



SOCIETY OF ACTUARIES

Managing the Impact of Long-Term Care Needs and
Expense on Retirement Security Monograph

How American Society will Address Long-Term Care Risk, Financing and Retirement

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How American Society Will Address Long-Term Care Risk, Financing and Retirement

John Cutler

Introduction

Mark Twain reputedly said “Everybody talks about the weather, but nobody does anything about it.” For those of us toiling in the world of long-term care (LTC, aka long-term services and supports (LTSS)), that sounds like us: Everybody talks about long-term care, but nobody does anything about it.

As to the problems we face, most scholarly papers devote the first five to 10 pages to the statistics of the problem. For that, I thank the federal Commission on Long-Term Care and many other scholars before them that have so expertly laid out the issues both as to the aging of the population¹ as well as the cost.²

Disclaimer: The views and opinions expressed in this article are those of the author and do not necessarily reflect the official policy or position of any agency or the federal government.

¹ Commission on Long-Term Care, “Report to the Congress” (Sept. 30, 2013) at <http://www.gpo.gov/fdsys/pkg/GPO-LTCCOMMISSION/pdf/GPO-LTCCOMMISSION.pdf>. See also “CBO Rising Demand for Long-Term Services and Supports for Elderly People” June 26, 2013. Accessed at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/44363-LTC.pdf>. In that report they note that “by 2050, one-fifth of the total U.S. population will be elderly (that is, 65 or older), up from 12 percent in 2000 and 8 percent in 1950. The number of people age 85 or older will grow the fastest over the next few decades, constituting 4 percent of the population by 2050, or 10 times its share in 1950. That growth in the elderly population will bring a corresponding surge in the number of elderly people with functional and cognitive limitations. . . . One study estimates that more than two-thirds of 65-year-olds will need assistance to deal with a loss in functioning at some point during their remaining years of life. If those rates of prevalence continue, the number of elderly people with functional or cognitive limitations, and thus the need for assistance, will increase sharply in coming decades.” The commission was created by Section 643 of the American Taxpayer Relief Act of 2012 (P.L. 112-240). See also Deanna Okrent, Alliance for Health Reform, “Covering Health Issues: A Sourcebook for Journalists” at <http://www.allhealth.org/sourcebooktoc.asp?SBID=7>, particularly Chapter 11 (“Long-Term Services and Supports”), at <http://www.allhealth.org/sourcebookcontent.asp?CHID=188>.

² See Lauren Harris-Kojetin, Manisha Sengupta, Eunice Park-Lee and Roberto Valverde, “Long-Term Care Services in the United States” (2013) accessed at http://www.cdc.gov/nchs/data/nsltcp/long_term_care_services_2013.pdf. From their “Fast Facts” highlight (footnotes omitted):

- About 11 million adults age 18 and older, almost 5 percent of the total U.S. adult population, receive long-term services and supports (LTSS).

This paper will not attempt to fully explore the problem. But, having said that, there is a wealth of information on the activities that will shape our world to come. AND some surprising notions become apparent when making such an environmental scan.

The thesis behind this paper is to assume the following is true: What if we have a crisis and no one comes? What if we muddle along and do nothing? Or rather, at best, we only move forward with incremental public initiatives, and the private sector similarly makes marginal product changes? What does America look like if we ignore all the warnings? What will happen to Medicare and Medicaid and private insurance? How will Social Security (not to mention pensions and personal savings and investments) fare? And what will the housing component look like? Caregiving? The workforce?

To repeat, there actually WILL be some modifications or changes in public and private systems, and many of these are already in play. In fact, it might well be that we ARE seeing long-term care reforms underway but too incremental (and fragmented) to be obvious. But will we see large-scale intervention or reform? Will there be something that breaks the mold? The overviews below are some of the things to consider.

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- In 2011, spending for LTSS was \$210.9 billion (9.3 percent of all U.S. personal health care spending).
 - 52 million unpaid caregivers, primarily family members and friends of those needing LTSS, provide the majority of care.
 - In 2010, about 47 percent of Medicaid LTSS spending was for home and community-based services (HCBS), up from 24 percent in 1997.
 - Personal care aides and home care aides will be the fastest growing occupational categories in the country between now and 2020.

See also Carol O'Shaughnessy, National Health Policy Forum, "National Spending for Long-Term Services and Supports (LTSS) (2012)," which is also a good source for information on spending for LTC. Accessed at https://www.nhpf.org/uploads/announcements/Basics_LTSS_03-27-14.pdf.

EXECUTIVE SUMMARY “ROAD MAP”

For those readers that want the answer to the story upfront, this paper essentially posits that there is more going on than meets the eye. This is true notwithstanding the likelihood policymakers will make marginal changes at best. Actually, it might even be better to suggest that the changes will be accidental as well as incremental. The private market will also change slowly. The author chose to discuss these in eight rather large buckets. Each of the “conclusions” (actually they are inferences the author draws from the research) is below. For the full analysis read those sections.

Medicaid

Medicaid remains untamed. In addition to a shift to managed care, we will see further benefit expansions. The program becomes more than a delivery mechanism for institutional care. It will also evolve to cover a wide range of LTSS, and states will find a way to cope.

Medicare

There will continue to be Medicare, and it will continue to cover certain benefits that are LTC in nature, whatever their name. Moreover, the expansion in what Medicare covers in the LTC realm may end up, in and of itself, creating a policy shift that finally admits Medicare coverage is not just post-acute care. Such recognition dramatically increases the possibility of reform of Medicare to cover LTC in a more comprehensive way. However, if that occurs it will likely be in the form of managed LTC. It may or may not also encompass financial trade-offs within the program—for instance, lower benefits for those coming in but enhanced benefits for those 85-plus.

Health Insurance

The importance of passage and implementation of the Affordable Care Act (ACA) to retirement and LTC decision-making has been underappreciated. Shoring up health insurance coverage for the population shy of 65 means better physical *and* financial health. What the ACA potentially means is that the Medicare eligibility age of 65 could be changed/aligned with Social Security’s normal retirement age of 66 (or even higher if members of Congress seeking to raise the Social Security age succeed) because individuals now have access to affordable health insurance with no fear bad health deprives them of access due to underwriting or pre-existing conditions.

Long-Term Care and Life Insurance, and Annuities

These changes in the life and annuity market to cover LTC may accelerate in the future. If so, the important point is that this helps with the annuitization of retirement, a goal of many aging experts. In a sense, the insurance component is simply a side dish to the main meal of retirement security. So a trend toward life-based LTC protection is an important development for the financial needs of those going into retirement. In addition, there is room for legislative action for private insurance products with little budget implication if the existing retirement products

(individual retirement accounts (IRAs) and the like) are restructured so there is explicit recognition of LTC.

Social Security

Nothing will be done (or maybe something minor), and Social Security will survive. But those Social Security checks will come in lower than what people expect. As a consequence they will delay retirement so as to “restore” the difference.

Pensions

There will be minor changes to pension issues, mostly around auto-enrollment and making sure companies are not held to severe fiduciary standards (meaning held liable if pension investments don't turn out well). But employers will mostly continue to avoid the problem by offloading retirement risk to employees by continuing the trend away from defined benefits to defined contributions. However, these trends weaken the safety and comfort of more and more Americans, and “economic fairness” moves to the forefront. This in fact may supplant the discussion of intergenerational equity by focusing attention across all age bands. Look to see this as a major part of the 2016 presidential campaign.

Housing and Reverse Mortgages

The home isn't going to be what it used to be, but there is still some money there AND better ways to get at it.

Family, Caregiving and Workforce

The family will continue to be the first line of care, but other unskilled caregiver systems will evolve to add to the mix. Society, especially including employers, will be forced to adapt.

Possibilities for More Expansive Reform

The tenet of this article is *not* that there won't be changes in the way insurance and retirement will be addressed. To the contrary, it seems probable that there will be a wide array of policy proposals or product ideas to address the growing number of individuals moving into older ages and retirement. But absent some completely unexpected policy proposal or product that fixes all these problems and makes them go away, these changes will be marginal and incremental.

However, we are at an exciting time for those trying out bolder and more serious policy proposals. This paper discusses some of those:

- The Commission on Long-Term Care
- William Galston at Brookings
- Robert Moffit at Heritage
- LeadingAge, and its guidelines (framework) for financing long-term care
- The Bipartisan Policy Center
- The Society of Actuaries (multiple areas of research including this call for papers)
- Paul Forte and his American Long Term Care Insurance Program.

Medicaid

Many advocates of social insurance seek a program that would provide long-term care (or LTSS) for those that need it. One could argue that we already have this. It is called Medicaid. While not as “guaranteed” a benefit as Medicare—in the sense there is a qualifications test to Medicaid that does not exist in Medicare—it reaches further in its coverage of long-term care than Medicare. Indeed, the growth of home and community-based services (HCBS)³ as an option within Medicaid arguably changes the program still further. Not only does it deliver institutional long-term care but now tantalizingly promises to include LTSS.⁴

It is unclear if these initiatives around increasing HCBS options for long-term care/LTSS will show savings. One could argue that if they are cost-neutral and also delivering the care people want, then the change is good.⁵ It is not realistic to expect this change to be cost-neutral when our experience in that respect has been in tightly controlled pilots. Hence these attempts may falter and the support of policymakers may dwindle.

³ Building on initiatives such as Money Follows the Person. See Carol O’Shaughnessy, National Health Policy Forum, “Money Follows the Person (MFP) Rebalancing Demonstration: A Work in Progress” accessed at https://www.nhpf.org/uploads/announcements/BP85_MFP_05-10-13.pdf. See also Mathematica, “Money Follows the Person: Expanding Options for Long-Term Care” accessed at <http://www.mathematica-mpr.com/health/moneyfollowsperson.asp>. See also Ethan Lieber and Lee Lockwood, “Costs and Benefits of In-Kind Transfers: The Case of Medicaid Home Care Benefits,” Michigan Retirement Research Center Working Paper 294 (2013).

⁴ The definition of “long term services and supports” is still in flux as it is a somewhat new renaming of the concept. Advocates and researchers believe “the name change will ‘reflect a more contemporary nomenclature used in the field and the life-span approach toward providing supportive services to individuals with chronic and disabling conditions regardless of setting.’” See, for instance, Statement of Academy Health’s Long-Term Care Interest Group, at <http://www.academyhealth.org/Events/events.cfm?ItemNumber=12491&navItemNumber=2034>.

Here is the definition used by the Administration on Community Living (formerly the Administration on Aging): “Long-Term Care is a range of services and supports you may need to meet your personal needs. Most long-term care is not medical care, but rather assistance with the basic personal tasks of everyday life, sometimes called Activities of Daily Living (ADLs)... Other common long-term services and supports are assistance with everyday tasks, sometimes called Instrumental Activities of Daily Living (IADLs)...” <http://longtermcare.gov/the-basics/what-is-long-term-care/> (accessed May 5, 2014). See also the CMS (Medicaid) description of LTSS, at <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Long-Term-Services-and-Supports.html>.

⁵ Ethan M.J. Lieber and Lee M. Lockwood, “Costs and Benefits of In-Kind Transfers: The Case of Medicaid Home Care Benefits,” Michigan Retirement Research Center (2013) accessed at <http://www.mrrc.isr.umich.edu/publications/papers/pdf/wp294.pdf>. (“Providing benefits in kind potentially distorts decisions and leads to a deadweight loss if recipients value the benefits less than a cost-equivalent cash transfer. Yet providing benefits in kind may have some offsetting benefits, especially in terms of improving the targeting of benefits to desired beneficiaries.”)

Also, in the real world, low reimbursement rates may well reduce HCBS quality just as they have on the institutional side. Perhaps this will decay the value and decrease utilization. It could also mean that individuals in these settings come to rely on informal care to fill gaps in care.⁶

Concomitantly with the HCBS experiment to curtail cost growth, are state efforts to manage the care better, particularly around the dually eligible population using both Medicare and Medicaid. Medicaid has been transformed in the past few years on the acute side to a managed care program,⁷ but, looking ahead, we would need to see true integration of care coordination.⁸ Or states can proceed (and probably will) by restricting eligibility or imposing waiting periods.

States may also increase the effort to implement Medicaid estate recovery rules, which would potentially deter individuals from spending down to get Medicaid long-term care. In theory states can recover, including against the house, for any recipient of Medicaid long-term care (either immediately or once the stay-at-home spouse has passed away).⁹ However, these efforts have been notoriously unsuccessful. More interesting is the recent effort of states to go after life insurance instead of the home. The way this is done is by having the state Medicaid officials suggest sale of the life insurance to a life settlement company so the individual has more resources and does not spend down as quickly, if at all.¹⁰

⁶ The author is making an assumption that HCBS are essentially structured loosely enough that beneficiaries can use informal/unskilled care whereas they are less able to do so on the institutional side.

⁷ Paul Saucier, Jessica Kasten, Brian Burwell and Lisa Gold, “The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update,” CMS (July 2012) at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf. See also presentation of Cheryl Phillips, “Managed Long Term Service and Supports (MLTSS),” presentation at RTI webinar May 27, 2014. Her slides can be accessed at http://www.rti.org/pubs/ltc_slideshow_policy_forum.pdf. She believes the shift, which has already come to 26 states (with another 10 soon to follow) is permanent, though the form may be different, e.g., bundled payments instead of true networks.

⁸ Lynda Flowers, AARP, “Getting Ready for Managed Long-Term Services and Supports,” (December 2013), accessed at http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/the-readiness-review-process-spotlight-care-report-AARP-ppi-ltc.pdf.

⁹ DALTCP, “Medicaid Liens” (Thomson/MEDSTAT April 2005) accessed at <http://aspe.hhs.gov/daltcp/reports/liens.htm> and DALTCP, “Medicaid Estate Recovery” (Thomson/MEDSTAT April 2005), accessed at <http://aspe.hhs.gov/daltcp/reports/estaterec.htm>.

¹⁰ Kelly Greene, “States Ease Use of Life Policies for Elder Care” *Wall Street Journal* (June 16, 2013). See also Allison Bell, “Texas Lawmakers OK Life Settlement LTC Financing Bill.” *LifeHealthPro* (May 29, 2013), at <http://www.lifehealthpro.com/2013/05/29/texas-lawmakers-ok-life-settlement-ltc-financing-b>. The funds from the life settlement would be placed in an irrevocable account that can only be used to pay LTC services. Other states considering similar legislation include Kentucky, California, Florida, Louisiana, Maine, Montana, New Jersey, New York and North Carolina. See “Kentucky Legislature Sends LTC Life Settlement Bill to Governor for Signature,” A.M. Best (April 1, 2014), at <http://www3.ambest.com/ambv/bestnews/newscontent.aspx?refnum=172891&URATINGID=2255588&altsrc=23>. See also Paula Span, “A New Way to Pay for Long-Term Care,” *New York Times* (Oct. 9, 2013), at <http://newoldage.blogs.nytimes.com/2013/10/09/a-new-way-to-pay-for-long-term-care/?src=recg> (writing about a company called Life Care Funding that offers to buy life insurance

One of the surprises in researching this article is the robustness of Medicaid. Or perhaps it is more accurate to say the robustness of efforts to defeat limits authorities try to place on Medicaid expansion. For instance, a recent letter to state Medicaid directors from the Centers for Medicare & Medicaid Services (CMS) states that they plan to regulate estate-recovery actions, though in the context of also implying they would allow states to proceed. The provision inserted into the original “claw back” provisions of the Social Security Act allowing recovery may send a signal to states that is unintended.¹¹

Another sign of the need for Medicaid to remain a strong part of any LTC reform is the resistance of the general population to alternatives such as private LTC insurance (LTCI). Research across a number of years and testing various scenarios all indicate the strength of Medicaid versus private coverage for this risk. Neither tightening Medicaid eligibility rules nor providing tax incentives for insurance has budged the public’s reliance on Medicaid.¹²

policies) and Miriam Rozen, “New Firm Swaps Life Insurance Policies for Long-Term Care,” *Financial Planning* magazine (Dec. 1, 2013).

¹¹ SMDL #14-001 (ACA #29) Feb. 21, 2014 “Application of Liens, Adjustments and Recoveries, Transfer-of-Asset Rules and Post Eligibility Income Rules to MAGI Individuals” at <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-001.pdf> (basically extending lien rules to MAGI individuals). See also Shannon Mullen, “Feds Worry Death Rules Will Limit New Medicaid Enrollees,” *USA Today* (March 10, 2014) accessed at <http://www.usatoday.com/story/news/nation/2014/03/10/medicaid-enrollees-billed-at-death/6262707/> and Tim Jost, *Health Affairs* blog “Implementing Health Reform: Medicaid Asset Rules and the Affordable Care Act,” (Feb. 24, 2014) accessed at <http://healthaffairs.org/blog/2014/02/24/implementing-health-reform-medicaid-asset-rules-and-the-affordable-care-act>.

¹² The most famous paper is by Jeffrey Brown and Amy Finkelstein, “Insuring Long-Term Care in the United States,” *Journal of Economic Perspectives* (Fall 2011) accessed at <http://pubs.aeaweb.org/doi/pdfplus/10.1257/jep.25.4.119>. The authors state that while Medicaid reform is necessary in order to increase the purchase of private insurance, it might not be sufficient given concerns about the product and the existence of substitutes including informal care by relatives and home equity.

Geena Kim found the same thing, that without Medicaid, LTCI demand would increase by only 5.3 percent. Indeed, she modeled tax incentives as well and found little increase in LTCI purchase. See Geena Kim, “Medicaid Crowd-Out of Long-Term Care Insurance with Endogenous Medicaid Enrollment” (University of Pennsylvania 2010) <http://repository.upenn.edu/edissertations/104/>. See also her presentation to the Long Term Care Discussion Group “The Impact of Tax Subsidies and Medicaid Financing on the Demand for Long Term Care Insurance” (Jan. 26, 2011) accessed at <http://www.ltcdiscussiongroup.org/archives2.html>.

There will also be no end to those who counsel potential beneficiaries on how to plan their estate so as to make it possible to gain access to Medicaid if they ever need LTC.¹³

Inference: Medicaid remains untamed. In addition to a shift to managed care, we will see further benefit expansions. The program becomes more than a delivery mechanism for institutional care. It will also evolve to truly cover a wide range of LTSS, and states will find a way to cope.

Medicare

Medicare is one of the more stable components of senior planning for retirement, though one with numerous changes recently with Medicare Advantage and the expansion of drug coverage, as well as cost-sharing for Part B.¹⁴ Here the focus will be on coverage outside acute care.¹⁵

Examples of this push and pull:

- Medicare changed the homebound standard to make it more restrictive.¹⁶

Other research found the same thing for a variant of LTCI called Partnership products that link the private insurance to Medicaid. In fact that variant potentially led to higher Medicaid expenditures. Anthony Webb and Wei Sun, “Can Long-Term Care Insurance Partnership Programs Increase Coverage and Reduce Medicaid Costs?” Center for Retirement Research at Boston (March 2013) at <http://crr.bc.edu/working-papers/can-long-term-care-insurance-partnership-programs-increase-coverage-and-reduce-medicaid-costs/>. See also Anthony Webb and Wei Sun, “Can Incentives for Long-Term Care Insurance Reduce Medicaid Spending?” Center for Retirement Research at Boston College (April 2013) at <http://crr.bc.edu/briefs/can-incentives-for-long-term-care-insurance-reduce-medicaid-spending/>.

For a contrary position on Medicaid crowd-out, see the various works of Steve Moses of the Center for Long-Term Care Reform, at <http://www.centerlrc.com/reports.htm>.

¹³ See, for instance, Sean Bleck, Barbara Isenhour and John A. Miller, “Preserving Wealth and Inheritance Through Medicaid Planning for Long-Term Care,” *Forthcoming Michigan State University Journal of Medicine and Law* (2014) at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2126111.

¹⁴ Medicare Part D did not so much increase seniors’ access to drugs (they were already buying them) but it did aid in the overall cost and therefore helps the highest-utilizing seniors the most, including those in need of LTC. Gary Engelhardt and Jonathan Gruber, “Medicare Part D and the Financial Protection of the Elderly,” NBER Working Paper No. 16155 (July 2010).

¹⁵ Not discussed here are the continuing fiscal issues around Medicare solvency. The 2014 Trustees report found that Part A will have sufficient funds to cover its obligations until 2030, four years later than was projected last year and 13 years later than was projected prior to passage of the ACA. See <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2014.pdf>.

¹⁶ For a good description see Center for Medicare Advocacy, “New CMS Proposed Homebound Policy Would Leave Medicare Beneficiaries Without Coverage” (November 2103) at

<http://www.medicareadvocacy.org/new-cms-proposed-homebound-policy-will-leave-medicare-beneficiaries-without-coverage/>.

- Until the *Jimmo* case reversed it, Medicare had a fairly restrictive definition of the need to show improvement in order to continue to receive Medicare-covered services.¹⁷ The standard for coverage of post-acute-care services now is “maintenance” but guidance from the U.S. Department of Health and Human Services (HHS) clarifying this has not been promulgated.
- We also saw HHS altering the definition of observation status pertaining to the requirement that without a three-day qualifying *inpatient* hospital stay, Medicare will not pay for subsequent care in a skilled nursing facility (SNF). This is called the “Two Midnight” rule and is still up in the air.¹⁸
- One would be remiss not to note what might colloquially be called “coverage creep.” In 1988, \$2.9 billion was spent on the Medicare benefits we might rightfully call LTC (home health and skilled nursing facility). By 2011 it was over \$65 billion, a rise from 3 percent to 18 percent.¹⁹
- Various legislative proposals to expand medical services in such a way that LTC (services and supports) are actually increased, breaching the concept that Medicare only offers a post-acute benefit.²⁰

¹⁷ The case was a federal class action lawsuit to eliminate the so-called “improvement standard.” Filed Jan. 18, 2011 in federal district court in Vermont and settled Oct. 16, 2012. On Jan. 24, 2013, the U.S. District Court for the District of Vermont approved the settlement agreement. This outcome restates that a person need not show “improvement” to receive Medicare covered services. ***JIMMO v. SEBELIUS*, Civ. No. 5:11-CV-17 (D. VT. 1/18/2011). The Settlement Agreement—No Expansion of Medicare Coverage:** The *Jimmo v. Sebelius* settlement agreement itself includes language specifying that “... this settlement does not represent an *expansion* of coverage, but rather, serve to clarify *existing* policy so that Medicare claims will be adjudicated consistently and appropriately.” See <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf>.

¹⁸ A class action lawsuit was filed, alleging that use of observation status violates the Medicare Act. The complaint was dismissed Sept. 23, 2013 and the plaintiffs filed notice of appeal. See ***BAGNALL v. SEBELIUS***, No. 3:11-cv-01703 (D. Conn., filed Nov. 3, 2011).

¹⁹ Joshua Wiener, “Financing Long-Term Care: More Same than Different, with Some Twists,” presentation at RTI webinar May 27, 2014. His slides can be accessed at http://www.rti.org/pubs/ltc_slideshow_policy_forum.pdf. The presentation was at an RTI Program, “The Past and Future of Long-Term Care: 1989 to 2039.” But by 2030 the youngest boomer will have reached retirement age.

²⁰ A measure called the Better Care, Lower Cost Act of 2014 from Senator Ron Wyden, chair of the Senate Finance Committee, to allow participating providers to offer LTSS as well as medical treatment. Discussed by Howard Gleckman, “Wyden Bill Would Integrate Medicare Health Care, May Open the Door for Long-Term Care,” *Forbes*, Jan. 22, 2014: <http://www.forbes.com/sites/howardgleckman/2014/01/22/wyden-bill-would-integrate-medicare-health-care-may-open-the-door-for-long-term-care/>. Others would say this is modest at best. Conversation with former Senate Aging Committee staffer Anne Montgomery, June 17, 2014. Another is the Medicare Transitional Care Act by congressmen Earl Blumenauer and Tom Petri to “ensure that appropriate follow-up care is provided” during transitions from hospitals to LTC, home and other settings, when patients are

Tensions around the sustainability of Medicare as the boomer cohort ages suggest no permanent realignment or expansion of Medicare to change the post-acute benefit to LTC, much less add a Medicare benefit for LTC. Indeed, the very expansion mentioned above means even MORE pressure to control Medicare cost growth and leaves policymakers and advocates seeking other ideas that would reform delivery and/or financing—for instance, creating an LTC gap-filling insurance product à la Medicare supplement insurance²¹ or perhaps restructuring Medicare to create an enhanced chronic care benefit for Medicare beneficiaries after age 85.²²

Regarding Medicare supplement (Medigap), one should not discount its importance to cost-sharing. Recent testimony on Medigap shows the importance of this product to Medicare:

Because Medicare imposes significant cost-sharing requirements, most beneficiaries have some type of supplemental coverage to fill in the gaps. According to data compiled by MedPAC, 89 percent of FFS beneficiaries in 2007 had supplemental coverage: 43 percent had employer-sponsored coverage; 29 percent had individually purchased Medigap coverage; 16 percent had Medicaid, and 1 percent had other public coverage.²³

most vulnerable. The bill includes a “flexible” benefit to support as improved assessment, planning, medications management, movement between care levels, and coordination of support services such as meals and medical equipment. See John Hall, “Medicare Bill Would Boost Transitions to Long-Term Care, Other Settings,” McKnight’s (June 2, 2014): <http://www.mcknights.com/medicare-bill-would-boost-transitions-to-long-term-care-other-settings/article/349267>.

²¹ John Cutler, Lisa Shulman and Mark Litow, “Medi-LTC—A New Medicare Long Term Care Proposal,” presentation for Georgetown Center on an Aging Society’s Long Term Care Financing Project (papers commissioned by Robert Wood Johnson Foundation to look at innovative approaches modeling possible LTC financing reform)(June 2007): <http://ltc.georgetown.edu/forum/1cutler061107.pdf>. Since about 6 percent of Americans have LTCI but something like 60 percent of seniors buy Medicare Supplement insurance, it might be worthwhile to add some LTCI plans to the standardized Medigap plans.

²² Statement of Cori Uccello (American Academy of Actuaries), Committee on Ways and Means Subcommittee on Health, U.S. House of Representatives, “Hearing on Examining Traditional Medicare’s Benefit Design,” Feb. 26, 2013 at http://www.actuary.org/files/Medicare_FFS_Testimony_030813.pdf. Another idea would re-craft the Medicare home health and nursing facility coverage to provide a three-month full front end of coverage (but with no net monetary change) and no coverage at all after day 90, then create private sector insurance coverage options of one, three or five years’ worth of coverage policies (with a three-month deductible) as wraps. The idea of a different benefit for age 85+ is that while hospital services comprise the largest share of Medicare benefit payments, coverage such as assisted living is more important for those over age 85. See Medicare Primer (2009) from Kaiser Family Foundation, at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7615-02.pdf>.

²³ Statement of Cori Uccello, op cit. at pages 7-9. For a review of the literature as to whether Medigap increases the cost of Medicare, see MedPAC *Report to the Congress: Aligning Incentives in Medicare* (June 2010). Their statement stated that research suggests that broad increases in cost-sharing, rather than targeted increases, reduce not only unnecessary care, but also necessary care, especially among the low income and chronically ill. In another study, RAND found that low-income individuals in poor health were more likely to suffer poorer health outcomes. Joseph P. Newhouse and the Health Insurance

Absent radical change, however, policymakers and stakeholders are left with the option to try to manage the care better, particularly the dually eligible population using both Medicare and Medicaid. Medicaid has already shifted on the acute side into a managed care program. But it has yet to do as much with managing chronic care. The care coordination required to combine care for people receiving both Medicare and Medicaid will be a challenge.

Before moving to that we should look at the impact of the ACA on Medicare:

Before the ACA, Medicare beneficiaries were arguably the best protected from financial risk, and individually insured under age sixty five were the most vulnerable of all insured. Following full implementation, Medicare beneficiaries are more vulnerable in several ways than younger insured who buy exchange plans. First, even if premiums consume a similar share of income for a member of each group with median household income, the ACA provides premium and cost-sharing subsidies for exchange coverage for those earning up to 400% of the FPL, significantly more generous than the subsidies available to retirees, only up to 135%.

Second, with the exchanges, the ACA attempts to create a marketplace with higher transparency and clearer choices [than in the private health insurance market] so that individuals can tradeoff premiums and cost sharing risk to some degree. Regulation of private Medigap plans has created a marketplace that is too opaque for retirees to make meaningful choices among supplemental coverage options. In response, most opt for the highest level of coverage in Plan F. If instead of being categorized by letters that have no meaning to consumers, Medigap plans were arrayed on a dimension of value and sold in a way that retirees might understand, more like exchange plans, beneficiaries would have a chance to make more educated tradeoffs.

Finally, Medicare beneficiaries likely face higher risk of spending on essential uncovered items than those with exchange coverage. The ACA includes most of the items and services someone with exchange coverage would use in the mandated essential health benefits.

Medicare's coverage gaps are more likely to leave retirees without benefits in areas where they need care. Even with supplemental coverage, many spend significant amounts

Experiment Group. *Free for All? Lessons from the RAND Health Insurance Experiment*. Harvard University Press (1993). Others found that savings associated with raising cost-sharing created offsets that are more substantial for the chronically ill. Amitabh Chandra et al., "Patient Cost-Sharing and Hospitalization Offsets in the Elderly," *American Economic Review*, pages 193-213 (2010). Percentages calculated from Figure 3-1 in MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System*, June 2011. The testimony also pointed out that supplemental coverage can remove the financial incentives for beneficiaries to control their health spending, and some research suggests that filling in Medicare's cost-sharing gaps results in higher Medicare spending than would have been incurred otherwise.

on drugs that are only covered in part or not at all under their Part D plans or on dental or vision care, as well as on long-term care. A retiree with few other necessary expenses may be able to manage this spending. On the other hand, most median-income retirees have fixed income and insufficient savings, and spending on health care could easily compromise their basic standard of living.

When viewed in comparison to the other forms of insurance coverage following implementation of the ACA, some retirees are in a relatively vulnerable position with high baseline costs and still the potential for catastrophic spending risk. Of course, they can rely on Medicaid as a safety net, but they must first deplete their assets and compromise their standard of living significantly to do so. This result could be avoided through more generous Medicare premium subsidies and reconsideration.²⁴

Inference: There will continue to be Medicare, and it will continue to cover certain benefits that are LTC in nature, whatever their name. Moreover, the expansion in what Medicare covers in the LTC realm may end up, in and of itself, creating a policy shift that finally admits Medicare coverage is not just post-acute care. Such recognition dramatically increases the possibility of reform of Medicare to cover LTC in a more comprehensive way. However, if that occurs it will likely be in the form of managed LTC. It may or may not also encompass financial trade-offs within the program—for instance, lower benefits for those coming in but enhanced benefits for those 85-plus.

Health Insurance

Before moving into the kinds of insurance designed specifically for aging and LTC, one would be remiss not to talk more about health insurance. In fact, as noted an expert as John Rother views it as an additional “leg” of the stool that individuals need in retirement.²⁵

Health insurance is often viewed as acute care with no element of interest to the LTC side of the ledger. But it has an impact in a number of ways. For instance, prescription drug coverage is vital for those with chronic care (or LTC) needs. And, at the end of life, hospice care is often covered by most insurance to a degree that provides close to total care.

The existence of health insurance also influences the decision to retire or change jobs. A study by Stanford University and the American Enterprise Institute found public employees are, depending on age, between 26 and 38 percent more likely to retire earlier if health coverage is

²⁴ Allison Hoffman, “Health Care Spending and Financial Security after the Affordable Care Act,” *North Carolina Law Review* (forthcoming 2014), pages 154-155, accessed at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2426401.

²⁵ Instead of a three-legged stool of Social Security, pensions and savings, he would add health insurance. See, for instance, his interview over a decade ago in the *Boston Globe*. Dolores Kong, “Penny Saved is Not Enough; AARP Says Millions Will Need to Work After Retirement,” *The Boston Globe* (May 23, 2001): <http://doloresskong0.tripod.com/52301.html>.

available. It can be inferred that individuals under the age of 65 who no longer have to fear loss of employer-based coverage will feel free to change jobs or move into earlier retirement. The research found that those between 55 and 59 are more likely to switch to part-time work or quit working entirely if retiree health plans are available.²⁶

One element that has not been fully factored into the way policymakers (and the public) think is that the advent of guarantee issue coverage for health insurance brought about by the ACA²⁷ means that a universal goal of Medicare extension for ages under 65 has been, in essence, achieved.²⁸

In essence, the ACA has accomplished a key goal of extending health insurance, long sought by advocates of universal coverage, via extension of Medicare to adults ages 55 to 64. At one time the debate was to reach the 55-plus cohort who had inadequate or no health insurance and could not wait until Medicare kicked in at age 65 (and also did not qualify for Medicaid). Now, with the expansion of Medicaid to single adults and the inclusion of tax subsidies for the lower-income quartile—along with the elimination of underwriting—it means the ACA has accomplished what advocates of early Medicare enrollment had sought.²⁹

A Kaiser Family Foundation report examined the current role and future outlook of employer-sponsored retiree health benefits for pre-65 and Medicare-eligible retirees (as well as the impact of recent legislation, such as the Medicare drug benefit and the ACA) on retiree health coverage. The report describes strategies employers pursue to limit costs associated with retiree health benefits. One intriguing finding is the possibility of using the new federal/state marketplaces (also known as “exchanges”) as pathways to non-group coverage for their pre-65 retirees.³⁰

²⁶ John Shoven and Sita Nataraj Slavovc, “The Role of Retiree Health Insurance in the Early Retirement of Public Sector Employees,” *Journal of Health Economics* (available online April 18, 2014): <http://www.sciencedirect.com/science/article/pii/S0167629614000447#>.

²⁷ Patient Protection and Affordable Care Act, Public Law 111-148 (signed into law March 23, 2010).

²⁸ Georgetown Health Policy Center, “Waiting for Medicare: The ACA Will Help Fill the Gap” (Sep. 5, 2013), accessed at <http://chirblog.org/waiting-for-medicare-aca-will-help-fill-the-gap/>.

See also Allison Hoffman, “Health Care Spending and Financial Security after the Affordable Care Act,” *North Carolina Law Review* (2014) http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2426401

²⁹ Andrew J. Rettenmaier and Thomas R. Saving, “Medicare at 55,” National Center for Policy Analysis (Dec. 15, 2009), at <http://www.ncpa.org/pub/ba682>. See also Z. Byron Wolf and Huma Khan, “Public Option No More? Obama Throws Weight Behind New Health Care Deal,” ABC News (Dec. 9, 2009) at <http://abcnews.go.com/Politics/HealthCare/health-care-harry-reid-senators-medicare-drop-public-option/story?id=9290406> (discussing the “deal” that was made in the U.S. Senate before the ACA morphed into its current design).

³⁰ Frank McArdle, Tricia Neumann and Jennifer Huang, “Retiree Health Benefits at the Crossroads,” Kaiser Family Foundation (April 14, 2014), at <http://kaiserfamilyfoundation.files.wordpress.com/2014/04/8576-retiree-health-benefits-at-the-crossroads.pdf>. See also an article by German Lopez, “Obamacare Will Let Americans Retire Earlier” in

Another idea being discussed is adding LTCI to the marketplace exchanges via a separate but linked portal connection. This might not happen for several years (to avoid interfering with the first couple years' operation of these systems). But LTC insurance would have a much easier time with education and access via the marketplace portal if those truly become the “one-stop” shopping for all health insurance needs. Previous discussions of similar efforts in the past—the otherwise-successful “Own Your Future” campaigns³¹ for one—floundered because of concerns about sending people to insurance companies. But the whole idea behind the marketplace is just that—a sales portal—and at least one state is already looking at adding ancillary products.³²

A subset of health insurance is the health savings account, or HSA. HSAs are tax-advantaged savings accounts, tied to a high-deductible health insurance plan. An HSA is funded with pretax contributions up to certain annual limits. Any growth inside an HSA is tax-deferred, and what one does not spend can carry over to future years. Just as importantly, withdrawals for qualified medical expenses are tax-free.

Tax-qualified LTCI premiums are a qualified medical expense eligible to be paid from HSA funds. The maximum annual premium you can pay tax free is subject to LTC premium deduction limits.³³ An annual census by AHIP of U.S. health insurance carriers shows that the number of people covered by HSAs/high-deductible health plans (HDHPs) totaled 13.5 million in January 2012, growing to 15.5 million as of June 2013.³⁴ This census does not include coverage associated with health reimbursement arrangements (HRAs), which are most commonly offered in the large-group market.

Equally important, expansion of Medicaid and tax subsidies is a clear income transfer from society as a whole to those recipients. On the assumption that most people on Medicaid or getting a tax subsidy are not in high tax brackets, this means a net gain for those income quartiles.³⁵

VOX (April 24, 2014), at <http://www.vox.com/2014/4/24/5643392/obamacare-might-let-people-retire-earlier>.

³¹ The lead and essentially only national website for LTC financing is an outgrowth of the HHS “Own Your Future” campaign and can be accessed at www.longtermcare.gov.

³² See Memo of Patty Fontneau, CEO of Connect for Health Colorado to the executive committee board members on “Establishment of a Separate Legal Structure” (April 7, 2014) at <http://connectforhealthco.com/wp-content/uploads/2013/04/20140407-Separate-Legal-Structure-Memo.pdf>.

³³ Evan Guido, “Paying for Long-Term Care Insurance with Tax-Free Funds” op cit.

³⁴ AHIP, “Health Savings Account Enrollment Reaches 15.5 Million” (June 26, 2013), at <http://www.ahip.org/HSA2013/>. Press release at <http://ahip.org/News/Press-Room/2013/Health-Savings-Account-Enrollment-Reaches-15-5-Million.aspx>.

³⁵ Jeffrey Sparshott, “Obamacare Effects Account for Most of Income, Spending Increases,” *Wall Street Journal* (March 3, 2014), at <http://blogs.wsj.com/economics/2014/03/03/obamacare-effects-account-for->

So how did the health care law result in such a rise? For one thing, it expanded the Medicaid program, a critical and highly controversial aspect of the law, by adding up to \$19 billion in benefits in January. On top of that, health care enrollees additionally received another near \$15 billion in the form of tax credits.³⁶

Inference: The importance of passage and implementation of the ACA to retirement and LTC decision-making has been underappreciated. Shoring up health insurance coverage for the population shy of 65 means better physical *and* financial health. What the ACA potentially means is that the Medicare eligibility age of 65 could be changed/aligned with Social Security's normal retirement age of 66 (or even higher if members of Congress seeking to raise the Social Security age succeed) because individuals now have access to affordable health insurance with no fear bad health deprives them of access due to underwriting or pre-existing conditions.³⁷

Long-Term Care and Life Insurance, and Annuities

The obvious way to pay for LTC/LTSS—outside of social insurance structure—would be for the private sector to create products for this need. If left as is, unfortunately many people in their 50s and early 60s are “accumulating insufficient resources to cover basic living expenses in retirement, let alone to finance potential long term care needs.”³⁸

One might be related to savings and investments (though a special product to urge people to save should not be needed since they need to do so for retirement), or it could be insurance. The need is certainly great enough that insurance could cover these costs,³⁹ and such products exist. They

[most-of-income-spending-increases/](#). Obama's 2010 health law was responsible for about three-quarters of a surprising January 2014 rise in U.S. consumer spending and American income growth, according to calculations by the *Wall Street Journal*. While not exceptional, the gains were significant: a 0.4 percent rise in consumer spending (\$45.2 billion) and a 0.3 percent rise in personal incomes (up \$43.9 billion), according to the Commerce Department's Bureau of Economic Analysis, at <http://www.bea.gov/newsreleases/national/pi/2014/pdf/pi0114.pdf>.

³⁶ Personal Income and Outlays, Bureau of Economic Analysis, at <http://www.bea.gov/newsreleases/national/pi/pinewsrelease.htm>.

³⁷ Individuals have tax subsidies and Medicaid expansion to cover the costs though admittedly not as good as Medicare. But if Medicare solvency is a stress point to that program this alters that debate.

³⁸ Judy Feder and Harriett Komisar, “The Importance of Federal Financing to the Nation's Long-Term Care Safety Net” Georgetown University (for the SCAN Foundation) February 2012, accessed at http://www.thescanfoundation.org/sites/thescanfoundation.org/files/Georgetown_Importance_Federal_Financing_LTC_2.pdf.

³⁹ 2014 Genworth Cost of Care Survey, “Home Care Providers, Adult Day Health Care Facilities, Assisted Living Facilities and Nursing Homes” (March 2014), accessed at https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/130568_032514_CostofCare_FINAL_nonsecure.pdf.

- Homemaker Services \$19 hourly (national median average)
- Home Health Aide Services \$20 hourly

are called LTCI, and no one buys it. Purchase of LTCI is variously reported around 6 percent for persons in midlife (say age 45) and 12 to 16 percent for those over age 65, depending on whether one looks at all seniors or those with some assets.⁴⁰

Experts that have looked at the existing market for private LTCI note that it finances only a small portion of LTC. Even among the population age 45 and older, only 7 million to 9 million Americans own a private LTCI policy. Within the past two decades, the number of insurance companies offering such coverage has plummeted from well over 100 to just a few. The group market (largely employment-based coverage) has shrunk dramatically, and the individual market is also in sharp decline.⁴¹

According to LIMRA's year-end report for 2013, the top writers last year (76 percent of the market) in the individual market are Genworth Financial, John Hancock, Mutual of Omaha, Northwestern Mutual and Transamerica (with Massachusetts Mutual on the list in 2012 but off as of 2013). However, if you look at the ranking by in-force premium it is: Genworth, John Hancock, MetLife, Northwestern Mutual and Transamerica (with Mutual of Omaha off the list). These top five carriers have 54 percent of the in-force premium in the individual market. The growth in the individual LTC market (new business) was a negative 8 percent in the period 2008 to 2013. Today there are 4.85 million insured in the individual LTC market.⁴²

Much of the growth in recent years has been in the group market. However, at the end of 2013, there were approximately 11,500 employers sponsoring group LTCI in the United States, 4 percent fewer than in the prior year. Overall participation in employer-sponsored LTCI plans declined 2 percent in 2013 to approximately 2.35 million insureds. These are the first in-force declines LIMRA has seen since it began tracking employer-sponsored group LTCI sales in the early 1990s.⁴³

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- Adult Day Health Care \$65 daily
 - Assisted Living Facility (ALF) \$3,500 monthly
 - Nursing Home Care semi private room \$212 daily
 - Nursing Home Care private room \$240 daily

⁴⁰ Marc Cohen, "Long-Term Care Insurance: A Product and Industry in Transition," Presentation to the NAIC Senior Issues Task Force (Nov. 28, 2012), showing that sales of individual LTCI policies have been flat since 2002 and policies in force flat since 2005. See http://www.naic.org/documents/committees_b_senior_issues_2012_fall_nm_ltc_hearing_presentations_cohen_revised.pdf (pages 4-6, 10). See also Joshua Wiener, "Financing Long-Term Care: More Same Than Different, with Some Twists," op cit.

⁴¹ John O'Leary, "Land This Plane: A Delphi Research Study of Long-Term Care Financing Solutions," Society of Actuaries (April 2014) at <http://www.soa.org/Research/Research-Projects/Ltc/research-2014-ltp-ltc.aspx>.

⁴² Karen Fisherkeller, LIMRA Annual Review 2013 "U.S. Individual Long-Term Care Insurance" (April 2013).

⁴³ Karen Fisherkeller, LIMRA Annual Review 2013 "U.S. Group LTC Insurance" (April 2013).

But probing beneath this dismal picture one might see a different story. For instance, market consolidation is likely a sign of a stronger industry since weaker players are removed while stronger ones survive. And if LTC usage is primarily something for older ages, the fact that there are now almost one out of 6 seniors with LTCI is a good sign, though admittedly a very slow one given the price of these products: \$2,359 for a buyer's first-year premium.⁴⁴ But more important than just having the policy is the use of these policies. There is now some evidence of a shift in payment of nursing home care, from Medicaid to private insurance.⁴⁵

The other reason to perhaps be less critical is that the industry has not stood still. Product changes are one way carriers can alter the environment. An example of changes in the product themselves are those that bring LTC and life insurance (or annuities) together.⁴⁶ These are not new concepts *per se* but until recently the market had focused on stand-alone LTCI—what might be called “pure” LTC protection—for decades.

Because the addition of a life or annuity product makes the total cost of hybrid LTCI policies greater, we will have to assume these new life and annuity products may not change that trajectory of flat sales.⁴⁷ However, in spite of the higher cost of the combination products there are tax advantages that offset that.⁴⁸

⁴⁴ Fisherkeller, Individual LIMRA Market Review, op cit.

⁴⁵ Sudipto Banerjee, “Effects of Nursing Home Stays on Household Portfolios,” Employee Benefit Research Institute (June 2012), at http://www.ebri.org/pdf/briefspdf/EBRI_IB_06-2012_No372_NrsHmStys.pdf. “In 2000, about 32% of U.S. nursing home entrants ages 65 and older were using Medicaid and just 6.4% were using private LTCI coverage. In 2010, about 30% of new nursing home entrants were using Medicaid and 14% were using private LTCI. The narrowing of the gap has also been dramatic for older people who have been in nursing homes for 180 days or longer. In 2000, 4.1% of longtime nursing home residents had private LTCI and about 49% were using Medicaid benefits. In 2010, more than 12% were using private LTCI and 47% were using Medicaid. Among older U.S. residents who are using professional home health care, the percentage that have private LTCI coverage has increased to 13%, up from 9.7% in 2000.” Cited in Allison Bell, LifeHealthPro (June 14, 2012), at <http://www.lifehealthpro.com/2012/06/14/ebri-14-of-nursing-home-entrants-had-ltci>.

⁴⁶ Another approach is to offer policies that offer bare-bones benefits (for instance as low as \$50 a day for only three months. See Howard Gleckman, “Not Interested in Long-Term Care Insurance?” How about Short-Term Care Insurance?” *Forbes* (March 18, 2013). <http://www.forbes.com/sites/howardgleckman/2013/03/18/not-interested-in-long-term-care-insurance-how-about-short-term-care-insurance/>. The premise is that insurers have to do SOMETHING to drop the cost of these policies but since people do not want catastrophic LTC—the tail end of coverage—any benefit reduction that drops the cost has to be on the front end.

⁴⁷ Industry surveys show this to be a very small part of the overall LTC insurance market. Fisherkeller, Individual LIMRA Market Review, op cit.

⁴⁸ An advantage of annuities under existing law is that the policyholder can convert an annuity (proceeds of which are taxable) into LTCI (which pays tax free). Evan Guido, “Paying for Long-Term Care Insurance with Tax-Free Funds” Broadridge Investor Communication Solutions published in the *Bradenton* [Florida] *Times* (Nov. 23, 2013) at http://www.thebradentontimes.com/news/2013/11/23/business_and_financial/paying_for_long_term_care

One would be remiss not to mention that stand-alone (for want of a better word) life insurance can in some cases be sold (viaticated) or accelerated for LTC or terminal illness. This acceleration of the benefit is a valuable aspect of such policies. But the policies best suited for this are whole or universal life (or variants) with large amounts of cash behind them, or life insurance expressly sold with a rider for LTC.⁴⁹ Most of the life insurance market is term life from an employer, which is not portable if you change jobs. In addition, it often disappears upon retirement either because it is a function of working or because the individuals feel they can lapse their life insurance when the kids grow up and leave home.⁵⁰

What people have with these more limited term products then is not adequate for LTC (and not intended for that use anyway). Once as high a penetration as 90 percent, life insurance has dropped considerably. Currently, 95 million Americans live without life insurance and only one-third of consumers are covered by individually owned life policies. That's the lowest level in 50 years, according to the 2013 Insurance Barometer Study out of the Life Foundation and LIMRA.⁵¹

[insurance with tax free funds/](#). “Generally, withdrawals from a nonqualified deferred annuity (premiums paid with after-tax dollars) are considered to come first from earnings, then from your investment (premiums paid) in the contract. The earnings portion of the withdrawal is treated as income to the annuity owner, subject to ordinary income taxes. IRC Section 1035 allows you to exchange one annuity for another without any immediate tax consequences, as long as certain requirements are met. ... [T]he Pension Protection Act (PPA) extends the tax-free exchange of annuities for qualified stand-alone LTCI or combination annuity/LTCI policies. This effectively allows you to purchase LTCI with annuity cash values that would otherwise have been taxable when withdrawn.” See also Robert Cochran, “Section 1035 Alternatives for Long-Term Care Protection,” *LifeHealthPro* (May 7, 2013), at <http://www.lifehealthpro.com/2013/05/07/section-1035-alternatives-for-long-term-care-prote?t=variable>.

⁴⁹ According to Chow, et al., older policies are those with accelerated benefits. Newer ones add supplementary extension of benefits (EOB) riders. This provides richer LTC coverage up to twice the length of time acceleration would and is more comprehensive. In addition, there is supposedly less risk for these carriers than with stand-alone LTC. Both have the underwriting risk (they would pay the life portion regardless), but a portion of the premium dollars offered by the base plan itself provides a buffer to the LTC risk. Linda Chow, Carl Friedrich and Dawn Helwig, “Quantification of the Natural Hedge Characteristics of Combination Life or Annuity Products Linked to Long-Term Care Insurance,” Product of the Society of Actuaries and presentation at the Intercompany Long Term Care Insurance conference (March 7, 2012), accessed at <http://www.soa.org/research/research-projects/ltc/research-2012-03-quant-nat-hedge.aspx>. The article also presents statistics (page 3) that only one-third of seniors have savings or income that would be sufficient to pay for LTC.

⁵⁰ See, generally, Anne Obersteadt, et al., “Study on the State of the Life Insurance Industry: Implications of Industry Trends,” Center for Insurance Policy and Research (August 2013), pages 41-66, accessed at http://www.naic.org/documents/cipr_home_130823_implications_industry_trends_final.pdf.

⁵¹ Barbara Manning, “Protecting Your Assets,” at FOX Business (Jan. 22, 2014), accessed at <http://www.foxbusiness.com/personal-finance/2014/01/22/life-insurance-myths-shouldnt-believe> (citing LIMRA 2013 Insurance Barometer Study). There is also a great deal of evidence that seniors lapse life insurance policies as they get older and feel the need for life insurance protection is less. See “Lifeline

Others have suggested that the modern LTC product can come through an IRA. “Clients also have the option of funding LTCI with tax-deferred IRA funds. By using pretax dollars that the client has already contributed to an IRA account, she can fund an IRA annuity that, in term, is set up to automatically fund a hybrid life-insurance-LTCI policy over a period of years. Because periodic payments are automatically transferred from the IRA annuity to the hybrid policy issuer, the risk that your client will miss a payment is eliminated. This strategy may be especially attractive to your clients who have heavily funded tax-preferred retirement accounts but have little cash on hand to fund the policy premiums.”⁵²

More modest proposals include changing the law so that LTCI is included in Section 125 cafeteria plans. It could also be broadened to allow 401(k) plans, IRAs (and FSAs as well) and similar retirement products to be tapped for LTC needs as well as to cover the premiums of LTCI. For IRAs, this is currently allowed as a penalty-free event outside retirement only in case of a permanent disability. It makes sense for this to be extended to LTC as well.⁵³

What is interesting about this—versus something like a new tax credit or deduction for LTCI—is that the cost to government should be neutral since these products are already tax-free; so under Congressional Budget Office rules these LTC proposals should “score” favorably, i.e., not show a revenue loss to Treasury.⁵⁴ (To be fair, these ideas could cost the government more money if the Treasury thought utilization would increase.)

Inference: These changes in the life and annuity market to cover LTC may accelerate in the future. If so, the important point is that this helps with the annuitization of retirement, a goal of many aging experts. In a sense, the insurance component is simply a side dish to the main meal of retirement security.⁵⁵ So a trend toward life-based LTC protection is an important

Program Study Reveals Low Awareness of Option to Sell Policies for Cash,” *Business Wire* Sept. 17, 2013, at <http://www.businesswire.com/news/home/20130917006245/en/U.S.-Seniors-Life-Insurance-Lapse-Survey-Finds>.

⁵² William H. Byrnes and Robert Bloink, “LTC’s Future Lies in New Crop of Hybrid Products,” (Nov. 21, 2013) at <http://www.lifehealthpro.com/2013/11/21/ltes-future-lies-in-new-crop-of-hybrid-products?t=ltei>.

⁵³ Karl Polzer, formerly of AHCA, has an intriguing notion of accessing 401(k) or IRA monies. Polzer, “Financing Future LTSS and Long Life through More Flexible 401(k)s and IRAs” (SOA, forthcoming).

⁵⁴ Section 125 is 26 U.S.C. 125. <http://www.law.cornell.edu/uscode/text/26/125>. An FSA is a type of cafeteria plan that covers qualified medical expenses.

⁵⁵ Robert Gazzale, Sandy Mackenzie and Lina Walker, “Default and Longevity Annuities Improve Annuity Take-Up Rates? Results from an Experiment,” AARP Public Policy Institute (October 2012), at <http://www.aarp.org/work/retirement-planning/info-10-2012/do-default-and-longevity-annuities-improve-annuity-take-up-rates-AARP-ppi-econ-sec.html>. The authors also hypothesize that there may be an untapped market for longevity annuities. Related to this, one could also mention contingent deferred annuities (CDAs), which emerged in late 2000 as a way to provide individuals with lifetime income but without the purchase of a traditional annuity. See, generally, Anne Obersteadt, et al., op cit. On a related note, on July 2, 2014, the U.S. Department of the Treasury released final regulations on longevity annuities, making them accessible to 401(k)s and IRAs by amending the required minimum distribution regulations to allow for payments starting in later years. The regulations are available at

development for the financial needs of those going into retirement. In addition, there is room for legislative action for private insurance products with little budget implication if the existing retirement products (IRAs and the like) are restructured so there is explicit recognition of LTC.

Social Security^{56,57}

The other large entitlement program is Social Security. Social Security remains the mainstay of retirement income for most seniors, while only about one-third receive regular payments from their pensions or retirement accounts. Social Security is particularly important to older Americans with low to moderate incomes, accounting for about 80 percent of their income.⁵⁸ Because so much of LTC services are paid directly by the individual, the amount of income available to someone has a large bearing on their ability to protect themselves from the devastating financial risk of LTC.

On a societal note, if Social Security's disconnect between outgo and income is not resolved it will become a more serious problem for seniors. A failure to act to alter Social Security's design

<http://www.gpo.gov/fdsys/pkg/FR-2014-07-02/pdf/2014-15524.pdf?elq=e2962b51e0bd49338c4687153e15f0b6&elqCampaignId=601>.

⁵⁶ There is a population of concern that is often subsumed in the debate over Social Security and that concerns those on Social Security by reason of disability. These individuals—almost 9 million in all—are often poorer (and younger) than the rest of the Social Security population. They are beyond the scope of this work but undoubtedly will have an impact on the debate. As stated in a recent report:

Currently, 8.8 million disabled workers (and nearly 2 million of their children) receive Social Security Disability Insurance (DI) benefits. For many, DI benefits are nearly all the income they have. The DI trust fund reserves are projected to be depleted in 2016, after which tax revenues coming into DI would cover only about 80% of scheduled benefits. Congress has never permitted such a drop in Social Security benefits to occur. A temporary reallocation of part of Social Security's 6.2% tax rate from the Old-Age and Survivors Insurance (OASI) trust fund to the DI trust fund would ensure that both funds can pay full benefits until 2033, after which scheduled taxes would cover about 75% of scheduled benefits. Congress has reallocated the tax rate 11 times in the past, making it what one expert has called "a traditional and noncontroversial action." Alternatively, a 0.2% increase in the tax rate for DI would make DI solvent for the next 75 years.

Virginia P. Reno, Elisa Walker and Thomas Bethell, "Social Security Disability Insurance: Action Needed to Address Finances," National Academy of Social Insurance (June 2013) at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2375239.

⁵⁷ It is outside the scope of this article but should be noted that the Social Security Trustees 2014 report found the fund has "dedicated resources" sufficient to cover benefits for the next 19 years, until 2033. However, the Social Security Disability Insurance Trust Fund only has until 2016. See <http://www.ssa.gov/OACT/TR/2014/tr2014.pdf>.

⁵⁸ Ke Bin Wu, "Sources of Income for Older Americans, 2012," AARP Public Policy Institute (December 2013) at <http://www.aarp.org/money/low-income-assistance/info-12-2013/sources-of-income-for-older-americans-2012-AARP-ppi-econ-sec.html>. (Earnings as a source of older people's income have risen steadily over the past two decades, while income from assets has fallen.)

will not lead to bankruptcy. Rather enrollees will get around 80 to 85 percent of what they “should” be getting, i.e., what they would be getting if they were a retiree today.⁵⁹

If one does the math as to what a person would be entitled at various retirement dates, a claimant would have to work two years longer (say to age 64 versus age 62) to make up for this kind of “shortfall.”⁶⁰ Even though not ideal, this “non-solution” might be good for the working population. The reason is that to cover a large shortfall, should this occur, most likely means doing more than a minor fix to cover the gap, for instance by increasing the payroll tax.⁶¹

There are some that argue that Social Security’s real retirement age is already drifting higher (older). Key findings from work by Alicia Munnell at Boston College include:

- Due to increases in Social Security’s Delayed Retirement Credit, the effective retirement age is now 70, with monthly benefits reduced for earlier claiming.
- Benefit levels at 70 appear appropriate given that rising deductions for Medicare and greater benefit taxation have reduced Social Security’s net replacement rates.
- The shift to 70 should be feasible for many workers given increases in life spans, health and education.
- But vulnerable workers forced to claim early will have low benefits and will be particularly harmed by any further cuts.
- Policymakers need to inform those who can work that 70 is the new retirement age and devise ways to protect those who cannot work.⁶²

Minor fixes leave the issue open for constant discussion about intergenerational equity and ripe for further change. In other words, there will still be the perceived need to do more (like increasing the Social Security payroll tax) or contemplate a reduction in benefits. From some experts in the field the most favored package of changes would gradually

⁵⁹ “Social Security in an Era of Retrenchment: What Would Happen if the Social Security Trust Funds Were Exhausted?” Kathryn Moore, Sept. 1, 2012, *ABA Journal of Labor & Employment Law*, Vol. 28, pp. 43-57, 2012. At http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2366525.

⁶⁰ See Social Security Administration calculator at <http://www.ssa.gov/planners/benefitcalculators.htm> and Virginia P. Reno, Jasmine V. Tucker and Elisa A. Walker, “NASI Brief: When Should I Take Social Security Benefits?” (February 2014), at http://www.nasi.org/sites/default/files/research/BRIEF_When_Should_Take_Social_Security.pdf (a worker getting \$1,000 at age 66 would get \$866 at age 64, or 86 percent as much).

⁶¹ Best guess as to another reform that could be put into place would be around the “chained CPI” that reduces the growth rate in Social Security. See Gary Koenig and Mikki Waid, “Proposed Changes to Social Security’s Cost-of-Living Adjustment: What Would They Mean for Beneficiaries?” AARP Public Policy Institute (October 2012) at <http://www.aarp.org/work/social-security/info-10-2012/proposed-changes-to-cola-insight-AARP-ppi-econ-sec.html>.

⁶² Alicia Munnell, “Social Security’s *Real* Retirement Age Is 70,” Center for Retirement Research (October 2013) at http://crr.bc.edu/wp-content/uploads/2013/10/IB_13-15.pdf.

eliminate the earnings tax, change the cost-of-living adjustment (COLA) to reflect inflation more accurately, and make other changes to modernize its structure.⁶³

Inference: Nothing will be done (or maybe something minor), and Social Security will survive. But those Social Security checks will come in lower than what people expect. As a consequence they will delay retirement so as to “restore” the difference. For individuals, it will continue to be an important means of paying for direct out-of-pocket LTC expenses.

Pensions

Pensions, along with Social Security and savings, are one-third of the three-legged stool one takes into retirement. An excellent summary of pensions can be found here, with the bottom line being that most workers are not saving enough for retirement:

Employer-sponsored pensions, the second tier of the United States retirement system, ought to be a major source of lifetime income in retirement for many, if not most, Americans. However, while employer-sponsored pensions are mandatory or quasimandatory in many countries, they are voluntary in the United States. That is, employers are not required to offer pensions, and when they do, they have considerable leeway about whom to cover and how much to contribute on their behalf. Not surprisingly, at any given time, only about one out of two American workers has a pension, and few can be confident that they will have enough income to meet their economic needs throughout retirement.

Moreover, 401(k)-type plans offered by employers have largely displaced traditional defined benefit plans as the dominant type of plan. Membership in a 401(k) plan, however, does not guarantee that retirement savings will be adequate; in fact, many 401(k) plan participants do not take full advantage of their plans in that they neither contribute the maximum nor take full advantage of employer matches. These days, the median balance of these plans is only around \$77,000, which is enough to finance a stream of before-tax annual income of about \$5,000 a year for life at current interest rates. Yet, 401(k) plans are not required to offer annuities and very few do. Indeed, there has been a significant decline in annuitization of retirement savings by workers. The shift to 401(k) plans is a large part of the story, but it remains true that people rarely choose to buy annuities voluntarily, even though annuities could provide them with very valuable insurance against living too long.⁶⁴

⁶³ Virginia P. Reno, “What’s Next for Social Security? Essential Facts for Action,” National Academy of Social Insurance (October 2013)

http://www.nasi.org/sites/default/files/research/Whats_Next_for_Social_Security_Oct2013.pdf.

⁶⁴ George MacKenzie and Jonathan Barry Forman, “Reforming the Second Tier of the U.S. Pension System: Tabula Rasa or Step by Step?” *John Marshall Law Review* Vol. 46 No. 3 (2013) accessed at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2390145. See also Rich Berger, “From Defined Benefit to Defined Contribution: A Systematic Approach to Transitioning Retirement Plans,” Society for

Of note, from research by the Society of Actuaries, many working people today *expect* to delay retirement because of uncertainty in their financial picture. *In reality* most retirees do not continue to work, in spite of the fact that as pre-retirees they did so envision doing exactly that.

In addition, many have too short a planning horizon and some do not plan at all:

Pre-retirees and retirees generally have a planning horizon that is shorter than their life expectancy. Both pre-retirees and retirees say they typically look 10 years (median) into the future when making important financial decisions. Almost three in 10 report they have not thought about their planning horizon (27 percent of pre-retirees and 29 percent of retirees) and nearly one in 10 state they do not plan ahead (7 percent and 8 percent).⁶⁵

There is also a separate but related issue as to whether we have an adequate understanding of the asset and income profile of older Americans. It is unclear whether middle Americans might have more than official figures are showing.⁶⁶ One consequence is that if middle-income seniors are not viewed as “at risk” by policymakers little will be done for them. That ratchets up the need to deal with issues such as economic fairness. While this has been kicking around for a while,⁶⁷ it could move to the forefront of the discussion.

Human Resource Management (Jan. 5, 2012) accessed at <http://www.shrm.org/hrdisciplines/benefits/articles/pages/transitioningplans.aspx>. Another more recent source is the presentation by Anna Rappaport and Donald Fuerst “Part 1: Setting the Stage: Why Lifetime Income is Important and Why Achieving It is a Challenge” at the National Academy of Social Insurance program “Securing Retirement Income for Life: Social Security and Defined Contribution Plans,” NASI (Jan. 29, 2014), at <http://www.nasi.org/events/161/roundtables>.

⁶⁵ 2013 SOA Retirement Risk Survey, “Understanding and Managing the Risks of Retirement,” Society of Actuaries (May 2014), pages 16-18, 22, at <http://www.soa.org/Files/Research/research-2014-retire-survey-findings.pdf>.

⁶⁶ The evidence that the majority of retirees rely mostly on Social Security benefits dramatically underreports the retirement income provided by employer plans and IRAs, and overstates the role of Social Security. In fact, income from private retirement plans is often significant for lower-income retirees as well as the wealthy. See Billie Jean Miller and Sylvester J. Schieber, “Employer Plans, IRAs and Retirement Income Provision: Making a Molehill Out of a Mountain” (October 2013) accessed at <http://www.towerswatson.com/en-US/Insights/Newsletters/Americas/insider/2013/employer-pensions-individual-retirement-savings-and-retirement-income-provision>. See also Gaobo Pang and Sylvester Schieber, “Workers’ Retirement Income Security Prospects: A Critique of Recent Assessments,” Towers Watson (May 6, 2014) at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2433193 and Andrew Biggs and Schieber, “Retirees Aren't Headed for the Poor House,” *Wall Street Journal* (Jan. 23, 2014) at http://online.wsj.com/news/article_email/SB10001424052702304603704579329012635470796-1MyQjAxMTA0MDIwNDEyNDQyWj. (The most commonly cited measure of retirement income ignores at least 60 percent of the money that seniors receive.) See also Alicia Munnell, Matthew Rutledge and Anthony Webb, “Are Retirees Falling Short? Reconciling the Conflicting Evidence,” Joint Meeting of the Retirement Research Consortium (Aug. 8, 2014).

⁶⁷ Former Senator Jim Webb (D-VA) talked about this years before it became such a frequently discussed topic. In early 2007 his rebuttal to President Bush’s State of the Union address made economic fairness the dominant topic of the speech. Accessed at <http://www.nytimes.com/2007/01/23/washington/23webb->

Inference: There will be minor changes to pension issues, mostly around auto-enrollment and making sure companies are not held to severe fiduciary standards (meaning held liable if pension investments don't turn out well). But employers will mostly continue to avoid the problem by offloading retirement risk to employees by continuing the trend away from defined benefits to defined contributions. However, these trends weaken the safety and comfort of more and more Americans, and "economic fairness" moves to the forefront. This in fact may supplant the discussion of intergenerational equity by focusing attention across all age bands. Look to see this as a major part of the 2016 presidential campaign.

Housing and Reverse Mortgages

The old model was to buy a house for, say, \$200,000 and pay off the mortgage. It would increase in value over the decades to \$600,000 and yield the owner a \$400,000 profit.⁶⁸ The new model is that the person may still buy at \$200,000 (or the equivalent current figure) but tap home equity for various things (children's education, home improvements, to cushion a period of unemployment, whatever). So, even if we consider the downturn of 2008 to be unusual, that \$600,000 sale will produce only \$400,000.

There is more bad news: Some housing experts predict housing prices to drop in many areas by one-third as the wave of boomers retires.⁶⁹ There is also the problem with supply and demand due to the demographic shift in the population. With more people selling and fewer people buying, prices will be depressed. So it is entirely possible that many people won't see that \$600,000 sale. If they are lucky then they may get \$400,000 and be able to pay off the \$200,000

[transcript.html?pagewanted=all&_r=0](#). More recently, Senator Elizabeth Warren (D-MA) has also been talking about "leveling the playing field." See <http://elizabethwarren.com/issues/leveling-the-playing-field>. Also see her interview, along with economist Thomas Piketty by Ryan Grim of Huffington Post on June 2, 2014, at <http://pol.moveon.org/warrenpiketty/watch.html?id=96720-14354814-AA44Gjx&t=1>. See also Joseph Stiglitz, "How Inequality Made Me an Economist," *Politico* July/August 2014.

⁶⁸ Compare Figure 5: Rising Home Values, by Age Median Value of Primary Residence in the 2007 Chartbook versus 2010. See Federal Reserve, "Survey of Consumer Finances Chartbook, 2007," at http://www.federalreserve.gov/econresdata/scf/files/2007_SCF_Chartbook.pdf and Federal Reserve, "Survey of Consumer Finances Chartbook, 2010" at http://www.federalreserve.gov/econresdata/scf/files/2010_SCF_Chartbook.pdf.

⁶⁹ Dowell Myers and SungHo Ryu, "Aging Baby Boomers and the Generational Housing Bubble," *Journal of American Planning Association* (Winter 2008) pages 17-33 at http://www.morpc.org/pdf/Myers_AgingBabyBoomers.pdf. In addition, the homes of older adults are also getting older and would erode in value if homeowners don't keep up with repairs, much less improvements needed to enhance resale. Researchers have found that appreciation rates are considerably smaller when the household head is over 75 years old. Barb Stucki, NCOA and MetLife, "The MetLife Study on the Changing Role of Home Equity and Reverse Mortgages" (June 2009) (footnotes omitted), at <https://www.metlife.com/assets/cao/mmi/publications/studies/mmi-tapping-home-equity-retirement.pdf>.

home equity debt.⁷⁰ This does not leave much for retirement, much less any appreciable LTC event. As with Social Security and pensions, remember the individual is the front line in terms of paying for LTC. It matters if their assumption about their home being part of the solution turns out wrong.

Individuals can use home equity to fund health and/or LTC expenses, though this is not a foolproof strategy:

... Older Americans often rely on housing wealth because they did not purchase long-term care insurance. Those who wait until their retirement years may also find that they do not qualify for coverage due to an existing health condition or find they can no longer afford it. Policymakers, advocates, and insurance companies have raised serious concerns about using home equity to purchase long-term care insurance.

However, home equity may play a different role to support Baby Boomers who buy long-term care insurance. A recent survey found that 84% of Americans who purchased a policy in 2008 were under age 65. To save costs, 76% of these buyers opted for coverage that would pay for a claim lasting five years or less. As they grow older and start to need help, policyholders may want to save their limited insurance coverage to pay for serious disabilities. They could tap home equity to pay for low-cost services that make it easier to stay at home. Small amounts of home equity could also pay for early interventions that can reduce health problems. ...

The popularity of [home equity lines of credit] and, increasingly, reverse mortgages with line of credit payment plans, suggests that an important reason why older Americans already tap home equity is to enhance their financial resilience.⁷¹

Products to better tap this equity include improvement to these reverse mortgage products. The 10-fold increase (from 1999 to 2009) in home equity conversion mortgages (HECMs) was mostly driven by growth in house prices. Design changes the HECM program announced in 2010 have resulted in reverse mortgage products that match better what consumers want. The change in regulations now allows lenders to offer fixed-rate mortgages on lump-sum loans with lower upfront costs. This is now 70 percent of their business.⁷²

⁷⁰ For a feel for the diverse situations that we will actually see go to Stucki, NCOA and MetLife report, op cit., pages 8-10. They categorize the population as house-poor and cash-poor (15 percent of households), house-rich but cash-poor (5 percent), of moderate wealth (30 percent), house or cash-rich (30 percent) and house and cash-rich (20 percent).

⁷¹ Barb Stucki, op cit.

⁷² Even newer changes are coming: The program will now have a single maximum loan amount based on the borrowers' age and the current interest rate. But to protect asset value, borrowers are limited to 60 percent of that maximum loan amount in the first two years. Perhaps the most significant requirement (beginning January 2014) is that lenders are required to financially underwrite prospective borrowers' ability to pay property taxes and insurance on the home. See Alicia Munnell and Steven Sass, "The

Another product option is a new approach to tapping the value by a startup venture called NestCare. The product is geared toward making sure the older homeowner has money for the (relatively) small costs of homeownership as well as larger needs. Technically, the NestCare Equity Access contract is an installment purchase of home equity, not a home equity loan or reverse mortgage. When the home is sold, the funder then receives a portion of the home sale proceeds (sold at its appreciated value, if any) and the homeowner receives the balance.⁷³

Inference: The home isn't going to be what it used to be, but there is still some money there AND better ways to get at it. However, individuals may be overestimating the value of their home at their own risk.

Family, Caregiving and Workforce

Family and unpaid caregiving always seems to come last, but in reality it is the primary means by which care is delivered. Paid care (public or private) only comes into play when the family's ability to deliver care erodes. Nevertheless, overreliance on unpaid caregivers (typically family members) has negative consequences for the family⁷⁴ and employers.⁷⁵

The LTC workforce won't keep up in numbers as the growth in customers (meaning frail seniors) increases.⁷⁶ Even if supply and demand did keep up, there are limits on the ability to pay for LTC: Among many reports, a recent one from AARP shows that extended private pay nursing home care is not affordable for middle-income families anywhere in the United States. The same is true for home health care: It also is unaffordable for middle-income older people at typical levels of use.⁷⁷

Government's Redesigned Reverse Mortgage Program" Center for Retirement Research (January 2014, at <http://crr.bc.edu/briefs/the-government%E2%80%99s-redesigned-reverse-mortgage-program/>).

⁷³ Information on NestCare accessed at <http://nestcare.com/> May 2014.

⁷⁴ See generally materials at the National Alliance for Caregiving at <http://www.caregiving.org/research>.

⁷⁵ Melissa Gong Mitchell, "Supporting Employee Caregivers: Good Practice and Good Business" (April 16, 2014) to the Long Term Care Discussion Group. See other materials from ReAct at http://respectcaregivers.org/wp-content/uploads/2013/11/EmployerResourceGuide_FINAL.pdf (there are 44 million unpaid caregivers in the United States and three-quarters are in the workforce).

⁷⁶ Nursing home statistics can be found at <http://www.cdc.gov/nchs/fastats/nursing.htm> and ALFs at <http://www.cdc.gov/nchs/data/databriefs/db91.htm>.

⁷⁷ Ari Houser, "A New Way of Looking at Private Pay Affordability of Long-Term Services and Supports," AARP Public Policy Institute (October 2012), at <http://www.aarp.org/home-family/caregiving/info-10-2012/private-pay-affordability-ltss-insight-AARP-ppi-ltc.html>. The paper was produced by the AARP Public Policy Institute with support from The SCAN Foundation and The Commonwealth Fund as a follow-on piece to *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*. <http://www.aarp.org/home-family/caregiving/info-10-2012/private-pay-affordability-ltss-insight-AARP->

An exogenous solution would be to add to the unskilled (but paid) workforce. Immigration reform would potentially secure a stable source of workers who today are limited by laws that make access to these kinds of jobs difficult for those not showing up in the system legally. Another large source of labor could be those coming out of prison. However, expanding requirements in the LTC provider field for pre-employment background checks means it may be unlikely that former prisoners will make up a large part of this workforce. (Presumably we'd have to see that criminal background checks weren't used to bar everyone just out of prison from a job, just those problematic to any specific job.) There has been a sea change even within the Republican Party about warehousing individuals.⁷⁸

Typically what happens is short-term planning for LTC. A recent session of the Intercompany Long Term Care Insurance Conference addressed the question: "What can you do if you didn't plan?" One speaker described how VA Aid and Attendance benefits, home equity and even annuities can help if LTCI is not an option. An elder law attorney discussed how to help without using Medicaid planning. Another speaker talked about bridge loans. Another focused on "financial concierge" services.⁷⁹

Beyond that, an intriguing and unsettling development is discussion of "family responsibility" laws as a matter of public debate⁸⁰ and law.⁸¹ The courts are going there as well: Witness a recent case that highlights the impact of these laws. In May 2012, the Superior Court of Pennsylvania found that the adult son of a woman who had received nursing care at a Pennsylvania facility for six months was liable for her bill (almost \$100,000). The court ruled that although the woman had other sources of payment—not only a spouse but other adult

[ppi-ltc.html](#).

⁷⁸ For a fascinating read on this see David Dagan and Steven M. Teles, "The Conservative War on Prisons," *Washington Monthly* (November/December 2012), at http://www.washingtonmonthly.com/magazine/novemberdecember_2012/features/the_conservative_war_on_prison041104.php?page=all.

⁷⁹ Romeo Raabe, Bridgette Duber and John Zwolanek, "Short-Term Planning for Long Term Care," Intercompany Long Term Care Insurance Conference (March 17, 2014) at http://www.iltciconf.org/index_htm_files/22-ShortTermPlanning.pdf.

⁸⁰ Robert Moffit, "How to Think About Long-Term Care," Heritage Center for Policy Innovation Discussion Paper #13 on Health Care (Oct. 4, 2013) at <http://www.heritage.org/research/reports/2013/10/how-to-think-about-long-term-care>.

⁸¹ Kelly Greene, "29 States That Could Make Adult Children Pay for Mom's Care," *Wall Street Journal* (June 25, 2012). See also Jack Tatar, "You Could Be Liable for Your Parents' Long-Term Care" *Market Watch* (Nov. 22, 2013) at <http://www.marketwatch.com/story/you-could-be-liable-for-your-parents-long-term-care-2013-11-22>.

children AND a pending Medicaid application—the son had the means to pay it and was therefore responsible.⁸²

There are multiple intersections of retirement and LTC. New surveys show that workers are willing to trade away paid time off (PTO) and promotions for stability: A Towers Watson Global Workforce study showed that almost half of U.S. workers (49 percent) are willing to forego vacations and future career advancement opportunities for guaranteed retirement benefits. That's in line with findings from the 2012 Retirement Confidence Survey, which shows just 14 percent of respondents are “very confident” they'll be able to finance a secure retirement. This is an all-time low in the 20 years that the Employee Benefit Research Institute has been conducting the survey.⁸³

Inference: The family will continue to be the first line of care, but other unskilled caregiver systems will evolve to add to the mix. Society, especially including employers, will be forced to adapt.

CONCLUDING THOUGHTS

The tenet of this article is *not* that there won't be changes in the way insurance and retirement will be addressed. To the contrary, it seems probable that there will be a wide array of policy proposals or product ideas to address the growing number of individuals moving into older ages and retirement.

This article posits that the picture today is instructive of what may come. Given the failure of society, including Congress and state governments, to make major changes in addressing the future, what *individuals* will be left with are the tools and techniques they—we—already have in play and with which we are familiar.

At this point most articles might leap forward to describe some completely unexpected policy or product that fixes all these problems and makes them go away. But major changes in public policy are few and far between. More importantly, individuals cannot plan for these. They cannot (or at least should not) assume they don't need to plan for the future because the government will wade into action.

Second, these are not static decision points. To give an example, someone may have a job change in their 50s. At 65 they decide on Medicare and related issues—for instance, whether to

⁸² See ElderLaw Answers, “Son Liable for Mom's \$93,000 Nursing Home Bill Under 'Filial Responsibility' Law” (undated, accessed May 2014) at <http://www.elderlawanswers.com/son-liable-for-moms-93000-nursing-home-bill-under-filial-responsibility-law-9873>.

⁸³ See Kelley M. Butler, “Workers Willing to Trade PTO, Promotions for Guaranteed Retirement Income,” *Employee Benefit News* (Nov. 19, 2012): http://ebn.benefitnews.com/blog/ebviews/workers-willing-trade-pto-promotions-guaranteed-retirement-2729145-1.html?ET=ebnbenefitnews:e5607:2172049a:&st=email&utm_source=editorial&utm_medium=email&utm_campaign=EBN_inBrief_112112.

buy Medigap. And somewhere in those years there may be downsizing to a new home, perhaps even a move to another state. If married, the spouse may pass away.

Individuals who confront an unexpected life event must rely on what the business world would call a “just-in-time” response. An example would be when someone comes out of a hospital to post-acute care and is then looking at a permanent move to an LTC facility. The options for some individuals, through luck or planning, are a series of choices. But for many, indeed most, the choices are more constrained.

What product developers and policymakers can do now is to make sure their products and policy suggestions set the stage for individuals to meet their needs. What we would want to see here would be a structure or environment where this happens.

For policymakers this probably means both small and large reforms should be advanced. This would include as many private sector solutions as possible because they will help deflect the individual from having to rely on social programs. But it also helps with integrating the public and private programs as opposed to ad hoc results. (Who would have thought the Medigap market would come into existence with the passage of Medicare?)

Some small steps might be to follow up with what was actually in the mandate to the Commission on Long-Term Care: Develop recommendations to Congress for a vote. Alternatively, we could go with an administration initiative. This was how the White House developed its package of LTC reform proposals in 1998 to 1999. They started as several ASPE research projects and then spun off into a package of proposals that was enacted into law.⁸⁴

Could we see a *deus ex machina* solution? It would have to be in the form of a social insurance program. But as Richard Frank, assistant secretary for Planning and Evaluation at HHS says: “In the United States, social insurance has become a political flashpoint in that it is a vehicle for expressing the enormous distrust of government prevalent in the United States. . . . The implication is that for the foreseeable future there is little change that a social insurance approach would be politically viable in the United States.”⁸⁵ He goes on to say: “This raises the policy challenge of whether it is possible to design an approach to insuring LTSS that is not mandatory,

⁸⁴ ASPE stands for Assistant Secretary for Planning and Evaluation. See White House Press Release, “President Clinton and Vice President Gore: Strengthening Families that Need Long-Term Care” (Jan. 4, 1999) <http://clinton4.nara.gov/textonly/WH/Work/010499.html>. There were four initiatives: a \$1,000 tax credit for families with members who need LTC (later upped to \$3,000); creation of a National Family Caregiver Support Program grant program to the states; launch of a national campaign to educate Medicare beneficiaries about the programs' limited coverage of LTC and how best to evaluate their options; and offering of an employee pay-all program of LTCI to federal employees. The author had the lead on the last two.

⁸⁵ Richard Frank, “Long-Term Care Financing in the United States: Sources and Institutions,” *Applied Economic Perspectives and Policy* (May 2012) at <http://aepp.oxfordjournals.org/content/34/2/333.full>.

uses private institutions, expands the financial protection against LTSS and offers fiscal relief to existing public programs like Medicaid.”⁸⁶

What do other policy experts say?

The most serious review of financing in recent years was supposed to be by the congressionally created Commission on Long-Term Care. Given the limited time frame they had, consensus would have been difficult even absent differences of opinion among the commissioners. They did come to consensus on the need for service delivery and workforce reforms. On financing there was a minority opinion favoring social insurance to the majority’s preference for work across a number of areas to get at that issue,⁸⁷ but little guidance as to how and what to do.

William Galston at Brookings believes it is possible that “our long-term care policy should shift dramatically toward forward-funded insurance based on individual contributions. As more people use such insurance, the pressures on public finances, especially at the state level, would decline. Such a shift would alleviate harsh trade-offs states confront between health care and education. It would also allow states to avoid choosing between Medicaid funds for health care for poor children and nursing-home operators.”⁸⁸

He also argues that, for various reasons, private LTCI won’t be the answer. Instead, one approach would be the German model, popularized by Senator Ted Kennedy and others. It is mandatory and universal, funded by a payroll tax. The other is one that mimics the ACA.⁸⁹

⁸⁶ Frank, op cit. One of the reasons he cites is the demise of the CLASS Act. The Community Living Assistance Services and Supports Act (CLASS) was Title VIII of the ACA. It was deemed structurally unsound and could not be fixed, in part because opposition to the ACA prevented the ACA legislation from going to a conference committee where those issues could be addressed. Failing that, the administration put the program on hold and Congress ultimately repealed it as part of the same law that created the Commission on Long-Term Care.

⁸⁷ Commission on Long-Term Care, “Report to the Congress,” op cit.

⁸⁸ William Galston, “The Long Term Is Now,” *DEMOCRACY* magazine, Issue No. 26 (Fall 2012) at <http://www.democracyjournal.org/26/the-long-term-is-now.php?page=1>.

⁸⁹ Galston, op cit. “The first option would work as follows: At age 40, every adult would be required to purchase a long-term care insurance policy or to pay a penalty equal to 2 percent of wage and salary income for each year without coverage. The policy would need to have certain features: a term of five years, a benefit of at least \$150 per day, an automatic annual inflation adjustment of 5 percent, a 90-day deductible, and benefits that could be received in cash or in kind and used for both home-based and institutional care. The government would provide subsidies for purchasing the plans. Individuals with household income between 150 and 300 percent of poverty would receive income-related premium subsidies; those below 150 percent would be enrolled for free.

“The federal government would create a competitive bidding process along the lines of, but broader than, the current system for federal employees (and the exchanges under the ACA), with the aim of creating a large menu of carefully vetted, readily comparable choices. After the five-year benefit period expires,

Galston believes that a plan mimicking the ACA (instead of trying to re-create a true social insurance program such as Medicare) has the best chance of passage. It also would reduce Medicare's expenditures to some degree because private insurance would finance a portion of the 100-day period. In addition "the impact on Medicaid would be far larger in fiscal terms, ... [because the new program would] serve as insurer of last resort after the expiration of the five-year private benefit period." ⁹⁰

Robert Moffit at Heritage would seek opportunities for consensus around three core areas:

- Encouraging personal responsibility and "maximizing personal freedom." (This includes encouragement of personal responsibility as well as filial responsibility but hard to see how either maximizes personal freedom.)
- Maximizing the flexibility of public and private institutional care to cope with the diversity of needs and innovations in the delivery of care.
- Balancing the need for a new LTC policy with controlling the rising costs of federal entitlements. (This includes the statement that "Policymakers should avail themselves of the unique advantages of federalism.") ⁹¹

LeadingAge, which represents mainly non-profit LTC providers, recently released guidelines (framework) for financing LTC. Its task force recommended seven "pathways" for improving the system:

- **Status Quo:** Continue to rely on public safety net programs but limit coverage.
- **Personal Responsibility:** Reduce the government role in funding LTC by limiting eligibility and providing preferential tax treatment for those who save for it.
- **Private Market:** Use government incentives and premium assistance for low-income individuals to move them from public programs to the private sector. Mechanisms would

Medicaid would assume full financial responsibility for any remaining costs. Individuals in this category would not be required to spend down their assets to be eligible.

"The five-year requirement is intended to track the distinction between normal expectations—the maximum amount of time that 80 to 90 percent of Americans will spend in nursing home care—and unusually long stays that represent the equivalent of financial catastrophe. The average nursing home stay is 2.4 years—higher for women, lower for men. As we've seen, relatively few stays last longer than five years. The choice of age 40 to mandate the purchase of insurance rests on a judgment as to when it is reasonable to expect adults to begin providing for events that may occur in later life.

"Insurers in the current federal program offer 40-year-olds the policy on which my proposal is based for an annual premium of \$1,285. With mandatory participation and more competition among insurers, premiums under this system should be substantially lower. Regulations would permit premium increases in only a narrow range of circumstances that companies would be required to document and subject to strict review."

⁹⁰ Galston, op cit.

⁹¹ Robert Moffit, "How to Think About Long-Term Care," op cit.

be needed to reduce risk for private providers so they enter the market.

- **Private Catastrophic:** Require that individuals purchase LTCI. This would be catastrophic coverage.
- **Public Catastrophic:** Support a public program that provides catastrophic LTC protection, in essence replacing the current Medicaid safety net.
- **Common Good:** Require (or highly incentivize) a public program that provides cash or services to individuals meeting specific income requirements. A defined dollar amount or time period would be established.
- **Comprehensive:** Combine public catastrophic coverage and the “common good” approach by providing a specific dollar amount or time period for funding but require copayments and deductibles.⁹²

In addition, there are still other groups looking at the issue. The Bipartisan Policy Center announced a review and study on April 7, 2014 with the idea of suggesting “a politically viable and fiscally sustainable path forward to improve the financing and delivery of LTSS for America's aging population and working-age Americans with disabilities. ... The BPC initiative will work to find a policy pathway that addresses the nation's current and projected need for long-term care. It will focus on integrating and emphasizing the role of long-term care within organized systems of care delivery and payment, and exploring sustainable approaches for financing at the individual, family, state, and national levels.”⁹³ Avik Roy, a senior advisor to the Mitt Romney presidential campaign, would divide Medicaid and have the states control the LTC portion while the federal government took over the acute care needs.⁹⁴

The Society of Actuaries has ongoing research in 2014 and likely 2015 and just completed a Delphi study of leading LTC financing experts. Possible proposals floated in their report: an LTC savings program, a high-deductible LTCI (basically catastrophic coverage), short-term care (less than a year), Medicare LTC and a universal life/LTC and/or mutual LTCI product.⁹⁵ This

⁹² LeadingAge, “Pathways: A Framework for Addressing Americans’ Financial Risk for Long-Term Services and Supports” (March 2014) at <http://viewer.zmags.com/publication/7ebedb28#/7ebedb28/1>.

⁹³ Bipartisan Policy Center, “America's Long-Term Care Crisis: BPC Launches Initiative to Find a Politically and Fiscally Viable Path Forward to Improve the Financing and Delivery of Long-Term Care” (April 7, 2014) at <http://bipartisanpolicy.org/sites/default/files/BPC%20Long-Term%20Care%20Initiative.pdf>. The SCAN Foundation is a major contributor to their effort and has been a major source behind other efforts to advance reform proposals. Bruce Chernof, the head of the foundation, was also the chair of the Long Term Care Commission. Their website is www.thescanfoundation.org.

⁹⁴ Avik Roy, “Transcending Obamacare: A Patient-Centered Plan for Near Universal Coverage and Permanent Fiscal Solvency,” Manhattan Institute for Policy Research (2014) at http://www.manhattan-institute.org/pdf/mpr_17.pdf.

⁹⁵ John O’Leary, “Land This Plane: A Delphi Research Study of Long-Term Care Financing Solutions,” Society of Actuaries (April 2014) at <http://www.soa.org/Research/Research->

group believes strongly in private LTCI but not as it is currently regulated and marketed. Absent some government involvement that either dramatically changes the regulatory environment or provides serious tax or other incentives (or mandates purchase of insurance), stand-alone LTCI is not viewed as viable in today's environment.⁹⁶

Even if a private market option is chosen it has to have government involvement. Both empirical research as well as expert opinion hold that the government must be involved as a key player.⁹⁷ One way to do this is clone the federal government's LTCI program (the largest program in the country at 270,000 enrollees). Paul Forte of Long Term Care Partners, the organization that operates the program for the federal government, has floated a proposal to create (re-create) the Federal Long Term Care Insurance Program for all Americans. His American Long Term Care Insurance Program relies heavily on the involvement of government even though it is a pure private sector insurance product.⁹⁸ If we could even see a doubling of those with private insurance, that would take significant pressure off public insurance programs.

Will we really see an LTC proposal adopted on the scale of, say, the ACA? Most likely not. Instead it will be incremental changes both in law and products as suggested in previous sections of this article. But while unlikely it is not impossible, especially if it is subsumed in something even larger such as entitlement reform. But the underpinnings are there now to be seen if any legislation *is* passed. Just as the 1965 Medicare law was essentially the Blue Cross Blue Shield standard option of 1964, any new social insurance legislation will be based on the experiences of the private insurance and retirement products of today.

[Projects/Ltc/research-2014-ltp-ltc.aspx](#). See also his presentation to the Long Term Care Discussion Group "Land This Plane: Insights from Experts on Solutions for the Nation's Long Term Care Financing Problem" (May 21, 2014) accessed at <http://www.ltcdiscussiongroup.org/archives.html>. Another group of experts suggested linking private LTCI to health insurance as well as either the creation of a national, voluntary opt-out LTCI program or adoption of single-payer LTCI system. Regina Shih, Thomas Concannon, Jodi Liu and Esther Friedman, "Improving Dementia Long Term Care," RAND (June 2014): http://www.rand.org/pubs/research_reports/RR597.html.

⁹⁶ O'Leary, op cit. See also Kylie Franklin, "Long-Term Care Insurance: Is It Really the Answer?" University of Iowa (Dec. 10, 2012) at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2308381. Her paper suggests a variety of approaches along the lines previously discussed either to sustain the industry or find other potential options to finance LTC. She hypothesizes those other approaches may be more sustainable for the companies and more accepted by the consumers.

⁹⁷ Eileen Tell and John Cutler, "A National Long Term Care Awareness Campaign: A Case Study in Social Marketing" CASES (George Washington University), Winter 2011. http://www.gwumc.edu/sphhs/departments/pch/phcm/casesjournal/volume5winter/peer-reviewed/V5w_Case4PR.pdf. (Discussion of the Own Your Future LTC campaign: "Public sector affinity and sponsorship of the Campaign is critical to achieving good response rates and ensuring consumer confidence in the objectivity of the information being provided....") See also "Social Marketing of Long-Term Care Planning," Poster session, AcademyHealth Annual Research Meeting, Boston, June 28, 2010.

⁹⁸ Paul Forte, "Fresh Thinking on Long-Term Care Financing: The American Long Term Care Insurance Program," *Contingencies* magazine (American Academy of Actuaries)(January/February 2014) at <http://www.contingenciesonline.com/contingenciesonline/20140102?pg=57#pg50>.