

Moving Beyond Medicaid: Long-Term Care for the Elderly as a Life Quality and Fiscal Imperative

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Citizens
League

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Project Advisors

Bernie Berger, Allianz Life Insurance Company of North America
Patti Cullen, Care Providers of Minnesota
Tom Devine, The David Agency, Inc.
Bright Dornblaser, Citizen
Larhae Knatterud, MN Dept. of Human Services
Gayle Kvenvold, Aging Services of Minnesota
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Kari Thurlow, Aging Services of Minnesota
Deborah Tompkins, DARTS
John Tschida, Courage Center



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Executive Summary

Most of us do not like to think about our future selves as elderly and frail, relying on others for help in managing our daily lives. In years past, such a future was far less likely, because the average life expectancy was shorter. Unlike today, medical advances were far less able to ensure survival from acute as well as chronic health conditions. In only a few generations, “old age” has gone from limited survival after retirement to “middle age” with almost twenty years of life ahead at retirement.

As welcome as this is, living longer has brought about a perplexing set of social and financial problems. Long-term care—the assistance needed to manage one’s daily life, whether at home or in a care facility—is both expensive and likely. At age 65, a person has about a 70% chance of needing some type of long-term care in their future years. Sixty percent will incur costs, spending an average of \$48,000; there is a 6% chance of costs exceeding \$100,000.

Traditionally, most long-term care has been “informal” (unpaid) care provided by family and friends. Informal care remains the mainstay of caregiving, providing about two-thirds of the dollar value and 90% of the time value of long-term care in Minnesota. Yet its share as a percentage of total care has been declining in recent years. There is no question that the informal sector needs reinforcement and support. The question, however, for this report is: *who and how will we pay for long-term care when needed?*

Despite the likelihood of needing long-term care, many people are financially unprepared for this potential cost. While *total* retirement assets have increased significantly over the past few decades, many people have failed to save adequately for their retirement needs, and more specifically, they have not saved for long-term care.

Because so few are prepared to finance long-term care, the default financing source has become Medicaid. Medicaid was originally created to provide publicly funded health care for those in poverty. In order to qualify for long-term care under Medicaid, a person must relinquish virtually all assets and nearly all income. Despite this, 40% of the long-term care expenditures for the elderly in Minnesota in 2004 were financed by Medicaid.

Medicaid is not sustainable as a default source of financing. If other forms of financing are not put in place, Medicaid funding for long-term care for the elderly could grow nearly fivefold in Minnesota, from \$1.1 billion in 2010 to \$5 billion in 2035. Unless we all agree to massive tax increases to pay for one another’s long-term care, Medicaid as the fallback is unsustainable.

How much money are we willing to personally set aside to ensure we have the care we want in our later years?

In 2009, a group of representatives agreed to fund and others agreed to participate in a Citizens League project aimed at developing a long-term care financing system for Minnesota. The participant group, composed of representatives from diverse backgrounds and perspectives is referred to as the Long-Term Care Collaborative in this report. After intensive study and review of the numerous challenges in addressing long-term care, and after convening a series of community workshops and focus groups, the Long-Term Care (LTC) Collaborative has agreed on a framework for financing long-term care in Minnesota, based on encouraging and supporting personal responsibility. In doing so, we also safeguard public support for those who are truly needy.

Goals

- By 2015, 50% of Minnesotans aged 45-65 will have some financial planning in place for their long-term care.
- By 2020, 85% of Minnesotans aged 45-65 will have some financial planning in place for their long-term care.

Recommendations

There are three essentials to creating an environment of personal responsibility: 1) strong **reasons** (i.e., Medicaid reform); 2) **opportunities** appropriate for varying family situations and financial capacities; and 3) the **knowledge** and information to make sound choices. Each is essential. Our recommendations follow accordingly.

1. Redesign Medicaid to provide a co-insurance option.
2. Make available and promote financial products, especially those aimed at middle income households: prize-rewarded savings; a new hybrid home equity/reverse mortgage product; and a broader mix of affordable insurance products.
3. Make unbiased information about long-term care planning and financial options readily available to the general public, so long-term care planning becomes an essential and ubiquitous part of retirement planning.

Will Minnesotans respond? Two-thirds of Minnesotans aged 42-60 are concerned about their ability to pay for long-term care. Eighty-six percent of Minnesotans surveyed said that developing new ways for helping people meet their long-term costs should be a top priority or a very important priority for government. The Long-Term Care Collaborative believes that given good information, appropriate financial products, and support through a Medicaid waiver, Minnesotans will respond positively to this call for action, and we will indeed meet our goals.

The situation is urgent. The first baby-boomers begin to retire this year, in 2010. Financial preparations for long-term care cannot be accomplished overnight, on either an individual or societal basis. Long-term care is everybody's business. Everyone carries some responsibility: the Governor and State Legislature; employers and businesses; social service and civic institutions; philanthropic organizations; and individuals and families. If we are to meaningfully address this enormous challenge, we must start **today**.

I. Introduction: We Have No System for Financing Long-Term Care

Most of us do not like to think about our future selves as elderly and frail, relying on others for help in managing our daily lives. In years past, such a future was far less likely because the average life expectancy was shorter. Unlike today, medical advances were less able to ensure survival from acute as well as chronic health conditions. In only a few generations, “old age” has gone from limited survival after retirement to “middle age” with almost twenty years of life ahead at retirement.

As welcome as this is, living longer has brought about a perplexing set of social and financial problems. Long-term care—the assistance needed to conduct one’s daily life, whether at home or in a care facility—is both expensive and likely. At age 65, a person has about a 70% chance of needing some type of long-term care in their future years. Sixty percent will incur costs, spending an average \$48,000; there is a six percent chance of costs exceeding \$100,000.

Today’s long-term care, the assistance needed to manage one’s daily life, is a variety of housing and services, encompassing far more than nursing home care.

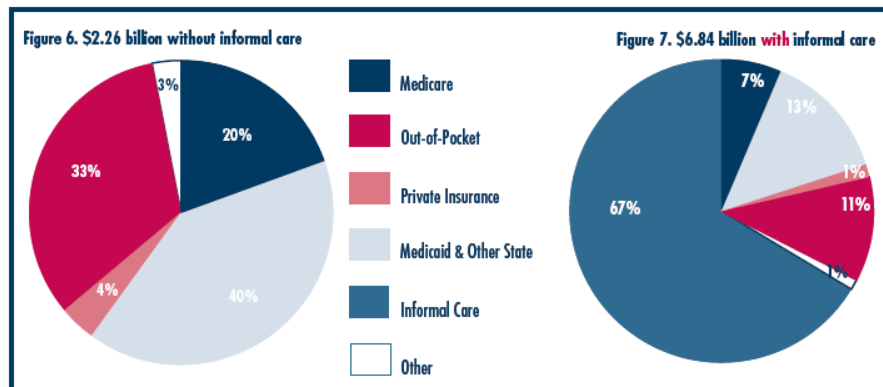
Traditionally, most long-term care has been “informal” (unpaid) care provided by family and friends (see chart on page two). Informal care remains the mainstay of caregiving, providing about two-thirds of the dollar value and 90% of the time value of long-term care in Minnesota. Yet its share as a percentage of total care has been declining in recent years. There is no question that the informal care sector needs reinforcement and support. The question, however, for this report is: *who and how will we pay for long-term care when needed?*

Despite the likelihood of needing long-term care, many people are financially unprepared for this potential cost. Retirement savings are typically inadequate. While *total* retirement assets have increased significantly (from \$400 billion in 1975 in the United States to over \$2 trillion in 1999, excluding Social Security) (Poterba et al, November 2001), many people have failed to save adequately for their retirement needs, and more specifically, they have not saved for long-term care.

- As life expectancy has risen, retirees must spread their retirement savings out over longer periods of time. Social Security will replace less pre-retirement income for the average earner, from 42% in 2001 to 36% projected by 2030 (Munnell and Soto, 2005).
- Out-of-pocket medical costs are projected to rise from 7% as a percentage of the average social security benefit in 1980 to 39% in 2030 (Munnell, 2009).
- A 65-year-old married American with median earnings and median retirement assets of \$119,000 would have the means to purchase an annuity that would replace less than 20% of the couple’s annual income (Purcell and Whitman, 2007).
- In Minnesota in 2001, 56% of senior couples had assets, excluding their home equity, of less than \$50,000 (MN DHS, 2008).
- In 2007, 29% of Minnesotans’ aged 42-60 said they plan to rely on Medicare to cover their long-term care costs, (Ecumen, 2007) yet Medicare’s coverage is limited to certain types of care for short periods of time.
- Purchase of long-term care insurance is low—an estimated 10% of Minnesotans aged 50 to 84 carry long-term care insurance.

Because so few are prepared to finance long-term care and because long-term care falls between the cracks of multiple systems designed for other purposes (such as Social Security, Medicare, health insurance, disability insurance, employment, and housing), the default financing source has become Medicaid. Whereas Medicare provides health insurance for the elderly, Medicaid was created to provide publicly funded health care for those in poverty. (See Appendix A for a brief description of Medicaid and Medicare.) In order to qualify for Medicaid, people must relinquish virtually all assets and nearly all income and spend their last days in poverty. Despite this, 40% of the long-term care expenditures for the elderly in Minnesota in 2004 were financed by Medicaid (MN DHS, 2005).

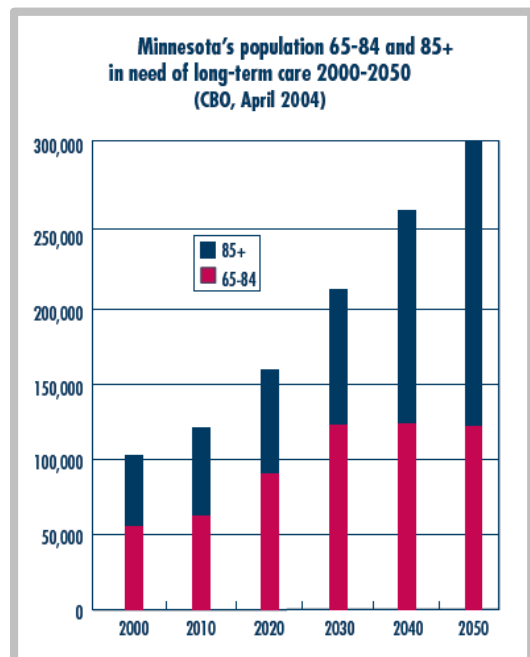
2004 Spending for Elderly Long-Term Care Expenses in Minnesota



Source: MN DHS, January 2005

Medicaid, a federal program in which the costs are shared between the federal government and the states, is not sustainable as a default source of financing. The growing number of people turning to Medicaid is creating a future crisis in public funding. If other forms of financing are not put in place, Medicaid funding for long-term care for the elderly could grow nearly fivefold in Minnesota by 2050 (MN DHS, 2005), from \$1.1 billion in 2010 to \$5 billion in 2035.

Over the course of our work, many people told us that they know of someone who has turned to government support for long-term care. But often they did not make the connection to who is actually paying for this care; that is, government funding is “us”—it is our tax dollars. In these instances, Medicaid is viewed as an entitlement or “beating the system.” An urgent public case must be made: planning for and contributing to one's own care also contributes to the good of the community. Failing to provide what we can for our own care pushes the financial burden to others, most likely our children. How much money are we personally willing to set aside to provide good care for ourselves in our later years? How much are we willing to set aside to ensure that we don't pass on an enormous fiscal burden to future generations of Minnesotans?



Source: MN DHS, January 2005

In short, we face an unprecedented set of enormous costs that we have not prepared for, either individually or publicly. Unless we all agree to massive tax increases to pay for one another's long-term care, Medicaid as the fallback is unsustainable. The answer lies in understanding and acting on our collective and individual responsibilities.

II. Toward Developing a Long-Term Care Financing System—The Long-Term Care Collaborative and Its Work

In 2009, a group of representatives, the Long-Term Care Collaborative (LTC Collaborative) agreed to fund and participate in a Citizens League project aimed at developing a long-term care financing system for Minnesota. Over time, representation and participation in this project have grown to include broad representation from diverse interests (see the full list of activities in Appendix B). Most participants have experienced firsthand the repercussions of the lack of a thoughtful, deliberate financing system—seniors with too little care, seniors who must spend their remaining years in poverty, family caregivers who sacrifice their own health and finances for a loved one, businesses that lose millions in productivity each year, families thrust into emergency situations by lack of planning, estate planners who help higher income families receive public financial assistance by carefully placing their assets out of reach.

In the summer of 2009, the LTC Collaborative sponsored a series of community workshops to explore a multitude of issues related to financing long-term care, including how to reduce demand for care by improving health and medical care, and how to better support family caregiving. Prior to the workshops, the LTC Collaborative developed the following parameters for the participants' work:

- View long-term care as a public-private partnership that clearly defines personal and public responsibility, and rewards those who assume personal responsibility.
- Target new incentives primarily at those of middle incomes, as this is the group with capacity for financial preparedness (compared to low income families) and fewer incentives to save (compared to higher income families).

The workshops produced many ideas (see Appendix C). The LTC Collaborative reviewed these ideas and decided to concentrate on the financing system, as it was the least likely to be addressed through other venues and it requires a proactive public policy approach. Workshop participants stressed that any financing system must be designed with an understanding of how people make decisions and suggested the following three-plank framework.

1. **Medicaid reform** to remove the current disincentives for personal financial responsibility.
2. **A mix of financial products**, to help people become better financially prepared.
3. **A broad campaign of informing the public**, many of whom are not aware of the likelihood, costs and lack of public funding for long-term care.

The LTC Collaborative adopted this framework, and after intensive study and discussion developed a set of recommendations pursuant to this framework. This report outlines the framework and associated recommendations. It concludes by considering how Minnesotans might respond to the

recommendations and by listing a series of next steps for implementation.

This report must be read with two important principles in mind. First, the emphasis on personal responsibility is not an effort to remove financial support from those who are truly needy. In fact, quite the opposite is true: The LTC Collaborative believes that unless those with greater means contribute to the extent of their ability, support for the impoverished will be jeopardized. Second, this report focuses only on long-term care for the elderly. While the struggles and needs of the non-elderly in long-term care are equally acute, the life and financial situations are rather different.

III. A Framework for a Long-Term Care Financing System Based on Personal Responsibility

It is a matter of public urgency to make financial preparations for long-term care. The Citizens League first began to look at the financial issues of aging almost thirty years ago, and today, on the brink of the first wave of baby boomer retirements, little has changed. Beginning in 1984, Citizens League reports outlined the importance of personal responsibility in financial planning, the cost of care, and the role of family support. Particular emphasis was placed on personal financial responsibility for long-term care. This is the same emphasis the LTC Collaborative puts forward today.

One approach to decrease reliance on publicly funded long-term care is to reduce demand by improving people's health and the way health is managed. This could entail encouraging and supporting family provided care, better management of chronic illness and disability (and improved health generally), and reducing medical costs through improved coordination between acute and long-term care.

The LTC Collaborative agrees with the importance of efforts to reduce demand for long-term care; two of the community workshops dealt explicitly with these topics (see Appendix C). However, it would be foolhardy to rely on reduced demand as the primary strategy. It simply is not possible to avoid long-term care costs. The same medical advances that keep people alive longer are those that contribute to the need for long-term care, because people are living more years with chronic conditions and disabilities. Medical advances may increase rather than decrease health care costs for the elderly (Friedman, 2006; Fogel, 2008; Rand, 2008). A new study found that staying healthy actually increases the likelihood of higher lifetime medical costs due to more years of health expenses and the higher probability of nursing home care that comes with advanced age (Wei San, Webb, Zhivan, 2010). One big exception, however, is addressing obesity. It has been estimated that nursing home costs could grow 10-25% above trend lines as a result of obesity (Reynolds, 2005).

The options for who will pay for long-term care are limited.

While the LTC Collaborative encourages and supports efforts to reduce the costs and demand for care, it turned its attention to financing the inevitable set of costs that will exist in the future. The options for *who will pay* for long-term care are limited.

1. Taxpayers, through a public program
2. Individual savings, for personal costs

3. Individual premiums, for insurance with pooled risk
4. The next generations, through deficit financing

The LTC Collaborative rejected the first and fourth options as the primary vehicle for financing long-term care. Members of the Collaborative, like most citizens surveyed on the issue (Ecumen, 2007; MetLife, 2002, Peter Hart, 2005) see long-term care as a personal responsibility or a shared responsibility with government. They also recognized that at times long-term care costs can be excessive, and families should be able to turn to public support. As currently structured, Medicaid is indifferent to whether or not someone has taken personal financial responsibility—indeed, in a sense it rewards those who have not. Research has clearly shown that Medicaid acts as a disincentive to personal responsibility, by discouraging people to save, to forgo insurance coverage, or to engage in asset planning that enables them to qualify for Medicaid while using their assets for other purposes.

A Necessary New Paradigm: "Personal responsibility will be publicly supported and rewarded."

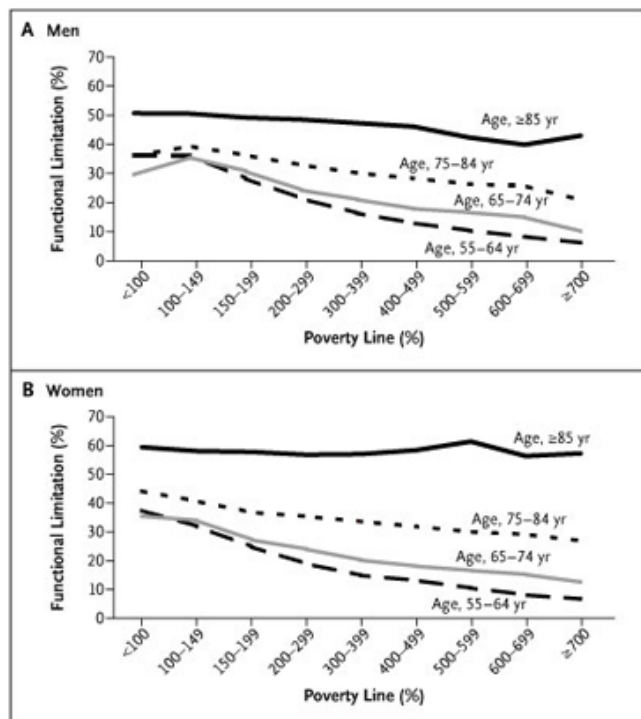
Creating a long-term care financing system for Minnesota requires cultivating a new culture of personal and financial responsibility. We must move from, "If you don't take personal responsibility, the public will provide your care but you first must become destitute" to "personal responsibility will be publicly supported and rewarded."

This requires us collectively as Minnesotans to address the following: How can public policy create incentives to increase personal responsibility for long-term care?

IV. Challenges

This framing of long-term care financing, one based on personal responsibility and public support, breaks with conventional policy approaches in a number of ways. The "system" recommended below does not take the form of a conventional government-led policy proposal. It is not a comprehensive scheme in the form of a new public program. It recognizes that at its heart, long-term care is a highly personalized issue, dealing with the most intimate concerns of life and death, relationships with our family members, and the financial dreams we set for our children and ourselves. Instead, the LTC Collaborative recommends a package of public incentives and private sector financial products that enables

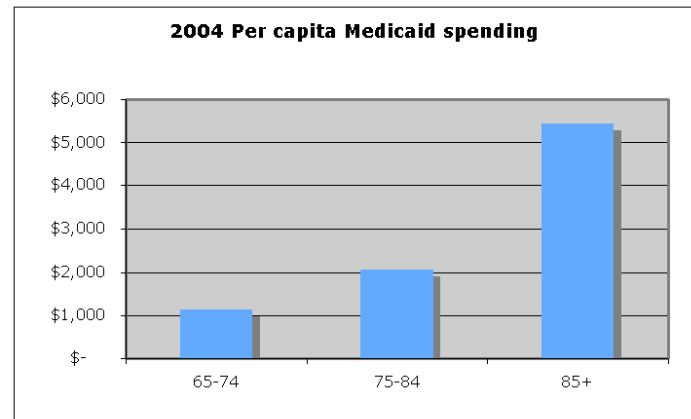
Disabilities by Age and Gender



Source: Minkler et al, 2005

people to create for themselves the most appropriate way to care for themselves in their older years.

An incentive-based system, rather than a mandatory system, must understand the concerns and perspectives of families from all walks of life in order to be effective; one-size-fits-all simply will not work. Focus groups conducted for the LTC Collaborative underscored this point: people differ in the approach and products they feel are right for themselves (see Appendix D). An effective system of incentives must be mindful of any number of vexing challenges.



Source: Centers for Medicare and Medicaid

Challenge one. *Prior to age 85, people who are least able to pay are the most likely to need help.* Prior to age 85, there is a clear link between disability, education and income (Lunn, 2004; Melzer et al, 2001; Minkler et al, 2006). Disability rates have been falling on average, but not for all income groups and races.

- In 2001, the median household income for elderly Americans not living in a nursing facility was \$30,200 for those with no disabilities, \$18,500 for those impaired in at least one “activity of daily living” (ADL), and \$14,200 for those with three or more ADLs.
- In 2002, median household wealth for elderly with no disabilities was \$206,000, compared to \$48,000 for elderly with 3 or more ADLs.
- Between 1993 and 2002, median wealth for those without disabilities increased 7% above inflation while it declined 41% for those with three or more ADLs (Johnson and Wiener).

At age 85, disabilities take a sharp upturn and are unrelated to education or income. However, many people who survive to age 85 (usually widowed women) find their financial resources exhausted, often by caring for a spouse.

Challenge two. *The financial pressures are driven largely by the demographic group with the least time to save—baby boomers.* The baby boom generation starts retiring this year. From 2005 to 2035, the population of Minnesotans aged 65 and older will double, from 623,000 to 1.4 million. Older Minnesotans will also increase as a share of the overall population, from 12% to 22% over the same time period (MN State Demographic Center, 2007). Therefore, there will be fewer workers per elderly person to support the health and care costs of the elderly through taxes.

Challenge three. *Socially, there is limited awareness, planning and cultural acceptance of responsibility for long-term care.* While this is beginning to change as baby boomers experience caring for their parents, only 35% of adults age forty or older think they or their spouse will need long-term care, when in fact the likelihood is closer to 75%. Thirty-two percent of this age cohort believes they will use insurance to pay for their care if needed—yet only an estimated 10% of the U.S. population has long-term care insurance (Peter D. Hart, 2005). Minnesotans, however, do have more realistic views

on these matters, with 20% citing that they would use long-term care insurance (Ecumen, 2007).

Challenge four. The lack of adequate personal funding and appropriate care does not result in expenditures that “go away” but *creates future liabilities* due to too little prevention and disease management, as well as financial and medical liabilities for family caregivers as they sacrifice their own earnings and health to care for others. For example, in 1999 the average loss of wealth for caregivers was estimated at \$659,000 over their lifetimes (1999 dollars) including lost Social Security benefits of \$25,000 and pension wealth of \$67,000. The remainder accrued from lost wages. In addition, caregivers spent an average of \$19,500 for out-of-pocket expenses to help the care recipient (National Alliance for Caregiving, 1999). Caregivers are also at higher risk of hypertension, pulmonary disease, diabetes and depression (Johnson and Weiner, 2006).

Challenge five. *The public policy tool of choice—tax incentives— is poorly targeted to those of moderate incomes* who are less likely to save and more likely to need Medicaid. In 2010, “tax expenditures” (i.e., reduced tax payments due to income deductions or credits) for individual income tax in Minnesota is estimated to total \$1.6 billion for retirement-related savings (Minnesota Revenue, 2010). Unpublished U.S. Treasury data suggested that two-thirds of the tax benefits for IRAs and pensions accrue to families in the top 20% of income scale. Minnesota House research estimates that 75% of the tax credit for long-term care insurance is taken by households in the upper 30% of Minnesota incomes (Dalton). Other research finds that tax incentives for LTC insurance costs the U.S. Treasury more than it saves because the benefits accrue to upper income individuals (Courtmanche and He, 2009; Cramer and Jensen, 2006).

Challenge six. *Medicaid as currently structured creates the wrong incentives* for personal responsibility for long-term care. This is a well-researched conclusion: in most income ranges, Medicaid acts as a disincentive to save and/or purchase long-term care insurance (Brown and Finkelstein, 2009; Courtmanche and He, 2009; Cramer and Jensen, 2006; Sevak and Walker). The financial disincentives embedded in Medicaid have been estimated to be so significant that they depress the willingness to purchase long-term care insurance for all but those in the top 30% of income levels for men, and the top 40% for women (Brown and Finkelstein, 2009). Medicaid has also been shown to reduce savings among certain income groups (Hubbard et al, 1995).

The Medicaid “spend down” (to poverty) provision encourages people to use their savings in less than optimal ways. While empirical evidence is limited (Bassett, 2004; Lee, 2006; O’Brien, 2005), anecdotes abound. Faced with costs as high as \$80,000 a year if nursing facility care is needed, even someone with \$30,000 in savings has no incentive to spend the savings on nursing home care because she can envision ending up destitute and turning to Medicaid anyway. This person might spend her savings in other ways. Similarly, one’s home is often exempt from the asset limits, so there is no incentive to use one’s home to help pay for care.

Challenge seven. *It is easy to get the incentives “wrong”* in any system that is not mandatory. (See for example, American Academy of Actuaries.) For example, the insurance sector must consider “adverse selection,” in which only those with the highest risk purchase insurance. If only high-risk individuals enroll, the premiums become so expensive that the product is no longer viable. It will also be critically important not to discourage family care-giving. This is an area where many Minnesotans take their personal responsibilities very seriously. Roughly 90% of the care in hours and 2/3 of the care in dollars (roughly \$4.6 billion) is provided by family members. Every 1% loss of family provided care is estimated to cost the state \$30 million in Medicaid costs (MN DHS, 2005).

V. Goals

As a State, we must become intentional about financial preparations for long-term care. Focusing on personal responsibility implies that Minnesotans must take individual actions. There are roughly 1.4 million Minnesotans between the ages of 45 and 65. We target our goals at this age group:

With the exception of Medicaid reform, the recommendations can be developed and enacted relatively quickly and with no or little cost to government.

- 50% of Minnesotans aged 45-65 will have some financial planning in place for their long-term care by 2015.
- 85% of Minnesotans aged 45-65 will have some financial planning in place for their long-term care by 2020.

The LTC Collaborative believes it is important to put forth measureable goals. Right now, we cannot say how many Minnesotans have actually begun to plan for their long-term care needs. We do know from a recent survey that, when asked how they would cover their long-term care costs, 32% of baby boomer Minnesotans say they do not know. Another 18% plan to rely on government programs, while 16% said that plan to rely on long-term care insurance (a larger percentage than actually have such insurance). Twenty percent said they would rely on personal savings or investments (MN DHS, 2010).

VI. Recommendations

The recommendations provide action steps to the framework described above. They are aimed at helping Minnesotans as individuals so that collectively, we will prosper as a state. The LTC Collaborative realizes that the recommendations are only a start toward a long-term care financing system, but they are intended to push us—quickly—down the path toward an effective system. With the first baby boomers retiring in 2010, time is of the essence. With the exception of Medicaid reform, the recommendations can be developed and enacted relatively quickly and with no or little cost to government.

In contrast, more extensive comprehensive public systems are controversial, and painstakingly slow to gain acceptance. In many respects, long-term care financing is still “inside baseball”—just as many people are not yet convinced of their own need for planning, they are also unaware of the crushing public burden coming down the road. It is not clear that there is public consensus on the need for a more comprehensive public option, although the passage of the CLASS Act in Congress (a public long-term care insurance program provided in the health reform bill, see below) suggests that we are nearing public acknowledgment of the need to address long-term care financing. It remains to be seen how attractive the CLASS Act coverage will be for Minnesotans.

More and more Minnesotans are becoming aware of the need to prepare for the possibility of long-term care. But too many do not really know how to prepare, or do not feel that they have the capacity to prepare. Or they feel they can put it off to a later time. The framework can be restated into three essentials that *must* exist to encourage and support personal responsibility. If we are to meet our goals, none of the three can be ignored.

1. A strong **reason** to become financially prepared for long-term care (i.e., Medicaid reform);
2. A mix of financial products that provide families the **opportunities** to financially prepare, appropriate for varying family situations and financial capacities; and
3. The **knowledge** and information to make sound choices.

By leading with these basic measures, we begin to draw attention to the need for financial planning for long-term care, and provide Minnesotans with the wherewithal to take personal responsibility. Over time, we will learn as a state whether or not these are sufficient and where the gaps are, both personally and publicly. Broader awareness and greater information gained from implementing these first steps will help Minnesota reach consensus on whether more extensive public options are needed here in Minnesota.

Recommendation One: Redesign Medicaid to Provide a Co-Insurance Option

The current structure of Medicaid contains disincentives for personal responsibility. Consequently, its function as a safety-net for long-term care for the elderly poor has been distorted. Medicaid has been dubbed “a public insurance with an extremely high deductible” (i.e., virtually all of one’s assets). We recommend that it become a type of *co-insurance*, with eligibility for co-insurance contingent on: 1) privately purchased long-term care insurance and/or savings for long-term care; and 2) income. Under the recent health reform law, Medicaid rules, including those pertaining to eligibility, cannot be made more restrictive until 2014. We recommend that Minnesota use the intervening time to create, analyze and agree on a co-insurance plan that can begin implementation in 2014.

While Medicaid was designed as a safety-net to assist only those in our society who are impoverished, today **Medicaid picks up 40% of long-term care costs for the elderly in Minnesota** (MN DHS, 2005). Its role as a safety net must be rethought, because the current Medicaid structure runs counter to encouraging the personal responsibility that is fundamental to any well-functioning, safety-net type program.

Embedded in Medicaid are a number of disincentives which have been researched and quantified. Perhaps the most significant disincentive is the poverty-based means testing. Medicaid currently operates as an “on-off” switch. A person is “on” if destitute, “off” if not. Under such rules, Medicaid benefits create an “implicit tax” on LTC insurance. The tax is equal to the amount of private insurance benefits that Medicaid would have otherwise paid. The higher the amount, the higher the “tax.” Why bother purchasing insurance if Medicaid will pay? This “tax” has been estimated to be so significant that (on average) people are unwilling to pay for long-term care insurance until they reach the top 30% of income levels for men, and the top 40% for women (Brown and Finkelstein, 2008).

The Medicaid “spend down” (to poverty) provision also encourages people to use their savings in less than optimal ways. Faced with nursing facility costs as high as \$80,000 a year, even someone with \$60,000 in savings has little incentive to use the savings for nursing care because she can envision ending up destitute and turning to Medicaid anyway. Similarly, one’s home can be exempted from Medicaid’s asset limits under certain conditions, so there is limited incentive to use one’s home to help pay for care.

Research also points to other provisions that depress the private insurance market, including using

Medicaid Co-insurance Design Objectives

1. If you have a qualifying LTC plan that enables you to self-finance your long-term care expenses above some threshold amount, Medicaid will supplement your effort based on new eligibility criteria that do not require a recipient to be entirely impoverished of assets and income. Traditional Medicaid would remain available for those who are unable or choose not to participate.
2. Medicaid co-insurance is an alternative to the traditional Medicaid option; people would elect to participate. Consider requiring that election be made at the time of applying for other benefits such as Social Security or Medicare.
3. A qualifying plan may consist of CLASS Act participation, and/or HSA savings, LTC insurance and/or home equity.
4. The amount of Medicaid assistance will be largely based on income and may operate on a sliding-fee and/or matching basis. Criteria for receiving assistance might also consider the overall costs of care in relation to the amount self-financed. The value of assets may be annuitized for purposes of calculating income.
5. Target group: **middle income** (25-65% of income distribution).
6. The Medicaid alternative must be more attractive than traditional Medicaid for the target group and provide incentives for them, by addressing these barriers: means-testing eligibility; Medicaid's secondary payor status for those with private insurance and/or reverse mortgages; the disallowance of supplemental policies.
7. Medicaid co-insurance should provide incentives to plan and be forward looking (e.g., based on lifetime earnings). However, it must also be accompanied by changes to the traditional Medicaid to make it a less attractive option for all families but those in the lowest quartile of income. Changes that ought to be discussed and considered include: amendments to the home equity exemption; income eligibility guidelines and spend down requirements.
8. It must result in savings of at least 1/3 for the target group compared to the status quo. To accomplish this, any co-insurance program must carefully avoid the possibility that a new program might increase the overall demand for Medicaid financing for long-term care.
10. It must be easy to understand.
11. For cost-effectiveness and ease of administration, it should utilize readily available data and documentation (e.g., income tax forms, HSA accounts or Social Security statements).

Medicaid as a secondary payor and the inability to buy supplemental insurance for Medicaid (similar to supplemental Medicare insurance). Medicaid has also been shown to depress savings among certain income groups (Hubbard et al, 1995).

Research makes clear that unless Medicaid is redesigned to remove disincentives for personal responsibility, other incentives (such as tax benefits) will have only marginal success. Medicaid redesign **must** be a component of any long-term care financing system. The implications of the research findings suggest that a more efficient role for Medicaid is one of co-insurer. Furthermore, the co-insurance must be aimed at families of middle incomes, or savings will not result. (See Dalton et al, 2009 for example.)

Co-insurance could be structured in a variety of ways. One possibility is to provide a co-pay on long-term care expenditures financed by private savings and/or private insurance. Another is to match the dollar amount of private insurance once private insurance benefits have been exhausted (DeNeui, 2010). As noted above, getting the details right is extremely important to achieving savings.

Designing, applying for and gaining approval from the federal government for an alternative Medicaid program is a time-consuming, uncertain, and somewhat costly process. Under the recently enacted federal health care reform, no changes can be made to Medicaid eligibility rules until 2014. We recommend that the Minnesota legislature direct DHS to convene a redesign effort and to complete this work no later than February 1, 2013. In the box on page ten we recommend design objectives for the restructured co-insurance program.

Recommendation Two: Make Available and Promote a Mix of Financial Products, Especially Those Aimed At Middle Income Families

A variety of savings and insurance products already exist to help families save for their retirement and long-term care: IRAs, 401k's, long-term care insurance, and Health Savings Accounts (HSAs), and very recently, public insurance through the federal CLASS Act, which will take effect in the coming years. While these products have had some success, they are insufficient because of the challenges and impediments described above. The LTC Collaborative recommends three very specific products to quickly increase the personal resources available for long-term care: prize-rewarded savings; new more affordable long-term care insurance products; and a new loan product to help seniors tap their home equity.

New product ideas were tested with Minnesotans in three focus groups and two presentations. (A summary of the focus groups can be found in Appendix D.) It was clear that a variety of products are needed because people differ in their financial situations as well as their financial preferences and risk-tolerance. Opportunities for financial preparation also differ with age.

Enable prize-rewarded savings in Minnesota. Until very recently, the U.S. has experienced a negative savings rate. Researchers from Harvard University's business school looked at the perspectives of lower and middle income families regarding saving. Based on this research, and based on longstanding and widespread international experience, a new type of savings vehicle was launched in 2009 by eight credit unions in Michigan: The Save to Win program. The program is based on the premise that savings should be fun, and that there is capacity to save (for example, judging by the amount spent each year on the State lottery and charitable gambling, which total about \$2.5 billion annually in

Minnesota).

The concept is simple. A saver creates a credit union savings account (with a one-year certificate and the ability to add deposits), and for every \$25 saved, is entered into a drawing for prizes. Small monthly prizes are awarded by each credit union, and a grand statewide prize of \$100,000 is offered annually. In eleven months, over 11,500 people opened accounts totaling \$8.5 million. The program succeeded in reaching non-savers and lower to middle income households: 56% had not saved regularly before; 44% had household income less than \$40,000 and 16% less than \$20,000; 39% had financial assets (excluding home equity) of less than \$5,000; and 59% played the lottery in the prior six months (Doorways to Dreams Fund, 2010). As a result of this early success, a total of twenty credit unions will be offering this savings program in Michigan in 2010. The program has the added benefit of supporting community financial institutions and local economies. And unlike tax incentives, it comes at no expense to the public purse.

Summary of Accounts for Non-Savers, Asset Poor and Low-to-Moderate Income

| | At December 2009 | | |
|------------------------|-------------------|-------------|-------------------------|
| | # Active Accounts | Total Saved | Average Account Balance |
| Non-Savers | 2,824 | \$1,660,897 | \$588 |
| Asset Poor | 1,849 | \$721,227 | \$390 |
| Low-to-Moderate Income | 2,162 | \$1,370,471 | \$634 |

Source: Doorways to Dreams Fund, 2010

The program in Michigan is a general savings program, but program implementers agree that it can be tailored to any number of policy objectives, including long-term care. In a broader sense, however, improving savings rates is instrumental to long-term care. Many families face “shocks” in their later working years that can readily deplete savings (Johnson et al, 2005). Savers would also have the option of transferring their prize-rewarded savings to a Health Savings Account, from which long-term care expenditures can be paid.

Prize-rewarded savings is not gambling—the depositor loses no money, and in fact earns interest (slightly below the going rate). Nevertheless, legislation would be needed to enable prize-rewarded savings in Minnesota. The LTC Collaborative requests the Minnesota legislature to pass this legislation in 2011. Three states, Rhode Island, Maine and Maryland, passed such legislation in 2010; four states in addition to Minnesota are expected to request such legislation in 2011.

Banking laws also govern programs such as this. For a variety of legal and mission-related reasons, it is most efficient to launch prize-rewarded savings through credit unions rather than banks. The Citizens League has been working with the Minnesota Credit Union Network (MCUN) to explore its members’ interest in designing and participating in a prize-rewarded savings program. In July of 2010, a key committee of MCUN recommended pursuing prize-rewarded savings.

Create a new hybrid home equity/reverse mortgage product. Most people’s largest asset is their home. This is true notwithstanding the recent fall in home prices. People of all incomes have savings in their homes. Medicaid often exempts people’s homes from the requirement that one must have no assets in order to qualify for Medicaid. Yet, it has been estimated that replacing Medicaid’s home exemption with “reverse mortgages” could save Medicaid from \$5 to \$20 billion a year in the United States (Moses, 2005; Stucki, 2004).

Reverse mortgages enable seniors to tap into their home equity. A senior with a small or no mortgage is eligible to mortgage their home for cash. Interest charges accrue, but payment is not due until the homeowner moves, sells the home or passes away. The vast majority of reverse mortgages are insured through the Federal Home Administration (FHA). In 2009, the federal limit for FHA insurance of a reverse mortgage was increased to \$625,000.

It would be highly cost-effective for the State of Minnesota to develop and/or support a new hybrid home equity/reverse mortgage product for long-term care and medical expenses.

From a public policy perspective, the program is inferior for two significant reasons: 1) seniors lose large sums of equity through transaction fees; and 2) the guaranteed nature and high fees encourage the selling of such loans, no matter how the funds will be used. Fees typically include: origination fees of \$2,500-\$6,000; a mortgage insurance premium at 2% of the maximum claim amount; mortgage insurance protection of 0.5% year; and a fixed monthly servicing fee of \$25-\$35. Reverse mortgages have recently become less expensive because lenders are starting to package the loans as securities and selling them to investors.

Reverse mortgages represent an enormous market. Almost half (48 percent) of the homeowners age 62 and older — 13.2 million people — are candidates for using a reverse mortgage for long-term care at home (Stucki, 2004). More than seven million people over the age of 65 with annual incomes less than \$30,000 own their homes outright (Bernard). The volume of reverse mortgages more than doubled between 2005 and 2008. During 2008, more than 100,000 seniors used reverse mortgages to tap more than \$17 billion in home equity, prompting the U.S. Comptroller John C. Dugan to state in 2009, “While reverse mortgages can provide real benefit, they also have some of the same characteristics as the riskiest types of subprime mortgages—and that should set off alarm bells” (“Reverse Mortgages...”, 2009). Likewise, an official of the Department of Housing and Urban Development recently stated, “(Reverse mortgage scams are) more of an emerging trend. We're starting to see it as a bigger problem” (Senior Journal).

It would be highly cost-effective for the state of Minnesota to develop and/or support a product that allows seniors to tap their home equity for limited purposes (e.g., health and long-term care costs, and costs that allow them to remain in their homes) under terms far more favorable than existing reverse mortgage terms. A simple way to reduce the risk and administrative costs would be to reduce the amount of equity that can be withdrawn, so that the ultimate home value (due to market forces or a lack of home maintenance) is of less risk. We recommend that a home equity product be designed along the lines shown in the box on page 14.

Support the development of a more robust market for long-term care insurance that offers a greater variety of products. In a recent survey of those who were targeted by the insurance industry to purchase long-term care insurance but declined to buy (“non-buyers”), 83% cited cost as a very important or important reason for not buying insurance. Forty-one percent are waiting for a better policy, while 49% said they do not mind using their own assets for whatever care they may need (Society of Actuaries, 2007).

Hybrid Home Equity/Reverse Mortgage Design Objectives

1. Loans are available to anyone drawing Social Security.
2. Funds are made available as a line of credit for specified purposes related to long-term care.
3. Rates for low income households may be subsidized.
4. Fees should total no more than 3-5% of the line of credit.
5. The loan should be excluded as an asset for determining Medicaid eligibility. (However, as noted above, proceeds from conventional reverse mortgages and housing assets should perhaps not be excluded.)
6. The loans can be administered either through the private market or the State.

Most of the long-term care policies that are offered and purchased are “comprehensive,” meaning that they provide benefits for home care as well as nursing facility care. This is sensible, since many more people will need home care rather than nursing facility care. However, one way to reduce premiums and protect one's assets is to purchase partial coverage, especially for less likely but more costly care such as nursing facility care. Possible examples are:

- “catastrophic care,” which would cover only nursing facility expensive care;
- very high-deductible policies which cover the later years of care;
- or term life insurance policies that convert to limited long-term care coverage.

A limited long-term insurance policy, by definition, would provide only partial coverage of potential long-term care expenditures. But for a reasonable cost it could insure against the set of costs that drives people to poverty and to Medicaid. Medicaid picks up 40% of the total long-term care costs of the elderly in Minnesota, as well as 40% of the nursing facility costs for the elderly. Only 25% of nursing home care is private pay (insurance or out-of-pocket). Of those who enter a nursing home on private pay, an estimated 20-25% will “spend down” to Medicaid—that is, they will exhaust all of their assets paying for the care because the care is so expensive (Adams et al, 1992).

For a reasonable cost, a “catastrophic” LTC insurance plan or other types of partial coverage could insure against the set of costs that drives people to poverty and to Medicaid.

If there is profit to be made, why aren’t these products offered? In long-term care, the predominant form of coverage has evolved to be comprehensive in nature. Very early on, most long-term care coverage did not provide home care, just as Medicaid did not. Some policy-holders were upset to find that their home care was not covered, and the preference for home-based care led to a demand for policies that cover such care.

It is possible that skepticism about payout of benefits may also act as an impediment. Forty-two percent of non-buyers stated that they don't believe the insurance companies will pay the benefits stated in the policy, while 55% said they are afraid the policy won't provide the types of benefits they'll need in the future (Society of Actuaries, 2007). The Minnesota Department of Commerce has adopted and implemented model legislation that is aimed at protecting consumers from non-delivery of long-term care insurance benefits.

Another early problem was the correct pricing of premiums. Accurate pricing—especially based on claims made well into the future—is dependent on being able to predict who will be in the pool of those insured. In a new small market, this is difficult to predict and can change quite drastically. Many insurance companies increased premiums as the market adjusted and more claims experience became available. Fifty-five percent of non-buyers listed fear of increased premiums as an important reason for not purchasing long-term care insurance. It is important to note that this very question—who will enroll—is at the heart of the debate as the federal government decides on premium levels for the new CLASS (Community Living Assistance Services and Support) Act.

The CLASS Act is a public program of long-term care insurance for workers; premiums are paid through payroll deductions. The exact details of the program will be worked out over the next eighteen months or so, but the basic structure is as follows.

Employers must decide whether or not to offer the program to their employees. If they do, employees will be automatically enrolled unless they make an active selection to opt out; CLASS will provide a cash benefit of \$50 to \$75 a day for as long as it is needed. Participants must pay into the program for at least five years before they can receive benefits, and they must be working for at least three of those years. The program therefore is less attractive to those on the verge of retirement. However, unlike private long-term care insurance, a person cannot be excluded for pre-existing conditions, so in this sense the CLASS Act widens the insurance market.

The premiums will depend a great deal on enrollment—the greater the enrollment the lower the premiums. The Congressional Budget Office estimated a \$123 average monthly premium (premiums are age-based, so younger enrollees will pay less, and older enrollees will pay more) assuming only a five to six percent participation rate. The law mandates that CLASS remain actuarially sound for 75 years, so premiums can change. However, premiums cannot increase for those who reach 65 and have paid premiums for at least 20 years.

All of these potential reasons for a limited insurance market and uncertainty about future enrollment in the CLASS Act must be understood in the context of our first recommendation. Why develop new products if Medicaid continues to crowd out demand for such products? Medicaid reform is essential to stimulating demand for new long-term care insurance products (Society of Actuaries, 2007). Among those aged 50 or more who purchase long-term care insurance:

- 76% have liquid assets of \$100,000 or more, compared to 30% of the general public over age 50;
- 49% have incomes of \$75,000 or greater compared to 31% of the general public.

An additional aspect of demand is knowledge, the subject of our next recommendation. Some products are available, but not typically offered (e.g., the federal government offers several long-term care plans, but only comprehensive long-term care coverage). A buyer would have to be very savvy,

knowing exactly what type of questions to ask and what type of features to request. On the contrary, 40% of people who made an active decision to decline purchasing long-term care insurance said that it was too confusing to figure out what policy was right for them. As we move to a more informed robust market, options for more limited coverage at lower premiums should become more widely available.

Recommendation Three: Make unbiased information about long-term care planning and financial options readily available to the general public so that long-term care planning becomes an essential and ubiquitous part of retirement planning.

Work with employers to educate their employees about the CLASS Act and other financial options. Employers have an enormous stake in long-term care financing. Caregiving for a loved one while employed can be extremely difficult to juggle. As a consequence, United States businesses lose an estimated \$33.6 billion a year in productivity from full-time employees who serve as caregivers, averaging \$2,110 per employee (Met Life, 2006). Two-thirds of caregiving employees say they arrive early and/or late or take time off during the day (National Alliance for Caregiving, 1999).

The Minnesota Chamber of Commerce is the first state Chamber in the country to formally address long-term care. The Chamber has recognized that employers play a major role in helping people plan for retirement and health needs, via annual enrollment and selection of benefits packages. Research has shown that employers are a highly effective source of education about financial options. For example, Health Savings Accounts (HSAs) are popular with Minnesotans, most of whom create HSAs through their employer's health insurance enrollment process. Minnesota has the sixth highest total enrollment in HSAs among the fifty states, at 361,000 in January of 2010, and at 9.2% of the private health insurance market, the second highest percentage among states (Center for Policy and Research, 2010). Moreover, 80% of these HSA accounts belong to lower-middle and middle-income families. Because HSAs are widespread among the targeted population of middle income Minnesotans and may be used for long-term care costs, including insurance premiums, they provide one option for families to prepare for their long-term care needs.

The CLASS Act offers an excellent opportunity for employers to provide an important round of awareness-building about the need to prepare financially for long-term care. A consortium, such as the one described below, should develop a standard set of (non-biased and non-marketing) materials to provide to employees. In easy terms, this information should help people understand why it is important to prepare and lay out options for such preparation, which might include: HSA contributions, prize-rewarded savings, LTC insurance, home equity loans, the use of CLASS Act, and participation in the Medicaid waiver when it becomes available.

Develop a collaborative web site to serve as a hub of non-biased information for all Minnesotans. Our current system of providing and financing long-term care is fragmented and confusing. It can be overwhelming to find useful, unbiased information that leads to good decision-making. Yet good information is critical to making sound decisions. For example, among non-buyers of long-term care insurance, 70% underestimated the costs. Of those who purchased long-term care insurance, 61% overestimated the costs (LifePlans, Inc., 2007).

Higher-income families often turn to financial and estate planners, who help them sort through long-term care planning and decisions. But most Minnesotans do not have access to that type of expert

advice. For example, 54% of Minnesotans find long-term care insurance hard to understand. It is perhaps not surprising that when asked, 95% of Minnesotans aged 42-60 said that an unbiased website should be developed to learn about and compare financial products for long-term care (Ecumen, 2007).

To ensure that the information is unbiased and is useful to the diverse needs of Minnesotans, we recommend that a consortium be created to develop and sponsor the website. At a minimum, the consortium should represent the State of Minnesota, employers, and senior and civic organizations. The web site should encourage and help people to prepare and provide measurements that can be tracked of the participation in various financial products. How many Minnesotans are enrolled in CLASS? How many have used a hybrid home equity loan? How many have a prize-rewarded-savings account?

VII. Conclusion—What Response Can We Expect from Minnesotans?

Based on recent survey information, Minnesotans may be ahead of policy-makers in recognizing the need for action in long-term care financing. The survey, which was conducted with those aged 42-60 in 2006-07, showed that 61% felt that they are very likely or somewhat likely to require long-term care services— a percentage that is fairly accurate. Two-thirds of Minnesotans are concerned about their ability to pay for long-term care. Eighty-six percent of Minnesotans surveyed said that developing new ways for helping people to meet the costs of long-term care should be a top priority (49%) or a very important priority (37%) for government (Ecumen, 2007).

Minnesotans also believe that long-term care should be a shared responsibility between individuals and the government: 86% of Minnesotans think that individuals bear some responsibility for their long-term care (9% think that individuals should bear no responsibility); and 92% are willing to put their retirement needs over leaving an inheritance (Ecumen, 2007).

However, understanding about the costs and financing of long-term care is still limited. Twenty percent of Minnesotans believe they have long-term care insurance to pay for their care, when in fact less than 10% have such insurance. Twenty-nine percent of Minnesotans plan to use Medicare, which pays only for short-term stays related to recovery from acute health care episodes (Ecumen, 2007).

These survey results suggest to us that Minnesotans are ready for, and perhaps even anxious to have, information and policies that can help them better prepare for their own care in their senior years. They might not yet realize how much is at stake for our collective welfare, but no one has really been talking about long-term care in those terms.

The situation is urgent. The first baby-boomers begin to retire this year, in 2010. Financial preparations for long-term care cannot be accomplished overnight, either by individuals or on a societal basis. If we are to meaningfully address this enormous challenge, we must start **today**. The Long-Term Care Collaborative believes that given good information, appropriate financial products, and support through Medicaid redesign, Minnesotans will respond positively to this call for action, and we will indeed meet our goals.

VIII. Next Steps

Long-term care is everybody's business. All Minnesotans have at least one role to play. In this section, we identify key responsibility areas and actions to achieve our goals in Minnesota.

Federal

- Support Minnesota's Medicaid reform
- Include long-term care insurance under Section 125 of the tax code

The Governor and The State Legislature

- Stand in a leadership position by recognizing that every day in which Minnesota fails to address long-term care financing, we are further burdening our state finances
- Enact prize-rewarded savings legislation
- Direct the Department of Human Services to convene a Medicaid redesign effort, reporting back to the legislature with mid-term progress in 2012, with final recommendations in 2013, with the intent of conducting a demonstration project shortly thereafter
- Direct the Department of Human Services and Minnesota Housing to support the development of a new home equity product for long-term care and medical expenses

Employers and industry

- Support the development of a standard, unbiased set of information for employees, and disseminate this information, especially during annual health care enrollment
- Participate in co-sponsoring the collaborative website
- Consider participating in the CLASS Act and/or offering long-term care insurance as an employee benefit
- Consider offering payroll deduction for prize-rewarded savings
- Work with the insurance industry to identify barriers to the development of a more robust mix of long-term care insurance products
- Take the lead on developing a new home equity product, partnering with DHS and MN Housing

Long-term care providers; social service and/or civic agencies

- Support the development of a standard, unbiased set of information for employees, and disseminate this information, especially during annual health care enrollment
- Participate in co-sponsoring the collaborative web site
- Assist the Department of Human Services as appropriate in redesigning Medicaid
- Use existing networks, mailing lists and events to inform Minnesotans about new policies and products as they are developed

Philanthropic Community

- Contribute prize funds for the initial year of Minnesota's prize-rewarded savings program
- Help underwrite the design of the hybrid home equity product and the Medicaid co-insurance alternative
- Participate in co-sponsoring the collaborative web site

Individuals and families

- Be clear and honest about the type of long-term care you would want if needed, and the potential cost of that care
- Have this conversation with any family members you may eventually provide care for
- Begin exploring ways to finance that care. Ask yourself: How much money am I willing to set aside for good care for myself? Five dollars a week? Ten? Twenty-five?
- Take the first steps toward financing your care, whatever they are
- Be aware that government-provided care comes at taxpayer expense. Not everybody realizes that.

Appendix A

What is Medicaid? What is Medicare?

Medicaid and Medicare are two governmental programs that provide medical and health-related services to specific groups of people in the United States.

- Medicare is a federal health insurance program for people age 65 and older and for some disabled younger people, serving more than 44 million Americans in 2008.
- Medicaid is a jointly funded (federal-state) medical services program for certain individuals and families with low incomes and few resources.

Together, Medicare and Medicaid represent 21% of the FY 2007 U.S. federal government. Both Medicaid and Medicare were created when President Lyndon B. Johnson signed amendments to the Social Security Act on July 30, 1965.

Medicaid

Eligibility. Thirty-two states and the District of Columbia provide Medicaid eligibility to people eligible for Supplemental Security Income (SSI) benefits. In these States, the SSI application is also the Medicaid application. Eleven states, including Minnesota, use their own eligibility rules for Medicaid, which are different from SSI rules. In these States a separate application for Medicaid must be filed. The remaining states use the same rules as SSI, but require a separate application.

Federal share. Each State is reimbursed for a share of their Medicaid expenditures from the Federal Government. This Federal Medical Assistance Percentage (FMAP) is determined each year and depends on the State's average per capita income level. Richer states receive a smaller share than poorer states, but by law the FMAP must be between 50% and 83%. In 2010, the FMAP ranged from 50% to 74%; since the last quarter of 2004, the FMAP for Minnesota has been 50%.

Paying for Long-Term Care for the Elderly

Medicare pays the *medical care* costs of people who need long-term care. However, Medicare's coverage of home care and nursing home care is very limited. Medicare pays for 100 days of nursing home care for beneficiaries with a prior hospital stay who need skilled nursing care or rehabilitative therapy. Medicare pays the full costs of care for the first 20 days of a nursing home stay; after that, beneficiaries make a substantial copayment of \$124 per day in 2007.

Similarly, Medicare covers home health care, but limits services to people with skilled care needs. To be eligible for home health services, beneficiaries must be "homebound," need "intermittent" skilled nursing or therapy services, and be under the care of a physician who prescribes their plan of care.

Medicaid financing for long-term care for the elderly is about double that of Medicare. Eligibility for Medicaid essentially requires a person in need of long-term care to relinquish virtually all assets and income. Medicare beneficiaries who use long-term care services are a high-cost population in Medicaid, representing just 4 percent of the Medicaid population, but accounting for 30 percent of Medicaid spending.

The above descriptions were condensed from: "Medicaid: The Federal Medical Assistance Percentage (FMAP)", Congressional Research Service, February 4, 2010; "Medicare and Long-Term Care Financing, Georgetown University; <http://www.medicalnewstoday.com>; www.ahrq.gov; www.socialsecurity.gov

Appendix B**Citizens League Activities Related to Long-Term Care Financing (2006-2010)****2006**

Minnesota Anniversary Project (MAP150) begins in 2006. Aging Services/Long-Term Care is identified in statewide polls as a key area for engagement. Aging Services becomes one of the five demonstration projects for MAP150.

2007

2020 Conference: The Citizens League helps form a bi-partisan group of legislators called the 2020 Conference. Aging and long-term care emerge as a top area in need of policy change among legislators and the provider community leading to events such as “The Pig in the Python” and “The Silver Tsunami” to help raise awareness.

MAP150: Project staff organizes resources around design workshops to test initial framing and findings.

2008

Policy Open House: Citizens League Policy Open House demonstrates and tests the approach to the design workshops.

Design Workshops: A cross-section of providers, policy makers and citizens impacted by the need for aging services take part in two days of workshop activities in late June.

Regional Policy Workshop: Communities for a Lifetime identified as one of three areas to address in workshops.

Policy Advisory Committee: Topic selection process determines that aging services is a key area for a policy review group to be established.

Long-Term Care Financing Organization Begins: MAP 150 demonstration concludes and group of funders and supporters coalesce around working toward a more focused set of solutions.

2009

Steering Team Established: Long-term care financing project begins.

Aging Services Policy Review Group: Policy Advisory Committee forms review group that reviews Citizens League policy history related to aging services. Six reports produced between 1984 and 1999 were reviewed. The role of personal responsibility is one of the themes identified in past study committees.

Design Workshops: The following was explored. How do we create incentives for personal responsibility in the areas of informal care, health and medical choices, and financial behaviors?

2010

Focus Groups: Held to discuss personal financial preparations for long-term care, these focus groups involved very knowledgeable front-line staff.

Mind Opener: Fundamental ideas in the report are presented and discussed at a Citizens League Mind Opener inviting more input and involvement.

Draft Report: is tested and reviewed over the last several months.

Appendix C: Summary of Community Workshops Convened in summer, 2009

Workshop One: Informal Care

Participants in this workshop transformed the current day version of informal care of one surrounded in confusion, dread and stress to a future version supported by community, connections and honor and fulfillment in service.

Many participants know the caregiver role personally. They described caregiving as essentially two jobs in one: 1) providing care; and 2) figuring out how to provide care. The stresses inherent in caring for a frail loved one are compounded by lack of training; not knowing what to do; uncertainty about where to find needed services and supplies; bureaucracies that respond with rules rather than personalized support; lack of support from others who might rightfully be expected to contribute; and as a consequence of all of this, an unspoken dread that they could fail in this most crucial of all roles at any moment.

The participants also spoke to the opposite side of caregiving. They showed pride in jobs well done; they received strong fulfillment from such an important responsibility; they had a sense of confidence—despite all the hurdles—they have prevailed. The work also takes on a sense of the profound. As one caregiver said, “It’s the last chance you have to make a connection.”

In the workshop, participants worked in three groups to develop statements describing the future of informal care. These are:

- **Provide personalized, respectful care that follows an agreed plan that instills confidence that care will be “affordable” and manageable.**
- **Be community-oriented, accessible and delivers more value, both personally and financially.**
- **Be person-centered; supportive of care-giver; flexible, cost-effective and coordinated.**

As a entire group, the participants identified these five critical elements of informal care:

1. Roadmap. The road map has two functions. The first is handling the external world—making it much easier to know what to do, how to do it, and accessing the needed services and supplies. Most of us have no role models for or experience with this type of care. The second is having a *general* plan of action for individualized care—good care is often a very responsive – it can be impossible to know what any given day will bring. A general plan of roles, responsibilities and emergency instructions can be of enormous help to the caregiver as they negotiate the day-to-day tasks. Like the children’s connect the dots puzzles, caregivers must connect the dots. But with caregiving the dots are not sequenced, so they have no way of knowing whether they are drawing the right picture or not.
2. Personalized. Every person has their own unique way of living their life, along with their unique set of strengths, challenges and desires for care. Dignified care means that these must be honored.
3. Better use of resources. Unpaid caregiving is a mainstay of our LTC system right now, but there are many attendant costs, such as loss of productivity to employers, and caregiver impoverishment. We need to strive for the optimal use of all resources.
4. Change in cultural attitudes. The lack of planning is the product of cultural attitudes in which we do not want to confront aging and death. Participants suggested that caregiving will remain more stressful and ad hoc than it need be until cultural attitudes change from fearing aging to honoring the elderly.
5. Community-based. If it takes a village to raise a child, why not a village to care for a frail elderly adult? Just

Appendix C, continued

as community support for child-rearing does not negate or diminish the primary role of the parent, community support for elderly caregiving does not imply less responsibility for the family. Rather it recognizes that the tasks at hand are enormous, sometimes stressful, and sometimes beyond the capacity of the immediate family to accomplish alone, and that there is societal, as well as personal value in a job well done. Primary caregivers need support.

Participants developed a creative list of ideas to improve informal care, and then selected or modified one of these ideas and began designing its features. The ideas and preferred solutions are notable for their clear priorities. The four preferred solutions aimed at making caregiving “easier” to do, primarily by drawing in community and providing easy connections for caregivers. They also implicitly dealt with the cost issues of care by assuming that community would act in a volunteer capacity. While most did not explicitly deal with lower income people who struggle to get care, often at the cost of impoverishing themselves, they did put in place mechanisms that could readily be adapted to provide free or lost cost care to lower income people—without the stigma associated with government’ run support programs. However, it is fair to say that the ideas, as refined, will need to be tested to see if they can meet this criterion.

Another interesting characteristic of most of the designs is that they recognized that the ideas will need to be “self-sustaining” from a funding standpoint—that is, they looked at current resource allocations and asked how the dollars could be put to better use. Most departed from the “more money” solution; most also departed from programmatic solutions, recognizing that programs often run counter to the need for personalized attention.

Three of the four ideas were grounded in volunteerism. They recognized three shortages in the future: family caregivers; time; and money to pay for care. Participants zeroed in on excess capacity—who has time and talents to contribute, and devised to ways to set those in exchange.

The ideas also focused on incentives to induce change, such as tax credits, reciprocal benefits, and working with organizations that have a self-interest in providing the needed service.

Perhaps most important, participants created a more hopeful and helpful society. Their visions were bound in cultural change: a greater sense of responsibility to family and society; recognition of the value of unpaid time; and dignity and honor that should come with old age.

Workshop Two: Health and Medical Choices

The topic of medical and health choices may have been the most difficult of the three workshop topics (informal care, medical and health choices, and financial behaviors). Participants described the systems surrounding health and medical choices for the aged as confusing, complex, crisis-driven and sometimes counterproductive, resulting in decisions that are often harried, costly, and misinformed. The end result is that care sometimes runs counter to the wishes or best interests of the patient.

The workshop participants’ charge was not to reform the health care system, but to identify ways to better manage costs within the Medicare and Medicaid systems. Participants grappled with the “overwhelmingness” of these systems, and in the end, put forth some practical ideas that would be both relatively easy to implement and effective.

Participants started day one working in one of four small groups: 1) chronic care management; 2) transitions between acute and long-term care; 3) the future of nursing homes; and 4) end of life decisions. They described the current environment for making decisions; the descriptions were quite similar across all four groups. Participants used words like: confusing; complicated; lack of coordination; bureaucratic, disjointed and fractured care. In short, the elderly operate in unproductive environments for what are literally life and death decisions. Taking “personal responsibility” in these environments is far more burdensome than it ought to be.

Appendix C, continued

It is easy to say that people should control their weight, follow doctor's orders, and have living wills. But these actions must be seen in the light of the reality of people's lives. What if the food in congregate care is unhealthy? What if I don't understand doctor's orders, which are ten pages of medical jargon? What if the paramedics resuscitate me even though I have a "do not resuscitate" order? What if the hospital discharges me and I have three hours to decide where to live? How do I make sense of what three sets of experts are telling me—what the doctor is telling me about my condition, what care insurance will pay for, and what living arrangements are available?

All of the groups aimed at finding ways of giving people more control over their health and medical conditions and improving their preparedness for crises when they arise. Each group prepared a list of possible solutions; these can be found in Attachment A.

As for preventative health, the four things that everyone can do but only 3-10% of Americans actually do to improve their health are:

- Never smoke (quitting will help greatly)
- Eat 5 servings of fruits or vegetables daily
- Exercise (150 min of low-moderate exercise weekly or 75 min of high intensity exercise weekly)
- Moderate alcohol consumption.

By implementing these 4 things into our daily lives we can reduce chronic disease such as obesity, heart disease, diabetes, high blood pressure, kidney disease from 20-60%.

On day two, participants were split into new groups; each group tackled one of five questions:

1. Design an initiative to improve disease management for the disabled.
2. Design a safety net that is NOT a nursing home (on day one, the group discussing the future of nursing homes stated that nursing homes are currently seen as the "safety net").
3. Design a product that can improve patients' understanding of their medical conditions and doctors' instructions.
4. Design a "single waiver" for Minnesota (on day one, the group discussing chronic care management stated that Minnesota could improve care if it could receive a block grant of sorts for both Medicare and Medicaid.
5. Design a product that can improve care coordination through better use of medical records.

Workshop Three: Financing

This workshop began by noting that never before has our society faced such huge looming costs (i.e., long-term care) with no plan for how to pay for them. Federal mandatory spending on the elderly is estimated to rise from roughly \$600 billion in 2000 to more than a trillion dollars in 2010, just as the huge wave of baby boom retirements gets underway. Life expectancy is rising, and thus retirees must spread their retirement savings out over longer periods of time. Social security is replacing less of one's preretirement income (from 41% in 2002 to 36% projected in 2030), and out-of-pocket medical costs are rising (from 7% as a percentage of the average social security benefit in 1980, to 25% in 2009, to a projected 39% in 2030).

Appendix C, continued

In 2004, an estimated \$2.26 billion was spent on long-term care for the elderly in Minnesota: 40 percent was Medicaid, 33 percent was out-of-pocket expenses by the elderly and their families and 20 percent was paid by Medicare. About 7 percent came from other sources, including private insurance. The number of seniors expected to need long-term care is estimated to more than double by 2030 and triple by 2050. If Medicaid remains the primary funding source, there is no question that the state's other major area of spending — K-12 education— will be crowded out.

On day one of the workshop, participants were asked to design a system of financing long-term care. They began by identifying a principle on which such a system should be based. The principles touched on these themes:

- The need for educating people of the financial consequences for themselves, their family and society
- The need for incentives
- Universality
- Benefits that allow personalized care
- Working longer when able to do so
- Greater personal responsibility, including use of assets
- Greater family responsibility
- Portfolio of financing programs to meet various interests and needs
- Financing system should encompass all age groups
- Must be generationally responsible
- Those who will need public support should rely on the same financing system as those who will not
- Build off Medicare as a system people are familiar and comfortable with
- Revamp (or eliminate) Medicaid
- Increase predictability of benefits
- Spread risk as widely as possible, but reward/incent individuals
- Self-adapting system

The three groups came up with the following statements of principles:

1. Shared accountability to establish, implement & continuously improve a long-term care program that is affordable, simple, transparent, equitable, self-directed, mandatory? insurance program w/opt-out and incentives to participate
2. Build off Medicare to provide menu of options to incentivize personal/family responsibility
3. Reward health and personal responsibility and create awareness for all generations; provide choice, flexibility and access to a basic benefit that assures safety and access to services

Next, participants worked in small groups to design a system that met their principles. They were instructed that their system must be grounded in the facts of the situation and be morally responsible (however they defined it) but should temporarily ignore questions of political feasibility and authority (state vs. federal).

Despite the fact that there was very diverse range of views (direct care providers, academia, family counselors, aging services nonprofits, ltc insurance industry, financial planners, business, and both liberal and conservative policy professionals) the groups' plans tended to focus similar **key features** (related to their principles) which are:

- Flexible benefits, preferably cash
- Use of incentives, both financial and health
- Multiple tiers of benefits, with a universal basic benefit
- Intergenerational equity
- Personal responsibility
- Education

:

Appendix C, continued

All three groups waived over whether their plans should be mandatory or voluntary.

The following morning the full group of participants discussed the common themes and issues that arose the day before, working together to develop a financing structure for a plan for Minnesota. The final outcome was a four-point plan as follows:

1. A mandatory plan that would provide a bare-bones cash benefit that could be used for LTC as the recipient preferred (similar to Hawaii's proposed program). It would be funded through small payroll deductions averaging \$10 a month. The benefit could be used to pay LTC insurance premiums.
2. A "buy up" plan that would have incentives for people to save, and could possibly include a prize-based savings instrument or new tax incentives.
3. Medicaid reform to remove both disincentives to save and barriers to a more robust insurance market (both of which have been demonstrated in research).
4. A broad, inclusive public campaign that would draw Minnesotans into the discussion about the need for financing reform for LTC, serving to raise awareness and to provide direction into the final design of the system.

The 4-point plan was arrived at through a lively group discussion, in which participants discussed the following:

- The urgency of the need for a financing plan. The longer we wait, the more baby boomers will retire and the more difficult solutions will be to implement.
- How to get money into the "system" so that dollars are available for those who simply cannot afford their own care.
- How confident we can be in actuarial projections of LTC insurance premiums or a universal program.
- The desire to make a financing system as simply as possible, possibly by tacking it on to health insurance.
- What incentives might be effective in getting employers to but into a financing program, such as the incentives that spurred widespread take up of 401Ks.
- The need to design a financing system with an understanding of how people make decisions.

Appendix D

Focus Groups Summary

In March 2010, three focus groups were held with employees of Ecumen to discuss personal financial preparations for long-term care. Ecumen employees were chosen as a group who has solid knowledge about what it means (and costs) to age, so that we could exclude lack of awareness of or education about LTC as a primary reason influencing people's decision.

Group one: Six people (two men, four women) at Ecumen's administrative offices in Shoreview. This group included high level administrative personnel who have worked at Ecumen from 18 months to ten years. Most had worked at Ecumen for three to four years.

Group two: Six women at Centennial House in Apple Valley, who were employed in caregiving activities and housekeeping. Three had worked with seniors/Ecumen for 2-4 years and the other three for more than ten years.

Group three: Five people (one man) at Lakeview Commons in Maplewood. They are employed as a CNA, an LPN, dining manager, sales and marketing, and activities. They all had worked at Ecumen for at least five to seven years, with two serving seniors for around fifteen years.

Focus Group Questions

1. How long have you worked at Ecumen and/or with seniors? Has your experience in this line of work changed your perceptions about aging?
2. Have you thought much about future long-term care needs? When you think about it, what do you think about?
3. How do you plan to pay for any long-term care?
4. What (financial) preparations have you made? Why or why not?
5. What preparations are you planning to make in the future? What would help you better prepare?
6. I'm going to share with you some ideas about ways that might help you financially prepare for long-term care, and I'd like your feedback on each of them.
 - Medicaid option
 - Prize-rewarded savings
 - Catastrophic LTC insurance
 - Home equity loans

Key Findings

1. All participants are very aware of, and concerned about, the costs of LTC and the general needs that come with aging, but few had specifically prepared.
2. Everybody bought into the idea of, and need for, personal responsibility.
3. There was general agreement that there is capacity to save (somewhat) more. Saving would need to feel "purposeful" (e.g., fun, like in the prize-linked savings; worthwhile because of different Medicaid incentives; simply not an impossible and overwhelming task; or because it's required?

4. It is clear that a number of different products to enhance savings should be offered, because different people preferred different alternatives.
5. Everyone favored restructuring Medicaid by using it as a supplement on a sliding scale.

All participants are very aware of, and concerned about, the costs of LTC and the general needs that come with aging, but few had specifically prepared.

When asked whether working with seniors had changed their attitudes about aging, most said yes.

- “I don’t know how you can work here and not have a change in attitude about aging.”
- They developed a new understanding that people live longer and run out of money.

Financial preparations were mixed, and mostly limited; only one person had a LTC insurance policy, although more had considered it.

- Preparations were mixed: one person (who described her husband as a worry wart) has a LTC policy; another bought a one-level townhouse; a number of participants were saving and/or investing; some plan to rely on their children; many plan on working past 65.

“My biggest asset is my ability to work.”

“Everybody needs to express what they want to family members.”

“None of us thought we’d get this old.”

“Trying to stay healthy.”

“Maybe we’re in denial...it sneaks up on you.”

- Nearer-term needs, like short-term disability policies, children’s college and weddings were higher on the financial priority list than saving for LTC, especially since the future regarding LTC is so uncertain.

It’s going to be so different, so vastly different.”

“By the time you do retirement, college, long-term care is overwhelming. Why bother?”

“I’m still paying for my mother’s nursing home bill.”

- Those who researched LTC policies chose not to buy (or canceled) for two primary reasons: 1) they were not convinced LTC policies will be worth anything when they are eventually needed; and 2) they found the policies too costly compared to benefits
- Similarly, they didn’t believe that public funding would be there either if needed. But they hope not to need Medicaid, believing that the choice and quality of care is limited.
- Almost everyone had some concern about their ability to pay for long-term care needs.

Everybody bought into the idea, and need for, personal responsibility.

- “Savings and how we take care of ourselves is our salvation.”
- Nothing’s going to happen unless we make it happen for ourselves.”
- But the rules don’t encourage personal responsibility: “The system is stacked against personal responsibility.”
- And there are some things we just can’t plan for: “Crazy stuff happens that no one predicted.”
- “No one is able to distinguish between the ones who deserve public assistance and those who don’t.”
- One person talked about personal responsibility in terms of managing resources; “You should start with the money you need when you’re born and have to manage it until the end of your life.”
- “Why am I paying for your kids to eat?”

There was general agreement that there is capacity to save (somewhat) more.

- “Saving is a learned behavior.” Some expressed a sense of urgency about savings, related both to their age and the economy. These participants tended to favor a “mandatory” savings plan, or at least the opportunity for payroll deduction. The less hassle, the better.
- Any incentives to save are positive, especially if it doesn’t cost the public anything.
- Automatic savings of \$25 a paycheck perhaps as high as \$50 maximum, would be doable.

It is clear that a number of different products to enhance savings should be offered, because different people preferred different alternatives.***Prize-linked savings***

- Some liked it a lot; others felt it was not for them but would appeal to other people. One person said, “I gotta do that.”
- Liked that your chances to win increased with the amount you save.). “It would be amazing how much you could save.” (regarding prize-linked savings)
- Felt that prize-linked savings should be marketed through employers. And make sign up fun too!

Catastrophic LTC policy

- Trust factor in insurance remains a problem
- “What you really worry about is being a burden.”
- The administrative group really liked the higher deductible, because regarding the cost of nursing home care: “It destroys everything you’ve worked for.”

- Centennial House participants were not so interested. They prefer fuller coverage. But the cost of LTC insurance is so pricey that they view it as money out the door given that they don't know they'll need LTC for sure.

Home equity product

- Everybody favored this idea.
- One participant described her mother's experience. "She saw a commercial and thought "I can get some money.""

People advocated for a multi-faceted approach

- "Not one thing is going to be the savior. (we) need to appeal to a wide group."
- We need "little mice instead of a big cow. Don't make it too complicated."
- If these ideas help reduce the public demand for Medicaid and cost nothing to offer, why not?

Everyone favored restructuring Medicaid by using it as a supplement on a sliding scale.

- It's humiliating to be on Medicaid.
- Would help remove some fraudulent practices.
- Some were resentful of current Medicaid practices, and see it as wasteful.
- Others had not considered that those who were "beating the system" were spending their tax payer money. Is it important that people know this? Yes!

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