending by beneficiaries accounted to close to one fifth of total spending, Chart B-1.

TABLE B-13 -- PER CAPITA DISTRIBUTION OF TOTAL HEALTH EXPENDITURES OF MEDICARE BENEFICIARIES BY PAYER, 2000

	All ($)	Aged ($)	Disabled ($)	All (In percent)	Aged (In percent)	Disabled (In percent)
Total	$10,250	$9,784	$13,247	100.0	100.0	100.0
Out-of-pocket	2,018	2,065	1,719	19.7	21.1	13.0
Private HMO	235	146	801	2.3	1.5	6.1
Private ins employer	710	658	1,041	6.9	6.7	7.9
Private ins individual	288	317	96	2.8	3.2	0.7
Private ins unknown	43	49	0	0.4	0.5	0.0
Other	305	168	1,187	3.0	1.7	9.0
Uncollected Liability	135	128	178	1.3	1.3	1.3
Medicare	4,438	4,365	4,908	43.3	44.6	37.0
Medicare HMO	714	762	402	7.0	7.8	3.0
Medicaid	1,270	1,035	2,776	12.4	10.6	21.0
VA	97	90	137	0.9	0.9	1.0

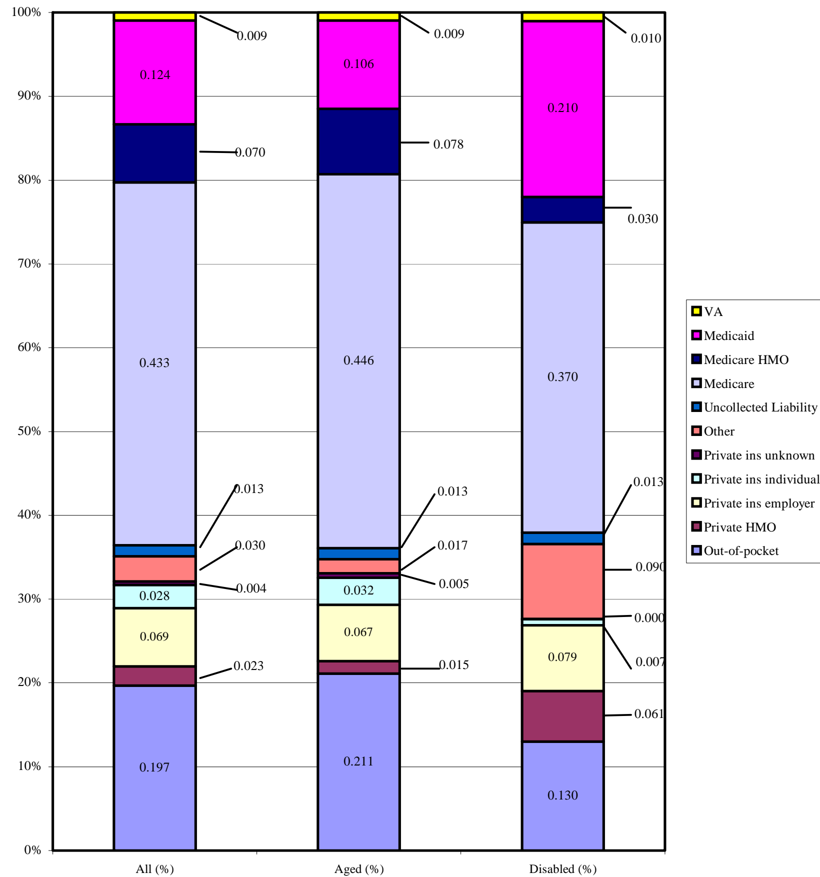
Note- Percentages may not sum to 100 due to rounding.
Source: CRS Calculations based on 2000 Medicare Current Beneficiary Survey.

CHART B-1--DISTRIBUTION OF EXPENDITURES OF ALL MEDICARE BENEFICIARIES BY PAYER, 2000



Note-Percentages may not sum due to rounding.
Source: Congressional Research Service, based on the 2000 Medicare Current Beneficiary Survey.

CHART B-2--DISTRIBUTION OF EXPENDITURES BY PAYER, TOTAL, AGED, AND DISABLED MEDICARE BENEFICIARIES, 2000



Note-Percentages may not sum due to rounding.
Source: Congressional Research Service, based on the 2000 Medicare Current Beneficiary Survey.

The contribution of different payer groups to total spending showed different patterns for the aged and disabled (Table B-13 and Chart B-2). While Medicare accounted for 52 percent of total spending for the aged, it represented only 40 percent of total spending for the disabled. Medicaid picked up almost twice as much of the costs for the disabled as for the aged (21 percent versus 11 percent).

Out-of-pocket costs accounted for 21 percent of total spending for the aged but only 13 percent for the disabled. Other private spending by insurers and managed care plans represented only 15 percent of total spending for the aged but 25 percent for the disabled. Spending by the Department of Veterans Affairs was comparable for both groups (1 percent of the total).

PROJECTED DRUG SPENDING

The Congressional Budget Office (CBO) has projected drug spending for Medicare beneficiaries for drugs not covered by the program. This includes spending by supplemental plans as well as beneficiaries' out-of-pocket costs. In March 2003, the estimate for the CY2003-2012 period was $1.6 trillion. (Any new Medicare benefit would pick up a portion of these costs.)

Over the CY2003-2012 period, median spending was estimated to increase from $1,390 in 2003 to $3,439 by 2013. Over the same 10-year period, mean spending was estimated to increase from $2,318 to $5,727. (Mean spending is higher than median spending because mean spending is highly influenced by the relatively small portion of the population with very high drug costs.) Projection increases in per capita spending over the period reflect a number of factors including price increases, utilization changes, and the inclusion of two high cost years (2011 and 2012, the first years when the baby boom generation becomes eligible for Medicare).

Drug spending is very unevenly distributed across Medicare beneficiaries. A relatively small proportion of the population accounts for a relatively large portion of total spending. CBO estimates that (excluding M+C enrollees), 10.3 percent of beneficiaries will have no drug spending in 2003. Slightly more than half (51 percent) of total drug spending will be for the 15.8 percent of the population spending $4,000 or more in the year. Approximately 31.7 percent of spending will be for the 7 percent of the population spending $6,000 or more in the year (see Table B-14).

TABLE B-14--ESTIMATED DISTRIBUTION OF MEDICARE BENEFICIARIES AND AMOUNT SPENT ON OUTPATIENT PRESCRIPTION DRUGS, 2003

Spending category	Percent of beneficiaries	Percent of total dollars
Zero	10.3	0.0
Greater than zero	89.7	100.0
$500 or greater	71.4	98.1
$1,000 or greater	58.3	93.8
$2,000 or greater	38.4	80.3
$3,000 or greater	24.8	65.2
$4,000 or greater	15.8	51.0
$5,000 or greater	10.2	39.7
$6,000 or greater	7.0	31.7
$7,000 or greater	5.1	26.0
$8,000 or greater	3.9	21.9

TABLE B-14--ESTIMATED DISTRIBUTION OF MEDICARE BENEFICIARIES AND AMOUNT SPENT ON OUTPATIENT PRESCRIPTION DRUGS, 2003-continued

Spending category	Percent of beneficiaries	Percent of total dollars
$9,000 or greater	2.8	17.6
$10,000 or greater	2.0	14.5
$11,000 or greater	1.6	12.3
$12,000 or greater	1.1	10.0

Source: U.S. Congressional Budget Office. Estimates using March 2003 baseline projections. Estimates based on data from the 2000 MCBS with adjustments to account for underreporting by community respondents and for non-response by nursing home residents. March 2003.

LONG-TERM CARE FOR PERSONS WITH DISABILITIES

OVERVIEW

Long-term care refers to a wide range of supportive and health services for persons who have lost the capacity for self-care due to illness or frailty. Chronic illness or conditions often result in both functional impairment and physical dependence on others for an extended period of time. Major groups of persons needing long-term care services and supports include the elderly as well as younger persons with disabilities, including persons with developmental disabilities, physical disabilities, and mental illness. The likelihood of needing long-term care assistance occurs more frequently with advancing age. However, advances in medical care are enabling persons of all ages with disabilities to live longer. The demand for long-term care services is expected to increase as the population ages.

The presence of a chronic illness or condition alone does not necessarily result in a need for long-term care services. For many individuals, an illness or a chronic condition does not result in functional impairment or dependence and they are able to conduct daily routines without assistance. When the illness or condition results in a functional or activity limitation, long-term care services may be required. The range of chronic illnesses and conditions resulting in the need for long-term care services and supports is extensive. Unlike acute medical illnesses which may be solved in a relatively short period of time, chronic conditions last for an extended period of time and are not typically curable.

Long-term care services include a continuum of health and social services provided in institutions, in the community and at home. However, the predominant source of long-term care support for persons with disabilities is through informal support services provided by unpaid family and friends. Despite the enormous amount of care provided by informal sources, long-term care spending - over $151 billion in 2001 - represents more than 12 percent of all personal health care spending.

The long-term care system is comprised of multiple types of providers financed by a myriad of federal health and social service programs primarily, but also income assistance and housing support programs to a lesser extent. The

principal source of public support for long-term care is the Medicaid program, chiefly through its coverage of nursing home care. Over the years, federal and state policymakers have devoted efforts to expand home and community-based long-term care services that most people prefer over institutional care. A significant Supreme Court decision in 1999 (*Olmstead v. L.C.)* has sharpened federal policy attention on federal and state programs that provide this care. The private long-term care insurance market is a growing option to provide protection against the high cost of long-term care for some people.

This Appendix presents an overview of long-term care, including information on current recipients, future need, providers, federal programs and the private long-term care insurance market.

Measuring the Need for Long-Term Care

The need for long-term care assistance is measured by assessing a person=s need for assistance with *activities of daily living (ADLs) and/or instrumental activities of daily living (IADLs).* ADLs are activities necessary to carry out basic human functions, and include the following: bathing, dressing, eating, getting around inside the home, toileting, and transferring from a bed to a chair. IADLs are tasks necessary for independent community living, and include the following: shopping, light housework, laundry, taking medication, telephoning, money management, and meal preparation. IADLs are sometimes used to measure a person=s need for assistance as a result of mental or cognitive disabilities as well as physical disabilities.

Recipients of Long-Term Care

About nine million persons over age 18 received long-term care assistance, either in community settings or in nursing homes. This includes 5.5 million persons aged 65 and older (in 1999) and 3.5 million persons aged 18-64 (in 1994) (61 percent and 39 percent of the total, respectively) (see Tables B-15 and B-16).[4]

The vast majority of adults who receive long-term care assistance reside in the community, *not* in institutions. About 7.2 million persons aged 18 and older received long-term care assistance in community settings, representing over 80 percent of all persons receiving assistance. Of all persons receiving assistance in the community, just over half are aged 65 and older, and about 47 percent are age 18-64.

Less than 5 percent of persons aged 65 and older - just under 1.7 million persons B received care in institutions in 1999. Less than one-tenth of one percent of persons age 18-64 received care in nursing homes in 1994 - about 138,000 persons (see Tables B-15 and B-16). About another 400,000 persons receive care in residential care facilities for persons with mental retardation or developmental disabilities or mental illness (Spector, Pezzin, and Spillman).

[4] Estimate based on data from the 1999 National Long-Term Care Survey (for persons aged 65 and older; and the 1994 National Health Interview Survey and the 1996 Medical Expenditure Panel Survey (for persons aged 18-64).

The likelihood of receiving long-term care assistance increases dramatically with age. However, while use of nursing home care occurs more frequently as a person ages, regardless of age, in 1999, most older people received long-term care assistance in community settings rather than in nursing homes, even those 85-94. It is only among the very old - those persons aged 95 and older - that persons have about an equal chance of being cared for in an institution or in the community (see Table B-15).

TABLE B-15--PERSONS AGED 65 AND OLDER RECEIVING LONG-TERM CARE SERVICES, 1999

[Population in Thousands]

Characteristics of persons aged 65 and older	Persons aged 65 or older	Percent receiving long-term care[1]	Percent receiving long-term care in the community[2]	Percent receiving long-term care in institutions[3]
Number	34,459	5,479	3,824	1,654
Percent	100.0	15.9	11.1	4.8
		Age		
65-69	9,443	5.7	5.0	0.7
70-74	8,785	8.8	7.2	1.7
75-79	7,305	13.6	10.1	3.5
80-84	4,797	24.8	17.3	7.4
85-89	2,601	39.8	24.8	15.0
90-94	1,133	59.8	33.7	26.1
95 years and older	396	72.1	35.7	36.4
		Gender		
Women	20,200	18.8	12.8	6.0
Men	14,260	11.9	8.8	3.1
		Race		
White	30,367	15.6	10.6	5.0
Black	2,869	20.8	16.6	4.2
Other	1,223	12.5	10.7	1.8
		Marital Status		
Married	17,990	9.7	8.3	1.4
Widowed	12,020	24.8	15.7	9.1
Never Married	1,293	23.5	12.1	11.5
Other	3,157	14.9	9.4	5.5

[1] Receipt of long-term care is defined as receiving human assistance or standby help with at least one of six ADLs or being unable to perform at least one of eight IADLs without help. The ADLs included are eating, transferring, toileting, getting around inside, dressing, and bathing. The IADLs are meal preparation, grocery shopping, light housework, laundry, financial management, taking medication, telephoning, and getting around outside.

[2] This does not include about 1.3 million persons with disabilities who do not receive chronic help, but use special equipment to manage their disabilities.

[3] This includes about 1.5 million persons in nursing homes and slightly more than 150,000 persons in other care facilities.

Source: Unpublished tabulations of the 1999 National Long-Term Care Survey by Brenda C. Spillman. The Urban Institute, 2003.

Future Need for Long-Term Care

While some research shows that the incidence of disability among the older population has decreased over time, the sheer numbers of older persons in the future will strain private and public resources devoted to long-term care. The increasing numbers of older persons, especially those who are in the oldest age categories will affect public and private financing for care and demand for services from long-term care service providers. The growth in the older population will also affect caregiving demands on families who are the primary source of long-term care assistance.

Experts predict that in the coming decades long-term care services will be in greater demand due to increased numbers of older persons, especially those in the oldest age categories. After 2011, the rate of growth for the population age 65 and older will considerably outpace the growth of the rest of the nation, and at its peak the elderly population will be growing eight-times faster than the population under age 65. This growth will lead to significantly higher ratios of elderly to non-elderly in the future. Chart B-3 shows the percent increase in the number of the elderly for each year from 2001-2030 compared to the change in the population under 65. The large increase in the elderly population in 2011 will present challenges for families.

TABLE B-16--PERSONS AGE 18-64 RECEIVING LONG-TERM CARE SERVICES, 1994

[Population in thousands]

Population age 18-64 not receiving long-term care assistance	155,200	100.0%
Persons age 18-64 receiving long-term care assistance[1]	3,502	2.26%
Persons age 18-64 receiving long-term care in the community	3,364	2.17%
Persons age 18-64 receiving long-term care in nursing homes[2]	138	0.09%

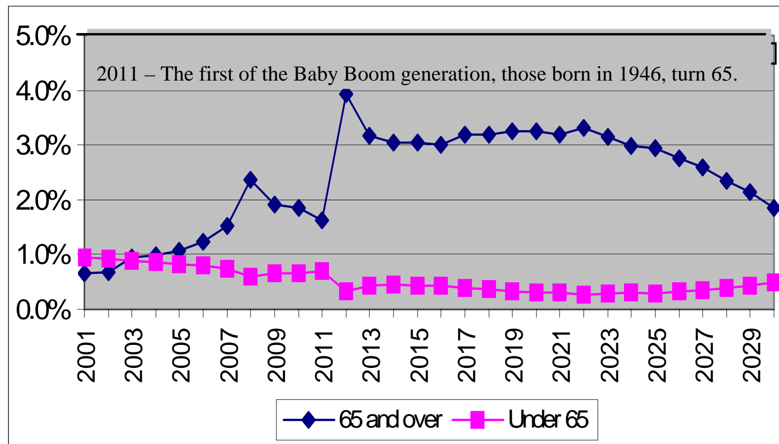
[1]Receipt of long-term care is defined as receipt of human help for ADLs and IADLs, including reminders and standby help, due to a physical, mental, or emotional problem. ADLS include bathing, dressing, getting around inside, transferring, toileting, and eating. IADLs include shopping, light housework, telephone, money management and meal preparation.

[2]The number of persons in nursing homes does not include about 0.4 million persons in intermediate care facilities for the mentally retarded (ICFs/MR) and State mental hospitals.

Source: William Spector, et al. *Characteristics of Long-Term Care Users.* Prepared for the Institute on Medicine, 1998. For persons receiving services in the community, the 1994 National Health Interview Survey, Disability Supplement. For persons receiving care in nursing homes, the 1996 Medical Expenditure Panel Survey Nursing Home Component.

In 2010, just before the first of the baby-boom generation (those born in 1946) turns 65, the U.S. Census Bureau projects that 13.2 percent of the U.S. population will be 65 and over; by 2030, when the last of the baby-boom generation (those born in 1964) will already have turned 65, 20 percent of the population will be 65 and older. Between 2000 and 2030, the number of persons 65 and older will more than double, from 35 million to more than 70 million persons. Furthermore, in 2030, 33 million of those people will be 75 and older, and almost 9 million will be 85 and older (see Table B-17).

CHART B-3--PROJECTED RATE OF GROWTH FROM PREVIOUS YEAR FOR SELECTED POPULATIONS IN THE UNITED STATES, 2001-2030



Source: Congressional Research Service (CRS) calculations based on data from the U.S. Census Bureau, *State Population Projections: Every Fifth Year*. 1996; available on-line at: [http://www.census.gov/population/www/projections/st_yrby5.html].

TABLE B-17--ELDERLY POPULATION AS A PERCENT OF TOTAL POPULATION IN THE UNITED STATES, 2030

Age group	2030		Percent increase 2000 to 2030
	Number (in millions)	Percent of population	
65+	70.3	20.0	101.9
65-74	37.7	10.7	107.4
75-84	23.7	6.7	91.9
85+	8.9	2.5	107.1
Under 65	280.8	80.0	16.8
Total population	351.1	100.0	27.5

Source: Congressional Research Service (CRS) calculations based on data from the U.S. Census Bureau, *State Population Projections: Every Fifth Year*. 1996; available on-line at: [http://www.census.gov/population/www/projections/st_yrby5.html].

The number of persons with disabilities will grow as the population ages. According to data prepared for the Department of Health and Human Services (DHHS), the number of persons receiving long-term care assistance will increase by over 80 percent from 2005-2035. Users of institutional care (nursing facilities and alternative living facilities, such as assisted living facilities) age 65 and older are estimated to increase by about 70 percent over this same period. Users of home care services are estimated to increase by 85 percent (see Table B-18). The number of persons aged 65 and older with at least two or more ADLs is estimated to increase by over 30 percent from 2000-04 to 2030-34.

TABLE B-18--PROJECTED GROWTH IN THE LONG-TERM CARE POPULATION, AGE 65 AND OLDER, 2005-2035[1]

Year	Total number of persons age 65 and older receiving care	Number of persons age 65 and older receiving home and community-based care	Number of persons age 65 and older receiving institutional care
2005	7.3	5.2	2.1
2015	8.8	6.5	2.3
2025	11.2	8.2	3.0
2035	13.2	9.6	3.6

[1]Projected number of persons receiving paid care throughout the year. Public policies are assumed to remain constant.

Source: The Long-Term Care Financing Model. Prepared by The Lewin Group, Inc. for DHHS, Office of the Assistant Secretary for Planning and Evaluation, 2000.

PROVIDERS OF LONG-TERM CARE

The primary source of long-term care assistance is from informal caregivers – families and friends of persons with disabilities who provide care and assistance without compensation. Estimates of the number of caregivers to persons of all ages receiving long-term care assistance range from 7 million to 54 million persons, depending upon the population served and the amount and intensity of care provided. Research has shown that while adults of all ages provide long-term care assistance, persons in middle to late middle age are most likely to be caregivers. While women are most likely to be in the caregiver role, both men and women provide care. In addition, caregivers often have competing demands – about one-half are employed and one-third have minor children in the home (Administration on Aging, August 2002).

Informal Care Provided by Families and Friends

Of the 3.9 million persons[5] aged 65 and older who received long-term care assistance in the community in 1994, nearly 60 percent relied exclusively on unpaid caregivers, primarily spouses and children. Only 7 percent relied exclusively on

[5] Total number of persons receiving care in the community differs slightly from number in Table B-17 due to differences in year of data collection.

paid services; slightly more than a third relied on a combination of paid and unpaid care. Of the 3.4 million persons aged 18-64 who received assistance in the community, nearly three-quarters of persons relied exclusively on unpaid caregivers. Only 6 percent relied exclusively on paid services (see Table B-19).

TABLE B-19--TYPE OF CARE RECEIVED BY PERSONS AGED 18 AND OVER LIVING IN THE COMMUNITY, 1994

Persons receiving long-term care assistance in the community	Persons age 18 – 64	Persons age 65 and older
Total	3.4 million	3.9 million
Percent receiving care from unpaid providers only	71%	57%
Percent receiving paid care only	6%	7%
Percent receiving unpaid and paid care	6%	36%
Unknown	17%	Not applicable

Source: For persons aged 65 and older: 1994 National Long-Term Care Survey; for persons 18-64, 1994 National Health Interview Survey, Disability Supplement. William Spector et. al. *Characteristics of Long-Term Care Users*. Prepared for the Institute of Medicine, 1998.

Formal Care Providers

In addition to the extensive informal care provided by families and friends, the long-term care services system includes thousands of formal care providers. They range from institutional providers, including nursing homes and residential care facilities for persons with mental retardation and developmental disabilities, to a variety of agencies and programs that provide a wide array of home and community-based services. These services include home health care, personal care, homemaker and chore assistance, adult day care services, home-delivered meals, transportation, and many others. In addition, assisted living facilities, adult foster care homes and other group homes provide both room and board as well as personal care and other assistance to persons who have lost the capacity to live independently in their own homes because of their need for assistance with ADLs or IADLs.

The growth in many formal providers has been influenced by the availability of federal financing sources. For example, the growth in the nursing home industry during the last fifty years has largely been a result of financing available through the Medicaid program and, to a lesser extent, the Medicare program. Before then, homes for the aged were supported by state-only funds and through private resources. On the other hand, home care agencies have a long history of support from the private sector through charitable and volunteer organizations, dating from the late 19th century. Like nursing homes, growth in the home care industry has been influenced by the availability of federal financing under Medicare and Medicaid. Adult day care services were modeled after programs that originated in Europe, and then were later adopted in the U.S. to fit available financing

mechanisms through the Medicaid, Social Services Block Grant (SSBG), and Older Americans Act programs. A relatively new model of care – assisted living – has recently become an important component of the formal long-term care system and is primarily financed by individuals' own resources – not through public sources.

Nursing Homes--While only a small proportion of persons receiving long-term care services reside in nursing homes, the largest proportion of public spending on long-term care is for this care. The growth in the nursing home industry was influenced by the creation of benefits under the Medicare, but especially, the Medicaid programs in 1965. Significant growth in number of nursing homes occurred during the 1960s – from 1960 to 1970, the number of homes more than doubled, from 9,582 to almost 23,000, and the number of beds more than tripled, from 331,000 to more than one million (U.S. Congress. Senate. Special Committee on Aging). While the number of homes has fluctuated over the years, the number has declined from the 1970 level. In 2003, there are about 1.8 million beds in more than 16,400 nursing facilities (Centers for Medicare and Medicaid Services, May 2003).

Residential Settings for Persons with Mental Retardation and Developmental Disabilities--The early history of services to persons with mental retardation is characterized by the development of large state institutions or training schools begun during the latter part of the 19th century and continuing through the first part of the 20th century. Between 1920 and 1967, institutions quadrupled in size and peaked to almost 200,000 individuals nationwide in 165 free-standing state-operated mental retardation institutional facilities (Braddock, 1998). In 1971, federal financing for intermediate care facilities for the mentally retarded (ICFs/MR) was authorized under the Medicaid program; states that were able to meet the federal requirements governing care for persons with mental retardation in ICFs/MR shifted their state-financed facilities to the Medicaid program. Today, although some states are still faced with the legacy of large state-operated and state-financed institutions, a major change has occurred toward care in smaller, community-based residences as well as home-based services for this population. In 2002, there were an estimated 125,415 distinct residential settings for persons with developmental disabilities nationwide (Prouty et. al.).

Home Care-- Home care services comprise a wide array of services designed to assist persons with disabilities and the frail elderly to reside in their own homes with appropriate health and supportive services. Home care services may include nursing, physical, occupational, and speech therapies, social services, case management and assessment, personal care, and homemaker/chore services, among others. Home care may be provided by agencies certified to participate in the Medicare and Medicaid program and area agencies on aging operating under the Older Americans Act, as well as other voluntary organizations. In 1997, there were an estimated 20,000 agencies that provide home care services (National Association for Home Care).

Adult day care programs--Adult day care programs provide health and social services in a group setting on a part-time basis to frail older persons and other

persons with physical, emotional, or mental impairments who require assistance, supervision and rehabilitation to restore or maintain optimal functioning. Services generally provided in adult day care settings include client assessment, nursing services, social services, therapeutic activities, personal care, physical, occupational, and speech therapies, nutrition counseling, and transportation to and from the center. These programs have grown from a handful of federally-supported research and demonstration projects in the late 1960s and early 1970s to more than 3,400 centers in 2003 (Cox).

Assisted Living Facilities--Assisted living facilities are designed for persons who need some assistance due to functional or cognitive impairment, but who do not need sustained nursing care. In general, these facilities provide room and board, personal care and supportive services while also providing some health-related care. They have become alternatives to nursing homes and are based on a philosophy that values consumer independence and choice. However, unlike nursing homes which receive Medicaid and Medicare funding, assisted living facilities are primarily financed by residents out of their own resources. It is estimated that there are about 30,000 assisted living facilities providing care to about one million persons.

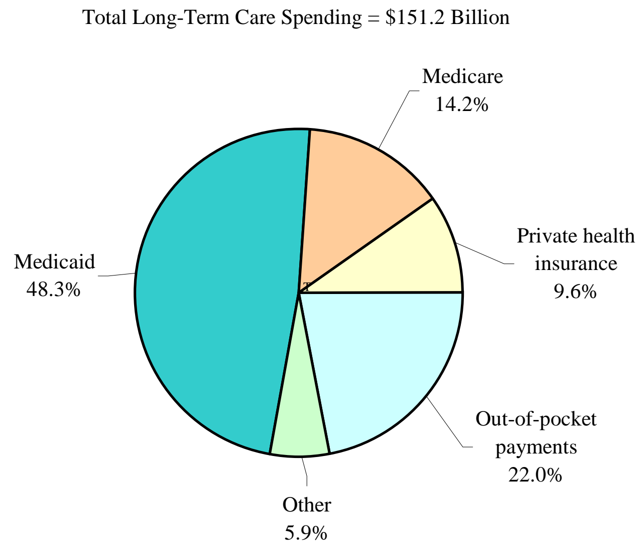
LONG-TERM CARE SPENDING

Of the $1.24 trillion spent on all U.S. personal health care services in 2001, $151.2 billion, or about 12.2 percent, was spent on long-term care. This amount includes spending for institutional care (nursing homes and intermediate care facilities for the mentally retarded (ICFs/MR)), and a wide range of home and community-based services, such as home health care services, personal care services, and adult day care, among others.

Long-term care is chiefly financed through the Federal-State Medicaid program. Of all U.S. long-term care spending in 2001, the Medicaid program financed 48.3 percent, or $73.1 billion. After Medicaid, private out-of-pocket spending is the next primary source of funding for long-term care. In 2001, out-of-pocket spending for long-term care was $33.2 billion, representing 22 percent of all U. S. spending on long-term care. Medicare plays a relatively smaller role in long-term care than Medicaid and out-of-pocket spending. In 2001, of total long-term care spending, Medicare accounted for 14.2 percent (see Chart B-4).

The spending in Chart B-4 excludes some other spending for care of persons with disabilities. For example, it does not include spending for home and community-based services under federal social service programs such as the Social Services Block Grant (SSBG) and the Older American Act. It also fails to account for spending for supportive housing services financed through the Department of Housing and Urban Development (HUD) programs. It also excludes spending for state-only funded long-term care programs.

CHART B-4—SOURCES OF LONG-TERM CARE SPENDING, 2001



Note- Does not include costs of some Federal and State social service and housing programs nor imputed value of informal caregiving.
Source: Chart prepared by CRS based on data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

In addition to these costs, spending shown in Chart B-2 does not take into account the economic value of care provided to persons with disabilities by uncompensated informal care providers. The value of informal caregiving is estimated to be quite significant. Placing a value on unpaid caregiving hours is dependent upon estimates of the number of persons who need help, the cost of caregiving, and the number of unpaid hours that are provided. According to one analysis, the economic value of informal caregiving to adults in 2000 ranged from $140 billion to $389 billion depending upon the number of caregivers (24.4-29.2 million), caregiving hours (24-27 billion), and an imputed value of hourly wages ($5.15 to $12.46) (Arno, 2002). Another study estimated the imputed value of informal caregiving at $168 billion based on 18.7 billion of caregiving hours priced at $9 per hour (LaPlante, Harrington, and Kang, 2002).

FEDERAL PROGRAMS THAT PROVIDE LONG-TERM CARE

Many federal programs assist persons needing long-term care services, either

directly or indirectly through a range of health and social services, through cash assistance, and through tax benefits. While Medicaid is the primary source of public financing for long-tem care, other programs, including Medicare, and social service programs provide assistance to persons who need long-term care support. No one program, however, is designed to support the full range of long-term care services needed by persons with disabilities. Eligibility requirements, benefits, and reimbursement policies differ among major programs. Many observers indicate that these varying features often result in a fragmented and uncoordinated service system.

Many observers indicate that Federal support for long-term care provides more support for institutional care (primarily through Medicaid) than for home and community-based care which most people prefer. A significant 1999 Supreme Court case (Olmstead v. L.C.) has had important implications for federal and state long-term care programs. In its decision, the Court stipulated that, under certain circumstances, institutionalization of persons who could live in community settings, and desire to do so, violates the Americans with Disabilities Act (ADA). In the case, physicians had determined that two patients living in a state psychiatric hospital in Georgia were able to live in community settings. When the State refused to transfer them to a less restrictive setting, the patients brought suit under the ADA. The Court ruled that the state had violated Title II of ADA which prohibits "unjustified isolation" and that it was discriminatory to force someone to remain in an institutional setting when (1) treatment professionals determine that a community setting is appropriate; (2) the individuals do not oppose the placement; and (3) the placement can be reasonably accommodated, taking into consideration the resources of the state and needs of other persons with disabilities. The Federal government has taken a number of steps to implement the *Olmstead* decision, including issuance of a series of policy guidance letters from DHHS/Centers for Medicare and Medicaid Services (CMS) and through an Executive Order issued by President Bush in June 2001 (Executive Order).[6]

The following briefly describes selected major federal programs. Not discussed are a host of other federal programs dealing with other aspects of long-term care, including housing assistance programs through HUD, as well as services administered by the Veterans Administration (VA).

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[6] On June 18, 2001, President Bush issued Executive Order 13217, *Community-Based Alternatives for Individuals with Disabilities*, calling for swift implementation of the *Olmstead* decision. The Executive Order states that the Attorney General, and the Secretaries of DHHS, Education, Labor, and Housing and Urban Development and the Commissioner of the Social Security Administration shall work cooperatively to see that this goal is accomplished (with DHHS as the designated lead agency). The order was based on the following justifications: the nation is committed to community-based alternatives for individuals with disabilities; the nation seeks to ensure that community-based programs effectively foster independence and participation in the community for Americans with disabilities; unjustified isolation or segregation of qualified individuals with disabilities through institutionalization is a form of disability-based discrimination prohibited by the ADA; and the Federal government must assist states and localities to implement the *Olmstead* decision to ensure that all Americans have the opportunity to live close to their families and friends, to live independently, to engage in productive employment, and to participate in community life.

Medicaid

The largest single public financing source for long-term care services in the nation is the Federal-State Medicaid program. Medicaid is administered by States within broad federal guidelines. Medicaid pays for a wide range of long-term care services for persons who meet Medicaid's categorical and financial eligibility requirements (see section on Medicaid eligibility). Medicaid covers services in nursing facilities, intermediate care facilities for persons with mental retardation (ICFs/MR), and a wide range of home and community-based services, including case management, home health care, personal care, homemaker services, among others.

Nursing Home Care--Medicaid's coverage of long-term care is driven primarily by its coverage for nursing home care which is the largest component of Medicaid long-term care spending. The Social Security Amendments of 1965 required that states cover skilled nursing facility services and gave these services the same level of priority as hospital and physician services. People eligible under the State's Medicaid plan are entitled to nursing home facility care; that is, if a person meets the State's income and asset requirements, as well as the State's functional eligibility requirements for entry into a nursing home, he or she is entitled to the benefit. In 2003, there are an estimated 1.6 million nursing home beds certified to participate in the Medicaid program (American Health Care Association).

Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)--Institutional care provided to persons with mental retardation and developmental disabilities in intermediate care facilities for the mentally retarded (ICFs/MR) is an optional benefit under the Medicaid program. All States opt to provide this care under Medicaid. Services include room and board and a wide range of specialized therapeutic services to assist persons with mental retardation and developmental disabilities to function at optimal levels. Medicaid-certified ICFs/MR must offer "active treatment"[7] to residents. Federal Medicaid law and regulations govern standards of care that ICFs/MR must provide, including staffing and resident care requirements and inspection and certification rules. In 2002, there were 6,623 Medicaid ICFs/MR nationwide serving about 110,600 residents; the average size of these facilities was 16.7 residents (Prouty et al.).

Home Health Care Services--All States are also required to provide home health services to persons entitled to nursing facility coverage under a State's Medicaid plan. Home health services are nursing services and home health aide services provided on a part-time or intermittent basis to persons who need assistance for an illness or condition; services may be provided through home

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[7] *Active treatment* is defined by regulation as aggressive, consistent implementation of a program of specialized and generic training, treatment, health and related services directed toward acquisition of behaviors necessary for the client to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of optional functional status. (45 CFR 483.440)

health agencies or, under certain circumstances, by a registered nurse. Services also include medical supplies, medical equipment and appliances suitable for use in the home. States may also choose to provide optional services, such as physical therapy, occupational therapy, speech pathology and audiology services.

Personal Care Services--States have the option to cover personal care services for Medicaid beneficiaries who need assistance with ADLs and IADLs. Medicaid statute defines personal care as services furnished to an individual at home or in another location (excluding hospital, nursing facility or ICF/MR, or institution for mental diseases) that are authorized by a physician, at state option, otherwise authorized under a plan of care. Services offered under the personal care option include assistance with bathing, dressing, eating, toileting, personal hygiene, light housework, laundry, meal preparation and grocery shopping. In 2002, 36 States covered personal care services as part of their state Medicaid plans.

Home and Community-Based Waiver Program--In 1981 Congress authorized expansion of home and community-based services under Medicaid. The program, known as the home and community-based waiver program (authorized under Section 1915(c) of the Social Security Act) allows the Secretary of the Department of Health and Human Services (DHHS) to waive certain statutory requirements to assist states in financing care at home and in other community-based settings for persons who, without these services, would be in an institution.[8]

States may choose to cover a range of community-based long-term care services for persons of all ages who meet the state's eligibility requirements. Services may include personal care assistance, homemaker/home health aid services, personal care assistance, adult day care, case management, and respite for caregivers, and habilitation,[9] among others. Spending for the Section 1915(c) waiver program has increased rapidly since FY1990 when it was $1.2 billion, reaching $16.4 billion in FY2002.

The home and community-based waiver program has been a significant source of support to care for persons with mental retardation and developmental disabilities. In FY2002, about three-quarters of waiver spending was for persons with mental retardation and developmental disabilities; the balance was spent on other persons with disabilities, including the elderly and persons with physical disabilities (Eiken and Burwell). Despite the growth in the waiver programs, many States have waiting lists for services, especially for persons with mental retardation and developmental disabilities.

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[8] States may waive the following Medicaid requirements: (1) statewideness – States may cover services in only a portion of the State, rather than in all geographic jurisdictions; and (2) comparability of services – States may cover State-selected groups of persons, rather than all persons otherwise eligible. In addition to waiving these requirements, States may use more liberal income requirements than would ordinarily apply to persons living in the community. That is, they may use the eligibility standard used to determine financial eligibility for nursing home care – income up to 300 percent of the SSI level ($1,656 in 2003).

[9] Habilitation refers to services to assist individuals in developing skills necessary to reside successfully in home and community-based settings. It includes such activities as prevocational, educational, and supported employment.

In January 2000, and in subsequent policy memoranda DHHS issued guidance to states in the implementation of the *Olmstead* decision as it relates to Medicaid home and community-based programs. (Centers for Medicare and Medicaid Services, January 2000) Specifically, DHHS indicated that *Olmstead* applied to all persons with disabilities and to persons already in institutional settings as well as those being assessed for institutionalization. Furthermore, DHHS recommended that States take a number of actions, including development of comprehensive plans to strengthen community service systems and serve persons with disabilities in the most integrated setting appropriate to their needs.

(For more information on Section 1915(c) waiver programs see the section on Medicaid.)

Medicaid Long-Term Care Spending

In FY2002, Medicaid spent $82 billion on long-term care services – representing more than one-third of all Medicaid spending (see Table B-20). In FY2002, of total Medicaid long-term care services, most – 70 percent or $57.4 billion – was spent for care in institutions. Of the $57.4 billion spent for institutions, slightly more than 80 percent was spent for care in nursing facilities, with the balance for care in ICFs/MR.

While overall long-term care spending increased by 178 percent over the period, the proportion of Medicaid funds spent on long-term care declined from 42 percent in FY1990 to slightly more than 35 percent in FY2002. This decline in the proportion of total spending used for long-term care services is influenced by a number of factors. These include, for example, the increased share of Medicaid spending for other services, such as prescription drugs, and changes in enrollment patterns.

The downward shift in the overall proportion spent for long-term care is also influenced by the changing patterns of long-term care service utilization. Despite the large proportion of funds for institutional care, over the last 12 years, there has been a shift in how Medicaid funds are used for long-term care. From FY1990 to FY2002, the proportion of Medicaid long-term care spending devoted to institutional care declined. In FY1990, almost 87 percent of long-term care spending was devoted to institutional care; in FY2002, it had declined to just over 70 percent (see Table B-20). This is in part due to a decreasing share of institutional spending used for care in ICFs/MR as states have made greater use of home and community-based waiver funds to serve persons with mental retardation and developmental disabilities.

In general, there has been a rather large shift in spending toward home and community-based care over this period. In FY1990, slightly more than 13 percent of Medicaid long-term care spending was for home and community-based care; in FY2002, this proportion had increased to about 30 percent. This shift is primarily due to increased spending on home and community-based services under the Section 1915(c) waiver program which represented almost one-fifth of Medicaid long-term care spending in FY2002 (see Table B-20).

TABLE B-20--MEDICAID LONG-TERM CARE SPENDING, SELECTED FISCAL YEARS 1990-2002

Measure	1990	1995	2000	2002
Total Medicaid spending (in billions)	$69.7	$151.4	$194.3	$243.5
Total long-term care spending (in billions)	$29.5	$49.4	$68.4	$82.1
Long-term care spending as a percent of Medicaid spending	42.4%	32.6%	35.2%	35.1%
Institutional care spending as a percent of long-term care spending	86.7%	80.8%	72.5%	70.5%
Nursing home spending as a percent of long-term care spending	60.9%	61.4%	57.9%	56.8%
ICF/MR[1] spending as a percent of long-term care spending	25.8%	19.4%	14.6%	13.7%
Total home and community-based services (HCBS) spending as a percent of long-term care spending[2]	13.3%	19.2%	27.5%	29.5%
HCBS waivers spending as a percent of long-term care spending	4.2%	9.4%	18.5%	19.1%

[1]Intermediate care facilities for persons with mental retardation.

[2]Includes HCBS waivers, home health and personal care services.

Source: Congressional Research Service (CRS) calculations based on CMS/HCFA 64 data provided by The Medstat Group, Inc. for various years. 1990 total Medicaid spending, based on HCFA 64 data provided by Urban Institute, Washington, D.C.

Medicare

The Medicare program covers skilled nursing home and home health care services for persons who need skilled or rehabilitative services of relatively short duration. It is not intended to be a primary funding source for long-term care for persons who need assistance with chronic conditions. Medicare's role is limited to financing care in skilled nursing facilities (SNFs) (up to 100 days after a hospitalization for persons who need continued skilled care), and home health services for persons who need skilled nursing care on a part-time or intermittent basis, or physical or speech therapies. Of the $21.5 billion Medicare spent on long-term care in 2001, about 54 percent was for skilled nursing facility care, and the balance was for home health care services.

Skilled Nursing Facility Service--Medicare covers SNF services for beneficiaries who require skilled nursing care and/or rehabilitation services following a hospitalization of at least 3 consecutive days. A physician must certify that the beneficiary needs daily skilled nursing care or other skilled rehabilitation services that are related to the hospitalization, and that these services, can only be provided on an inpatient basis. Medicare does not cover SNF care for persons who need care for chronic conditions or disabilities alone. In 2003, of the almost 1.8 million nursing facility beds nationwide, about 1.2 million were certified to participate in both the Medicare and Medicaid programs, and another 63,000 were certified for Medicare only (American Health Care Association).

Home Health Care Services--Medicare covers home health care services for

beneficiaries who are homebound based on the need for intermittent skilled nursing care, physical therapy or speech therapy. Beneficiaries receiving at least one of these services may also receive, as covered benefits, home health aide services, medical social work services, and occupational therapy. Services provided must be medically necessary and carried out under a plan of care prescribed by a physician. Medicare's home health benefit is not intended to cover personal care for persons who need care for a chronic condition or disability alone. In 2001, about 3.5 million persons qualified for Medicare on the basis of disability received care from nearly 7,000 Medicare-certified home health agencies (Centers for Medicare and Medicaid Services, March 2003).

Other Federal Programs

A variety of other Federal programs support long-term care services. Primarily these are the Older Americans Act and the SSBG (Title XX of the Social Security Act). Both support a variety of home and community-based services, such as homemaker and chore services, home-delivered meals services, transportation, and other services for persons who have chronic and disabling conditions. While total spending under these programs is small compared to Medicaid spending devoted to long-term care, in many communities these programs represent an important source of support for the frail elderly and other persons with disabilities by filling gaps in services not met by Medicaid or Medicare.

The Older Americans Act supports a wide variety of services for persons age 60 and older through state and area agencies authorized under Title III of the Act. A majority of its spending for home and community-based long-term care services is for home-delivered meals programs. State and area agencies use Title III funds for home care, adult day, congregate nutrition services, and transportation among other services. In FY2002, Title III spending for home-delivered meals, personal care, homemaker, and adult day care services totaled almost $920 million (Administration on Aging, 2002). In addition, the National Family Caregiver Support program, authorized in 2000, offers assistance to informal caregivers of the frail elderly; FY2003 funding is $142 million.

The SSBG authorizes grants to states for a wide range of services to diverse populations, including children and families as well as the elderly and persons with disabilities. States are allowed considerable discretion in their support for social services as long as services are aimed at achieving a number of goals, including preventing or reducing inappropriate institutional care through home and community-based care. Under the program, home and community-based long-term care services must compete with many other social services for other population groups, including children and at risk youth. (In 2001, the largest expenditures categories for SSBG services were for child protective services and children's foster care).

Many States supplement the Federal Supplemental Security Income (SSI) cash welfare payments to low-income elderly and disabled persons to enable them to pay for home and community-based services, or to reside in non-medical

residential services, such as board and care homes. In addition, certain programs authorized under the Rehabilitation Act of 1973 provide a range of supportive services to persons with disabilities to enable them to be employed. The Department of Veterans Affairs (DVA) provides a wide range of long-term care services to the Nation's veterans, including nursing home, domiciliary, home health care, and assistance to caregivers. Finally, programs administered by HUD support limited assistance to persons with disabilities through its Congregate Housing Service Programs (CHSP) and Assisted Living Conversion Program (ALCP), and through services coordinators who work in multifamily housing projects.

PRIVATE LONG TERM CARE INSURANCE

Private long-term care insurance is considered by some to be a promising private sector option. This insurance provides persons needing assistance with ADLs protection against the high cost of long-term care services without relying on public sector programs such as Medicaid. Although it is a relatively new insurance product, the market has grown rapidly. Since 1987, when the Health Insurance Association of America (HIAA) began surveying the industry, the market has grown by an average 18 percent per year, reaching more than 700,000 policies sold in 2001 by 137 companies (with 80 percent accounted for by the ten largest sellers). HIAA reports that at the end of 2001, about 7 in 10 policies sold since 1987 remained in force (based on 77 percent of all policies sold in the individual and group association market as of the end of 2001) (Health Insurance Association of America, 2003).

Care in a variety of settings may be covered, including nursing facilities or assisted living facilities, or the individual's own home through home health, respite care for caregivers, homemaker and chore services, and medical equipment, among others. Some policies will pay relatives for providing care; others pay only for licensed professionals. Eligibility is based on limitations in ADLs.

Long-term care policies vary with regard to features. These include criteria to qualify for benefits; a waiting ("elimination") period between the onset of qualifying impairments and commencement of payment; dollar limits on payments and possible inflation adjustments of the limits; whether payments are a flat daily amount regardless of expenses or are paid only as reimbursement for approved expenditures; and the length of time over which benefits may be paid (such as 1 year, 3 years, or longer).

Long-term care insurance policies may be sold to an individual, based on that individual's age and health-related factors, or may be sold to a group; they may also be employer-sponsored, or be part of a life insurance policy. Of the cumulative 8.3 million policies sold over the period 1987-2001, 80 percent had been sold to individuals or group associations; about 16 percent were employer-sponsored with the balance sold as part of life insurance policies (see Table B-21).

TABLE B-21--LONG-TERM CARE INSURANCE PRODUCTS BY PERCENTAGE OF POLICIES SOLD AND AVERAGE AGE OF BUYER

Long-term care product	Percent of companies[1] (n=137)	Percent of policies sold 1987- December 2001 (n=8.26 million)	Percent of policies sold in 2001 (n=732,000)	Average age of buyer
Individual and group association	81	80	76	62
Employer-sponsored	10	16	24	46
Long-term care as part of a life insurance policy	13	5	NA	66

[1]Totals more than 100 percent because some companies sell their products in more than one type of market.

NA-Not applicable.

Source: Health Insurance Association of America. *Long-Term Care Insurance in 2000-2001*. Washington. January 2003.

The age of purchase of policies varies with the type of product purchased. As shown in Table B-21, in 2001, the average age of purchase for policies sold in the individual and group association market was 62 years; the age of purchase in the employer-sponsored market was 46 years, and as part of life insurance was 66 years. According to HIAA, the average age of purchasers who buy policies in the individual market has steadily decreased – decreasing from age 72 in 1990 to 62 in 2001.

Individual policies are sold with substantial “underwriting” – meaning the carrier requires detailed information regarding one’s medical history – while group policies may or may not be sold with full or partial underwriting. Age rating is very important because the probability of claims is highly correlated with age. Underwriting is used by insurers to protect against the “adverse risk selection” that can occur if individuals buy policies when they know or suspect that they may soon need to make use of the insurance.

Affordability of Long-Term Care Insurance

One of the key issues in considering the role private insurance can play in long-term care is affordability, and the price for these insurance policies depends greatly on the individual's age at the time he or she first purchases the policy – the older the individual, the higher the premiums. Once the policy is purchased, premiums generally remain fixed throughout the policyholder's lifetime. Under certain circumstances, a carrier may seek approval from state insurance commissioners to raise rates for all policyholders (in the same class). An unexpected rate increase may affect a policyholder’s desire and ability to continue the policy. According to HIAA, however, average premiums reported by leading insurers in 2001 had remained fairly constant compared to premiums for leading

companies in 1999.[10]

TABLE B-22--AVERAGE ANNUAL PREMIUMS FOR LEADING LONG TERM CARE INSURANCE SELLERS IN 2001[1]

Age	Base	With 5% Compounded Inflation Protection (IP)	With Nonforfeiture Benefit[2]	With Inflation Protection and Nonforfeiture Benefit
Coverage amount: $100 daily benefit amount, 4 years of coverage, and a 20-day elimination period:				
40	$310	$641	$387	$786
50	$401	$849	$502	$1,022
65	$996	$1,726	$1,219	$2,261
79	$4,180	$5,821	$5,087	$7,002
Coverage amount: $150 daily benefit amount, 4 years of coverage, and a 90-day elimination period:				
40	$396	$834	$498	$1,001
50	$510	$1,009	$642	$1,369
65	$1,263	$2,273	$1,554	$2,988
79	$5,265	$7,588	$6,379	$8,883

[1]Eleven insurance sellers were identified as having sold 80 percent of all individual and group association long-term care insurance policies in 2001.
[2] A non-forfeiture benefit refers to benefits that return a portion of policyholders' benefits if they drop coverage, commonly through return of premiums or through coverage for a shortened period.
Source: Health Insurance Association of America. Long-Term Care Insurance in 2000-2001. Washington. January 2003.

The cost of polices varies depending not only upon age of purchase, but also policy features. According to an HIAA survey (based on 11 insurance sellers selling 80 percent of all individual and group association policies in 2001), the average annual premium for a policy paying a $100 per day benefit (with a 5 percent compounded inflation protection, a 20-day elimination period, and four years of coverage) was $849 if purchased at age 50, rising to $1,726 if purchased at age 65 and $5,821 at age 79 (see Table B-22; based on data from eleven insurance sellers having sold 80 percent of all individual and group policies in 2001).

Very likely, most people would find this product too expensive if they started considering purchase when already retired; others may not be able to afford it while still working. Generally speaking, the prime market for long-term care insurance is for persons who have average to somewhat above average income levels. At high levels of accumulated wealth, individuals can bear the financial risks without purchasing insurance. At low levels of wealth, insurance is unaffordable. At middle-income levels, many will find insurance desirable, especially if they are concerned about providing income or assets for a spouse or passing on their wealth to their children. Others may be willing to take the chance of spending down their assets to qualify for Medicaid if necessary.

[10] Health Insurance Association of America. *Long-Term Care Insurance in 2000-2001*. Washington. January 2003.

Employer-based Group Coverage

Affordability could be enhanced if insurance was purchased at group rates by individuals still in their working years. Even though most group plans to date have not featured employer contributions toward the premiums, some research shows that the plans can be as much as 15 to 30 percent less costly than policies purchased individually. Employment-based group premiums are lower because: (1) marketing can be targeted to younger individuals who generally have lower rates; (2) savings can be achieved through lower administrative costs and lower commissions; and (3) employers can bargain for reduced profit percentages and improved benefits. According to the HIAA, employer-based activity has been growing faster than the individual market, and accounted for almost one-quarter of policies sold in 2001 (see Table B-21). These employer- based plans may cover employees, their spouses, retirees, parents, and parents-in-law.

In 2002, pursuant to the Long Term Care Security Act, P.L. 106-265, the federal government became the largest employer to offer group long-term care insurance. One of the intended purposes (aside from increasing the attractiveness of federal employment) is a possible demonstration effect; that is, encouraging more private-sector employers to offer such an insurance plan and ultimately having some impact on public spending. Some 20 million people are eligible to participate in the federal program, including active and retired federal employees, their spouses and some relatives. However, only active employees and their spouses can enroll with minimal medical qualification, and these only within two months of being hired or during an initial open season in 2002. In that open season, 265,000 applications were received. The program is administered by a joint venture of Metropolitan Life and John Hancock Life for an initial contract period of 7 years.

Tax Treatment of Long-Term Care Insurance

The Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) established new rules regarding the tax treatment of long-term care insurance and other long-term care expenses, effective January 1, 1997. Qualified long-term care insurance is treated as accident and health insurance, and its benefits are treated as amounts received for personal injuries and sickness and for reimbursement of medical expenses actually incurred. As a consequence, long-term care insurance benefits are excluded from the gross income of the taxpayer (that is, they are exempt from taxation). The exclusion for insurance benefits paid on a per diem or other periodic basis is limited to the greater of (1) $220 a day (in 2003) or (2) the cost of long-term care services.

Employer contributions to the cost of qualified long-term care insurance premiums are excluded from the gross income of the employee. The exclusion does not apply to insurance provided through employer-sponsored cafeteria plans or flexible spending accounts.

Unreimbursed long-term care expenses are allowed as itemized deductions to the extent they and other unreimbursed medical expenses exceed 7.5 percent of adjusted gross income. Long-term care insurance premiums can be counted as

these expenses subject to age-adjusted limits. In 2003, these limits range from $250 for persons age 40 or less to $3,130 for persons over age 70.

Self-employed individuals are allowed to include long-term care insurance premiums in determining their above-the-line deduction (a deduction not limited to itemizers) for health insurance expenses. Only amounts not exceeding the age-adjusted limits can be counted.

HIPAA also provided definitions for key long-term care insurance terms:

- *Qualified long-term care insurance* is defined as a contract that covers only long-term care services; does not pay or reimburse expenses covered under Medicare; is guaranteed renewable; does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed; applies all refunds of premiums and all policy holder dividends or similar amounts as a reduction in future premiums or to increase future benefits; and meets certain consumer protection standards. Policies issued before January 1, 1997, and meeting a state's long-term care insurance requirements at the time the policy was issued are considered qualified insurance for purposes of favorable tax treatment.
- *Qualified long-term care services* are defined as necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which are required by a chronically ill individual, and are provided according to a plan of care prescribed by a licensed health care practitioner. However, amounts paid for services provided by the spouse of a chronically ill person or by a relative directly or through a partnership, corporation, or other entity will not be considered a medical expense eligible for favorable tax treatment, unless the service is provided by a licensed professional.
- *Chronically ill persons* are defined as those individuals:
  (1) unable to perform without substantial assistance from another individual at least two of the following six limitations in ADLs for a period of at least 90 days due to a loss of functional capacity: bathing, dressing, transferring, toileting, eating, and continence;
  (2) having a level of disability similar to the level of disability specified for functional impairments (as determined by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services); or
  (3) requiring substantial supervision to protect them from threats to health and safety due to severe cognitive impairment.

A qualified long-term care insurance contract must take into account at least five of the six ADLs identified above.

HIPAA required that a licensed health practitioner (physician, registered professional nurse, licensed social worker, or other individual prescribed by the Secretary of the Treasury) certify that a person meets these criteria within the preceding 12-month period.

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