Wye River Group On Healthcare

THE IMPLICATIONS OF AN AGING AMERICA: Creating Security for Retirement and Aging in an Era of Elders

OVERVIEW:

This paper reflects the views and opinions of a broad cross-section of healthcare stakeholders, based on comments and presentations at a series of 5 meetings on the implications of an aging America conducted by WRGH over the past year. We as a nation are just beginning to grapple with the complex challenges inherent in the burgeoning needs and demands of our aging population. This is not an advocacy paper. Our purpose is to share our learning with others who have a vested interest in working collectively to explore options that can constructively address the some of the key facets of this important public policy issue: long-term care and financing, chronic care and disability.

BACKGROUND

When one considers the growing gap between personal savings and retiree health care costs, as well as the fragmentation in healthcare delivery that currently exists, it is clear that our nation faces a serious problem in addressing the future healthcare needs of its aging population. There are tremendous implications for all areas of society as we prepare to enter the "era of the elders."

Looking ahead, it seems likely that the "baby boomers" – less trusting, more empowered and more demanding than their parents' generation – will redefine the way our society serves its older population. But their efforts will require support and guidance.

In April, 2002, Wye River Group on Healthcare assembled public policy thought leaders and a diverse group of private and public sector healthcare executives from all industry stakeholder groups. (1) The purpose was to begin a dialogue related to the implications of an aging America and try to reach agreement on necessary next steps to constructively address these challenges. We continued to evaluate this complex

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issue through 3 sector meetings organized in conjunction with RWJF (2) and a 2nd retreat in March, 2003. (3)

There is clear consensus among these experts that our country faces a domestic crisis in the making. It is a crisis for which we are ill-prepared, and one that requires us to rethink our current health care delivery system and reimbursement structures. At the heart of the problem is the current acute care delivery model and the lack of financial preparedness of individuals. Exacerbating these issues is the cost associated with advanced technology and chronic disease. The real issue is paying for long term LIVING!

We need to create a new paradigm. The traditional approach of tinkering with Medicare and employee benefits will not suffice. Our acute care model healthcare is ill suited to serve the healthcare needs of a growing elderly population with multiple chronic diseases, and it is a model we can no longer afford.

The country needs to completely re-examine its financing mechanisms and models for long-term care and encourage the creation of more flexible savings and spending options. Under the current environment, it is unrealistic to expect that society or individuals will be able to meet the burgeoning needs. A more expedient model empowers, educates and motivates individuals to behave differently and actually plan for their future. Achieving this may require changes in regulation and taxation. It will certainly require changes in expectations.

The good news is that we can avert this crisis if we work together. By collaborating to create change now rather than later, we can have a positive impact on the lives of millions of Americans in the future.

THE FACTS

U.S. Census trends indicate that during the next fifty years more people will live longer and need more care, but there will be fewer non-elderly people to care for them. The median and mean ages of the population will increase, but most significantly, there will be a shift within the population's age group cohorts. All age cohorts over 55, and especially the cohort over 85, will balloon during the next fifty years. But the traditional "caregiver group" – those aged 20-54 – will shrink as a percentage of population.

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Another way of looking at the problem is to consider the trend in taxpayer contributions to the Social Security system. In 1950, there were 15 people paying in to Social Security for each recipient. But today that ratio has fallen to 4 payers per recipient. By 2030, there will be an average of only 2 individuals paying in to the system per recipient.

Healthcare faces a similar picture. The burden on payers will increase dramatically as a result of the growing proportion of elderly patients within the overall population. It has been projected that by 2020 the elderly will account for 50% of the nation's healthcare expenditures and the need for long-term care will greatly tax the entire system.

These facts beg the question—how do we as a society want to handle the growing burden of the aging population? Will we have to resort to placing more elderly patients in huge, 800- or 1000-bed nursing home warehouses? If so, how will we staff them? If we aim to keep people in their own homes, who will care for them? In *Age Wave*, Ken Dychtwald suggests that the baby boomers could become "population velociraptors" that consume every resource in sight. It is a prospect that most of us would prefer to avoid.

Hopefully, we can start to create incentives that encourage individuals to take better care of themselves so that they can remain independent longer, and perhaps work longer. At the same time, we need incentives to develop care systems that support the elderly in the most cost-effective, efficient and integrated setting.

Let's take a look at some aspects of financing.

Seventy-seven million baby-boomers are on the brink of retirement and the majority of them are not going to receive employer-sponsored retiree health benefits. Ten years ago, about 60% of large employers offered medical coverage to their retirees, but now the number is under 30%. Only 23% of the companies that provide retiree health benefits continue coverage for the Medicare eligible. More than 30% of these companies don't provide any subsidy for the retiree coverage; it is entirely paid for by the former employee. Most telling of all, 75% of employees, most of whom work for small or mid-sized companies, never had the option of retiree health benefits at all.

According to Pricewaterhouse Coopers (PWC) 18% of workers are accumulating some money or a benefit for their retiree health needs, but coverage is not necessarily available at the group rate. Some employees get a little of both

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The erosion of employer-sponsored health benefits is the result of several contributing factors: global competition, healthcare inflation, Medicare changes, court rulings and the onslaught of retiring baby boomers. Companies continue to either go bankrupt over these issues or export jobs overseas.

Health benefits costs have skyrocketed in the past few years. At one large employer, the average per capita medical plan cost for a non-Medicare retiree was $5000 in 1998. The company paid the full cost because the plans were under the cap. But by 2005, that cost is predicted to double – with the employer paying between $7000 and $7500 while retirees will be asked to pay $3000-$3500.

For the Medicare eligible, the average per capita cost of a medical plan was just over $2000 in 1998. Again, the company paid the full cost because the plans were under the cap. But the cost for Medicare eligibles is expected to triple by 2005. The employer will likely pay between $3000-$3500 of the cost and retirees will be responsible for about $2800-$3300.

But most Americans are hardly prepared to pick up their share of these higher costs. According to AARP, the median net worth of Americans who are just 10 years from retirement is $150,000.00, including their home. The bottom quartile has a net worth of just $ 6,500.00! Where will the money come from to take care of them if it doesn't come from their own savings or the contribution of their employers?

As an AARP executive put it, "We have been talking to people the wrong way about a three-legged stool: Social Security, an employer pension, and individual savings. People need to think about work as part of their retirement plan." Individuals need to be protected against healthcare costs after retirement or they won't have security.

At the heart of preparing for the myriad challenges we face as an aging nation, is the need to give individuals the ability and incentive to plan prospectively for their financing and care delivery needs. The current sources of individual spending--personal funds, family funds, employer funds, government funds and charities--have many limitations that often preclude their matching the needs and desires of older Americans. Many of the savings vehicles do not support additional living costs, such as medical expenses, housing, assisted living, and decision support. We first have to identify the vehicles that will help us help ourselves. But we also have to recognize that in our pluralistic nation, approaches and solutions will be diverse and multi-faceted.

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STAKEHOLDER MEETINGS

To better understand different sectors' perspectives on these issues and their implications, WRGH worked with Robert Wood Johnson Foundation to plan and execute a series of three meetings—one with a wide range of healthcare providers, one with insurers, health plans and financial planners, and one with both large and small employers and associations that represent them. We also wanted to gauge their level of interest in a campaign to raise public awareness and create tools to help individuals plan for their long-term care needs.

Woven into discussions and debate about aging are numerous issues – prevention, care management, access, quality, financing, and consumerism – that are each complex in and of themselves. As we facilitated meetings focused on specific industry stakeholders, we learned that, few were proactively engaged, for a variety of reasons. Some felt ill-prepared because of a lack of tools, other sectors were distracted by what they perceive to be more pressing issues.

The meeting confirmed that long-term care and broader issues related to aging are widely misunderstood by policymakers, the public, and the employer community. In fact, the term long term care is perceived as a narrow concept focused only on insurance. Many view it as an ill defined and outdated term. The notion that insurance alone is the answer is completely unrealistic.

The far-reaching implications of this lack of understanding, if left unaddressed, will compound our current health and healthcare crisis in a way that is unimaginable. While planning for the care of an aging population is a complex problem that has unattractive connotations, it is one that is vitally important to all sectors, and each has a direct stake in understanding how to improve its financing and delivery. At the most basic level, it is a problem that demands definition and clarification as a primary first step.

Several key themes emerged in these stakeholder meetings: 1st, the need for public education; 2nd, the need for long-term care product definition; and 3rd, the need to create innovative new financing mechanisms. There was less emphasis on the issue of new models of care delivery, although its critical importance was recognized. Rather, there was a sense that we must first promote awareness and create a better approach to financing, then tackle the complex issues on the delivery side.

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EDUCATION

An important first step is to bring attention to the scope and breadth of the issues both within and outside the public policy arena. It was suggested that Congress, for example, should establish a focused initiative to learn about the implications of an aging population.

All participants agreed that the public is largely uninformed about the issues related to aging or of long-term care. People don't understand its terms, and they don't fully appreciate the financing and care needs they are likely to face in the future. They have the illusion that some public program—Medicare, Medicaid or Social Security—will pay for needed services. As a result, there is little planning, especially among those of modest means for whom long-term care is a very distant priority. According to insurance agents and financial planners, people generally are resistant to hearing about long-term care or insurance in the context of financial planning.

Physicians report that few among them advise their patients on this component of their care. They say that this is not a high priority to them as practitioners. Hospitals and other care facilities discuss long-term care needs with patients, but typically only in the context of discharge planning.

Insurers are "schizophrenic" in their view of the world of long-term care. When it comes to developing and marketing long-term care insurance, some see the product as an investment strategy, others as health insurance. Most recognize the product's potential. But while some see it as a ripe market, given the inevitable growth and associated needs of this segment of our population, others who began offering long-term care insurance a number of years ago have sold that part of their business.

Employers believe that employees should think about work continuance, insurance options and consistent savings as the "three legs of the stool" in well-aging. However, for the most part, they are not yet involved in helping their employees evaluate their future needs. Large employers, who generally are sophisticated with regard to benefit planning, recognize its importance but offer minimal planning tools and navigational help. Their main concern is the cost of retiree health coverage. However, they are interested in these issues from the perspective of employee productivity as impacted by health and by caregiving responsibilities.
All sectors report there is a tremendous amount of information available but that it is too complicated, uncoordinated, and under-publicized.

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The consensus is that we need to develop a national health policy focused on a vision of healthy, active, productive aging in America. Public policy should reflect this as the reality for most of our older citizens. Then we need to promote that model and its implications through a public awareness campaign. The widely held view is that educating lawmakers is a critical first step.

Government, communities and employers need to be talking about the problems and potential solutions. Messages need to be simple, targeted for different groups, and culturally acceptable. There is a need for solutions that are appropriate for people at all income levels.

The participants in our meetings expressed the belief that government should take on the primary role of spearheading the education campaign. However, most agreed that employers can and should be involved in educating their employees. Although it is unrealistic to expect small employers to take on a significant role, all employers and providers can serve as information outlets.

FINANCING ISSUES

With regard to financing issues, the consensus is that the current situation is dismal. There needs to be a complete rethinking of strategies for long-term care financing—where funds come from, when and how people plan for their needs, and for what purpose the funds can be used. In general, current tax law does not allow long-term care insurance or services to be tax deductible.

At this time, most long-term care is financed by the government or provided by unpaid family caregivers. Government payment systems are under funded and limit reimbursement to medical interventions, ignoring other low cost care alternatives.

Long-term care insurance, as a product is poorly defined and poorly understood outside, and even within, the industry. Is it a health insurance policy, a financial savings/retirement tool, income protection, asset protection, or an annuity? Most policies are sold in the individual market, and are expensive and inefficient from a marketing perspective. Brokers have a very difficult time attracting clients to long-term care products because the prospect of planning for one's "decrepitude and demise" is hardly appealing. Individuals with means do not see the need to purchase insurance and those of modest means cannot afford it.

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We need to take the critical first steps that would enable insurers to offer more attractive financing options and provide clearer product development and definition. New and expanded financial incentives are needed to attract the industry and the purchaser.

It would be helpful if there were incentives for employers to offer, and employees to fund, long-term care products and savings accounts while the employee is still working. Changes in the tax code would allow employers to offer long-term care insurance products and other savings mechanisms as part of a cafeteria plan or allow 401K plans to be used to purchase it. We could promote the use of HRA-type vehicles and other savings account mechanisms to provide a means for tax-advantaged payment for non-covered social and support services.

Another potential source of resources to help with long term care needs was cited by the National Council on Aging at our March, 2003 retreat, that of home equity. The vast majority of Americans who need long term care would prefer to receive it in their homes. Eighty percent of older Americans own their homes, tying up more than 1.5 trillion in home equity. This combination of facts has led NCOA to recommend the use of reverse mortgages to pay for long term care needs.

CARE DELIVERY/SERVICE ISSUES

The existing delivery model for long-term care in this country is, on the whole, unattractive. When most people think of long-term care, they think of nursing homes. As we consider the attributes of a well functioning, long-term care delivery model, we can envision better choices and benchmarks or standards for different sites of care and care services, e.g., home care. It is critical that there be patient-centered coordination of all services—medical, social and logistical—that the elderly individual will need.

NEXT STEPS

Several targeted next steps emerged from the series of meetings on the implications of an aging America. The presentations and discussions have suggested an initial focus on the following:

- Educating lawmakers at the state and federal levels on the facts and encourage their involvement in the development of public policy that proactively addresses

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these issues. We plan to begin by holding a hill briefing to share what we have learned from these meetings.

- Working with the IRS and others we will explore changes in tax law or its' interpretation relative to "accounts" to expand these financing mechanisms and permit their use for long-term care needs.

- Working with employers, insurers, financial planners and actuaries to develop new products and savings vehicles that create incentives for active workers to financially prepare for their future.

Other potential activities that we will consider, in partnership with other organizations, include:

- Developing an outline for a public awareness campaign that describes resources, targets and messages. The campaign needs a message that is tailored to the specific vested interests of each sector: government, employer, individuals, etc.
    - Lawmakers, who will see a burgeoning share of state and federal budgets consumed by long-term care costs, may be receptive to a message that demonstrates how certain policy changes might encourage people to plan for their own future needs and rely less on government as the payer of last resort.
    - A message targeted to employers should focus on their specific concerns, such as loss of productivity when employees have to take time to care for family members. Employers will be most receptive to education on how addressing the long-term care needs of their employees also benefits the company.
    - At the individual level, people would be most interested, presumably, in learning how they personally benefit by taking steps now to plan for their long-term needs.

- Working with other interested parties to develop and disseminate the necessary educational tools to raise public awareness of the challenges individuals face as they age and the limitations of current public programs.

- Providing a credible one-stop information source for the public at the community level, possibly through a community-based web site.

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In summing up the situation, an executive with a major US employer put it very well:

"This is a national problem. It calls for a national approach. It calls for getting the best minds as representatives from all generations. It calls for understanding, empathy, and practicality – all rolled into one initiative. It calls for a national imperative with a DEADLINE – a timeframe in which we have to come up with the solutions and lay the blueprint for the future…………

We can't stop aging – and I wouldn't want to try. We aren't going to stop [medical] technology – pharmacogenomics ise going to get medical treatment down to each specific individual in the very near future. And we certainly aren't going to stop demand.

So let's concentrate on what we CAN do. And what we can do involves [recognizing] that it is a national problem, heightening awareness of the problem and creating an imperative, and getting a cross-representative group together to roll up our sleeves, attack the problem with compassion, and come up with the solutions that fit our culture, our checkbooks, and our future. The clock is ticking. Let's not wait."

Regardless of age, financial situation or professional position, it is hard for anyone to rationally deny or ignore the serious consequences we all face if we do not begin today to plan for our future long-term care needs.

WRGH is committed to helping constructively frame the challenges, activate the public policy community, work with industry to develop financial tools and raise public awareness. This issue is too important to the health of our nation to wait until it becomes a crisis!

Endnotes:
(1) At the April, 2002 retreat, executives from the following organizations participated: AARP, American Academy of Actuaries, American Hospital Association, American Medical Association, Columbia Public Affairs, Congressman Johnson's office, Definity Health, Employee Benefit Research Institute, Ford Motor Company, Hospice of Michigan, IBM Corporation, Lumenos, Mayo Foundation, Motorola, National Center for Policy Analysis, National Pharmaceutical Council, Pareto Institute, PriceWaterhouseCoopers, Progressive Policy Institute, Project Hope/Health Affairs, Robert Wood Johnson Foundation, Texas Health & Human Services Commission, TRW, White House Council of Economic Advisors, Wye River Group on Healthcare

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(2) At the fall, 2002 sector meeting with healthcare providers, executives from the following organizations participated: Advamed, American Healthcare Association, American Hospital Association , American Medical Association , American Medical Group Association, American Nurses Association, American Psychological Association, Center on an Aging Society, Mayo Foundation , National Pharmaceutical Council, PhRMA, Robert Wood Johnson Foundation, Strauss Surgical Group, Texas Health & Human Services Commission

At the fall, 2002 sector meeting with payers and financial planners, executives from the following organizations participated: American Association of Health Plans, American Benefits Institute, Blue Cross Blue Shield Association, Cassaday & Company, Center on an Aging Society, Cigna, House Committee on Education & Workforce, Humana Senior Products, Long-term Care Planning Services, Lumenos, PriceWaterhouseCoopers, Progressive Policy Institute, Robert Wood Johnson Foundation, Smith Barney

At the fall, 2002 sector meeting with employers, executives from the following organizations participated: CalPERS, Cassaday & Company, Center on an Aging Society, Chicago Business Group on Health, Ford Motor Company, Hewitt Associates LLC, House Committee on Education & Workforce, IBM Corporation, Marsh Advantage America, Motorola, National Association of Manufacturers, Ogletree Deakins, Robert Wood Johnson Foundation, The MEDSTAT Group, US Chamber of Commerce, White House Council of Economic Advisors

(3) At the March, 2003 retreat, executives from the following organizations participated: American Cancer Society, American Hospital Association, American Medical Group Association, American Medical Association, Cassaday & Company, Chicago Business Group on Health, Cigna, Definity Health, Finch University, House Committee on Education & Workforce, IBM, Marsh Advantage America, Mayo Clinic, Motorola, National Council on Aging, Partnership for Caring, PriceWaterhouseCoopers, Robert Wood Johnson Foundation, Senator Lieberman's office, White House Council of Economic Advisors, Wye River Group on Healthcare

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