



**Retirement Saving and Long-Term Care Needs:
An Overview**

**The Retirement Security Project
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Introduction

The nation is aging: The elderly population is expected to more than double by 2030. Yet many households -- likely to be somewhere between one-quarter and one-half -- are not saving adequately for income and health care needs during retirement. One of the difficult challenges in saving for retirement is the substantial uncertainty associated with long-term care, which can impose massive costs on those who have not insured against the risk. This overview paper documents trends affecting financial security during retirement; examines the financing of long-term care; and then explores the role of pension saving in preparing for financial needs, including long-term care.

I. Trends Affecting Retirement Security

Over the past thirty years, the quality of life of the nation's seniors – measured in terms of both economic and health security – has increased dramatically. Poverty rates have fallen and life expectancy has increased markedly. However, this security will come under increasing pressure due to two trends: a rapidly aging population, and increases in chronic illness and an associated need for long-term care among the elderly.

Demographic trends

Over the next two to three decades, the population over age 65 will rise rapidly. The Census Bureau projects that the number of Americans aged 65 or over will rise from 35 million today to 55 million by 2020 and 71 million by 2030. This growth in the senior population outstrips that which occurred in the past fifty years. The share of the population aged 65 or older increased from 8.1 percent in 1950 to 12.4 percent in 2000. By 2030, that share is expected to increase to 20 percent (Table 1). To put this into perspective, this is slightly higher than the current share of the elderly population in Florida.

Even more dramatic changes will occur among the “oldest” old. As Table 1 indicates, the population aged 85 or above has increased by an average of more than 4 percent per year since 1950. The total population has increased by only 1.3 percent per year over the same time period. As a result, the share of the population aged 85 or above has risen from 0.4 percent in 1950 to 1.5 percent in 2000. It is expected to increase to almost 4 percent by 2040. The oldest old as a group are also growing more rapidly than the elderly population as a whole: The share of the *elderly* population that is age 85 or above has risen from 4.7 percent in 1950 to 12.2 percent in 2000, and is expected to reach 19.2 percent by 2040.

Table 1: U.S. population

	Total population (in thousands)	Share of population:	
		65 and above	85 and above
1950	150,697	8.1%	0.4%
2000	282,125	12.4	1.5
2010	308,936	13.0	2.0
2020	335,805	16.3	2.2
2030	363,584	19.7	2.6
2040	391,946	20.4	3.9
2050	419,854	20.7	5.0

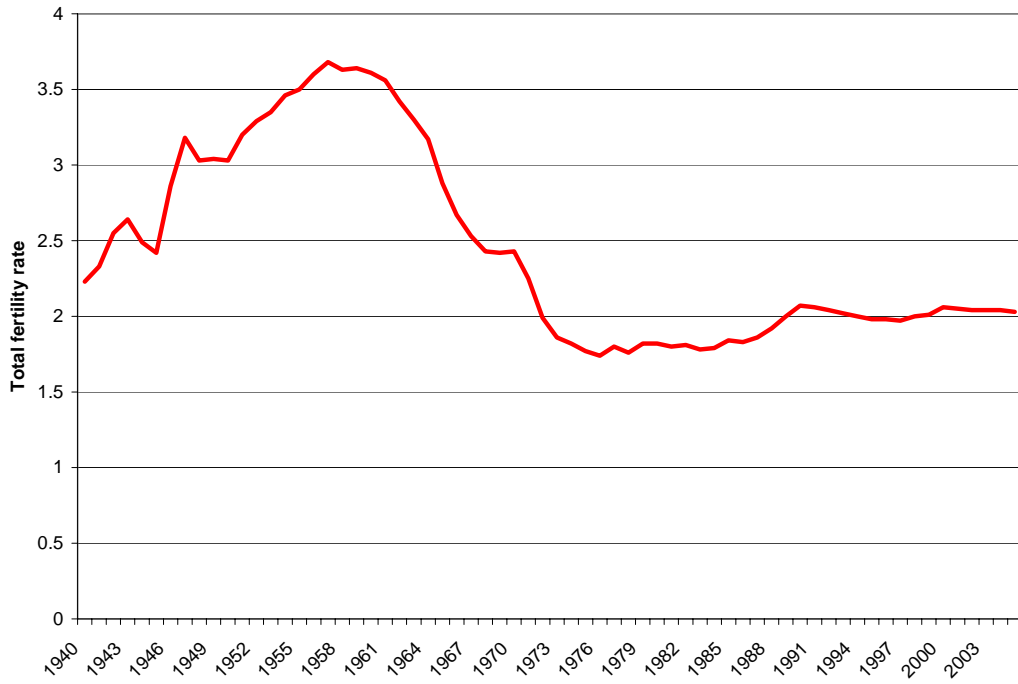
Source: Bureau of the Census and authors' calculations.

This aging of the population primarily reflects two demographic factors: fertility rates and life expectancy.¹ Figure 1 shows that the total fertility rate rose from 2.2 in 1940 to 3.6 in 1960, as the baby boomers were born.² It then fell substantially, before rising slightly as part of the “baby boomlet” in the 1980s and 1990s. The reduction in fertility rates since the 1960s, all else equal, slows population growth and increases the share of the population that is elderly.

¹ A third factor is net immigration rates. Net immigration rates have risen since 1950, but remain too small to offset the effects of reduced fertility rates and longer life expectancies in producing an older population. We therefore focus on fertility and life expectancy in the text.

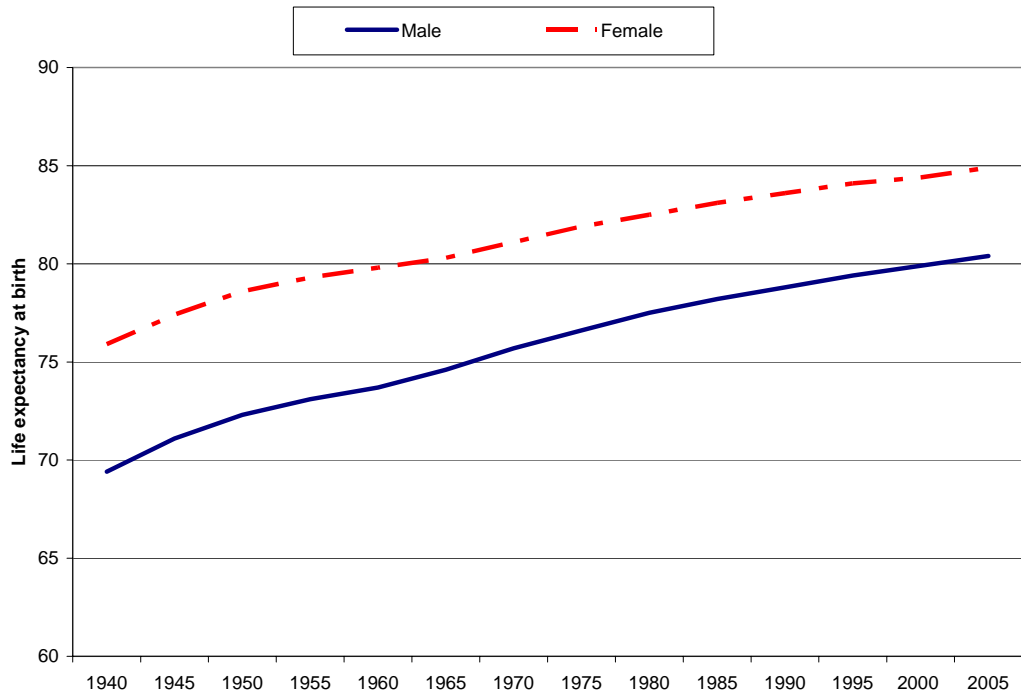
² The total fertility rate is defined as the mean number of children per woman over a woman's lifetime. A total fertility rate of 2.1 would maintain a roughly constant population given zero net immigration and constant death rates.

Figure 1: Fertility rates



Source: Social Security Administration.

Figure 2: Life expectancy at birth



Source: Social Security Administration.

Age-adjusted mortality rates have also declined significantly, resulting in longer life expectancies. Between 1950 and 2004, life expectancy at birth has risen from 72 to 80 years for males and 79 to 85 years for females (see Figure 2). The reduction in mortality rates in all age groups and associated increase in life expectancies also contributes to the aging of the population, and is the primary explanation for the particularly rapid population growth among the oldest old. Interestingly, life expectancy has been rising particularly rapidly among those with higher earnings and more education. In other words, life expectancies have been growing more unequal by socio-economic status: Higher earners are increasingly living longer than lower earners.³

Chronic illness and disability trends

Research generally suggests that the elderly are not only living longer, but also living healthier lives at any given age.⁴ However, as seniors live longer and medical technology advances, a so-called chronic disease epidemic has arisen. In 2000, an estimated 125 million Americans had at least one chronic condition and 60 million had multiple chronic conditions. The number of Americans with a chronic illness is expected to rise to 157 million by 2020. Over the same time period, the number of people with multiple chronic illnesses is projected to increase by 30 percent.⁵

³ For further discussion, see Peter A. Diamond and Peter R. Orszag, *Saving Social Security: A Balanced Approach*, Brookings Institution: 2004.

⁴ See, for example, Dora L. Costa, "Long-Term Declines in Disability Among Older Men: Medical Care, Public Health, and Occupational Change" (paper presented at the annual meeting of the American Economic Association, Boston, Mass., January 7-9, 2000); Kenneth G. Manton, Larry Corder, and Eric Stallard, "Chronic Disability Trends in Elderly United States Populations: 1982-1994," *Proceedings of the National Academy of Sciences*, vol. 94, no. 6 (March 18, 1997), pp. 2593-2598; and David M. Cutler, "The reduction in disability among the elderly," *Proceedings of the National Academy of Sciences*, vol. 98, no. 98 (June 5, 2001), pp. 6546-6547.

⁵ Gerald Anderson, "Chronic Conditions: The Cost and Prevalence of Chronic Conditions are Increasing," National Institute of Health Care Management, Expert Voices Issue 4, 2002.

The odds of having a disability or chronic illness increase with age. An estimated 42 percent of individuals age 65 and older have a chronic condition causing disability, while 83 percent of individuals age 85 and older live with multiple chronic conditions and disability resulting in functional limitations.⁶ One study predicts an increase from 3.8 million people with Alzheimer's disease in 1990 to 14.3 million by 2040.⁷ Thus, as the population ages, the number of people with functional limitations will increase, which in turn will raise the demand for long-term care services.

Growing population needing long-term care (LTC)

The 2000 National Health Interview Survey conducted by National Center for Health Statistics reported that approximately 10 million people need LTC services because of their limited ability to complete Activities of Daily Living (ADLs) and/or Instrumental Activities of Daily Living (IADLs). ADLs include activities such as bathing, eating, dressing, toileting, and getting around the home. IADLs are additional abilities such as meal preparation, managing money, and shopping for groceries. Most people (63 percent) needing LTC are aged 65 and older.⁸

Beyond aging and chronic illness trends, other factors -- including the incidence and severity of disability -- will also affect the overall amount and nature of LTC service needs in the future. Although overall disability incidence rates are declining at any given

⁶ U.S. Census Bureau, "Disability Status: 2000," 2000.

⁷ U.S. Department of Health and Human Services, "The Characteristics of Long-Term Care Users," Rockville, MD: Agency for Healthcare Research and Quality, September 2003.

⁸ Ellen O'Brien and Risa Elias, "Medicaid and Long-Term Care," Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, 2004.

age, researchers are observing a trend toward more severe disability among those needing LTC services. In other words, while a smaller percentage of the population at any age is disabled, those who are disabled are increasingly likely to have severe disabilities. For example, a Department of Health and Human Services study reports that, among seniors receiving any long-term care assistance, the proportion with 3 to 6 ADLs increased from 34.4 percent to 42.9 percent between 1984 and 1994.⁹ Severe disability requires both more and relatively expensive long-term care assistance.

Thus, demand for LTC services will likely increase because of the heavier needs of a small group of individuals and the simple fact that the baby boomer retirement wave increases the number of people who are most likely to need LTC services. Forecasts suggest that by the year 2030, the number of individuals over 65 years of age requiring LTC services will double to approximately 12 million.¹⁰ Over the next 20 years, almost half of those aged 65 or older are projected to use a nursing home at some point during their lives, and the number entering facilities may double.¹¹ Given the potentially catastrophic costs involved, LTC poses a substantial risk to many households' retirement savings.

II. Long-term care financing

LTC costs can have a significant effect on retirement security. Many retirees will need some LTC services as they age, the costs of which could become overwhelming, yet

⁹ Agency for Healthcare Research and Quality, "The Characteristics of Long-Term Care Users," Washington, DC: U.S. Department of Health and Human Services, 2000.

¹⁰ CBO, *Projections of Expenditures for LTC Services for the Elderly*, 1999.

¹¹ Jame Lubitz and Brenda Spillman, "New Estimates of Lifetime Nursing Home Use," *Medical Care*, vol. 40, no. 10 (2002), pp. 965-975. As noted in the text, 63 percent, or about 6 million, of the roughly 10 million people currently needing LTC services are over age 65.

few people adequately consider these potential costs as they plan for their retirement needs. LTC costs expose households to the risks of burdening family members, depleting retirement savings, and/or curtailing their choice of LTC services to ones covered by Medicaid.

LTC financing differs from that of other health care in two significant ways. First, a vast majority of people needing LTC receive it on an informal basis, through family members or friends, and so this care is not formally “financed.” The average informal caregiver spends 16 hours per week providing care, and the majority of informal caregivers are females belonging to the “sandwich generation” that has responsibility caring for both parents and children. With respect to formally financed care, a second difference is striking. For health care in general, employer-based health insurance is the largest payer, followed by Medicare and Medicaid.¹² In contrast, LTC is primarily financed through Medicaid and personal resources, limiting the resources available for other basic needs, such as food and housing. Out-of-pocket spending as a percent of all spending on nursing home and home health care is over twice as large as that for hospitals and professional services (23 versus 9 percent in 2002).¹³ Once such resources are depleted, Medicaid may begin paying for their nursing home care. A small but growing private long-term care insurance system is emerging, as described below.

¹² Katharine Levit, Cynthia Smith, Cathy Cowan, Art Sensenig, Aaron Catlin, and the Health Accounts Team, “Health Spending Rebound Continues in 2002,” *Health Affairs*, vol. 23, no. 1, (2004), pp. 147-159.

¹³ *Ibid.*

Medicaid

Medicaid, the federal-state funded health program for low-income and sick people, pays for LTC for individuals with limited financial resources. In 2002, Medicaid was the primary source of payment for 67 percent of all nursing facility residents and was the largest single payer for LTC.¹⁴ To be eligible for Medicaid's assistance, an individual must either have very low income (below about 75 percent of the poverty level) and assets (below \$2,000 for a single, \$4,000 for couples) or be "medically needy." For a person to qualify as medically needy in most states, she has to have extensive medical costs and contribute all of her income (except for a small amount for personal needs) toward the cost of care, and also spend down her assets to below the asset limit (not including her housing assets).¹⁵ Despite these strict eligibility limits, the high cost of nursing home care means that one-third of individuals who are admitted to nursing homes as "private pay" patients end up becoming eligible for Medicaid because there is no viable financial alternative.¹⁶

States may also choose to provide LTC assistance under Medicaid home-and community-based care waiver programs. State-funded home-and community-based LTC programs are an appealing alternative to institutional care in two ways: they allow states some flexibility in the level and types of care provided to some populations, and the majority of the elderly would prefer to stay in their homes while receiving care.

¹⁴ AARP, "Across the States: Profiles of Long-Term Care," 2002.

¹⁵ Joshua M. Wiener and David G. Stevenson, "Long-Term Care for the Elderly and State Health Policy," The Urban Institute, 1997.

¹⁶ Ibid.

However, unlike other Medicaid eligibility categories, Federal law allows states to strictly limit the number of people that receive waiver assistance.¹⁷ As such, despite recent growth, these Medicaid waiver programs serve only a fraction of the people needing LTC outside of institutions.

Out-of-Pocket Spending

In 2002, 18 percent of home care expenditures and 25 percent of nursing facilities costs were paid for by patients out-of-pocket.¹⁸ The true out-of-pocket costs are much greater, however, because family and friends often provide many hours of informal or unpaid care to those in need. The cost of formal LTC care services, whether provided in a nursing home, an assisted living facility, or a home, is so substantial that people needing extensive amounts often exhaust their ability to pay.¹⁹ For many people, paying out-of-pocket for LTC is thus a transitional state before eventually needing Medicaid coverage.

Medicare

Medicare is not a major financier of LTC services, although it does provide coverage of skilled medical care in skilled nursing facilities and in the home.²⁰

¹⁷ States cannot restrict the number of eligible Medicaid beneficiaries who enter nursing homes.

¹⁸ Levit et al., 2004

¹⁹ Y. Chen, 2003.

²⁰ Medicare covers home health services in limited circumstances (when physician certification and homebound requirements are met) and skilled nursing facility services after a qualifying hospital stay, but only for 100 days. Medicare differentiates between skilled care, defined as care that is provided directly by or under the supervision of a registered nurse or other licensed professional, and personal care or custodial services, including incontinence care or assistance with dressing or eating. A patient must need skilled nursing care to qualify for Medicare payment in a skilled nursing facility or in the home.

Medicare pays for approximately one-third of all formal home-based care, but only about 13 percent of all nursing facility spending.²¹

Long-Term Care Insurance

LTC insurance is designed to protect policyholders from the catastrophic cost of LTC services should they need it. In 2002, private insurance (both LTC insurance and general health insurance that covers some LTC services) accounted for 10 percent, or \$14.4 billion, of national nursing home and home health care spending.²²

LTC insurance policies generally specify the amount of care they will cover on a daily basis, the settings in which the policyholder can receive care, and the total amount of money or total time period the policy covers.²³ For example, a policy might cover care in a nursing home or in the home, and might cover up to \$100 a day in care for three years.²⁴ The average cost of a day in a nursing home is now \$160, and four hours of home health care costs between \$75 and \$150, depending on the skill level of the nurse.²⁵ As a result, while it provides important protection against high LTC costs, LTC insurance may not be sufficient for those with lengthy and costly LTC needs.

LTC insurance coverage begins when a policyholder has a certain level of disability (e.g., has trouble with two or more ADLs), cognitive impairment, or in some

²¹ Levit et al, 2004.

²² Levit et al., 2004.

²³ Health Insurance Association of America, "Who Buys Long-Term Care Insurance in 2000?" 2000.

²⁴ Some LTC insurance policies provide a "pool of money" wherein the policyholder can choose the amount of services and the site of care they wish up to a daily cost limit. Unused money from each day of care can be used to extend the length of the policy.

²⁵ Metlife Mature Market Institute, "The Metlife Survey of Nursing Home and Home Care Costs," 2003.

cases, a physician certification of needed care. After this threshold is met, a waiting period may be required (e.g., 30 or 90 days) before the insurer will begin paying the costs of care.²⁶ There are many additional benefit options and consumer protections that are offered with some LTC insurance policies, such as inflation protection, flexible benefits, and some benefit upon termination of premium payments. Such options generally increase the premium for the policy.

LTC insurance policies have been shaped to a considerable degree by the conditions for tax-favored treatment of LTC. In the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), Congress clarified that favorable tax treatment -- generally similar to the tax treatment of health insurance and services and employer health plans -- would apply to long-term care insurance policies meeting certain statutory conditions. A policy would qualify for favorable tax treatment if it: limited benefit eligibility to an inability to perform at least two ADLs for at least 90 days or diagnosis of a severe cognitive impairment, covered only certain LTC services performed by a licensed health care provider, included certain consumer protections, and met certain disclosure requirements.

Who Purchases LTC Insurance. In 2003, the average LTC insurance buyer in the individual market was 67 years old.²⁷ Only one out of three buyers was younger than 65

²⁶ A waiting period acts like a deductible does for health insurance. Having a waiting period reduces the monthly premiums on a policy because it reduces the total financial responsibility of the insurer.

²⁷ Marc A. Cohen, “Private Long-Term Care Insurance: A Look Ahead”, *Journal of Aging and Health*, vol. 15, no. 1, 2003.

years, and purchasers tend to be married, female, and retired.²⁸ LTC insurance buyers have higher levels of income and assets than individuals without insurance.²⁹ Within the employer group market, the average buyer is generally male (62 percent), married (75 percent), college educated (65 percent), between the ages of 40-59 (79 percent) and has an annual income over \$40,000.³⁰

People report a number of reasons for buying long-term care insurance policies. The protection from asset depletion is an important motivation, as is the belief that insurance lessens the dependence on family help and expands the choice of care setting.³¹ About 60 percent of LTC insurance claimants indicated that without their policy benefits, they would not be able to afford their current level of care.³² Over half of all claimants do not have children living within 25 miles of them.³³ Private LTC insurance helps people who lack family support receive care in their home and community rather than in institutional settings.

LTC Insurance Market. Between 1991 and 2001, the total number of LTC insurance policies ever sold grew from 2.4 million to 8.3 million, and the Health Insurance Association of America reported that 7 out of 10 policies ever sold -- 5.8 million -- were still in force.³⁴

²⁸ Ibid.

²⁹ Ibid.

³⁰ Ibid.

³¹ Ibid.

³² Ibid.

³³ The Home Care Research Initiative: A Program of the Robert Wood Johnson Foundation, "The Impact of Private Long-Term Care Insurance on Claimants: Formal and Informal Care in the Community," Policy Brief, Spring 2002.

³⁴ HIAA, "Long-Term Care Insurance in 2000-2001," 2003.

Despite recent growth, the LTC insurance market is small. Numerous reasons have been suggested for this. Most young people, especially those in good health, have difficulty imagining the real possibility of developing a chronic illness or disability requiring LTC. A large segment of the population, both young and old, also assumes that, should they need LTC in the future, government programs such as Medicare and Medicaid will cover this kind of care.³⁵ Some attribute the small market to adverse selection.³⁶ LTC insurance is also complicated to understand and purchase and has perceived quality problems. Some argue that inadequate tax incentives and the presence of Medicaid discourage people from purchasing it.³⁷ In addition, until recently, the way state insurance departments regulated LTC insurance allowed unique problems with the product to develop.³⁸ For example, some policyholders have reported 700 percent premium increases over 7 years, some lost all of their premiums as the insurer went out of business, and others found that the policies cover inadequate amounts and little care outside of nursing homes.³⁹ States and the National Association of Insurance Commissions (NAIC) have worked to improve consumer protections, but problems persist.

Problems with the LTC financing system

Major gaps in LTC financing have serious and growing consequences. Four of these consequences are outlined below.

³⁵ Georgetown University, LTC Financing Project, 2003.

³⁶ Edward Norton, "Long-Term Care," in AJ Culyer and JP Newhouse (eds), *Handbook of Health Economics*, Elsevier Science, 2000.

³⁷ Congressional Budget Office (CBO), *Financing Long-Term Care for the Elderly*, Washington, DC: 2004.

³⁸ Stephanie Lewis, "Regulation of Private Long-Term Care Insurance: Implementation Experience and Key Issues," The Henry J. Kaiser Foundation, 2003.

³⁹ Ibid.

Stress on Medicaid. Medicaid is currently playing more than a safety net role in the financing of LTC services. The failure of private insurance and Medicare to pay for expensive nursing home care leads to impoverishment and subsequent Medicaid coverage for two-thirds of all of those in nursing homes. As such, a large and growing share of Medicaid expenditures is being devoted to long-term care – despite the program’s other important functions, such as paying for health care for low-income children. In 2002, 34 percent of all Medicaid benefit spending was for LTC, even though the vast majority of Medicaid beneficiaries are low-income adults and children not needing such services.⁴⁰ Between 2000 and 2020, the share of LTC that is financed by the public is projected to increase by 20 percent.⁴¹

Given the pressure from increasing costs, it is not surprising that two-thirds of the states report that they plan on reducing Medicaid benefits, increasing co-pays, or restricting eligibility and removing people from the program.⁴² Medicaid is the second largest item in state budgets, accounting for over 15 percent of state spending. With most states having balanced budget requirements, Medicaid must be balanced with other state priorities.⁴³ As the population ages and health care costs rise more rapidly than other costs, Medicaid will consume a larger proportion of their budgets and likely force the adoption of cost-containment strategies, tightened eligibility criteria, or reduced services.

⁴⁰ O’Brian and Elias, 2004.

⁴¹ CDC, 2003.

⁴² B. J. Edlund, 2003.

⁴³ Kane, Orszag, and Gunter (2003) document the increasing pressure from Medicaid expenditures on state support for higher education. Thomas Kane, Peter Orszag, and David Gunter, “State Fiscal Constraints and Higher Education Spending,” Urban-Brookings Tax Policy Center Discussion Paper No. 12, May 2003.

Under-Funded Community-Based Services. Medicaid, Medicare and, to a lesser extent, private LTC insurance provide limited coverage for services in the home or in non-nursing facility settings, even though many people may prefer to receive care in such a setting instead of a nursing home. In most cases, Medicaid only pays for care in a nursing home, and patients do not get to choose the facility, the quality of care, or the location of the facility.⁴⁴ States may choose to provide assistance under their home- and community-based waiver programs in Medicaid (described earlier), but Federal regulations allow states to strictly limit the number of people that receive waiver assistance.⁴⁵ Some states have been active in moving care to community settings, but despite this trend, seven in ten Medicaid enrollees still get their LTC in a nursing home.⁴⁶

Medicaid's "institutional bias" means that most beneficiaries cannot access less expensive and more suitable care in home- and community-based settings. In addition, Medicaid's eligibility is restricted to those individuals who are the most severely disabled. If the program could assist beneficiaries in the community with limited need of LTC services, the program might help prevent enrollees from becoming more disabled and ending up in a nursing home. At the same time, there is the potential that this could result in increased public spending as families currently providing informal LTC themselves could seek relief from new home- and community-based services offered by Medicaid.

⁴⁴ B. J. Edlund, et al. 2003.

⁴⁵ Ibid.

⁴⁶ Heidi Reester, Raad Missmar and Anne Tumlinson, "Recent Growth in Medicaid Home and Community Based Services Waivers," The Health Strategies Consultancy for The Kaiser Commission on Medicaid and the Uninsured, April 2004.

Medicare has a home health benefit. However, its increased use for personal assistance needs in the early 1990s led to legislation restricting it to skilled care for the homebound. Even though Medicare's home health benefit is more limited than before, it remains a major source of funding for formal, community-based long term care when beneficiaries can meet its strict eligibility criteria. It is unlikely, though, that this role will expand in the future to provide more LTC services, as Medicare faces its own set of financing challenges.

Private insurance also typically includes some – albeit limited -- coverage for community-based care. Often this type of benefit comes at the cost of higher premiums since it is more commonly used than nursing home services and can, over time, be expensive. In short, the type of long-term care that probably makes the most sense from a health policy and consumer perspective has the least coverage by public and private sources of insurance.

Strain on Family Caregivers. As people age into retirement, they transition through significant physical and social changes. Physical activity might become more restricted, eyesight fades, balance decreases, and strength decreases. Gradually, the elderly rely more on their spouses, their neighbors, and their children to help them. Most elderly want to, and do, remain in their homes even when they are not fully able to take care of themselves or their homes. Even seniors who move to retirement communities are in essence choosing to remain independent. Studies suggest that nursing home residents' isolation from family and friends and the feeling of lack of control of their

lives have profound effects on physical and mental health. This aversion to entering a nursing home likely influences the decision by the elderly and their offspring to try to provide care in the home.

An estimated one out of every four households -- or 22.4 million households -- provides some type of LTC to persons aged 50 and older.⁴⁷ As noted above, most informal caregivers are women in their mid to late 40s, thus belonging to the “sandwich generation” that has responsibility caring for parents as well as children.⁴⁸ The average informal caregiver spends 16 hours per week providing care.⁴⁹ In addition to the direct cost and opportunity costs of time away from work, informal caregiving may exact an emotional cost. Studies have shown that depression is a major problem among full-time informal caregivers.⁵⁰ Half of all caregivers say they need help managing their stress and/or depression levels, and rate their own health as slowly deteriorating because of reduced exercise, lack of personal attention, and poor mental health.⁵¹ The lack of a rational LTC financing system means that the catastrophic monetary and emotional costs of LTC too often fall on both the elderly and their children.

⁴⁷ S. Pandya and B. Coleman, “Caregiving and Long-Term Care”, AARP, 2000.

⁴⁸ National Alliance for Caregiving and AARP, “Caregiving in the U.S.,” 2004.

⁴⁹ M. J. Moore, et al, “Informal Costs of Dementia Care: Estimates from the National Longitudinal Caregiver Study,” *Journal of Gerontology*, vol. 56B, no. 4, 2001.

⁵⁰ See for example: R Schulz and LM Martire, “Family Caregiving of Persons with Dementia: Prevalence, Health Effects, and Support Strategies,” *American Journal of Geriatric Psychiatry*, vol. 12, no. 3, (May-June 2004), pp. 240-9; PP Vitaliano, J Zhang, and JM Scanlan, “Is Caregiving Hazardous to One’s Physical health? A Meta-analysis,” *Psychol Bulletin*, vol. 129, no. 6, (November 2003), pp. 946-72; and R Schulz and SR Beach, “Caregiving as a Risk Factor for Mortality,” *JAMA* , vol. 282, no. 23, (December 1999), pp. 2215-2219.

⁵¹ Family Caregiver Alliance, 2001.

Impact on Retirement Income and Savings. An unacknowledged reality is that the gaps and disincentives in the long-term care financing system threaten retirement security. One year in a nursing home costs on average \$52,000, which is more than most people's entire retirement savings. Without insurance, LTC needs that are not met by Medicaid must be financed from retirement income, savings and other assets, or by imposing burdens on family members or friends.

The existence of Medicaid does not necessarily reduce the risk that LTC needs will consume available assets. Housing equity is no longer protected under Medicaid. Federal law requires that states conduct "estate recovery," or collecting from the estate of a deceased beneficiary the amounts paid by Medicaid for nursing home and certain other services. Although implemented with varying degrees of effectiveness, the idea behind estate recovery is to provide eligible homeowners the needed health and LTC but to require that they pay back as much of the Medicaid cost as possible from their home equity and other resources upon their death. Because this provides an incentive for at-risk individuals to transfer housing and other assets to others, the law has a "look back" clause that limits Medicaid eligibility for people who transferred assets in the recent past.⁵²

Private long-term care insurance is consequently purchased by some to protect homes and other assets from Medicaid estate recovery. However, the fact that most policies have time- or dollar-limited coverage means that even a person with a LTC insurance policy may need additional funding through Medicaid and have claims placed

⁵² O'Brian and Elias, 2004.

on home equity. At present, no element of the LTC financing system truly protects retirement security which, as noted above, is relatively weak for a significant minority of the population even in the absence of LTC risks.

III. Retirement saving

The aging and changing health needs of the population – including the risks of substantial LTC costs – underscore the importance of ensuring that elderly households have adequate resources during retirement to finance consumption and health care needs. Without sufficient preparation, the transition to retirement will prove unnecessarily burdensome for the households themselves and for the nation as a whole. Unfortunately, as the following sections document, a substantial share of American households have not prepared adequately for their income and health care needs during retirement.

Other than Social Security, the primary vehicles for generating income during retirement are pensions and saving plans favored by tax incentives, like 401(k)s and IRAs. In 1998, pensions and tax-preferred saving plans covered more than 70 million workers. Pension coverage is less universal than Social Security — only about half of workers are covered at any one time and about two-thirds are covered at some point in their career. Coverage is particularly low among lower earners. In aggregate, pension plans in 1998 received more than \$200 billion in new employer and employee contributions, had total assets of more than \$4 trillion, and provided one-fifth of the

income of the elderly.⁵³

Defined contribution plans like 401(k)s have become an increasingly dominant type of employer-sponsored pension plans since 1975. Between 1975 and 1998, the number of defined contribution (DC) plans more than tripled and the number of active participants more than quadrupled. During the same period, the number of defined benefit (DB) plans, in which firms are responsible for providing a retirement benefit, rather than merely making a contribution, fell by almost half and the number of active participants fell by one-quarter. Defined contribution plans accounted for more than 80 percent of contributions to pensions in 1998, compared with just over one-third in 1975.

Table 2: Ownership of defined contribution and IRA assets, for households aged 55-59 (2001)

Percentiles of income	Percentage of households with DC/IRA retirement assets	Median DC/IRA assets	Median DC/IRA assets among those with an account	Share of aggregate DC/IRA assets
Less than 20	25.0%	\$0	\$8,000	1.1%
20-39.9	49.6%	\$0	\$12,000	4.2%
40-59.9	61.6%	\$7,200	\$28,000	8.6%
60-79.9	91.0%	\$50,000	\$54,000	16.7%
80-89.9	95.4%	\$148,000	\$190,000	18.8%
90-100	92.1%	\$215,000	\$299,000	50.6%
Total	63.6%	\$10,400	\$50,000	100%

Source: Authors' calculations using the 2001 Survey of Consumer Finances.

Despite the shift from defined benefit to defined contribution plans, many households approach retirement with meager defined contribution balances. The median

⁵³ Department of Labor, Pension and Welfare Benefits Administration, *Private Pension Bulletin: Abstract of 1998 Form 5500 Annual Reports*, Number 11 (Winter 2001-2002), Table A1; and Employee Benefit Research Institute, "Income of the Elderly, 1998," January 2000.

defined contribution balance among all households aged 55 to 59 in 2001 was only about \$10,000 (Table 2), in part because 36 percent of households had no IRA or defined contribution plan account. Excluding those households, the median balance for this age group was just \$50,000. To put these figures in context, note that one year in a nursing home costs, on average, \$52,000.

Adequacy of retirement saving

Given the modest accumulation of defined contribution assets for most families and the gradual erosion in defined benefit coverage, the majority of studies have found that at least a significant minority of U.S. households are saving too little and therefore arrive at retirement with insufficient wealth to maintain their current living standards.

In a review of the research on the adequacy of retirement saving, the Congressional Budget Office (CBO) recently concluded that about only half of baby boomer households are adequately saving for retirement and about one-quarter is not adequately saving. For the other one-quarter of households who are neither adequately saving nor clearly under-saving, conclusions are very sensitive to the assumptions employed. For example, home equity represents the most significant asset for the vast majority of families.⁵⁴ Some elderly families may be willing to move out of their home, or reduce their equity in their home, in order to finance consumption during retirement, which can significantly affect savings adequacy levels. To date, however, studies suggest

⁵⁴ According to the Census Bureau, the home ownership rate among those 65 years and older was 80 percent in 2000, relative to 41 percent among those under 35 and an overall rate of 67 percent.

that housing wealth is typically not used to support non-housing consumption during retirement.⁵⁵ Whether households increasingly tap their home equity to finance retirement needs can have a substantial effect on the results regarding adequate saving needs.

Another important factor affecting the adequacy of preparation is the age at retirement. Retiring later means more time to accumulate assets, a larger monthly Social Security benefit, and fewer years over which the savings must be spread. The Congressional Budget Office has found that a couple with the median income for married households ages 55 to 64 would need more than \$500,000 in assets at age 62 to retire immediately at the same standard of living as prior to retirement; about \$250,000 in assets at age 62 to retire at age 66; and only about \$50,000 to retire at age 70 while maintaining the same standard of living.⁵⁶

Finally, the adequacy of saving involves a certain degree of uncertainty over future income, rates of return, and needs during retirement – including long-term care and other health care. Engen, Gale, and Uccello take some components of such uncertainty into account – although they use only a very rough approximation for likely health care and LTC needs. They conclude that savings adequacy levels are actually higher than most studies suggest, because the studies ignore uncertainty and suffer from other

⁵⁵ Eric M. Engen, William G. Gale, and Cori E. Uccello, “The Adequacy of Household Saving,” *Brookings Papers on Economic Activity* 1999(2), pp. 65–165. See Steven F. Venti and David A. Wise, “Aging and Housing Equity,” in Olivia S. Mitchell and others, eds., *Innovations in Retirement Financing*, Philadelphia: University of Pennsylvania Press, 2002, pp. 254–281.

⁵⁶ Congressional Budget Office, “Retirement Age and the Need for Saving,” May 2004.

biases.⁵⁷ Even Engen, Gale, and Uccello, however, find evidence of undersaving among households at the 5th-25th percentiles of the wealth-earnings distribution.

The conclusion is that a substantial minority of households are not adequately saving for retirement. Studies typically find that these households disproportionately tend to have modest incomes.⁵⁸ Individuals who have little education, are in poor health, or do not own a home have been found to be particularly at risk. These individuals will face difficult decisions in the future: either reducing their standard of living in retirement or being forced to work longer than they may currently expect.

Problems with the existing pension system

Higher-income households are generally saving adequately for retirement and are most likely to have pensions, but their pension contributions represent less new saving and more asset shifting (and, hence, tax avoidance) than do the pension accumulations of lower earners. Conversely, lower-income households are less likely to be saving adequately for retirement and are less likely to have pensions than are higher earners, but their pension contributions are more likely to represent net additions to saving.⁵⁹

⁵⁷ For example, an important issue involves home equity, which represents the most significant asset for the vast majority of families. Some elderly families may be willing to move out of their home, or reduce their equity in their home, in order to finance consumption during retirement, and that could significantly affect savings adequacy levels. But Venti and Wise (2000) argue that housing wealth is typically not used to support non-housing consumption during retirement. See Steven F. Venti and David A. Wise, "Aging and Housing Equity," in Olivia S. Mitchell, Zvi Bodie, Brett Hammond, and Stephen Zeldes, eds., *Innovations in Managing the Financial Risks of Retirement*, Philadelphia: University of Pennsylvania Press, 2002.

⁵⁸ See Congressional Budget Office, "The Retirement Prospects of the Baby Boomers," March 2004, and Congressional Budget Office, "Baby Boomers' Retirement Prospects: An Overview," November 2003.

⁵⁹ For a broader discussion of these issues, see William G. Gale and Peter R. Orszag, "Private Pensions: Issues and Options," in H. Aaron et. al., eds., *Agenda for the Nation*, Brookings: 2003. For a broader

Much of the problem stems, at least in part, from the traditional *form* of the tax subsidy to pensions. Pension contributions and earnings on those contributions are treated more favorably for tax purposes than other compensation: they are excludible (or deductible) from income until distributed from the plan, which typically occurs years if not decades after the contribution is made. The value of this favorable tax treatment depends on a taxpayer's marginal tax rate: the subsidies are worth more to households who face higher marginal tax rates, and less to households who face lower marginal tax rates.⁶⁰ The pension tax subsidies, therefore, raise two important concerns: They reflect a mismatch of subsidy and need, and also represent a poorly targeted strategy for promoting national saving.

- First, the tax subsidies are worth the least to lower-income families, and thus provide minimal incentives to the households who, on average, most need to save to provide for their basic needs in retirement. The tax preferences instead give the strongest incentives to participate in pensions to higher-income households who

discussion of the objectives of the private pension system and why the system has not done more to address the needs of moderate- and lower-income households, see J. Mark Iwry, Testimony before the House Committee on Education and the Workforce, Subcommittee on Employer-Employee Relations, June 4, 2003.

⁶⁰ Technically, the lifetime subsidy from such accounts comes from (a) the difference (if any) between the tax rate at which the contribution is deducted and the tax rate at which the withdrawal is taxed, and (b) the accumulation of funds at a tax-free rate. See Leonard E. Burman, William G. Gale, and David Weiner, "The Taxation of Retirement Saving: Choosing between Front-Loaded and Back-Loaded Options," *National Tax Journal*, vol. 54, no. 3 (September 2001), and Eric M. Engen, John Karl Scholz, and William G. Gale, "Do Saving Incentives Work?" *Brookings Papers on Economic Activity* 1994(1), pp. 85-151. In practice, however, these items are often correlated with the tax rate at the time of the contribution, and casual evidence suggests that the up-front deductibility of most of these plans (such as 401(k)s and traditional, deductible IRAs which provide the tax advantage at the time of contribution rather than distribution) may be an important determinant of whether people make contributions.

least need to save more to achieve an adequate retirement living standard.⁶¹

- Second, higher-income households are disproportionately likely to respond to pension tax incentives by shifting assets from taxable to tax-preferred accounts. To the extent such shifting occurs, the net result is that the pensions serve as a tax shelter, rather than as a vehicle to increase saving, and the loss of government revenue does not correspond to an increase in private saving. In contrast, moderate- and lower-income households, if they participate in pensions, are most likely to use the accounts to raise net saving.⁶² Because moderate-income households are much less likely to have other assets to shift into tax-preferred accounts, any deposits they make to tax-preferred accounts are more likely to represent new saving rather than asset shifting.

In part reflecting this upside-down set of incentives, the nation's broader pension system betrays several serious shortcomings:

- Only about half of workers participate in an employer-based pension plan in any given year, and participation rates in Individual Retirement Accounts (IRAs) are substantially lower.

⁶¹ Evidence indicates that low- and moderate-income households are the most likely, and high-income households are the least likely, to need additional saving to have adequate living standards in retirement. See, for example, Eric M. Engen, William G. Gale, and Cori E. Uccello, "The Adequacy of Household Saving," *Brookings Papers on Economic Activity* 1999(2), pp. 65–165.

⁶² See Eric M. Engen and William G. Gale, "The Effects of 401(k) Plans on Household Wealth: Differences Across Earnings Groups," Brookings: August 2000; and Daniel Benjamin, "Does 401(k) Eligibility Increase Saving? Evidence from Propensity Score Subclassification," *Journal of Public Economics*, vol. 87, no. 5-6, (2003), pp. 1259-90.

- Even those workers who participate in tax-preferred retirement saving plans rarely make the maximum allowable contributions. Data from the Congressional Budget Office suggest only 6 percent of all 401(k) participants made the maximum contribution allowed by law in 1997.⁶³

These findings indicate problems with the current pension system as well as opportunities for reform. The problem is that pension benefits accrue disproportionately to high-income households with little improvement in the adequacy of saving for retirement and little increase in national saving. By contrast, lower- and middle-income households gain less from the pension system, but these benefits—where they exist—appear both to increase saving and to help households who would otherwise save inadequately for retirement. The goal of reform should be to encourage expanded pension coverage and participation among low- and middle-income households, a step that would boost national saving and build wealth for households, many of whom are currently saving too little.

⁶³Author's calculations based on Congressional Budget Office, "Utilization of Tax Incentives for Retirement Saving," August 2003, Table 2. See also General Accounting Office, "Private Pensions: Issues of Coverage and Increasing Contribution Limits for Defined Contribution Plans," GAO-01-846, September 2001. Similarly, an unpublished study by a Treasury economist found that only four percent of all taxpayers who were eligible for conventional IRAs in 1995 made the maximum allowable \$2,000 contribution. Robert Carroll, "IRAs and the Tax Reform Act of 1997," unpublished mimeo, Office of Tax Analysis, Department of the Treasury, January 2000. For IRA contributors at the limit, see also Craig Copeland, "IRA Assets and Characteristics of IRA Owners," EBRI Notes, December 2002. See also David Joulfaian and David Richardson, "Who Takes Advantage of Tax-Deferred Saving Programs? Evidence from Federal Income Tax Data," Office of Tax Analysis, US Treasury Department, 2001.

Conclusion

The nation's retirement saving system and its long-term care system are both frayed, with the flaws in one exacerbating the problems in the other. Too many families – likely somewhere between one-quarter and one-half – are not saving enough for retirement. Many families are also not protecting themselves against the risks of LTC costs, thereby threatening both their own retirement security and ultimately taxpayer dollars. The average cost of a nursing home for just one year is more than the typical family on the verge of retirement has saved in a 401(k) or IRA. The ultimate burden of LTC is thus too often shifted to family members, either by exhausting assets that had been intended to be bequeathed or by relying excessively on informal care. Policy-makers, analysts, and the public must increasingly come to view inadequate saving for retirement and the financial risks associated with LTC and other health problems as part of the same broader problem.