Budgetary Implications of an Aging Population: The Case of Long-Run Medicaid Expenditures

Testimony before the United States Senate
Committee on the Budget

by

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Chairman Gregg, Ranking Member Conrad, and members of the Committee. I am Jeffrey Brown, Assistant Professor of Finance at the University of Illinois at Urbana-Champaign.[1] I thank you for the opportunity to appear before you today to discuss the long-run implications of an aging population for the Medicaid program.

I. Overview of the Budgetary Challenges of an Aging Population

In recent weeks, there has been a vigorous public discussion about the implications of an aging population on the future of one of the United States' largest entitlement programs – Social Security. As a result of a declining ratio of workers to retirees, Social Security's pay-as-you-go financial structure is fiscally unsustainable and in need of real reform.

As important as the debate over Social Security is, however, it is equally important to remember that Social Security is not the only large entitlement program whose finances are adversely affected by population aging. Medi*care*, the public health insurance program for the elderly, and Medi*caid*, the means-tested program for the poor, are also facing rapidly rising costs, thanks in part to an aging population. While I plan to focus primarily on Medi*caid* in my testimony today, I do want to take just a moment to place Medicaid's cost growth into this larger context.

In just three years, the leading edge of the baby boom generation will begin claiming Social Security benefits. In just five years they will begin claiming Medicare. In the years to follow, millions of them will find that, due to declining health, they need long-term care services, including nursing homes. As a result of the substantial costs of paying for long-term care, many of them will end up relying on Medicaid to finance their care after their own financial resources have been exhausted.

The rising costs of these programs clearly indicate reason for concern. Under 2004 Trustees' intermediate assumptions and CBO's long-term Medicaid estimates, spending for Social Security, Medicare, and Medicaid combined will grow from 8.5 percent of GDP today, to 15.6 percent of GDP by 2030 – just 25 years from now.[2]

Let's be clear about what this means. By the time today's 40 year-old reaches age 65, our nation will be spending $1 out of every $6.40 produced by the entire economy, just to support these three entitlement programs.

The farther into the future one looks, the larger these programs grow relative to the economy. Today, total spending by the *entire* federal government accounts for about 20

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[2] A substantial part of the short-term cost growth is due to the start-up of prescription drug coverage under Medicare.

percent of GDP.[3] *Absent significant reform of our entitlement programs, in just 75 years, Social Security, Medicare, and Medicaid alone are projected to consume 25 percent of GDP*. This means that one-quarter of the nation's total output will be spent on these three programs alone.

This is before we have set aside a single penny to support national defense, homeland security, environmental protection, education for our children, or any number of other national priorities. Nor does it include rising expenditures by state and local governments. Furthermore, that is just the consumption that is publicly financed, i.e., that which is to be paid out of taxes on future generations. One must also keep in mind the obvious fact that the workers of tomorrow – who are our children today – will still need money to live on as they start careers, buy homes, raise families and save for their own retirement.

To sustain these programs on a pay-as-you-go basis in future decades would require substantial increases in tax burdens. Unfortunately, large tax increases can in turn serve as a drag on future economic growth.

Thus, the time to begin thinking about the long-term prospects for all of these programs is now. As with any financial problem, the earlier one starts to address them, the more choices there are available.

II. An Overview of Medicaid Expenditure Growth

Medicaid today is an important source of health care financing for approximately 46 million individuals,[4] who become entitled to benefits by being part of an eligible group, including:

- Pregnant women
- Children and teenagers
- Aged individuals
- Individuals who are blind or disabled

This program plays an extremely important role in the lives of its beneficiaries, providing access to health care for segments of the population that are economically vulnerable, and who otherwise might not receive the health care they need.

However, the financial burden of Medicaid, which is shared by the Federal and state governments, is very large, and growing at a rapid rate.

In 2005, for example, it is expected that the Federal government will spend nearly $190 billion on Medicaid, while total federal plus state spending will be on the order of $325 billion, or 2.6 percent of GDP.[5]

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[3] Budget for Fiscal Year 2006, Historical Tables, Table 1.2, page 24.
[4] Remarks by Secretary of Health and Human Services on Medicaid, February 1, 2005, States News Service.
[5] Estimates based on Office of Management and Budget's FY 2006 Budget, "Analytical Perspectives."

As large as this level of spending is, the *trend* in spending is even more noteworthy. From 1995 through 2004, federal spending on Medicaid nearly doubled at a time when GDP rose by less than 60 percent.[6] The OMB predicts that over the next five years, Medicaid expenditures will grow at approximately a 7 percent annual rate, which is significantly faster than inflation or GDP growth. As a result, Medicaid will continue to grow as a share of the economy and as a share of the federal budget.

When thinking about future trends in Medicaid cost growth, it is important to distinguish between different causes. For example, changes in Medicaid rules that relax or restrict Medicaid eligibility requirements can lead to one-time changes in Medicaid spending that do not necessarily change the trend in cost growth. Similarly, cyclical increases in Medicaid spending, such as those that might be driven by temporary increases in the number Medicaid beneficiaries during periods of economic downturn, are not indicative of long-term trends. Some sources of increased spending, however, are more systemic, such as those due to an aging of the population.

The focus of my testimony today is on *long-term* trends in Medicaid costs. In particular, I want to focus on how an aging population will likely influence future Medicaid program costs.

III. Population Aging and Medicaid Costs

To set the stage, I would like to begin by highlighting three basic facts that, together, indicate why it is important to think about the future of Medicaid expenditures:

1. First, as already indicated, America's population is growing older. Thanks to dramatic declines in mortality at all ages over the past century, the share of the U.S. population over age 65 has grown from under 5 percent in 1900 to approximately 12.5 percent today. It is expected that this trend will continue, and that by the year 2050, over 21 percent of the population will be over age 65.

2. Elderly Americans account for a highly disproportionate share of national health care spending. This is particularly true of certain types of expenditures, a perfect example being long-term care services, such as nursing homes.

3. The Medicaid program is the largest single source of financing for long-term care in America today, covering nearly 40 percent of nursing home expenditures and 35 percent of total long-term care expenditures, according to recent CBO estimates.

[6] Federal Medicaid spending rose from $89 billion in 1995 to $176.2 billion in 2004 (Budget for Fiscal Year 2006, Historical Tables, Table 8.5). Nominal GDP in 1995 was $7.4 trillion (Economic Report of the President), while nominal GDP in 2004 was $11.73 trillion (OMB 2005).

Therefore, absent policy or other changes that significantly alter the way we pay for long-term care in the U.S., our nation will likely face rapidly growing fiscal pressure on the Medicaid program in the decades to come.

To put it in the simplest possible terms, America is growing older. Older individuals use more long-term care. Medicaid is the leading payer of long-term care expenses. Therefore, Medicaid expenditures are expected to rise rapidly in the coming decades.[7]

Estimates from the long-range model used by the OMB suggest that the federal share of Medicaid expenditures, as a fraction of GDP, will double over the next 60 years, rising from an estimated 1.5 percent in 2005, to 3.0 percent in 2065.[8] Importantly, this understates the impact of Medicaid expenditure growth because it focuses only on the federal share. Assuming that the federal share of Medicaid expenditures stays at just under 60 percent, this implies that by the time today's Kindergartners reach age 65, total Medicaid spending will consume over five dollars out of every one hundred dollars generated by the U.S. economy.

Having now made the broad point that population has the potential to increase Medicaid expenditures, it is important to examine the details of these relationships in more detail. To do so, I would like to proceed in four steps:

1. First, I will discuss the composition of overall Medicaid spending today, focusing on how that spending is divided at a broad level across elderly versus non-elderly populations.

2. Second, I will highlight the large and growing role that Medicaid plays in financing long-term care for the elderly.

3. Third, I will examine the trends in long-term care expenditure growth, and discuss what this likely means for growth of Medicaid spending.

4. Finally, I would like to say a few words about the role that Medicaid plays in the market for private insurance against long-term care expenditure risk.

A. The Composition of Medicaid Spending

As already noted, Medicaid serves a wide range of eligible groups, including pregnant women, children, individuals who are blind, persons with disabilities, and the elderly.

However, from the perspective of budgetary and economic impact, not all Medicaid beneficiaries are created equal.

[7] As will be noted below, trends in disability rates, and other demographic changes, can also influence the growth in long-term care utilization, and thus Medicaid costs.
[8] Table 13-2 on page 209 of Budget for Fiscal Year 2006, "Analytical Perspectives."

For example, roughly half of persons served by the Medicaid program are children. However, children comprise only 16 percent of Medicaid expenditures.[9]

In contrast, the aged currently represent just over 10 percent of Medicaid enrollees, but account for over one quarter of all expenditures.

As we move into the future, it is reasonable to expect that a higher proportion of Medicaid recipients will be elderly individuals. Because this group spends disproportionately more on care than younger beneficiaries, this will place extra pressure on Medicaid finances.

When focusing on the elderly population, it is important to note that approximately two thirds of Medicaid expenditures on the aged is due to long-term care services, such as nursing homes and home health services. Put differently, roughly one out of every six dollars that the entire Medicaid program spends today is on long-term care services for the aged. This fraction is likely to increase in the future.

B. How is Long-Term Care Financed Today?

Because of the important effect that long-term care expenditures for the aged have on Medicaid financing, I want to turn now to a discussion of how long-term care is financed in the United States today. As a starting point, it is very important to know that the financing of long-term care differs markedly from that of acute care in this country.

Several features stand out:

1. First, Medi*care*, which pays the lion's share of acute medical care for the elderly, has extremely limited coverage of long-term care.

   While Medicare does cover 25 percent of total expenditures, this is primarily limited to short-term coverage. As recently explained by the CBO, "Medicare does not cover long-term care per se, but has become a de facto LTC financier through its coverage of care in skilled nursing facilities (following hospitalization) and its home health care benefit."[10]

2. Second, the share of long-term care expenditures paid by private insurance coverage is very small. Recent estimates by the CBO indicate that private insurance covered only 4 percent of total long-term care expenditures for the elderly in 2004.

3. Medi*caid* is the largest single source of financing for long-term care, covering approximately 35 percent of all expenditures. Because its payments are somewhat skewed toward coverage of institutional care, Medicaid pays nearly $2

[9] Estimates from Center for Medicare and Medicaid Services.
[10] CBO, "Financing Long-Term Care for the Elderly," April 2004.

out of every $5 spent on institutional long-term care of the elderly in the United States.

4. This leaves nearly one-third of long-term care expenditures to be paid for out of pocket by individuals. To put this in perspective, for the health sector as a whole, only 17 percent of expenditures are paid out of pocket.[11]

In short, the relation between Medicaid and long-term care is a two way street. Long-term care expenditures comprise a large fraction of total Medicaid spending. And Medicaid is responsible for a large fraction of total long-term care expenditures.

Thus, absent significant policy changes in the way we finance long-term care in the U.S., the rise in future Medicaid costs will be closely linked with growth in long-term care expenditures of our aging population.

C. Projected Long-Term Care Expenditure Growth and Implications for Medicaid

In my simplified analysis above, I focused on the primary demographic change, which is the fact that the number of elderly in the U.S. is growing rapidly. The Census Bureau estimates that the number of elderly individuals will double from 2000 to 2030. As a share of the population, the 65+ age group will rise from 1 in 8 today to over 1 in 5 by the middle of the 21st century.

Research indicates that, among those reaching age 65 in good health, the average age of first use of a nursing home is 83 for men and 84 for women. Therefore, it is particularly noteworthy that the share of the US population that is age 85 or older is expected to triple by mid-century (from 1.5% in 2000 to 5.2% in 2050).

It is clear that, all else equal, rising elderly populations will increase demand for long-term care, and thus increase fiscal pressures on Medicaid. However, not all else is equal. Forecasting future long-term care utilization is difficult due to several factors that work in offsetting directions, including:[12]

(i) One factor that could help to partially mitigate the rising dependency on formal long-term care is if, as individuals live longer, they also live healthier. That is, if we observe a declining prevalence of functional impairments, such as the ability to engage in activities of daily living, this could partially counteract the demographic pressure on long-term care costs. The evidence on functional impairment is mixed. There is substantial evidence that rates of impairment fell dramatically over the last century, and many analysts believe that recent rates of improvement will continue. However, there is also some

[11] National Center for Health Statistics, 2002. "Health, United States, 2002 with Chartbook on Trends in the Health of Americans." Hyattsville, MD.

[12] For a more in-depth discussion of the demographic trends affecting long-term care utilization, see the April 2004 CBO Report, "Financing Long-Term Care for the Elderly." My discussion of demographic trends draws substantially from that report.

evidence that impairment among people under age 65 may be increasing, which could lead to higher elderly impairment rates down the road.

(ii) Another factor that is difficult to forecast is the availability of informal substitutes for institutional care, such as that provided by family members. For example, many women provide informal care for their husbands, enabling them to stay at home rather than entering into a formalized care setting. As women live longer, on average, this may enable them to provide informal care for husbands at older ages.

(iii) As family sizes have fallen in recent decades, so too has the supply of potential adult child caregivers. When combined with increasing labor force participation rates of women, which has the effect of reducing the number of hours of care giving, the demand for long-term care services from the formal, paid sector, may rise.

These issues, and others, suggest that it is difficult to pin down a precise estimate of future long-term care expenditure growth. Nonetheless, most plausible scenarios suggest that expenditures for long-term care will likely outpace GDP growth over the next several decades. In other words, it is to be expected that Medicaid expenditures will continue to rise relative to the size of the economy.

D. Medicaid and the Market for Private Long-Term Care Insurance

As noted earlier, one of the major differences between acute health expenditures and long term care expenditures is the relative role of private and public insurance. In particular, private insurance covered only 4 percent of total long-term care expenditures in the U.S. in 2004.

Looking to the future, an important question is to what extent some of the future costs of paying for long-term care can be "off-loaded" onto the private sector through private long-term care insurance contracts. Indeed, several recent federal and local policy efforts have been focused on trying to stimulate this market.

There are many potential reasons that the private market in the U.S. is limited in size, including limitations on both the demand and supply side of the market. Given my focus on Medicaid today, however, it is instructive to consider the role of the existing Medicaid system.

In short, the Medicaid program appears to provide a disincentive for individuals to purchase private insurance policies against long-term care expenditures. This disincentive arises from the fact that, when a person buys a private contract, a large fraction of the benefits that they are purchasing are duplicative of what Medicaid would otherwise pay. In essence, Medicaid imposes a large implicit tax on the benefits of the private policy that renders its purchase unattractive for all but the highest wealth households.

This implicit tax arises for two reasons. First, a private policy protects a person's financial assets when they go into care. However, by protecting their assets, they also reduce the individual's ability to qualify for Medicaid coverage. Second, even in the event that the individual spends down enough to qualify for Medicaid benefits, Medicaid is structured as a secondary payer, which means that the private policy must still pay full benefits before Medicaid will pay.

As a result, absent significant structural changes in interactions between public and private insurance, there is strong reason to doubt the efficacy of public policy interventions designed to stimulate private coverage.

IV. Concluding Remarks

Americans are living longer than ever before, and that is good news for each of us as individuals. As a nation, however, we must recognize that an aging population will place growing fiscal pressures on all pay-as-you-go entitlement programs that are designed to provide financial assistance to older cohorts.

Having a larger share of our population over age 65 means that we should and will be spending a larger share of our GDP to support the consumption of the elderly.

However, we must also recognize that existing financial structure of key government programs that serve the elderly will place an ever-increasing tax burden on future generations. Social Security, Medicare, and Medicaid combined are projected to grow much faster than the economy. In just 75 years, it is estimated that these three programs will consume nearly one quarter of GDP.

If we continue to try to finance all of these programs on a pay-as-you-go basis, we will have no alternative but to impose an ever-larger tax burden on future generations, to scale back benefits, or to dramatically reduce all non-entitlement spending.

The best, and possibly only, alternative to trying to pay for these programs on a pay-as-you-go basis is to increase national saving. Increasing national saving, which requires that we reduce current consumption in order to invest for the future, can help to grow the economy as well as provide the resources from which to pay for the consumption of tomorrow's elderly.

Thank you for the opportunity to speak with you today.