

Retirement: How to Live Well

Few people want to leave their home as they grow older. Smart planning about health care can make all the difference.

By

RESHMA KAPADIA

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It may be the most dreaded family talk after the one about the birds and the bees. It certainly gets scant mention in the retirement ads featuring a happy couple strolling along a beach. But long-term care is the elephant in the room that can upend an otherwise meticulously crafted retirement plan.

No one wants to broach the topic of what life may be like when you or a loved one can't live independently. But the reality is that about 70% of people over the age of 65 will need some sort of long-term care, ranging from assistance with dressing and bathing to medication management and skilled medical help. Yet aging experts say that eldercare decisions are typically made in the midst of a crisis, often by a family member.

"This is the single-most important issue to discuss with your family when planning retirement. Not having the talk could derail all the previous financial planning," says Cyndi Hutchins, Bank of America Merrill Lynch's director of financial gerontology. "It also allows people to maintain control in their life when they may not be able to, physically or mentally."

THERE'S A WHOLE INDUSTRY built around protecting investors against worst-case unknown events, or tail risk. In retirement, that risk isn't unknown—it is, for virtually everyone, longevity, and what it can cost. Of the nation's top earners, the best- and worst-case long-term care scenarios (in terms of costs) creates a 40 percentage-point difference between the likelihood of not running out of money—from a 99% chance of having enough to only 59%, according to the Employee Benefit Research Institute, a nonprofit research firm.

And especially with long-term care, "low cost" is relative. According to insurer Genworth's latest cost-of-care survey, the median annual cost of a private room in a nursing home is \$91,250. The median cost of a one-bedroom in an assisted-living facility is \$43,200 for a year, or \$3,600 a month, but upscale facilities charge more than triple that.

Planning ahead allows retirees to better evaluate costs, which differ considerably across the country. The median price for a one-bedroom apartment in an assisted living facility ranges from as little as \$33,000 a year in Missouri, to \$94,000 in Washington, D.C., according to Genworth. Advanced planning also gets them a spot on the waiting lists at more popular facilities—increasingly important as more baby boomers enter their 70s and 80s.

Long-term care insurance will cover some of these, and other, costs but before you buy a policy, you need to know what the various options of care entail because planning for long-term care goes beyond just how to pay for it. “It’s a decision with big ramifications on your quality of life, as well as your longevity,” says Rodney Harrell, director of Livable Communities at the AARP Public Policy Institute.

In the past, the continuum of care was short. Most people went into a hospital and ended up in a nursing home. Today, the nursing-home industry is in flux, with the number of occupied beds steadily falling. Many who can afford other options simply use nursing homes for short-term rehab after a hospital stay.

Many seniors are staying at home longer, helped by technology, such as telehealth, which lets doctors and loved ones monitor them remotely, and services like Uber that let them get around after they stop driving. When they do move out of their homes, there are myriad options—many that feel like five-star hotels with gourmet restaurants, concierge services, and a long list of daily activities, rather than institutionalized convalescence homes.

With the increase in options comes complexity. Perhaps just as difficult as starting the talk is evaluating the choices, each with an array of pricing models and fine print—all in a lightly regulated industry that varies from state to state. To make it even harder, the industry itself is in flux, with business models and services still evolving.

While financial advisors are often the go-to for all things retirement, navigating the ins and outs of long-term care frequently falls beyond their realm of expertise. A recent survey by Lincoln Financial showed that only 40% of respondents had discussed long-term care planning with their financial advisors, and just 10% of advisors are using a long-term care solution, such as insurance, for the majority of their clients. Many advisors refer clients to elder-law attorneys to help with the due diligence on contracts, and turn to geriatric-care managers, who charge \$90 to \$225 an hour, to consult with doctors to assess a retiree’s needs, coordinate care, and help families make long-term care decisions.

The intricacy begs for the type of early planning that is the norm for other aspects of retirement. Here’s what you need to know:

Some 90% of those 65 and over want to stay in their homes as long as possible; this is known as aging in place. Analysis begins with whether it is truly feasible. Stairs spell trouble later in life, especially if they're necessary to reach the bedroom, bathroom, or laundry. Houses can be retrofitted to accommodate a wheelchair, while harsh winters, proximity to board-certified hospitals, or access to public transportation can't be changed. "Most people will have temporary periods of incapacitation from an illness or injury. Why not choose housing appropriate for those periods?" says Catherine Anne Seal, an elder-law attorney in Colorado Springs, Colo. "If you want to live independently, think not just about whether it is the right house, but also the right place." Moving to a new area that's warmer, nearer to family, or otherwise more suitable is easier when you're younger and better able to acclimate and enjoy your new community.

Not only is it more comfortable, but aging in one's home and using community-based services for long-term care can also cost a third of what's charged in an institutional setting. There's a movement toward trying to make this work for more people, according to AARP's Harrell. For example, there are villages started by grass-roots movements in areas such as Beacon Hill in Boston and Chevy Chase, Md. Some charge an annual membership fee that covers activities such as walking groups and lecture series, escorts from doctors' offices, access to volunteers who can run simple errands or come by to chat, and a network of discounted service providers to help seniors stay at home. While these environments seem promising, they're new enough that they haven't yet been tested. "We haven't seen a lot of heavy-duty service intervention needed in the villages yet. The jury is still out on how that membership business model will work when the residents get more disabled," says Robyn Stone, senior vice president of research for LeadingAge, an association of nonprofit aging-services providers.

THE KEY TO AGING AT HOME is getting help there—skilled medical care, as well as companionship, and someone to do light housework and run errands. There is less variability in pricing than in other types of long-term care options, with the average cost of \$20 an hour. However, quality is erratic because it's not regulated, says Bob Bua, head of Genworth's CareScout service, which focuses on long-term assistance.

Given the lack of oversight, eldercare experts recommend using an agency to hire a certified health-care aide. Agencies provide background checks and backup care, and handle the logistics around workers' compensation insurance and taxes.

Technology is also helping people stay put longer—a trend likely to accelerate as today's tech-savvy baby boomers move through retirement. Already, technology can remotely monitor blood pressure and blood-sugar levels, or even when someone is out of bed. Skype-like services can help doctors monitor patients with chronic conditions like

congestive heart failure without visiting them. Transportation is often a concern for seniors, but services such as Uber allow them to get around easily.

Home health care can be cheaper than a nursing home, but there's less financial assistance: Medicare covers only some skilled in-home medical care, and long-term care insurance typically only covers unskilled care once a retiree can't dress, bathe, or accomplish other such tasks themselves. Costs can also rise quickly once someone needs 24-hour care. For those who prefer a live-out, rather than live-in, aide, this means someone for the day shift and night shift. Two aides at a time are often required for people who need assistance getting in and out of bed. Around-the-clock care can quickly mount to \$400 or more a day. "Once you go beyond needing six hours of care, you are getting to the point that assisted living may be less expensive," says Catherine Collinson, president of Transamerica Center for Retirement Studies.

There are ways to offset the costs, using family caregivers—who often provide a large majority of care—and using unfortunately named adult day-care centers. These facilities are a relatively new addition to the continuum of care and use models similar to those of day care for children, allowing seniors to use them for a half or whole day and providing a social outlet for seniors who otherwise would be isolated. It also is a way to give caregivers a reprieve, and can be useful in cobbling together care.

The national daily median average for centers that offer structured activities and some medical services is \$69, or almost \$18,000 a year if you go five days a week, according to Genworth. The median cost is as low as \$9,100 in Texas and as high as \$32,000 in Alaska, in part because some facilities rely on government subsidies or donations. "If a facility serves someone for many hours, the daily rates start to look quite reasonable," says Genworth's Bua.

Assisted Living

A variety of facilities fall under the broad moniker of assisted living, with more-upscale ones focusing on hospitality. Some offer a host of activities, such as cultural outings and art classes, as well as amenities such as concierge services, fitness centers with on-staff trainers, and multiple restaurants.

The time to switch from aging in place to assisted living may be when assistance is needed for daily tasks like bathing and dressing, but not around-the-clock skilled medical care. Personality plays a big role in finding the right facility—a center with scheduled group dining may be a poor fit for a fiercely independent person who values time to be alone. "You want to make sure it's the right place. Older adults don't want to move again, and doing so can be detrimental to their health," observes Sandy Adams, a financial advisor at the Detroit-

area Center for Financial Planning, who has taken gerontology classes to better serve aging clients.

Unlike nursing homes, assisted-living facilities aren't regulated uniformly. As a result, they vary a good deal, based on the states in which they are licensed. Eldercare experts recommend unplanned visits, and spending several hours or even overnight to get a true sense of the community and staff.

WHAT ASSISTED LIVING doesn't offer is nursing care. Some facilities don't even have a nurse on duty. Look for a facility that has some sort of medical care, and ask how long it takes to get medical assistance if something goes wrong. Staff-to-resident ratios are another factor, and arguably more important than amenities. Also ask: Under what circumstances will the facility push someone out for needing too much care?

In the past, people with cognitive impairment were sent to nursing homes because they needed constant oversight, even though they didn't require skilled medical care. With about half of those over 85 developing dementia, more assisted-living facilities are offering a hybrid, with memory-care wings that aren't as restrictive, but that offer more services than a nursing home.

The fees are complex: Some charge monthly for a set of services; others use a tiered approach, pushing residents into the next tier as they require more services. Some just charge for room and board, and medical care is pay as you go.

Read the fine print: Better yet, hire a lawyer to do it. Many centers try to pressure residents into agreeing to not make big financial gifts to their family once they have entered the facility. Sometimes, elder-law attorneys say they find provisions in the fine print that don't make much sense and can be negotiated or struck, such as clauses that require payment for daily care, even after the resident no longer lives there.

One-Stop Senior Living

Continuing-care retirement communities, or CCRCs, offer the entire continuum of care—from independent living in an apartment to assisted living to skilled nursing care—all at one location. The highest-end facilities have beautifully manicured, expansive campuses, with perks such as acting classes and volunteering opportunities. Some have wellness programs that include medical clinics, gerontologists, or social workers who can help residents get into better shape than they were when they arrived.

These facilities often appeal to couples who might not need the same level of care at the same time, or for seniors looking for more social interaction. Most will not take anyone with

a chronic illness, however, says Linda Fodrini-Johnson, a geriatric-care manager and founder of Eldercare Services near San Francisco.

About 40% of the contracts LeadingAge has seen are “life care” agreements that require a sizable one-time fee—at least \$100,000, but sometimes up to seven figures. Atop that, monthly fees cover accommodations and services, assisted living, and nursing care. Long-term care insurance usually won’t cover the entrance fee, and typically only covers part of the monthly fee once a certain level of assistance is needed.

These models have raised red flags for the U.S. Government Accountability Office. A GAO report warned that as older Americans stay in their homes longer, people may spend less time in independent-living units at CCRCs, potentially hurting their long-term finances, because residents in the independent-living part of the facility help subsidize those in assisted living or nursing care.

As the industry evolves, so do the financial arrangements. Some facilities offer modified contracts that charge a lower entrance fee, but with monthly fees that cover only a limited amount of nursing or medical care before you need to pony up more. Other centers have an a la carte model, in which skilled medical care costs extra, but residents gain priority admission to the facility’s assisted-living and nursing services.

AND THEN THERE ARE contracts that can differ quite a bit year to year, even at the same center. Beware provisions that try to make residents’ children liable for their parents’ bills. The same goes for those requiring arbitration. These terms often can be negotiated away, says Shirley Whitenack, an elder-law attorney at Schenck, Price, Smith & King, who works with financial advisors and wealthy clients. Another area that can be negotiated: refunds of the entrance fee once a resident dies or leaves. Because these contracts are essentially for the resident’s life, they require careful financial scrutiny, as well. That’s no easy task because states, which usually oversee these centers through their insurance agencies, require different, and sometimes minimal, disclosure.

California, New York, and Texas are among the handful of states that look beyond financial statements into actuarial reports that can be more telling about a center’s long-term viability. Debt covenants and information on how a center’s reserves are invested are a better indication of a facility’s future financial health than past financial statements. “The contracts are expected to cover a much longer period of time than a nursing home, where average stays are typically just a year,” says Alicia Puente Cackley, GAO’s director of financial markets and community investment. “And the contracts encompass not just housing, but the care you receive, the meals, and facility. The risks are not necessarily just financial, but

related to the quality of care and around who decides when you move from independent living to assisted living.”

That decision is sometimes made by a board or other residents, or is based on certain conditions—ask the facility how it decides. Some centers, for example, won’t allow a health-care aide or hospice worker to come into an independent-living situation, which could negate the reason a resident chose the facility in the first place.

Ultimately, though: “The biggest pitfall,” Adams says, “is waiting too long.”