

Aging and Health Care

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Aging and Health Care

Introduction

Since 1900, the percentage of Americans 65 years old and older has more than tripled. Almost 2 million people celebrated their 65th birthday in 1999. The older population numbered 34.5 million in 1999 (DHHS, 2000). In the same year, about 1.8 million of this older population died, resulting in a net increase of approximately 200,000. The older population will continue to grow significantly in the future. By 2030 there will be about 70 million older people, more than twice the number in 1999. In 1996, 27 percent of older people assessed their health as fair or poor. Older people generally have at least one chronic condition and many have multiple conditions. Older people accounted for 36 percent of all hospital stays. Their average length of stay was 5.3 days. Older Americans spent 12 percent of their total expenditures on health, three times the proportion spent by younger people (DHHS, 2000).

As the population continues to age, there is a significant shift in the proportion of retired citizens to workers, as well as the sheer numbers of frail elderly, which is resulting in increased allocation of health care resources to the very old. Therefore, any solution to the present crisis in health care financing must take into account, these projected demographic changes as well as accounting for the health of individuals. It must be able to finance programs that will improve or at least hold stable, the common good and vitality of society as a whole. The rising costs of health care can be measured by the total percentage of the Gross National Product (GNP) spent on health care. Another measure that could be used, due to the above mentioned nature of health care expenditures would be to measure the out of pocket expenses of those over age 65. Currently, out of pocket expenses are approximately 12 percent of the older populations total income even with Medicare benefits (Hacker, 1994).

Medicare, America's largest public-health program, provides 39 million elderly and disabled beneficiaries with medical coverage. The program requires beneficiaries to pay a portion of the cost of treatment through premiums and co-payments, but payroll taxes on current workers pay for the majority of Medicare's costs. This pay-as-you-go funding scheme faces a crisis in the coming years as baby boomers begin to retire, causing a dramatic drop in the number of workers supporting each beneficiary. Although the booming economy of the 1990s has brightened the financial outlook for Medicare, the trust fund is expected to be bankrupt by 2029 (Aston, 2001). Congress and the administration are struggling to

find ways to reform the program to avert a financing crisis that will surely become a health care crisis if Medicare is allowed to fail. Of the options being studied at present, the only ones felt to be viable by politicians are to increase funds going into the trust fund using increased payroll taxes, to decrease the number of persons eligible for benefits by increasing the eligibility age or by relating eligibility to income. There are those in Congress who believe that there is no doubt that once the large portion of baby boomers moves into retirement there will be some kind of tax increase. The time to start establishing the groundwork for Medicare efficiency has nearly passed, the funding and benefit issues need to be addressed now if some kind of fix is going to be effective.

Medicare Eligible Beneficiaries

This evolving demographic in the United States will force changes in the delivery and financing of health care. Experts predict that this impending financial crisis will force people to become more sensitive to the ramifications of their use of available medical-resources. There are also those that predict that the first ones to face sacrifices will not be the consumers, but health plans and providers. We have already seen some of this with the advent of managed care plans and the gradual decrease in specialty physician incomes in the latter part of the 1990s.

Overall, the American health care system is seeing a growing dissatisfaction and distrust by consumers with what has become the traditional “allopathic” or “western” type of high tech, high intervention, acute care method of health care delivery. Forty-two percent of Americans now seek alternatives to traditional “allopathic” medical interventions except in the most dire of emergencies (e.g., millions of women are taking soy preparations rather than using hormone replacement therapy). Many people are trying entirely different approaches to health care from chiropractic to homeopathy to quartz crystals. Probably the fastest growing segment in the health care industry is actually a return to ancient herbal remedies, for which there is an ever-growing quantity available and a very persuasive market.

But, due to financing limitations for the age 65 and older there is Medicare and the “allopathic” health care industry with its’ expensive medications, hospital stays, surgical interventions and late in life preventive measures. But, even Medicare has come of age from the typical indemnity style reimbursement scheme to a much more complex managed care program. There is still not much choice between allopathic medicine and homeopathy or other alternative treatment strategies, but the Medicare

financing plan was not designed to have that much flexibility. Instead, during the 1990s, following the passing of the Health Maintenance Organization Act and during the initial phases of attempts to restructure Medicare, the traditional indemnity plan gave way to three options under one plan. These plans are broken down by how much is paid in by patients, how much is paid in by the trust fund, what extra benefits are available, which doctors to visit, and where to seek care.

The original Medicare plan is also known as “fee-for-service”. This is the one that is available nationwide and through which most care is delivered. The patient is usually charged a fee for each health care service or medical supplies needed. Most patients that utilize this plan also choose a supplemental insurance that pays that portion of expenses not covered by Medicare. Most of these supplemental plans are very expensive on an annual basis and can be difficult for those on fixed incomes to manage. Medicare also has a managed care plan. This plan is also called an HMO. It is offered by private insurance companies and is available in many areas of the country. Medicare pays a set amount of money each month to the private insurance company, based on patient enrollment. In most managed care plans the patient can only go to plan doctors and hospitals and these facilities and providers are contracted to provide services at a reduced rate, which benefits patients as well as the Medicare trust fund. The newest health care plan under Medicare is called private-fee-for-service plan. Private insurance companies offer this plan. It is available in some areas of the country. Medicare pays a capitated amount to a local private insurance company. The insurance company rather than the Medicare program, decides how much it pays and how much the patient pays, for the service provided.

One of Medicare’s biggest shortfalls is in its lack of coverage for prescription drugs on an out patient basis. Older Americans typically need more medication than younger people do. Because these medications are being used to treat ailments that have usually been acquired over lifetimes, they are expensive and there are relatively few inexpensive options available. Prescription medications are therefore a major expense for both the patients and the industry overall. Some estimates of this expense put it in the range of \$12.9 billion dollars annually. Interest in offering some type of coverage for medications is growing as more employers are offering medication plans or prescription drug coverage as an essential tool for medical management in their benefit packaged, but Medicare still does not primarily because of the cost. This type of benefit is extremely expensive and benefits few younger workers the

way it would the elderly population. Medicare does provide drug coverage to beneficiaries who are inpatients in hospitals or skilled nursing facilities. This high cost of prescription drugs represents a real financial hardship for the millions of Medicare beneficiaries who have inadequate or no insurance coverage for prescription drugs. There is also the fear by many that offering any type of prescription benefit under the Medicare umbrella will speed the loss of funds from the Medicare trust fund and hasten the collapse of the entire funding scheme.

Military Medicare Eligible Beneficiaries

Since Medicare eligible uniformed service retirees, their spouses and survivors who are age 65 and over represent approximately 1.4 million of the total 34.5 million people age 65 and over nationally, it is only appropriate to discuss the 2001 National Defense Authorization Act (NDAA). On October 30, 2000, former President Clinton signed the 2001 National Defense Authorization Act (NDAA). Of the many authorizations contained in this act, one directed the Department of Defense to provide medical care to all eligible beneficiaries including retirees who are Medicare-eligible. This new addition to the military medical care program is known as TRICARE for Life. These military beneficiaries had traditionally received this care at military treatment facilities when there was extra provider and space capacity, or space available, or they had to rely on Medicare to pay medical bills when there was no military treatment facility available (Sears, 2001). Many of these retirees had been fairly successful in receiving the needed care directly from the military until the early 90s when the Department of Defense closed or downgraded services at many of their facilities as it attempted to balance its shrinking budget. Following a lawsuit by a group of military retirees in 1999, claiming that they were owed lifetime care due to promises made to them when they joined the military, Congress directed the Department of Defense through the 2001 NDAA to find a way to provide the services being requested within the current budget allowance (Sears, 2001).

Within the 2001 NDAA Medicare-eligible military retirees, their family members and survivors now have TRICARE as the 2nd payer to Medicare as long as they are enrolled in Medicare Part B. The coverage is similar to the supplemental policies purchased by other non-military Medicare eligible beneficiaries, except the military retiree pays nothing out of pocket for the coverage. Medicare Part B

covers doctors' services, outpatient hospital care, blood, medical equipment and some home health services. It pays for other medical services such as laboratory tests, physical and occupational therapy, and some preventive health care, such as mammograms and flu shots.

With enrollment in Part B the beneficiary will be provided with the following coverage:

- If the medical care is a benefit of both Medicare and TRICARE, Medicare will pay the allowable amount for the care. TRICARE will pay the amount that is the Medicare cost share, as well as the Medicare deductible. Most, but not all medical services are a benefit under both Medicare and TRICARE.

- If the medical care received is a benefit of Medicare, but not a benefit of TRICARE, Medicare will pay its normal amount and the beneficiary will be responsible only for the Medicare deductible and cost-share. An example of this type of care is certain types of chiropractic care that is covered by Medicare but not TRICARE.

- If the medical care received is a benefit of TRICARE, but not a benefit of Medicare, Medicare pays nothing. TRICARE will pay the amount it pays for the same service received by a retiree under the age of 65. In this case, the beneficiary must pay the applicable TRICARE cost-share and deductibles. An example of this type of coverage is the prescription drug benefit.

Another program that was expanded under the NDAA was the pharmacy benefit program for beneficiaries over the age of 65. The pharmacy benefit provides Medicare-eligible retirees of the uniformed services, their family members and survivors the same pharmacy benefit as retirees who are under the age 65. This includes access to prescription drugs not only at military treatment facilities, but also at retail pharmacies and through the mail order pharmacy program. This program will limit the out-of-pocket costs and increase access to a National Mail Order Program and retail pharmacies that are part of the Department of Defense network, which include many major chain drug stores. Under the pharmacy program, beneficiaries will not pay enrollment fees or annual premiums, but will pay modest co-pays when using the National Mail Order Program and retail network pharmacies. In addition, beneficiaries will also be able to use non-network pharmacies, but this option will entail a slightly higher co-pay and deductible. The expected cost of this pharmacy benefit program is projected to be \$800 million per year for the military retiree population.

Providing the Care

The majority of senior citizens remain in traditional and expensive, fee-for-service Medicare plans. Because of this factor, group medical practices need to prepare for the challenges that they will face with this ever-increasing older population. When providing medical care to the growing elderly population, there are three key factors that should be considered – providing care locally, educating support staff and patients, and making the facility accessible to senior citizens.

Surveys have suggested that senior citizens do not want to travel long distances for primary care and that they prefer smaller, more personal locations with a low employee turnover rate and a patient, friendly and caring staff. Educating support staff and patients is important in ensuring the health care needs of senior citizens are met, (e.g., theories about aging, physiological changes that occur with aging and how to identify high-risk patients). Patients should be instructed on how to access the facility, how to receive after-hours and emergency care. The facility layout should be accessible to the senior citizen. Wheelchair accessible, adequate seating, clear signs, and handrails in the hallways are just a few of the additional requirements necessary when ensuring that the medical treatment facility is equipped to handle the elderly (Gerrity, 1998).

Family members currently provide approximately 80 percent of the necessary care for the elderly. Although a caregiver can be anyone – a spouse, child, friend or neighbor, usually it is a woman. The typical caregiver is a 57-year old, female, married and employed outside of the home (Clark & Weber, 1997). Many older adults develop mental or physical impairments requiring assistance with eating, toileting and or dressing. The availability of caregivers to the elderly is a critical factor in their being able to remain in the home, rather than having to be placed in a more expensive institutional setting.

Conclusion

The focus for all health care programs should be placed on prevention. Medicare and TRICARE programs offer services that are aimed at preventing disease and maintaining healthy people. Preventive services include screenings, immunizations, and counseling from health care professionals. Medicare has expanded coverage of some preventive services that encourage beneficiaries to stay healthy. TRICARE has always provided preventive services to the young active duty population and now under the TRICARE for Life program these services are available for the over 65-age group.

As the American health care system continues to evolve, from a traditional fee-for-service through the implementation of managed health care to whatever the next era will be called, there are still a number of issues that must be addressed if this system of care is to survive. At a time when the system is trying to hold on to gains made in inflationary costs, placing more and greater restrictions on measures that increase cost effectiveness is counter to what is needed if health care is to be made more affordable to a greater number. Holding the line on access should not be seen as decreasing quality, when access to many of the "modern" higher cost modalities has no proven benefit when applied in the context of increased quality life expectancy. Instead, the focus should still be on methods of reducing cost, increasing access to needed health care, and improving the quality of that care. In order that these issues be addressed, the American health care system must be viewed as a whole with the Military Health System as a partially self-sustaining segment of that whole. With over 1.4 million uniformed services retirees, spouses and survivors over the age of 65 that total 3.45 million Americans over the age of 65 changes undertaken by the Military Health System should not be ignored, but should be used as a training or testing ground for possible changes to the larger system.

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