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Older Minnesotans need a new way to afford care

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Whenever Minnesotans fume about chronic government deficits and pinched public services in the face of rising demand, there's an elephant in the room that's seldom explicitly acknowledged.

It's long-term care for the impoverished frail elderly.

Care for the elderly is on track to quintuple in cost to state government over the next 25 years, from $1.1 billion (about 7 percent of total state spending) to more than $5 billion per year, according to a Citizens League analysis.

That's in large part because a spike is coming both in the population that's age 80-plus, and in the share of them expected to qualify for public assistance. It's why long-term care budgets are a major driver of projected federal and state deficits.

That's not to mention what long-term care services can and, for an estimated 70 percent of today's 65-year-olds, will do to family assets. That 70 percent can expect to spend an average of $48,000 on care in their lifetimes; an unlucky 5 percent will spend more than $250,000.

Despite those potential costs, only 13 percent of today's 60- to 69-year-olds have long-term care insurance.

Elected officials are often loath to talk publicly about the long-term care cost crunch that's coming. Fortunately, that reticence didn't extend to six in-the-know Minnesotans with diverse perspectives who gathered at the Star Tribune on Nov. 22.

They said they're worried that a majority of Minnesota seniors and their families are unprepared for the financial calamity that long-term care can inflict. And they talked about what can be done about it.

Here are excerpts:

Becker: People need to know that chances are good that they'll need some help when they get older. Not necessarily a nursing home, but help getting through their daily lives.

Schubert: They also need to know that unless they have a private long-term care policy, they're not covered. There's a good chance that if they need a lot of care, they'll eventually have to move to Medicaid. Medicare pays for a very limited amount of care.

Newman: People don't want to discuss this until they are at the doorstep of needing care, and then it is too late to do any planning.

Knatterud: We're at a teachable moment. For

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boomers, it's because they are taking care of their parents. They begin to realize, this is not funded (by someone else). Hopefully, boomers are learning what the gaps are, and what they might have to do for themselves.

McMullen: Those of us who are younger are skeptical about government entitlement programs in general. We're not counting on Medicare and other programs like that. There may be a misperception about whether Medicare will cover our parents' long-term care. But we don't expect that anything will be there to protect us.

Knatterud: We are seeing signs that younger people are taking more personal responsibility for their futures, with higher rates of saving.

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More personal responsibility via private or quasi-public long-term care insurance. That's been discussed for decades as a preferred brake on government long-term care spending.

Two big deterrents to that strategy have stood in the way: The high cost of private insurance, and Medicaid rules that allowed elderly people needing long-term care to impoverish themselves to qualify for government help.

Both of those things need to change, the panel said -- and in some respects, they already are:

Becker: As long as Medicaid is structured the way it is, it is a really powerful disincentive to go out and take personal responsibility. People we talked to for the Citizens League project all know about the option to let go of assets and "go on the county" to get the care they need. A lot of people who can afford care spend a lot of time with their financial advisers and attorneys figuring out how not to pay for it.

People are smart. They are doing exactly what the rules are set up for them to do. We have to change that Medicaid structure.

Newman: There are already new rules. The rules changed, in 2006. The period of ineligibility for Medicaid (for people who spend down or give away assets to qualify for Medicaid five years before applying) now begins on the day you are out of money and goes forward. ... That got rid of a big loophole that people had been using to qualify for Medicaid.

Knatterud: It's true that there are perverse incentives in this program. Yet we need it as a safety net. People do exhaust their resources and need some way to provide for their care.

We need positive incentives for people to take personal responsibility. We need to find some mechanism for that -- long-term care insurance, home equity, life insurance and longevity insurance that kicks in after a certain age. More of those products are being deveoped now.

The incentive we're offering now is the partnership

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program. It's a long-term care insurance policy that has a lifetime benefit of a set amount. If you use that policy and exhaust its resources, you can keep your assets up to the value of that policy and still qualify for Medicaid. You wouldn't need to spend down to poverty level. We need more approaches like that.

Newman: Most of what's being sold now is partnership policies. The average age of people buying them is 57. That's been coming down. It's being purchased by people with both middle and upper incomes, and it's cheaper if people buy it when they're in their 40s. There are really innovative things going on in this market, and the prices are coming down.

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While tighter Medicaid eligibility rules and less expensive private insurance are steps toward personal responsibility, the federal government's recent experience points to the inherent flaw in a voluntary insurance model. It's the same problem that exists with health insurance generally -- "adverse selection." That means, in essence, that only sick people want to buy it.

An inability to come up with an actuarially sound business model that would enroll people with pre-existing conditions has scuttled at least for now the optional long-term care insurance feature of the Affordable Care Act, known as the Community Living Assistance Services and Supports, or CLASS Act.

Schubert: That means that this is our issue now. This has been dumped in our laps. This is a Minnesota problem with an opportunity for a Minnesota solution. If Minnesota wants more classrooms, more roads, more of the things that government has usually paid for to make this a robust state, we have to figure out how to finance long-term care in another way.

We need a variety of vehicles that fit different people. For example, for lower-income people, there could be prize-rewarded savings. Michigan has that, through credit unions. A more affordable reverse mortgage product to use home equity for care could be a Minnesota-specific initiative.

Durenberger: The opportunity today to re-examine the role that insurance plays is huge. We've made a big step with the Affordable Care Act in saying health insurance is not the same as casualty insurance. Health insurance is heading toward universal coverage. That means that how you keep people healthy, how you prevent illnesses, how you reverse chronic illnesses, become great topics for talented people in the insurance industry who want to make money.

The next step I see is to segregate out supportive services from medical services for people with disabilities and cover those with a separate insurance product. It's a quick step from that to combining health services and disability services in the same product.

There can be a lot of creativity when you redefine

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what is health insurance. And when you think of government's role as supplying a premium subsidy for those who need it.

Knatterud: Traditional Medicaid says, dump out all of your assets before we'll help you. What if we were instead to say, you have private responsibility, but you also have the public side encouraging that. There's a great opportunity to rethink how Medicaid works.

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One year ago, a Citizens League study recommended essentially that. It called for an overhaul of Medicaid's role in long-term care financing, turning it into co-insurance that supplements private insurance for all but the lowest-income Minnesotans.

That change can't be made without federal permission. Human Services Commissioner Lucinda Jesson said last week that working toward that kind of change is on her agency's to-do list, but not at its top.

First up, she said, is a federally funded public awareness pilot project, tentatively slated for next year in northeastern Minnesota.

The idea is to see what a sustained push involving employers and civic organizations can do to convince 40- to 60-year-olds that "you need to save and plan if you want to have choices in your future."

That's a needed message. But with so many middle-class, middle-aged people hard pressed by an economy that isn't in their favor, another message is needed too: We're all in this together.

"Government will provide" isn't a sensible long-term care plan. But neither is "You're on your own." M innesota ought to be a leader in finding a third way.

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is a Star Tribune editorial writer and columnist.

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