

THE FUTURE OF OLDER ADULT SERVICES IN A TIME OF DISRUPTION

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The U.S. is at a critical inflection point in its care for older adults. Demographic challenges are colliding with pressures to control costs, politics are increasingly at odds with economics, and the healthcare system is struggling to understand how it should interact with the social supports many older adults need.

Recent policy decisions are further weakening an already fragile system of services for the aging. And costs for both medical and long-term care continue to rise, even as households and the government are under financial stress.

The overarching question is: Do we try to rebuild a system of care that is already failing? Or, instead, should we reimagine how medicine, social supports, housing and family finances can be brought together to maximize the well-being of older adults?

To address this dilemma, it is important to understand the significant challenges involved in delivering the supports and services our nation's aging population needs. These issues and growing stresses on healthcare, housing and social services call for major changes to our fragmented care model that will allow older adults to age with dignity and compassion.

CHALLENGES OF CAREGIVING IN THE U.S.

The challenge is immense: The U.S. — along with the rest of the developed world — faces an exploding population of older adults, many living with chronic conditions. The oldest baby boomers are reaching age 80, and the fastest-growing population in the U.S. is the cohort of 85-year-olds.¹ This is critical because, while health remains relatively stable for the “young old” (those now in their 60s and early 70s), it begins to decline rapidly after age 75.²

Long-term care, or long-term services and

supports (LTSS), is the assistance people with chronic conditions need to live their best possible quality of life. It is not medical treatment but complements healthcare. It is often described as assistance with activities of daily living, such as personal care and nutrition, but more broadly also may include managing finances, social interactions and even appropriate housing.

Family caregivers remain the bedrock of the U.S. care system. More than 80% of those receiving long-term care live in the community rather than in senior living facilities.³ About two-thirds of them are cared for only by family members and friends, with no paid assistance.⁴

As the number of older adults grows, the supply of family and paid caregivers can't keep up. The ratio of family caregivers to those who need assistance is shrinking. A simple example: In the U.S. in 2010, there were seven people of prime caregiving age (those between ages 45-64) for every person aged 80 or older. By 2030, there will be four, and by 2050, three.⁵

And that does not account for population mobility, which results in parents and their adult children living in distant cities. Among those aged 75 and older, nearly one-quarter of men and more than 40% of women live alone.⁶

Those family members who do care for their loved ones often pay a significant physical, emotional and financial price. They run a high risk of back injuries and depression. And as many as 1 in 5 working family caregivers reduce their

hours. Others take leaves, quit their jobs or retire early.⁷ By one estimate, a woman who leaves her job to care for a family member will lose more than \$200,000 in lifetime income.⁸

The growing shortage of paid aides increases the burden on family caregivers. One study finds the demand for care workers in the U.S. will exceed supply by 151,000 in 2030 and by 355,000 by 2040.⁹

Many aides left the industry during the COVID-19 pandemic. Others are retiring from physically difficult work. More than 40% of personal care aides are aged 50 or older.¹⁰

This trend is exacerbated by the current administration's immigration policies. Before the ongoing immigration crackdown, close to one-third of care workers were immigrants.¹¹ Now, at least 1.4 million fewer immigrants live in the U.S. than in January 2025,¹² likely making care worker shortages more severe.

Finally, care for older adults and others with chronic conditions is deeply fragmented. Even in an era of near-ubiquitous electronic medical records, communication among physicians — and with patients and their families — often is wanting.¹³ Critical continuity of care may be lost when patients are transferred among hospitals, skilled nursing facilities and home.

These gaps are even more severe when a patient requires long-term services and supports, which require a high level of integration between two siloed care systems. Hospital discharge planners are often ill-equipped and time-constrained to provide useful information about post-acute care. Most physicians have little knowledge and few financial incentives to advise their patients about personal care needs.

In general, the government payment system struggles to recognize how LTSS can improve seniors' health and potentially reduce medical costs. And even when it does, the system suffers from what economists call the "wrong pocket problem." For example, a state may spend to improve its Medicaid LTSS program, but generally will not share in any Medicare cost savings from those initiatives.

GROWING BUDGET PRESSURES

Housing also plays a critical role in supporting older adults.

Because Medicaid pays for room and board only in nursing facilities, it steers frail older adults to that high-cost care setting. Medicaid cuts enacted in 2025 are likely to further shift Medicaid home and community-based care, an optional benefit, to nursing home care, which states must provide.

For those with low incomes who can live independently, the U.S. has a system of affordable, subsidized housing, though it is woefully underfunded. At the same time, the U.S. faces an enormous gap in middle-income housing for those who may benefit from limited support. For example, there are no incentives for owners/developers to provide routine health screenings or place social workers in buildings with large numbers of middle-income older adults.

The U.S. faces these multiple challenges against the backdrop of rapidly growing federal budget deficits and the rising costs of healthcare, a significant contributor to both public and private expenditures.

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The U.S. spends nearly 20% of its economy on healthcare. Medicare, Medicaid and Social Security, the largest programs that support older adults and younger people with disabilities, account for more than half of all federal government spending, excluding interest on the debt.¹⁴

In that environment, support for seniors inevitably will face growing budget pressures in the coming years.

RETHINKING CARE MODELS

How can we address these complex and potentially costly challenges?

It will be critical to think broadly and creatively about a future system of care for older adults with significant medical and personal care needs. And as we consider these reforms, it is important to keep in mind that delivery and financing are

inextricably linked. Without sufficient funding, public or private, no reforms are likely to succeed.

Start with the biggest payer: Medicaid. To be eligible for Medicaid LTSS, people need to have very low incomes and few financial assets and, broadly, need a nursing home level of care, though qualifications vary widely by state.

Despite spending more than \$200 billion annually on LTSS,¹⁵ Medicaid often provides insufficient care to meet the needs of its enrollees. At the same time, it is difficult to coordinate a fragmented payment system in which Medicaid funds personal care and Medicare pays for medical care.

That leads to a key question: Do we want to continue building an LTSS system primarily on an income-based program, such as Medicaid, or shift to an insurance model for all but those with the lowest incomes?

A second question: Are there ways to better integrate today's deeply fragmented care model? The U.S. could do this in several ways:

■ **Shift some government spending from medical care to LTSS.** This rebalancing of priorities would bring the U.S. more into line with other major developed countries.

■ **Expand Medicaid funding.** This could make Medicaid LTSS more robust, but would add to government costs and require reversing recent policy changes that limited access to the program. In addition, it would not break down the existing silos between Medicaid and Medicare.

■ **Create a new Medicare LTSS benefit.** In recent years, Medicare has made small changes in that direction. For those enrolled in traditional Medicare, it is providing caregiver support and care navigation for the first time, though only through limited demonstration programs.

One example is CMS's Guiding an Improved Dementia Experience (GUIDE) Model, which supports families of people living with dementia. Medicare also developed other demonstrations that would give financial incentives to providers for including LTSS-like services in medical practices and health systems. For example, the updated Long-term Enhanced Accountable Care Organization Design (LEAD) model encourages participating medical practices to develop interventions to prevent falls, a step that could include a range of nonmedical services, such as home modifications, better nutrition and family caregiver education.¹⁶

CMS has also created opportunities for more

robust LTSS through managed care, such as Medicare Advantage and Special Needs Plans, and through the Program of All-Inclusive Care for the Elderly (PACE), which is funded through both Medicare and Medicaid. This concept could be significantly expanded by creating a separate Medicare LTSS benefit. However, this step would likely increase federal spending or premiums, which are already substantial.

■ **Establish a public long-term care insurance program.** Washington state has enacted such a program, which provides an immediate benefit of up to \$36,500. It is fully funded with a payroll tax of about 0.6% and has started paying benefits this July.

Several other states, including California, Minnesota, Massachusetts and Illinois, are exploring their own state-based LTSS financing programs.

A second option would be federal long-term care insurance. One bill, the Well-Being Insurance for Seniors to be at Home (WISH) Act, has modest but bipartisan support in the House. Unlike the Washington state program, it would create universal catastrophic insurance that provides partial lifetime support after a possible waiting period of one or two years. WISH is also intended to be fully funded, although key details remain unresolved (I advise on technical aspects of this bill).

The catastrophic model could lower Medicaid LTSS spending by as much as one-third over the long run. However, a universal, fully funded program would require some form of tax increase, which many in Congress would resist.

Any of these changes would be deeply disruptive to providers who have built their business models around the existing payment system. The challenge will be for them to help develop reforms that are financially sustainable and align with the mission of improving the lives of the older adults they serve.

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NOTES

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Upcoming Events

from the Catholic Health Association

Faith Community Nurses Networking Call

July 21 | 1 – 2 p.m. ET

United Against Human Trafficking Networking Call

July 23 | 1 – 2 p.m. ET

Global Health Networking Call

Aug. 5 | 11 a.m. – 12:30 p.m. ET

Mission in Long-Term Care Networking Call

Aug. 27 | Noon – 1 p.m. ET

We Are Called Networking Call

Sept. 10 | 1 – 2 p.m. ET

Community Benefit Networking Call

Sept. 17 | 1 – 2:15 p.m. ET

