U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

# SYMPOSIUM ON HEALTH AND RETIREMENT SAVINGS ACCOUNTS:

## SUMMARY AND RECOMMENDATIONS

June 2010

## Office of the Assistant Secretary for Planning and Evaluation

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) is the principal advisor to the Secretary of the Department of Health and Human Services (HHS) on policy development issues, and is responsible for major activities in the areas of legislative and budget development, strategic planning, policy research and evaluation, and economic analysis.

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This report was prepared under contract #HHSP23320095654WC between HHS's ASPE/DALTCP and the Urban Institute. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the office at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. The e-mail address is: webmaster.DALTCP@hhs.gov. The Project Officer was Hunter McKay.

# SYMPOSIUM ON HEALTH AND RETIREMENT SAVINGS ACCOUNTS: Summary and Recommendations

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# INTRODUCTION

Government-subsidized health and retirement savings accounts (HRSAs) are one potential way of encouraging consumers to pre-fund their long-term care expenses and thereby diminish future demand for publicly financed care. HRSAs would allow Americans to contribute to tax-advantaged savings accounts, possibly with a government match, and use the proceeds to purchase a private long-term care policy. In 2008, the Urban Institute completed a feasibility study of these accounts for the Office of the Assistant Secretary for Planning and Evaluation (ASPE), showing likely participation, the likely balances that would accumulate, and the likely impact on Medicaid spending (Mermin, Johnson, and Lewis 2008). The study also showed how various government matching mechanisms might influence outcomes. In 2010, ASPE and the Urban Institute convened a panel of experts to evaluate the study and discuss the potential of HRSAs to finance long-term care expenses.

This report summarizes the reviews and recommendations of the expert panel and proceedings of the panel meeting. The report begins by providing some background on long-term care financing, describing how HRSAs might work, and summarizing the results of the earlier Urban Institute study. We then discuss the feedback from our expert panel about our study and the idea of using tax-advantaged savings accounts to pre-fund long-term care, and we summarize the broader debate among panel members about long-term care financing.

# BACKGROUND

Most Americans will eventually develop disabilities and need long-term care. In 2005, about 42 percent of adults age 65 or older had limitations with activities of daily living or instrumental activities of daily living or received nursing home care (Federal Interagency Forum on Aging Related Statistics 2008). Nearly seven in ten adults age 65 in 2005 will eventually need long-term care, including nearly eight in ten 65-year-old women (Kemper, Komisar, and Alecxih 2005/2006). Most care is provided by unpaid family members, principally wives and adult daughters. Only 3.5 percent of adults age 65 and older received nursing home care in 2004 (National Center for Health Statistics 2010), and only about 10 percent of community-dwelling adults age 65 and older with disabilities received paid care at home (Johnson and Wiener 2006).

The demand for paid long-term care services will likely increase in coming decades, however, in response to social and demographic changes. The availability of family caregivers will fall over time because more frail older adults will be divorced, more will be childless, and family sizes will be smaller. The rising labor force participation of women will also reduce their ability to provide informal care, and it is unclear whether men will fill the gap. One study estimates that the number of older Americans receiving nursing home care or paid home care will more than double between 2000 and 2040 (Johnson, Toohey, and Wiener 2007).

Long-term care is costly, and few Americans are accumulating enough wealth to cover the expense on their own. In 2009, home health aides charged $21 per hour, on average, while personal care aides charged $19 per hour (MetLife Mature Market Institute 2009). With home care recipients averaging 60 hours of care per month (Johnson and Wiener 2006), these hourly rates translate into annual costs of more than $13,600. A year of nursing home care in a semi-private room averaged $72,000 nationally in 2009, and much more in certain parts of the country (MetLife Mature Market Institute 2009).[1]

Long-term care financing options are limited. Medicare covers long-term care services only under certain circumstances. For example, it covers up to 100 days of nursing home care following hospital stays. Traditional private health insurance does not cover long-term care. Insurance companies sell long-term care insurance, but only about 10 percent of Americans age 65 and older have coverage (Johnson, Schaner, Toohey, and Uccello 2007). As a result, many Americans pay for their long-term care out of pocket until their resources run out, at which point they turn to Medicaid. In 2007, median financial assets held by families amounted to only $68,100 for those headed by adults age 65-74, and only $41,500 for those headed by adults age 75 and older (Bucks, Kennickell, Mach, and Moore 2009). Median total household wealth for adults age 65 and older was $240,000 in 2008, about two-thirds of which was housing equity.[2]

The public sector pays about two-thirds of long-term care costs, which totaled about $178 billion in 2006 (Kaiser Commission on Medicaid and the Uninsured 2009).[3] Medicaid covered 40 percent of costs, Medicare covered 23 percent, and other public sources covered 3 percent. About one-fifth of expenditures (22 percent) were paid out of pocket by recipients or their families. Private insurance covered only 9 percent of long-term care costs in 2006.

Many older Americans who receive help from Medicaid with their nursing home costs received substantial earnings during their working lives and could likely have afforded private long-term care insurance coverage (Johnson and Mermin 2008). Encouraging more Americans to save and purchase private insurance could reduce their reliance on Medicaid in old age, in turn lowering public expenditures, protecting more families from catastrophic long-term care costs, and enabling older adults with long-term care needs to receive better care than they might obtain with Medicaid funding. HRSAs might be one way of encouraging Americans to save for their future long-term care needs.

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[1] The average annual cost of a semi-private nursing home room in Connecticut was $124,000 in 2009, for example (MetLife Mature Market Institute 2009).

[2] Author's estimates from the 2008 Health and Retirement Study.

[3] This estimate includes formal costs only. It ignores the value of unpaid family care, which in 2006 was as much as $350 billion (American Association of Retired Persons [AARP] 2008).

# HOW HEALTH AND RETIREMENT SAVINGS ACCOUNTS COULD WORK

The goal of the proposed HRSA is to stimulate private savings to cover future long-term care needs. Enrollees would make tax-advantaged contributions to these accounts, which would earn investment returns over time. The government might match contributions for certain enrollees. Participants would use the account balance to purchase private long-term care insurance.

Several plan parameters that would affect program participation, costs, and effectiveness must be set before HRSAs could become operational. For example, what restrictions (such as age or income) would be placed on program eligibility? How much would enrollees be permitted to contribute each year? A higher cap would enable adults to set more money aside for future needs, but it would increase lost tax revenues, raising program costs. What would be the nature of the tax advantage? Would participants contribute pre-tax dollars, as in traditional Individual Retirement Accounts (IRAs), or would they contribute post-tax dollars but avoid taxes when they withdraw funds, as in Roth IRAs? Would the government match participant contributions? If so, what would be the match rate? Would only certain enrollees, such as those with low-incomes, qualify for a government match? What restrictions would be placed on participants' use of their account balances?

In modeling the feasibility of HRSAs, the Urban Institute, with ASPE's guidance, set the following plan parameters:

- In the baseline scenario, all adults could begin participating at age 25, regardless of income. Two alternative scenarios limit participation to adults with incomes below 200 percent of the federal poverty line (FPL) or to those with incomes below 400 percent of the FPL.

- Participants would contribute pre-tax dollars.

- Total contributions could not exceed $1,000 per year in 2008, but that cap would grow over time with the economy-wide average wage.

- Participant and government contributions would accumulate tax-free.

- The baseline scenario did not include any government match. In alternative scenarios, the government would match individual contributions for all participants (regardless of income) at rates of 20 percent, 50 percent, 100 percent, or 150 percent (depending on the alternative).

- Participants who accumulated enough funds to purchase a long-term care policy at age 55 would be required to obtain coverage. Those whose account balance was too small to purchase a policy could spend their balance only on long-term

care expenses. Participants with excess funds after purchasing a policy could use these funds for selected other purchases, such as medical care.

# SUMMARY OF THE URBAN INSTITUTE'S FEASIBILITY STUDY

The Urban Institute used survey data, results from a random assignment experiment, and a dynamic microsimulation model to simulate the potential impact of HRSAs. The goal of the simulations was to assess who would participate in HRSAs, how much money would accumulate in the accounts, how much the program might save Medicaid, and how much it might cost the government. Estimated participation rates and contribution amounts were based on IRA contributions reported in the 2003 Survey of Income and Program Participation, a nationally representative survey conducted by the U.S. Census Bureau. Results from an experimental study that offered matching funds for IRA contributions to a random sample of H&R Block customers seeking tax-preparation assistance (Duflo et al. 2005) were used to estimate the impact of a government match on HRSA enrollment and contributions. We then put these estimates into DYNASIM3, the Urban Institute’s dynamic microsimulation model, to project individual contributions, account accumulations at age 55, government spending, and Medicaid savings for the cohort of Americans turning age 25 between 2008 and 2013. The analysis assumed that workers would not contribute to HRSAs in years in which they could make contributions under the same (or better) terms to an existing savings vehicle, such as an IRA or 401(k), because those plans impose fewer restrictions than HRSAs on how the account balances can be used. Additional details are available in Mermin, Johnson, and Lewis (2008).

The results show that relatively few adults would enroll in an HRSA without a significant government match, but that a government match could generate sizeable account balances. With no government match, we estimated that only 1 percent of adults would participate in an HRSA. On average, each participant would accumulate an account balance of about $19,000 (in 2008 dollars) at age 55, more than enough to fund the purchase of a private long-term care insurance policy. Simulated account balances are large partly because we assumed (for tractability reasons) that people predicted to participate at age 45 will participate throughout their lives (from age 25 to 55), an admittedly unrealistic assumption. Participation rates would increase with the government match. About 10 percent of adults would participate if the government matched 20 percent of contributions for all enrollees, and 15 percent would participate if the government match were 50 percent. Participation rates would increase to 26 percent under a 100 percent match rate and to 37 percent under a 150 percent match rate. Average account balances for enrollees would reach about $70,000 at age 55 for match rates of 20 percent or more.

The HRSA program would not save the government much money if it matched contributions for all enrollees, regardless of income. With a 20 percent match rate, for

example, the combined cost of the match and lost tax revenue would about equal Medicaid savings. With a 50 percent match, costs would exceed savings by more than $7,000 for each enrollee. With a 150 percent match, costs would savings by about $22,000 for each enrollee.

The simulations show, however, that more targeted matches could cut overall government costs. If the program were restricted to adults with incomes below 200 percent of the FPL, the government could save more than $10,000 per enrollee. Even if the program matched contributions at a rate of 150 percent, the government would ultimately save more than $1,000 per enrollee if only those with incomes below 200 percent of the FPL could participate.

# ISSUES RAISED BY EXPERT PANEL

We held an invitation-only roundtable discussion on March 31, 2010 at the Urban Institute to solicit expert opinion on HRSAs and our simulations and to obtain guidance on next steps for policy development. Several experts submitted written comments on the report before the meeting. Appendix A lists the roundtable participants.

A fundamental issue that emerged at the roundtable is that potential enrollees will likely view HRSAs more as long-term care insurance than as tax-advantaged savings accounts, because enrollees would be required to purchase a long-term care insurance policy. As a result, using participation patterns in IRAs and 401(k)s to model enrollment in HRSAs may be inappropriate. The issue seems particularly problematic for low-income adults. Under the current system, Medicaid will generally cover long-term care needs (especially nursing home care) for low-income adults, so it may be unlikely that they would participate in HRSAs even if the government offered generous matches. The simulations should devote more attention to the decision to purchase private long-term care insurance and the interaction with Medicaid coverage.

The roundtable discussion also revealed concerns about some technical modeling issues that may have led us to overstate participation rates and account balances. For example, to make the estimation tractable, we modeled HRSA participation as a one-time decision, made by adults in their mid forties. It is more likely, however, that many people who would choose to participate at age 45 would not participate at age 25, when many are still paying off student loans and saving for home purchases. One of the roundtable participants also questioned the way we applied the results of the H&R Block random assignment experiment to our simulations, which he believed may have overstated the impact of the government match for low-income adults. Our simulated enrollment rates may be more realistic for moderate and higher-income adults, who have at least some assets they wish to protect. They may also be willing to purchase private insurance to improve the quality of long-term care they might receive.

Roundtable participants agreed that it would be useful to model scenarios in which there were no income restrictions on HRSA enrollment but that restricted the

government match to low and moderate-income enrollees. This approach would better target government funds to those most likely to turn to Medicaid in the absence of HRSAs. It would be inefficient to subsidize those who would have purchased private insurance without HRSAs. Some simulations completed so far restricted enrollment to low and moderate-income adults, but did not impose different eligibility rules for enrollment and government matches.

Some concerns were also raised about various administrative issues. For example, insurance companies would be unlikely to sell a long-term care insurance policy with a single balloon premium. As one roundtable participant put it, because morbidity is difficult to predict, insurers rely heavily on the ability to adjust premiums over time should their assumptions be incorrect. Nonetheless, HRSA enrollees could use their account balances to fund annual premium payments beginning at age 55. Other roundtable participants worried about the cost of administering the account balances, especially if enrollment rates (and account balances) were relatively low. For example, the government might have to monitor how the account balances are invested, establish eligibility for matches, deposit the match in appropriate accounts, and regulate the purchase of private insurance.

Finally, several roundtable participants emphasized that we should view financial preparations for long-term care within the broader issue of retirement income security. There is growing concern that many Baby Boomers are not saving enough for retirement, although the empirical evidence is mixed (Munnell, Webb, and Golub-Sass 2009; Penner 2008; Scholz, Seshadri, and Khitatrakun 2006). More policy focus on boosting saving incentives could improve future retirement incomes. For example, encouraging more employers to automatically enroll workers in 401(k) plans and to automatically escalate contribution rates over time could expand savings in private retirement plans. Creating automatic IRAs, by which employers would automatically deduct a portion of the worker's salary from his or her paycheck and deposit it into an IRA in the worker's name, could also expand retirement savings, especially for the roughly half of workers whose employers do not offer retirement plans. At least one roundtable participant voiced concern that HRSAs might crowd out other types of retirement savings.

These efforts would not necessarily improve Americans' long-term care financing options, however, unless people purchased private long-term care insurance (or participated in a public insurance program). The costs of long-term care are too steep and unpredictable for many adults to self-insure successfully, even if government subsidies encourage them to save more. Without a robust public long-term care insurance program, the key will be to increase private insurance coverage rates.

# CONCLUSIONS

To accurately assess the feasibility of HRSAs as a viable financing mechanism for long-term care, we need better information on adults' decision-making process

regarding private long-term care insurance. Persistent low coverage rates suggest most Americans are not particularly interested in obtaining coverage. Is that because they do not correctly perceive the risks that they will need long-term care or the cost of nursing home and in-home care? Do they mistakenly believe that Medicare or Medicaid will shoulder most of the costs? Do many wait until they are older to consider purchasing coverage, and then discover they can no longer afford the premiums or they have health problems that disqualify them? The answers to these questions will partly determine the feasibility of HRSAs as a solution to the long-term care financing dilemma.

Another challenge for HRSAs is understanding how well they would fit in with other retirement savings vehicles. Would they expand total retirement savings, or would they simply offset savings currently undertaken in employer-sponsored retirement plans, IRAs, and other savings vehicles? Would the HRSA tax advantages and government matches go to people who are not currently saving, or would they subsidize people who are already saving on their own? An alternative to creating new HRSAs might be to allow people to use part of their 401(k) balances to cover long-term care premium payments before age 59 and one-half. (Under current law, people may not generally withdraw from their 401(k) accounts before age 59 and one-half if they remain with their employer, and former employees who withdraw funds before that age face a 10 percent tax penalty.)

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# APPENDIX A.
# PARTICIPANTS AT EXPERT PANEL MEETING

**March 31, 2010**
**Urban Institute, Washington, DC**

- Loida Abraham, LTC Edge
- Judy Feder, Georgetown University
- Suzanne Gleason, Treasury Department
- Howard Gleckman, Urban-Brookings Tax Policy Center
- Mark Meiners, George Mason University
- Janemarie Mulvey, CRS
- Susan Reinhard, AARP
- John Sabelhaus, ICI
- Gene Steuerle, Urban Institute
- Richard Johnson, Urban Institute

## ASPE Participants

- Richard Frank, HHS/ASPE
- Ruth Katz, HHS/ASPE
- Bill Marton, HHS/ASPE
- Hunter McKay, HHS/ASPE
- John Drabek, HHS/ASPE

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