Facing Change in the United States.....

OASDI MODERNIZATION AND LONG TERM CARE AS INTERTWINED ISSUES

A Nation in Pursuit of Solutions

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I. OASDI MODERNIZATION

A. The National Retirement Age

1. We are living longer. The ratio of the life in retirement to the work life is increasing. This makes OASDI more expensive. However, it is suggested that most enlightened individuals between ages 65 and 70 would rather work and remain productive. This argues for a later national retirement age.

2. A gradual movement toward a national retirement age of 70 (instead of the scheduled 67) more closely maintains the relationship between the life in retirement and the life in active work which was established at the birth of the OASDI program.

3. This gradual change in the national retirement age from the current 65 to 70 might be introduced slowly, advancing one year toward age 70 for each three years

of elapsed time, so that age 70 prevails by the middle of the first decade of the 21st century.

4. An early stagger to age 70 as the national retirement age would solve several problems at once: (i) reduce the cost of OASDI, (ii) extend the useful working lives of the younger segment of our elderly and (iii) add economic supplements to the age 65 to age 70 component of our society.

5. Some have asserted that advancement of the normal retirement age is a breach of the national promise to the retiree. Such an assertion fails to recognize the contrasting argument that the real promise is maintenance of an "equivalent" retirement age. See Appendix A.

6. It is appropriate, nevertheless, to recognize that aging is not measured chronologically. As in all of nature's behavior, the clock of aging is stochastic.

7. Accordingly, at age 65 (and perhaps even earlier) a new category of "elderly disabled" (in contrast to total and permanently disabled) might be introduced. This category of entitlement might be governed by a strict administration of tests as to the inability to perform "activities of daily living," such as inability to bathe, dress, toilet, eat, transfer from place to place and be mobile. Inability to satisfy two or more of these tests might qualify the elderly claimant for collection of full benefits before the normal retirement age without a discount due to early

commencement of benefits. For further related observations, see Part II.

B. Coupling and Uncoupling

1. Some of the cost reduction in the OASDI program attributable to advancing the national retirement age can be used to address another OASDI modernization problem. Instead of future earnings being credited individually to each partner in a marriage, the total taxable earnings of the couple should be split, with half of the total credited to each individual. This enables portability when partners separate and, thereafter, remain single or reunite with other partners.

2. The combining and halving of married OASDI earnings credit make the program more expensive because earnings reassigned will, on average, lead to higher total benefits due to higher percentages being applied against the averaged indexed monthly earnings of each married individual. This result is attributable to the regressive nature of the OASDI benefit formula. However, if this split is gradually accomplished over the same time frame as the movement to the age 70 national retirement age, the combined impact should be a net cost reduction.

II. LONG TERM CARE...ISSUES AND COSTS

A. Background

1. Living longer adds lustre to retirement years.

2. However, living longer also adds a greater likelihood that the infirmities, frailties and chronic maladies of old age will intrude.

3. Long term care (LTC) is needed by those who, because of the infirmities, frailties and chronic maladies of old age (or because of a crippling disability), require assistance with the activities of daily living (ADL).

4. Assistance with ADL has been widely accepted as assistance with such basic activities as (i) transferring [for example, from bed to chair], (ii) mobility [either walking or wheeling], (iii) dressing, (iv) eating, (v) toileting and (vi) bathing.

5. LTC is popularly perceived to be necessary if the individual in need (whether impaired by age or disability) requires assistance with some of the ADL.

6. LTC is often provided in a skilled nursing facility (SNF) or through home health care (HHC) provided by visiting practitioners.

7. Today, much LTC is provided by family members (usually either a spouse or child). When assistance is not

available [or when such assistance is only partially available] it can alternatively be financed in one of four ways [or a combination thereof]:

- from individual savings
- from claims on an LTC insurance policy
- from Medicare [available only for LTC needs associated with an acute condition...not a chronic condition...where observable rehabilitation or improvement can reasonably be expected within a short term]
- from welfare, [Medicaid] available only if the individual, including spouse spend(s) down his/her/their assets to the poverty level

B. Anatomy of the National LTC Coverage Problem

There are five problems to be solved if chronic incapacity-driven LTC is to be made available under a national intergenerational transfer program such as Medicare [instead of becoming available under a public program only as the result of needs testing as in Medicaid]:

1. A satisfactory description (acceptance) of the "gatekeeper" mechanism, which will affirm LTC entitlement, must be found.

2. The appropriate level and the nature of LTC must be determinable under a given code, formulation or other

means.

3. The national program must not, because of its very existence, bring forth a preponderance of claims for LTC cost reimbursement which would not otherwise have appeared were the program not to have been created.

4. The national program should provide incentives to encourage the contribution of family-provided LTC.

5. The program should be affordable within the context of the other intergenerational social programs, OASDI (cash Social Security benefits) and Medicare/SMI. Or, these other programs should be cut back in what they deliver so as to facilitate the co-financing of all of these, with LTC finding a proper and appropriate place next to OASDI and Medicare/SMI in its claim to national dollars.

6. Because of the significant impact of problems 1 through 4 in the determination of affordability (problem 5), the solutions to problems 1 through 4 must facilitate reasonably accurate pricing. Otherwise, affordability likely would only follow cutbacks from a program in place which turns out to be too expensive...or the introduction of a program which would be unacceptably inadequate and perhaps deliver greater injustices from having been installed than had nothing at all been done.

It is anticipated that the solution to problem 6..., which puts restrictions on the solutions to problems 1 through 4

in establishing an affordable program...is likely to be the most difficult problem of all.

C. Putting the Cost of a National Long Term Care Program Into Perspective

1. In terms of 1989/90 dollars, the cost of an average LTC claim is likely to be of the order of magnitude $75,000 (plus or minus $25,000).

2. If for our approximate 2 million national deaths each year, one-third will have required the average order of magnitude LTC regimen, then the annual cost of LTC is likely to be approximately $75,000 times 2 million times one-third, or $50 billion.

3. This is approximately the annual cost of Medicare.

4. If the gatekeeper mechanism were to have weaknesses, if LTC services were more liberally provided than reasonably required, if induced utilization (see paragraph B3 preceding) were insufficiently monitored, if incentives for family provided LTC support were inadequate...these costs could easily double. [Each, on average, would need to be under estimated by a margin of less than 20%.]

5. Moreover, none of the above takes into consideration the impact on the unit cost of LTC services if there is a gradual but snowballing increase in demand.

6. The nation could simply not afford such a scenario.

D. Cost Containment

1. To prevent a runaway cost scenario such as has been postulated in the preceding paragraphs, it will be necessary to limit program funding.

2. But cost containment measures are difficult, if not impossible, to impose in a third party reimbursement system (i) when gatekeeping rules subject to individual interpretation are to be applied, (ii) when subjective decisions are to be made as to the level of care needed, (iii) when the existence of a program attracts claimants not likely to have come forward if the program did not offer its benefits and (iv) when close relatives withdraw support otherwise given freely.

3. Nor is it reasonable to anticipate the successful application of a pre-admission reimbursement concept such as has been used to contain Medicare costs. The confinements are long term in nature and not subject to concrete diagnosis.

E. What Are the Alternatives?

1. The general alternatives are two:

   a. The nation might abandon any effort to offer long term care as part of a national intergenerational transfer program. Instead, the private insurance industry is encouraged to offer LTC products to

the general public at an acceptable level of care and price.

b. The nation might design an LTC program managed by the private sector but subject to monitor by the government (to discourage subjective abuse as respects entitlement to LTC and level of care) and for which the price of entry is the applicant's OASDI cash income benefits (to discourage claimant entry and to encourage alternatives).

2. It is suggested that whatever the action path in respect of a national intergenerational transfer system, no decision be made until experimental programming is initiated.

   a. A model LTC program could be installed.

   b. Eligible elders could be those with a common last three digit ending of Social Security number. This would mean only 1 in 1,000 would be eligible and would facilitate a study of experimental results.

3. It is suggested that any national support of LTC coverage product development by the insurance industry be introduced only with concurrent admonitions regarding pitfalls:

   . overpricing (to protect the insurance industry), even when purchased as part of a group

- strict underwriting
- "rule book" claims administration
- likely perception of inadequate size of claim award (relative to outlook at time of purchase) due to impact of inflation
- expensive cost of coverage upgrade at later ages

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Appendix A

Retirement Age (Years and Months) 1940-2060, Equivalent to Age 65 in 1940[1]

Year	Equivalent Retirement Age
1940	65:00
1945	65:11
1950	66:05
1955	66:11
1960	67:00
1965	67:03
1970	67:09
1975	68:06
1980	68:10
1985	69:02
1990	69:09
1995	70:03
2000	70:07
2005	70:10
2010	71:00
2015	71:03
2020	71:05
2025	71:08
2030	71:10
2035	72:01
2040	72:03
2045	72:06
2050	72:08
2055	72:11
2060	73:01

[1]Retirement age is defined as life expectancy at retirement divided by years in labor force where entry into labor force is assumed to be age 20. Calculations based on the latest historical and projected U.S. mortality rates, provided by the Office of the Actuary, Social Security Administration, November 1985.