

# Background

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## *Demographics*

Between now and 2030, Oregon and the country will experience an unprecedented shift in the age of our population. According to 2000 Census data, those individuals 65 years of age and older make up nearly 13 percent (438,177) of Oregon's population. This number is projected to more than double to 1,029,230 or 20 percent of the overall population (an increase of over 50 percent) by 2030.<sup>1</sup> In other words, for the first time in history, our population will have more elders than youth. Such a population shift has significant implications for the future of Oregon.

With the increase in the elderly population there is also an anticipated expansion in the number of individuals with disabilities. This is due in part to advances in medical science and to the increased prevalence of disability as we age, especially for those 80 years of age and older (73.6 percent of those 80 plus have a disability).<sup>2</sup> It is projected that the number of individuals 85 years of age and older will more than double by 2030, an increase from 1.7 percent (57,431) to 3 percent (136,437) of Oregon's total population, or 13 percent of the 65-plus population.<sup>3</sup>

The number of elder individuals from various racial and ethnic minority populations is also expected to increase by 2030. The unique differences and cultural expectations, as well as a history of discrimination and general disadvantage, compels the acute and long-term care service delivery systems to become culturally competent. In Oregon, the percent of minority people age 65 and older (includes Non-Hispanic and Hispanic) is a little over five percent of the total 65-plus age cohort.<sup>4</sup> Poverty rates among Black and Hispanic elders are today 2.5 times more than those among Whites. When gender is added to race, the disparities become even more notable.<sup>5</sup> Concrete steps must be taken to improve the retirement prospects and long-term care needs of people of color. Not only are they disadvantaged by a lifetime of employment inequities, they are often at greater risk for a number of chronic diseases, including diabetes, strokes, and heart disease.<sup>6</sup>

## *Women, Family and Informal Care Providers*

Women have a longer life expectancy than men, earn less than men (72 cents to the man's dollar), provide the majority of unpaid care for children and elders, and also have a higher incidence of chronic diseases that impair mobility such as arthritis and osteoporosis.<sup>7</sup> Therefore, women tend to be both the highest users of long-term care as well as the primary caregivers for those needing long-term care. The number of

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<sup>1</sup> Office of Economic Analysis, Department of Administrative Services, State of Oregon, [www.oea.das.state.or.us/demographic/longterm/or\\_age5.htm](http://www.oea.das.state.or.us/demographic/longterm/or_age5.htm).

<sup>2</sup> Jack McNeil, "Household Economic Studies Current Population Report P70-73, Americans With Disabilities: 1997," United States Census Bureau, created March 1, 2001 <http://www.census.gov/hhes/www/disable/sipp/disab97/asc97.html>.

<sup>3</sup> Source: Census Data, <http://www.census.gov/population/projections/state/stpage.txt>.

<sup>4</sup> Administration on Aging, <http://www.aoa.gov/Census2000/minority-sumstats.html>.

<sup>5</sup> Robert B. Hudson, "Getting Ready and Getting Credit: Populations of Color and Retirement Security," *Public Policy and Aging Report*, Volume 12, No. 3, Spring 2002, 1.

<sup>6</sup> *Keeping Oregonians Healthy: An Assessment of Leading Causes of Death and Related Behaviors in Oregon*, 1999, Oregon Health Division, 60-66.

<sup>7</sup> Pamela Herd, "Care Credits: Race, Gender, Class, and Social Security Reform," *Public Policy and Aging Report*, Volume 12, No.3, Spring 2002, 14.

women receiving long-term care paid by Medicaid is nearly three times greater than men.<sup>8</sup> With the trend toward smaller and more mobile families, the availability of children to provide care to aging parents is reduced. This trend coupled with women in the workforce further reduces the availability of family and informal care providers. Even so, 80 percent of care is provided by family members, predominantly women. Therefore, public and private policies that support family caregivers are crucial to keeping the costs for long-term care down.

## *Workforce*

Not only are there fewer family and informal care providers, there is also a shortage in health and long-term care workers. For example, it is projected that Oregon will need over 39,000 registered nurses by 2010, but will fall short of the demand by over 7,000 given the graduation rate of the year 2000. Even if the graduation rate doubles each year beginning in 2005, there will be a shortage of over 3,000 registered nurses by 2010.<sup>9</sup> Other health care and long-term care jobs are experiencing similar shortage issues.

Several factors contribute to the scarcity of paid health and long-term care workers including:

- An increase in demand by an aging population
- Retirement of current health care workers
- Few men and minorities entering the field
- Poor working conditions such as mandatory overtime, lifting and other physical demands, and emotional stress
- Too much paperwork incurred by reimbursement
- Lack of training programs to promote upward career mobility for those with English as a Second Language (ESL) needs
- Shorter hospital stays that increase the need for outpatient and home health care, and
- Regulations that limit flexibility in responding to workforce shortages.<sup>10</sup>

With the aging of the baby boomers, the scarcity of health and long-term care workers will only increase unless action is taken now to recruit, train and retain them.

## *Long-Term Care Costs*

Long-term care is very expensive. Nationally, the average annual cost of in-home care is \$20,000 and is expected to jump to \$68,000 by 2030. The average annual cost of nursing facility care is \$50,000 and is expected to climb to \$190,600 by 2030.<sup>11</sup> The average cost per person in Oregon, who receives care in a nursing facility paid by the Medicaid program is approximately \$2,400 per month, or \$28,800 per year. The average cost for in-home care, paid by the Medicaid Program is approximately \$800 per month or \$9,600 per year.<sup>12</sup> The average cost of care for an individual receiving services paid by Oregon Project Independence is \$153.04 per month or \$1,836.48 per year.<sup>13</sup> Those who pay privately for long-term care in Oregon pay more and often subsidize the rate paid by Medicaid. The cost of long-term care is only expected to continue to rise, making its financing a huge policy issue.

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<sup>8</sup> Source: Oregon Department of Human Services, Seniors and People with Disabilities, 360 Assessment Data, June 2001.

<sup>9</sup> Source: NWHF Report, "Projected Decline in RNs due to Retirement, Projected Growth in RN Positions, and Effect of Doubling RN Graduation Rate Beginning 2005," 2001 and the Oregon Employment Department.

<sup>10</sup> *Health Care Sector Employment Initiative: An effective course of treatment for some of Oregon's most pressing health care workforce challenges*, a project of the Oregon Workforce Investment Board, May 2002.

<sup>11</sup> The Federal Long Term Care Insurance Program Brochure, FED00048(0502).

<sup>12</sup> Source: Oregon Department of Human Services, Seniors and People with Disabilities, 360 Assessment Data, June 2001.

<sup>13</sup> 2001-2003 Oregon Department of Human Services, Senior and Disabled Services Division, Budget Narrative adopted by the Oregon Legislature, Long-Term Care, Oregon Project Independence, 226.

Medicaid caseload projections indicate an increase from approximately 31,000 cases in 2002 up to 75,665 by 2020 depending on the scenario used. This would mean a general fund expenditure increase from a little over \$200,000,000 in 2002 to more than \$600,000,000 (trended forecast) in the year 2020.<sup>14</sup> Neither of the forecast scenarios adjusts for inflation. In other words, general fund expenditures for Medicaid long-term care consumers could triple in less than 20 years. Such an increase in general fund expenditures will have a tremendous impact on all state-funded programs and services.

## *Medicaid, Medicare and Long-Term Care Insurance*

Medicaid has become the default mechanism for payment of long-term care for most elderly and persons with disabilities regardless of income. While Medicaid was never intended to become the primary source of long-term care payment, it has become so, primarily because individuals who begin as middle class and paying for their long-term care privately, end up spending down their resources and impoverishing themselves, making them eligible for Medicaid. Currently, Medicaid and Medicare are the two major payment systems for acute and long-term care for seniors and people with disabilities. Medicare is a federal health insurance program, while Medicaid is a medical assistance program jointly financed by the state and federal governments for eligible low-income individuals. Medicaid provides payment for acute medical care, long-term care and prescription drugs. Medicare Part A covers inpatient hospital stays, limited skilled nursing care, home health care, and hospice services. It is funded primarily through payroll taxes paid by employees, employers and the self-employed, but also is funded by premiums paid by enrollees. Medicare Part B covers inpatient and outpatient services received from physicians, additional medical services such as outpatient and emergency hospital care, therapy services, ambulance transportation, equipment and supplies, and home health care. Part B Medicare is funded primarily through monthly premiums paid by enrollees (who must cover 25 percent of the Part B costs) and through general tax revenues.

Medicare does not pay 100 percent of all medical bills, nor does it cover prescription drugs or a variety of long-term care services provided in community-based settings. Since there are gaps in what Medicare pays, many elders and people with disabilities also purchase Medicare supplement insurance policies from private insurers, enroll in a Managed Care Organization, or purchase a tax-free savings account plan earmarked for health care expenses.

A much smaller number of seniors and younger people actually purchase long-term care insurance. According to the Health Insurance Association of America, 6.8 million long-term care policies had been sold by the end of 1999. In 1999 alone there were 750,000 long-term care insurance policies sold.<sup>15</sup> However, nationally, only one percent of all long-term care is paid by private long-term care insurance.<sup>16</sup> As a result, many individuals who require long-term care spend down their resources to pay for their care and eventually become eligible for Medicaid.

Oregon has a long history of managed care and high enrollment of seniors in Medicare Managed Care Plans, resulting in lower medical costs. In order to keep the cost of medical care down, Medicare sets reimbursement rates for various services by region. Therefore, since Oregon has been able to keep costs down relative to the rest of the country, physicians are penalized by receiving a much lower reimbursement rate than physicians in other parts of the country (i.e., the same procedure is reimbursed at a higher rate in New York than in Oregon.) Further, the way physicians are currently reimbursed does not encourage good chronic disease assessment, management and preventive care.

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<sup>14</sup> Department of Human Services, Office of Finance and Policy Analysis, *Long Range Caseload Estimates for the Medicaid Long-Term Care Program of Seniors and People with Disabilities*, June 2002.

<sup>15</sup> "Long-Term Care in 1998-1999: Summary of Study Findings," Health Insurance Association of America, <http://www.hiaa.org/research/usefulfacts.cfm#/longtermcare>.

<sup>16</sup> Senior Health Insurance Benefits Assistants (SHIBA) A Volunteer Training Manual, Oregon Department of Consumer and Business Services, 2002, 10.

## *State Long-Term Care Service Delivery System*

The Department of Human Services' (DHS) policy unit, Seniors and People with Disabilities (SPD) is responsible for administering programs for children and adults with developmental disabilities, seniors and people with physical disabilities. The overall mission of Seniors and People with Disabilities is to assist seniors and people with disabilities of all ages to achieve well-being through opportunities for community living, employment, family support and services that promote choice, independence and dignity. The services provided by Seniors and People with Disabilities and its local partners (area agencies on aging) include: long-term care services, licensing and planning, eligibility, case management, cash assistance, and protective services. Seniors and People with Disabilities and its local partners also administer and implement the following programs: Medicaid long-term care services, Older Americans Act (OAA), Oregon Project Independence (OPI), Employment Initiative, Employed People with Disabilities, Employment for People with Developmental Disabilities, Family Support, Children's Intensive In-Home Services, 24-Hour Residential Services, and the Staley Agreement.

These programs are funded through a mix of federal and state sources. Medicaid and Oregon Project Independence require individuals to be low-income, have few resources and meet other conditions. However, eligibility for Older Americans Act Programs only mandates that individuals be 60 years of age or older, with no further requisites.

Elder Oregonians and younger persons with disabilities have a variety of long-term care options available to them in most regions of the state. These options include:

- ❖ Respite Care
- ❖ Adult Day Services
- ❖ In-home Services
- ❖ Adult Foster Homes
- ❖ Assisted Living Facilities
- ❖ Residential Care Facilities
- ❖ Continuing Care Retirement Facilities
- ❖ Other Non-Licensed/Certified Retirement Homes
- ❖ Nursing Facilities
- ❖ Program for All-inclusive Care for the Elderly (PACE) (*Multnomah Co. only*)

## *Chronic Disease Prevention and Management*

During the 20<sup>th</sup> Century, the leading causes of death changed from infectious diseases to chronic diseases. Today, heart disease, cancer, stroke, diabetes and lung disease are the leading cause of death. Chronic diseases account for seven out of every ten deaths in Oregon. As the "Baby Boom" generation ages, the number of Oregonians affected by chronic diseases will escalate rapidly, increasing both health care costs and the burden of chronic disease. According to the Robert Wood Johnson Foundation, individuals with chronic conditions are healthcare's largest, highest-cost and fastest growing service group, accounting for 75 percent of all healthcare spending.<sup>17</sup> Two-thirds of Medicare spending is on behalf of the 20 percent of people who have five or more chronic conditions.<sup>18</sup> The more chronic conditions an individual has, the higher out-of-pocket expenditures they will incur.<sup>19</sup> If we are to compress morbidity (the time in which chronic disease occupies one's life span, allowing for a shorter time of disability prior to death) and subsequently decrease medical and long-term care costs, Oregonians need to modify three behaviors in

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<sup>17</sup> Richard Bringewatt, "Be Aware of Chronic Care," *State Government News*, August 2002, 28.

<sup>18</sup> "Medicare: Cost and Prevalence of Chronic Conditions," *Partnership For Solutions*, July 2002, [www.partnershipforsolutions.org](http://www.partnershipforsolutions.org).

<sup>19</sup> Health Policy Alternatives, Inc. in collaboration with The National Chronic Care Consortium, *A Guide to Regulatory Reform for People with Chronic Conditions*, March 2002, 3.

particular: 1) quit smoking, 2) eat a healthy diet, and 3) exercise. Other modifiable factors include eliminating drug and alcohol abuse, infections, and environmental contaminants.<sup>20</sup>

While we are living longer with less disability over all, it is not certain this trend will continue for baby boomers. The prevalence of risk factors among adults approaching their later years is alarmingly high in the United States. The vast majority of the population age 51 to 61 (89 percent) have at least one modifiable risk factor, and almost one-fifth (19 percent) have three or more modifiable risk factors.<sup>21</sup> Over 500,000 or approximately 20 percent of Oregonians smoke. Furthermore, only 27 percent of Oregonians engage in regular physical activity, contributing to an alarming trend of overweight and obesity. Over half (57 percent) of Oregon adults are considered either obese or overweight.<sup>22</sup> Since smoking, overweight and physical inactivity are key risk factors of chronic diseases, individuals, businesses, the state, its communities, and health and long-term care providers need to work together to increase the potential for health and decrease the incidence of chronic diseases.

## *Retirement Income*

With the uncertainty of the continued solvency of Social Security, the dissolution and dwindling of various private and public sector pension plans and the lack of personal savings by most baby boomers, the future financial stability of many is uncertain. According to United States Senator Larry Craig (Idaho), member of the U.S. Senate Special Committee on Aging, “The personal savings rate is almost zero. Many Americans are spending more than they save.” He further stressed that the average retirement savings account balance is now about \$35,000 and the median is \$14,000 and that 61 percent of all workers between the ages of 25 and 64 did not own a retirement savings account in 1998.<sup>23</sup>

As one might guess, women and minorities tend to be those most at risk of financial insecurity as they age. Single mothers who never married are especially vulnerable. Women continue to have lower labor force participation rates and earnings than men, mainly due to their disproportionate responsibility for raising children and caring for the elderly. Also, women still earn less than men.<sup>24</sup>

For baby boom females in Oregon, retiring at the Social Security normal retirement age, the average total, before-tax annual retirement income, ranges from just under \$20,000 to approximately \$24,000 annually. For Oregonian baby boom men, retiring at the Social Security normal retirement age, their annual income will range from approximately \$27,000 to \$33,000 (expressed in 2001 dollars).<sup>25</sup> While this may be enough income to meet most baby boomers’ basic expenses, it ceases to be enough for many, when health and long-term care costs enter the picture.<sup>26</sup>

Therefore the need for Oregonians to save for future retirement and potential long-term care is most pressing. With anticipated increases in life expectancy and increases in health and long-term care costs as well as living expenses, it is doubtful that pensions and social security alone will be enough to ensure a retirement that will meet the basic needs of many aging baby boomers.

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<sup>20</sup> Source: *Keeping Oregonians Healthy: An Assessment of Leading Causes of Death and Related Behaviors in Oregon*, Department of Human Services, Oregon Health Division, 1999.

<sup>21</sup> “At Risk: Developing Chronic Conditions Later In Life,” *Challenges for the 21<sup>st</sup> Century: Chronic and Disabling Conditions*, National Academy of an Aging Society, February 2000 , 1.

<sup>22</sup> Source: Centers for Disease Control and Prevention.

<sup>23</sup> U.S. Department of Labor and Congressional Research Service as cited by U.S. Senator Larry Craig, Press Release, February 26, 2002.

<sup>24</sup> Pamela Herd, “Care Credits: Race, Gender, Class, and Social Security Reform,” *Public Policy and Aging Report*, Volume 12, No. 3, Spring 2002, 13 and 14.

<sup>25</sup> Jack L. VanDerhei and Craig Copeland, *Oregon Future Retirement Income Assessment Project: Final Report*, Employee Benefit Research Institute, September 7, 2001.

<sup>26</sup> Jack L. VanDerhei and Craig Copeland, *Oregon Future Retirement Income Assessment Project: Final Report*, Employee Benefit Research Institute, September 7, 2001.