

ERISA Benefit Statements of the Future: The Need to Explain the Cost of Retirement, Including Out-Of-Pocket Medical and Long-Term Care Expenses

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“**H**ow much money will I need in retirement?”¹ “How Much Money Will You Need When You Retire?”² “How to Calculate How Much Money You Will Need to Retire.”³ Those are just the first three articles in the queue when I “Googled”⁴ the following key words: “how” “much” “money” “needed” “retirement.” If you are more interested in academic articles, then you can read “Addressing Retirement Readiness;”⁵ “Are You Sure You’re Saving Enough for

Retirement?”⁶ and “Can Americans Afford to Retire? New Evidence on Retirement Saving Adequacy.”⁷ There are also books galore, including: “The 7 Most Important Equations for Your Retirement;”⁸ “A Million is Not Enough: How to Retire with the Money You’ll Need;”⁹ and “The Savage Number: How Much Money do you Need to Retire?”¹⁰ Just to continue emphasizing the abundance of resources out there, the government has been involved, with reports such as: “Retirement Income: Ensuring Income throughout Retirement Requires Difficult Choices”¹¹ and an official “Retirement Calculator” available through the Department of Labor.¹²

What is the purpose of this article if there is already so much guidance out there? First, it is to emphasize that, in this author’s opinion, there is never a magic number.¹³ Rather, this article emphasizes the need for two wealth components during retirement: a substantial income stream, which will generally be used to pay off predictable retirement expenses such as expected monthly living expenses; and, a substantial endowment, which will be liquidated as needed to pay off unexpected and unbudgeted expenses as they are incurred, and which will then be used to fund the retiree’s legacy wishes upon his or her death. Second, this article tackles the very complicated rules and moving parts of Medicare, and of Medicaid for needy individuals, and attempts to quantify the out-of-pocket costs incurred by retired individuals as they receive medical care and services and long-term care and services. Third, the article proposes the content that, if included in benefit statements and other communications from employer-sponsored retirement plans, could educate millions of Americans to ideal retirement strategies, incorporating the expected out-of-pocket spending, which will likely be new information to the average American who has not had hand-on experience assisting a parent or other friend or family member in navigating all of the nuances of applying for and paying for Medicare, and of applying for Medicaid. This seems to be a great target area because there are about 130 million Americans who are current or former participants in an employer-sponsored retirement plan,¹⁴ who must receive regular communications from the plan sponsor.¹⁵ This proposal is hopefully timely, as the Department of Labor is currently in the process of drafting regulations for the proper content of benefit statements.¹⁶

The first part of this article introduces the concept of retirement, lists the risks that can cause an improperly financed or otherwise unpleasant retirement experience, and then, after a detailed differentiation of annuity streams and endowments, summarizes a way for people to think about life expectancy and about some of the living options one has during retirement. The article then moves to what is possibly the most crucial portion, as it attempts to quantify the out-of-pocket costs individuals

should expect to incur during retirement, even if they are enrolled in Medicare, such as monthly premiums, annual deductibles, and co-pays for Medicare Parts A, B, C, and D. The second part begins with a crucial differentiation of medical care costs and long-term care costs, and then after the discussion of medical care covered by Medicare, summarizes long-term care costs, and the way that needy individuals can apply for Medicaid, or aid and assistance benefits if a veteran, or self-pay. The third part of this article then incorporates the out-of-pocket costs explained in the second part, and advises how individuals should generally think about their income streams and endowment at the beginning of retirement, and then throughout the retirement phase of life. The fourth part reviews the communications that ERISA retirement plan sponsors are required to provide to plan participants, and suggests how an education about the costs of retirement can be included in such ERISA communications. The final part of the article represents the author's model benefit statement, which was submitted to the Department of Labor as personal comments, as they are preparing to draft new regulations regarding the content of ERISA benefit statements.

THE WAY TO THINK ABOUT BEING FINANCIALLY SECURE IN RETIREMENT

What is Retirement?

First, we need to explore the term retirement. While employers might have mandatory (or suggested) retirement ages, or might otherwise attempt to encourage older individuals to leave the workforce, different individuals classify themselves as “retired” at different points in time, and possibly in different stages of life. Individuals generally control when they will retire, unless chronic illness and/or physical or mental disability interferes with the planned continued working, or unless a specific employer does not want members of its workforce to delay retirement.

Depending on any individual's health (and his or her family's health), financial security,¹⁷ and willingness of his or her employer, retirement can be elected as a cliff event (*i.e.*, working full time one day, then, after a going-away party and receiving the fabled gold watch, complete and total retirement) or a gradual diminution of active working hours, responsibilities, and salary, with increasing amounts of leisure time, and possibly with the full or partial distribution of retirement benefits from the employer-sponsored retirement plan. In today's society, retirement can include:

- Continuing at the current employer, at the same position, but with reduced hours and resulting reduced salary;

- Continuing at the current employer, at the same or similar position, but with changing employment status from employee to consultant (but watch out for income tax, payroll tax, and health and welfare benefits issues if classified as an “independent contractor” rather than a “common-law employee”);¹⁸
- Seeking employment with a new employer (possibly in a new industry);
- Starting a new business or for-profit enterprise, or starting a charitable or other non-profit organization;¹⁹
- Volunteering instead of paid employment; or
- Enjoying full time leisure, pursuing additional formal education, attending to other personal and familial obligations, or remaining basically sedentary due to failing health.

As can be seen, retirement means a lot of different things to different people.²⁰ However, all of these choices depend on the individual’s need for additional money or sources of wealth and the individual’s vocational skills for generating additional salary or income, on the individual’s ability to choose an immediate retirement or a gradual transition into full retirement, and on the individual’s and dependent family members’ health conditions. Any of us can sit and dream of when our perfect retirement will begin, what we will do during retirement, and how much money, if accumulated on the first day of that fantasy retirement, will be sufficient to cover all of our desired and necessary expenses during retirement and to cover our legacy expectations during our lives and upon our deaths. However, as we all know from our respective life experiences, our retirement dreams from our twenties and thirties rarely materialize, and therefore, all of the best and savvy financial planning of accumulating a specific amount of wealth by a specific date is a great idea, but usually only somewhat reflective of reality.

In qualified plans,²¹ the idea of “phased retirement” has become part of the nomenclature, but has not been fully developed, at least through statutory or regulatory guidance.²² The actual terms that should be used are either “in-service distributions”²³ from 401(k) plans and profit sharing plans (where a plan document can allow distributions from employer contributions anytime after a fixed number of years) or “distributions during a working retirement”²⁴ from defined benefit plans and money purchase pension plans (where a plan document can allow distributions to an individual who is continuing to perform

services to the sponsoring employer after attaining age 62 but before the normal retirement age defined in that plan document).

This article proposes that individuals need to be educated about all of these moving parts, and on the contingencies that their actions, even if deemed to be reasonable along the way, cannot guarantee a financially sound retirement. This article suggests that either Congress, through amendments to ERISA, or the Departments of Labor and Treasury, through Regulations, can require all employers in all of their retirement plan communications to provide a basic education on general fiscal responsibility and financial mathematics, juxtaposed with the reality of the expected expenses and costs in retirement and the frailty of the human body and mind. Obviously, either way, a model communication will at least be instructive to employers, even if any particular employer wants to add additional content. This article concludes with a proposed model that can hopefully be the starting point.

Risks During Retirement

Before focusing in on all of the financial aspects of planning for retirement, some of the more common risks in retirement should be noted. In a recent study, the Society of Actuaries listed several post-retirement risks, and in each case, provided a background for the risk and its predictability, as well as ways to potentially manage the risk and other comments from the study's authors.²⁵ Using that report as a starting point for risks that most experts in the economics and financial planning sectors inherently understand,²⁶ the author expands the list,²⁷ and enumerates the following as a more realistic and comprehensive list of retirement risks (although admittedly not in and of itself all comprehensive, as there might be additional hazards and unexpected liabilities for any particular individual or family unit):

- Longevity (the risk of outliving retirement resources);²⁸
- Inflation (the risk that rising costs of all consumption, especially in regards to health care and other commodities that have no natural substitutes, outpace the investment return on endowments and the increases in annuity payments from one period to the next);²⁹
- Interest rates (in addition to affecting an individual's level of wealth because of lower than expected returns on stock investments, the risk of higher than expected interest rates could increase monthly or other periodic payments required for adjustable-rate mortgages or on general consumer debt that are adjustable and tied in to the prevailing interest rates);³⁰

- Stock market (although stock market returns are still heralded as outpacing inflation over a long horizon, individuals in retirement have a lesser period of time to make up for losses than younger working individuals who would suffer for the same losses);
- Business continuity (most employer-sponsored retirement plans, other than those sponsored by governments and churches, are governed by ERISA and pay premiums into the Pension Benefit Guaranty Corporation, but that federal agency only guarantees a statutorily-capped annuity at retirement for participants in a defined benefit plan where the sponsoring employer goes into bankruptcy, and although financial institutions and insurance companies are generally regulated, there is no guarantee that all assets will be replaced if the institution fails);
- Employment (the risk that an individual cannot continue working or find alternative employment opportunities later in life, especially if additional wages are needed to cover retirement expenses);
- Public policy (the general risk of increasing taxes or new types of taxes, or the reduction in benefits or increases in costs for Medicare, Social Security, Medicaid and other federal, state, and local governmental programs);
- Unexpected health care needs and costs (health care costs for physical and mental illnesses, although relatively easy to predict for a large group over a limited time, are quite difficult to predict on an individual basis for periods extending far in the future);³¹
- Lack of available facilities or in-home caregivers (especially in geographic areas where demand exceeds supply and in instances where only one spouse or significant partner needs the facility or in-home caregiver);
- Loss of ability to live independently (the sudden or gradual need for long-term care³² due to deteriorating physical health or diminished mental capacity);³³
- Change in housing needs (the risk that the current domicile cannot be retrofitted for, or is otherwise dangerous to, the incapacitated individual, or to accommodate the needs of a caretaker);

- Death of a spouse or other family member (the emotional and practical impacts in addition to financial impact);
- Other change in marital status or relationship status (divorce, remarriage, resumed sexual activity and a possible deviation away from monogamy, and, for a growing number of individuals, public acceptance of sexual identity expressed earlier in life, or experimentation later in life in order to realize true sexual identities that were hidden earlier in life);
- The psychological depression that might accompany retirement (especially if it is an unexpected retirement due to disability; and, even if a planned retirement, the realization that there is either not enough money or that the physical limitations and chronic illnesses interfere with the dreams of an ideal retirement; and, in too many instances, an otherwise happy relationship earlier in life when the couple only saw each other for a few hours each day that sours as retirement forces the couple to be together 24 hours a day, 7 days a week);³⁴
- Unforeseen needs of family members (including the need for the retiree to become a full time caregiver to someone else);
- Bad advice, negligence, complacency, fraud or embezzlement of the investment, maintenance and liquidation of money, wealth and other property;³⁵ and
- Physical, emotional, or sexual abuse (which becomes more likely as individuals age, lose their social networks, and generally become more vulnerable to abuse or neglect).³⁶

The Difference Between an Annuity and an Endowment

The initial discussion regarding financial adequacy in retirement must be an explanation of the difference between an annuity stream and an endowment. Generally, retirees should have several “pots” of “money” for various purposes: fixed or predictable monthly living expenses can be paid from fixed income sources; whereas, discretionary and unpredictable expenses for emergencies, for self-indulgence, for lifetime gifts to family, friends, and charity, and for funding a legacy upon death can come from the liquidation and spend down of the endowment.

In the attempt of invoking a mental picture, think of a mailbox³⁷ for the annuity, (or income stream)—there will be a check in the

mailbox every month while still alive (and if additional protection was “purchased,” then until a term period has expired or until a second individual has also died), and then think of a piggy bank³⁸ for the endowment—there is a pool of money or other assets that can be liquidated and spent down as needed (until the endowment is completely depleted). For purposes of this article, all discussions of annuities will assume the most basic form of a life annuity, which, as explained later in this article, for a premium, can be transformed into an annuity with some sort of protection.

There are positive and negative aspects of both annuities and endowments, which is why each individual should have a good mix of income streams and endowment, and, as important, a properly balanced and diversified investment portfolio in each. Since income streams (and the relative values of their alternate forms, which provide various levels of protection) are generally irrevocable, sometimes individuals are encouraged to underestimate the income stream and then use the larger endowment to purchase additional fixed income streams during retirement as needed.³⁹

As to annuities and most income streams, especially those that continue for as long as the individual or beneficiary is alive, a very important positive attribute is the mitigation of longevity risk, as an individual can never outlive his income stream (however, unless the annuity includes inflation protection, the monthly checks will continually cover less of the individual’s needed consumption). Another positive aspect of an annuity or income stream is that the individual can easily budget for and adjust his or her general lifestyle. The greatest negative aspect of annuities is the lack of any discretionary funds for emergencies, legacy planning, or for personal enjoyment.

As to endowments and other accumulated wealth, a very important positive attribute is that any amount not spent (or gifted) during retirement can be bequeathed upon death⁴⁰ (however, the individual needs to make investment choices that maintain principal and yield at least enough interest to keep up with inflation, and to avoid other market risks). If the individual does not appoint an agent and provide specific wishes and instructions through a properly executed Durable Power of Attorney for property while he or she maintains adequate mental capacity, then a court-appointed guardian might not meet that individual’s gifting, legacy, and investment strategies later in life when the retired individual can no longer manage his or her property and a court adjudicates the retiree as lacking sufficient mental capacity.⁴¹

This strategy (or at least idea) of utilizing an income stream in conjunction with the spend-down of an endowment is not unique to this article, but in so many of the titled books and articles listed in this

article's introduction, that point is not made abundantly clear, especially for an individual who is not financially savvy. For example, a 2011 GAO Report states:⁴²

Experts we interviewed tended to recommend that retirees draw down their savings strategically and systematically and that they convert a portion of their savings into an income annuity to cover necessary expenses or opt for the annuity provided by an employer-sponsored DB pension, rather than take a lump sum. The experts also frequently recommended that retirees delay receipt of Social Security benefits until they reach at least full retirement age. However, according to the experts, the combination of these strategies depends on an individual's household circumstances, such as the standard of living the household seeks, its financial resources, and its tolerance for risks such as investment, inflation, and longevity risk.

Long before that GAO report, industry experts compared annuitization strategies because:⁴³

Baby Boomers nearing retirement are now targeted by competing financial service providers seeking to help them manage their money in their golden years.... On the one hand, insurers offer life annuities as the preferred distribution mechanism. On the other, mutual fund providers propose phased withdrawal plans as the better alternative. This paper compares different retirement payout approaches to show how people can optimize their retirement portfolios by simultaneously using investment-linked [savings] along with life annuities.... we show that retirement planning would not involve a simple choice between annuitizing all one's money versus selecting a phased withdrawal plan, but rather it requires a combined portfolio consisting of both annuities and mutual fund investments.

Additionally, the Retirement Income Industry Association was founded "to provide a view across the business silos in order to shape the future of the retirement industry to better serve the millions of Americans facing retirement income security challenges,"⁴⁴ and in a recent article, the curriculum for their professional designation of Retirement Management Analyst was summarized as teaching retirement advisers "how to build a floor of sufficient income through

guaranteed or low-risk sources while creating the potential for growth through exposure to riskier asset classes.”⁴⁵ The article continues to describe a new application for iPads and other tablets developed by Ameriprise titled “confident retirement.”⁴⁶

The foundation of the retirement strategy is to cover all essential expenses that are considered predictable and recurring, such as food, housing, utilities, taxes and medical expenses, with guaranteed or stable income [which] might include Social Security or pension benefits, as well as annuities and certificates of deposit. Once essential expenses are covered, advisers can work with clients to identify additional goals, such as travel or hobbies, and identify appropriate sources of income to fund these optional expenses. Typical solutions would focus on a strategic allocation for cash, as well as investments designed for income and growth. Unexpected risks can devastate retirement plans, so the third step in the strategy includes insurance solutions to deal with medical and long-term care expenses, personal liability exposure, and providing adequate protection for a surviving spouse. After accounting for essential, lifestyle and unexpected expenses, the final step is to create a legacy plan for any remaining assets.

Sources of Annuities and Income Streams in Retirement

Fixed income comes in a variety of ways. For purposes of this article, the starting point is through an employer sponsored retirement plan. Currently, retirement plans, especially qualified retirement plans, come in two forms: a defined contribution plan and a defined benefit plan.⁴⁷ Defined benefit plans must provide as the normal form of benefit a life annuity;⁴⁸ however, if a participant entitled to start receiving benefits is married on the annuity starting date, then the normal form of benefit is a qualified joint and survivor annuity.⁴⁹ So, if one of the spouses of a typical married couple⁵⁰ is entitled to an annuity from the employer sponsored retirement plan, then the conversion of that single life annuity to a joint and survivor annuity (where the spouse is the second life) with a 75 percent remainder annuity seems to make sense. However, the major caveats to this component of retirement income are: first, the decreasing number of individuals actually covered under an employer sponsored pension plan means that many individuals do not enjoy an opportunity for a source of fixed income through an employer sponsored retirement plan,⁵¹ and second, of those dwindling few participating in a pension plan, the replacement income generated

by participating in that pension plan will not generally allow a high replacement of preretirement income levels.⁵²

On the other hand, by its very legal definition, the normal form of benefit in a defined contribution plan, and the manner it is communicated to a plan participant while still an employee of the sponsoring employer, is an account balance,⁵³ which is generally paid out as a lump sum or is rolled over into an IRA, where it will remain invested until distributed, again generally paid out as a lump sum. The Departments of Labor and Treasury issued a Request for Information Regarding Lifetime Income Options for Participants and Beneficiaries in Retirement Plans, which included questions relating to how the regulatory framework governing defined contribution plans and IRAs can be amended to encourage plan sponsors and IRA custodians to at least offer ways to convert all or part of the account balance into an annuity stream.⁵⁴ Treasury Regulations (currently in proposed form) would allow a defined contribution plan to add the option of using up to 25 percent of the account balance (but not more than \$100,000) to purchase a qualified longevity annuity contract, which would be a deferred annuity through a proper insurance company which must commence by the individual's 85th birthday.⁵⁵ On the Department of Labor side, they recently issued a notice of proposed rulemaking, where they will likely require sponsors of defined contribution plans to somehow illustrate the income stream that the account balance would purchase (all of the details are yet to come).⁵⁶

In addition to employer-provided retirement benefits, most older individuals are also entitled to an annuity in the form of old age benefits or survivor benefits from Social Security.⁵⁷ Those who have worked for at least 40 quarters⁵⁸ and have enough social security earnings and have paid premiums⁵⁹ into the system are entitled to full benefits at their Social Security Retirement Age,⁶⁰ but may elect to start taking a lesser amount upon attaining age 62⁶¹ or can opt for an actuarially increased amount if delayed until the attainment of a later age up to age 70.⁶² In addition to providing benefits for these members of the workforce, Social Security also provides annuity benefits to current spouses,⁶³ or divorced spouses who have not remarried,⁶⁴ while the primary beneficiary is alive (they choose between their individually earned benefits or 50 percent of their spouse's benefits), and then survivor benefits⁶⁵ after the spouse has died.

Other general sources of annuities or income streams in retirement include (this is not an exhaustive list): annuities and similar financial products from private insurance companies; corporate or municipal bonds that pay interest at specific points in time for a stated term; stocks that pay cash dividends; rental income; royalties; alimony and

other family support payments; installment payments from damages awarded through lawsuits or settlements; sales of personal assets or businesses through an installment sale;⁶⁶ certain long term care insurance policies that provide monthly income to cover costs for assistance with Activities of Daily Living;⁶⁷ financial assistance from a government program (Supplemental Security Income, welfare, Supplemental Nutrition Assistance Program, housing support, ...); reverse mortgages with an income stream; and, grantor trusts with an income stream (including charitable trusts).

Types of Retirement Expenses That Can Be Paid From An Annuity

Most of the following costs are controllable, and can be reduced to appropriate levels with proper planning and time horizons. However, since health care costs other than fixed monthly premiums and annual deductibles are usually uncontrollable, they should be paid from the endowment, and not budgeted from the income stream.

Typical expenses to consider (whether monthly, quarterly, biannually, or annually) include:

- For each home (primary, secondary, or vacation)—mortgage or rental payments, property taxes, utilities, cable and phone bills, homeowners insurance, community assessment dues, alarm systems, landscaping and cleaning services, and, other planned and expected maintenance costs;
- Federal and income taxes;⁶⁸
- State and local income taxes, sales taxes, renewal and licensing fees, and other required remittances;
- Credit card and other personal debt obligation payments;
- Automobile—maintenance and tune ups, insurance, and fees for parking passes, city stickers, and disability vehicle placards;
- Insurance premiums—life insurance, long-term care insurance, homeowners or rental insurance, and health insurance;
- Food and clothing; and
- All other discretionary expenses that can be budgeted ahead of time—vacations, hobbies, gifts, charitable contributions, dues for

clubs and other organizations, securing professional services such as house keepers, barbers, attorneys and accountants, and general entertainment.

Sources of Endowments in Retirement

Discretionary withdrawals and spending-down of the endowment and other accumulated assets come in a variety of ways. For purposes of this article, the starting point is a lump sum distribution through an employer sponsored retirement plan or an IRA. As discussed, under current rules, lump sum distributions are the normal form of benefit distribution from defined contribution plans and IRAs, and are oftentimes an optional form of benefit distribution (and ostensibly the most commonly-elected method) from a defined benefit plan. Remember, however, the longevity risk associated with lump sum distributions and endowments in general, and that a lump sum distribution may prove to be inadequate for a participant that actually outlives his or her life expectancy.⁶⁹ Therefore, the irrevocable election to receive a lump sum distribution in lieu of any form of annuity is a gamble, and healthy individuals that outlive their assumed life expectancies will “lose” out on any future plan benefits once the lump sum distribution has been wholly depleted. However, there are required minimum distributions from Qualified Plans and IRAs once the individual attains age 70½,⁷⁰ which can upset the planned decumulation and spend-down phase.

Other general sources of discretionary income in retirement include (this is not an exhaustive list): withdrawals from bank accounts or investment accounts (but watch out for fees for trades and premature liquidation); reverse mortgages or home equity loans that provide withdrawals as needed; grantor trusts with a discretionary distribution option; monetary awards from litigation; gambling winnings; the sale of property, a business, or other personal assets; the return of principal after the term of a corporate or municipal bond has expired; distributions from previously-established Health Savings Accounts;⁷¹ financial gifts and support from family and friends; financial gifts and support from charities, societies, or other organizations; and, loans from, or viatical agreements⁷² against, life insurance policies.⁷³

Types of Retirement Expenses that Can Be Paid from an Endowment

Most of the following costs are unbudgetable,⁷⁴ and will generally be paid on an as needed basis. Typical expenses to consider (whether periodic, random, or contingent upon other events) include: unexpected

medical emergencies; other health care expenses; retrofitting expenses in the home due to a disability; moving expenses if the current home cannot be retrofitted; assistance to a family member who is out of work, has a new baby, gets married, moves, goes to college, or other pleasant or emergency needs; and large donations to charities or for funding of a legacy. As can be seen from this short list, the spend-down of the endowment could, and should, be used for some happy, pleasurable, and positive expenses that were not budgeted, as well as expenses associated with emergencies.

Life Expectancy

A life expectancy is basically defined as “the average number of years that a person at that age [at birth, at age 65, or at any other age] can be expected to live, assuming that age-specific mortality levels remain constant.”⁷⁵ In other words, the life expectancy is the prediction, based on the most recent statistical data, of the age by which 50 percent of the cohort will have died, but by which 50 percent of the cohort will still be alive. This is a very important aspect of any individual or family unit to predict how long they will live when they approach or enter retirement.

In the private sector, insurance companies and other financial institutions develop proprietary mortality tables predicting life expectancies, and they generally differentiate the underwriting tables, which determine premiums, based on sex, race, socio-economic factors, health traits, and other predictable measures. A recent research study by the Society of Actuaries was undertaken “to uncover the differences in mortality expectations between life insurance, annuity and pension products at older issue ages, and to increase awareness of potential impacts that these differences may have on managing the risk assumed for various financial services products in the United States” and found “significant differences between the mortality assumptions in different product lines, and even between different companies within a single product line.”⁷⁶ In fact, even the US Government’s Center for Disease Control separates life expectancy and mortality predictions based on sex and race.⁷⁷

A major issue, and some argue a major hindrance, when taking an annuity from a retirement plan governed by ERISA is the assumption for life expectancies. Under the long-standing interpretation of ERISA, in light of Title VII of the Civil Rights Act, The US Supreme Court has spoken twice on prohibiting ERISA plans from being allowed to discriminate on the sex of an individual. First, the Court prohibited plans from requiring larger contributions by women since they will statistically live longer than men, even though the plan demonstrated that by

doing so, the benefits from the plan would be actuarially equivalent for men and women.⁷⁸ Then, in a later case, the Court observed that “[w]e have no hesitation in holding, . . . , that the classification of employees on the basis of sex is no more permissible at the pay-out stage of a retirement plan than at the pay-in stage”⁷⁹ and concluded that “the use of sex-segregated actuarial tables to calculate retirement benefits violates Title VII [of the Civil Rights Act] whether or not the tables reflect an accurate prediction of the longevity of women as a class, for under a statute [e]ven a true generalization about [a] class’ cannot justify class-based treatment.”⁸⁰ The dissenting opinions in both of these cases question why insurance companies, although regulated by the individual States, are allowed to use sex, race, and other factors in their proprietary mortality tables, but ERISA governed pension plans cannot.

Simply stated, all other things being equal, the life expectancies of women exceed those of men. For example, using the mortality assumptions for Social Security, a female born in 2011 has a life expectancy of 80.6 compared to a male born in 2011 who has a life expectancy of 75.9.⁸¹ The same table predicts that a female who attains age 65 in 2011 has a continued life expectancy of 20.0 years (*i.e.*, to age 85.0) compared to a male who attains age 65 in 2011 who has a continued life expectancy of 17.7 years (*i.e.*, to age 82.7).⁸²

However, for purposes of this article, unless Congress amends ERISA to indicate that Title VII of the Civil Rights Act does not control the plan’s development of actuarial assumptions, then unisex life expectancies must be used to calculate actuarial equivalences of optional forms of benefit distributions. However, a statement should advise the individuals that in reality, individual factors, such as gender, race, socio-economic status, genetics, and health status *might* be a better predictor of their individual expectations on life.

Living Options in Retirement

Before exploring actual health care expenses and long-term care expenses, and which expenses will be paid by Medicare or Medicaid, and which expenses will be paid by the retiree out-of-pocket, it is important to provide a brief overview of where individuals can live in retirement. The actual living space depends largely on the individual’s and family’s physical, emotional, and logistical needs, as well as the ability to pay. If already in a hospital or nursing home, or if receiving care at home by a proper home health agency, then discharge planners and social workers can explain the options and can help arrange the proper care.⁸³ There are also agencies in the various states that can assist with long-term care choices.⁸⁴

Individuals can live in the following places during retirement.⁸⁵

- If they want to live at home, then assuming the house can be retrofitted for any physical limitations, the following services and programs are found in many communities: adult day care; meal programs (like Meals-on-Wheels); senior centers; friendly visitor programs; help with shopping and transportation; and help with legal questions, bill paying, or other financial matters. Program for All Inclusive Care for the Elderly (PACE)⁸⁶ manages all of the medical, social, and long-term care services for frail people to remain in their homes and to maintain their quality of life. PACE is available only in states that have chosen to offer it under Medicaid.⁸⁷ The goal of PACE is to help people stay independent and to live in their community as long as possible, while getting the high quality care they need. To be eligible for PACE, the individual must be age 55 or older, live in the service area of a PACE program, be certified as eligible for nursing home care by the appropriate State agency, and be able to live safely in the community.⁸⁸
- There are special dwellings that still represent living in the community, although they are not the normal domiciles used before retirement: an Accessory Dwelling Unit⁸⁹ (sometimes called an “in-law apartment,” an “accessory apartment,” or a “second unit”), which is a second living space within a home or on a lot, usually with a separate living and sleeping area, a place to cook, and a bathroom (local zoning law must be complied with); subsidized senior housing,⁹⁰ where certain Federal and state programs help pay for housing for some older people with low to moderate incomes (some of these housing programs also offer help with meals and other activities like housekeeping, shopping, and doing the laundry, the residents usually live in their own apartments in the complex, and rent payments are usually a percentage of income); and board and care homes⁹¹ (sometimes called “group homes”), which are group living arrangements designed to meet the needs of people who can’t live independently but don’t need nursing home services.
- Assisted living facilities,⁹² which provide help with activities of daily living like bathing, dressing, and using the bathroom. The ASL staff (of mostly nonmedical professionals) may also help with care most people do themselves like taking medicine or using eye drops and additional services like getting to appointments or preparing meals. Residents often live in their own room or apartment within a building or group of buildings and have some or all

of their meals together. Social and recreational activities are usually provided. Some of these facilities have health services on site. In most cases, assisted living residents pay a regular monthly rent, and then pay additional fees for the services they get. The term “assisted living” may mean different things in different facilities. Not all assisted living facilities provide the same services.

- Continuing care retirement communities (CCRCs)⁹³ are retirement communities that offer more than one kind of housing and different levels of care. For example, in the same community, there may be individual homes or apartments for residents who still live on their own, an assisted living facility for people who need some help with daily care, and a nursing home for those who require more care. Residents move from one level to another based on their needs, but usually stay within the CCRC. A CCRC contract usually requires the resident to use the CCRC’s nursing home if nursing home care is required. Some CCRC’s will only admit people into their nursing home if they have previously lived in another section of the retirement community, such as their assisted living or an independent area. Many CCRCs generally require a large payment before an individual moves in (called an entry fee) and then may charge monthly fees. Due to the high entrance fees, even though the resident does not receive equity ownership, some CCRCs are providing cash payments to heirs if the resident dies within a few years of moving into the CCRC.
- Hospice care⁹⁴ is a special way of caring for people who are terminally ill (diagnosed with six months or less to live), and for their families. Hospice care includes physical care and counseling. The goal of hospice is to provide comfort for terminally ill patients and their families, not to cure illness. If an individual qualifies for hospice care, then he or she can get medical and support services, including nursing care, medical social services, doctor services, counseling, homemaker services, and other types of services. As part of hospice care, the individual will have a team of doctors, nurses, home health aides, social workers, counselors, and trained volunteers to help the individual and the individual’s family cope with the illness. Depending on the individual’s condition, the hospice care may be provided at home, or in a hospice facility, hospital, or nursing home. Some nursing homes and hospice care facilities may provide respite care, which is a very short inpatient stay given to a hospice patient so that the usual caregiver can rest.

- Finally, there are nursing homes. Nursing Homes⁹⁵ are regulated under respective state laws, and those that receive Medicaid funds are also regulated under federal laws. Nursing homes primarily provide skilled nursing or medical care and related services; rehabilitation needed due to injury, disability, or illness; and long term-care not available in the community, and needed regularly due to a mental or physical condition.

THE COST OF MEDICAL CARE AND LONG-TERM CARE

While everyone will have their own unique expenses in retirement (quality of housing, clothes, travel and vacations, food, utilities, property taxes and community assessments, gifts and support to family and friends, etc.), most of those costs are controllable, and the amount devoted to all of those costs are generally dictated by the amount of total retirement endowment and income available but not spent on healthcare. The costs of healthcare are unpredictable, because no one knows in which years they will be healthier than in others, and how many total years they will ultimately have been unhealthy. The discussion below is a quick summary of all of the moving parts that affect the total out-of-pocket spending on health care any retiree can anticipate (assuming, of course, that each retiree is exactly the “median” or “average” retiree).

The Difference Between Medical Care and Long-Term Care

It is crucially important for every individual going into retirement to truly understand the difference between medical care and long-term care. Basically, medical care represents the prevention, amelioration, and rehabilitation of an individual’s body, and medical care costs are the amounts paid to medical professionals and associated institutions, service providers, and equipment dealers. However, once the medical community can no longer “fix” the body or “prevent” it from getting worse, (*i.e.*, the patient plateaus), then the individual moves into the very murky world of maintenance. Pretty much, that individual will live with his or her chronic illness(es) for the rest of his or her life (whether or not the individual ultimately dies from that chronic illness, a different chronic illness, or for some other reason). If the maintenance requires the assistance medically-trained professionals, then under the current system, those services might be considered to be medical care.⁹⁶ However, if the maintenance requires nonmedically-trained professionals, and the individual can be assisted by a family member or by a paid caregiver, then those maintenance costs are usually considered to be long-term care costs.

The cost of medical care is generally unpredictable, based mostly on how healthy or unhealthy the individual happens to be in any given year.

Even with proper medical care insurance, such as Medicare, employer-provided retiree health care, or self-paid health insurance, there are usually out-of-pocket costs, such as premiums, deductibles and co-pays. Obviously, in years that an individual is unhealthy, the out-of-pocket costs will be very high and, without upper limits, can be devastating. The cost of long-term care, on the other hand, is quite predictable, as individuals can investigate the out-of-pocket costs for nursing home placement, in-home care, or premiums for long-term care insurance while young. The problem with long-term care is that no individual knows with certainty if they will die before needing long-term care and assistance. The other problem with long-term care is that most private health insurance and Medicare will not pay for such expenses, and the individual will either need to pay for long-term care himself or herself, or will need to be indigent (even if selectively indigent through legal and proper Medicaid planning), so that his or her state Medicaid program will pay for the long-term care.

Medical Care

The following medical care categories are purposely divided so that they can easily be identified with coverage or noncoverage from Medicare or Medicaid⁹⁷:

- Preventative care (such as annual physicals and targeted cancer screenings);
- Ameliorative care (whether as an inpatient or an outpatient):
 - For non-chronic illnesses (such as broken legs or concussions),
 - For lifetime, but not chronic illnesses (such as allergies),
 - For chronic illnesses⁹⁸ (such as a heart condition, kidney failure, diabetes, Parkinson's disease, or cancer);
- Urgent care (such as admittance to a hospital through an emergency room or Emergency Medical Technicians coming to the home or place of accident or illness);
- Rehabilitation after urgent care (such as physical therapy);
- Maintenance to control a chronic illness or several concurrent chronic illnesses
 - Medical treatments (such as therapy and checkups),
 - Durable medical equipment,⁹⁹

- Prescription drugs, or
- Life Sustaining care (such as a feeding tube for someone in a vegetative state);
- Affirmative decisions and procedures after which death is likely to ensue
 - Hospice care,¹⁰⁰ or
 - Death With Dignity;¹⁰¹
- Care for mental or emotional illness
 - Voluntary (such as counseling sessions upon the death of a spouse, family member, or friend), or
 - Diagnosed disorder (such as dementia or bipolar disease);
- Vanity procedures (such as nonmedically necessary cosmetic surgery); or
- Other services:
 - Dental care and dentures, oral care and hearing aids, and ophthalmological care and eyeglasses;
 - Nontraditional treatments (such as acupuncture);
 - Travel to and from health care services (such as by an ambulance, a special transport vehicle, or a taxi);
 - Getting a second opinion before surgery;
 - Disease and pain management programs or advice;
 - Palliative care;¹⁰²
 - Wellness programs or advice (such as for weight loss or smoking cessation); or
 - End of life planning.¹⁰³

Long-Term Care

The bifurcation at this point of the article, especially as a prelude to the respective Medicare and Medicaid discussions, is needed to differentiate those expenses that will be classified as long-term care expenses rather than medical care expenses. Here, the concept of activities of daily living (ADLs) becomes important. Such term refers to the basic tasks of everyday life, such as:

- Eating,
- Bathing,
- Dressing,
- Toileting, and
- Transferring [actions such as going from a seated to standing position and getting in and out of bed].

Measurement of the activities of daily living is critical because they have been found to be significant predictors of admission to a nursing home, use of paid home care, use of hospital services, living arrangements, use of physician services, insurance coverage, and mortality.¹⁰⁴ For research on the elderly, the ability to perform the ADLs has become a standard variable to include in analyses, just like age, sex, marital status, and income.¹⁰⁵ When people are unable to perform these activities, they need help in order to cope. This help and assistance can come in a variety of ways, can be delivered by a variety of individuals and/or mechanical devices, and can be performed in a variety of settings.

Although persons of all ages may have problems performing the Activities of Daily Living, prevalence rates are much higher for the elderly than for the non-elderly. Within the elderly population, ADL prevalence rates rise steeply with advancing age and are especially high for persons aged 85 and over.¹⁰⁶ It is estimated that about “70% of people turning age 65 can expect to use some form of long-term care during their lives.”¹⁰⁷ The likelihood of the need for long-term care increases with age, is greater for women (who statistically “outlive men by about five years on average, so they are more likely to live at home alone when they are older”), and is greater for people with disabilities and in whose health status is poor.¹⁰⁸ On average, an adult who is 65 will need some sort of long-term care services and support for three years (and if broken down by gender, then on average women require

3.7 years of LTC and men require 2.2 years of LTC).¹⁰⁹ However, looking at the tails on a normal curve, 33 percent of today's 65-year-olds "may never need long-term care support, but 20 percent will need it for longer than 5 years."¹¹⁰

It is probably important at this point to provide some estimated costs for assistance with ADLs, and the article will then explore whether, for any particular individual, they represent rehabilitation (a form of medical care), which might be paid for by Medicare under its current iteration, or if they represent long-term care, which will only be paid by Medicaid if the individual is deemed to be indigent upon applying for Medicaid assistance.

From the 2012 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs,¹¹¹ the national averages are:

- **\$70 daily** / \$2100 monthly / \$25,200 annually for adult day care services¹¹²
- **\$21 an hour** for a home health aide:¹¹³
 - \$84 daily / \$2,520 monthly / \$30,240 annually for 4 hours per day
 - \$168 daily / \$5,040 monthly / \$60,480 annually for 8 hours per day
 - \$252 daily / \$7,560 monthly / \$90,720 annually for 12 hours per day
 - \$336 daily / \$10,080 monthly / \$120,960 annually for 16 hours per day
 - \$504 daily / \$15,120 monthly / \$181,440 annually for 24 hours per day
- **\$3,550 monthly** / \$42,600 annually for assisted living¹¹⁴
- **\$222 daily** / \$6,660 monthly / \$79,920 annually for a semiprivate room in a nursing home¹¹⁵
- **\$248 daily** / \$7,440 monthly / \$89,280 annually for a private room in a nursing home.¹¹⁶

Medicare is Usually the Primary Insurance Policy for Medical Care Expenses for retirees

Medicare was enacted in 1965,¹¹⁷ and has been amended several times, including amendments through the Patient Protection and Affordable Care Act of 2010.¹¹⁸ Each of the four parts of Medicare covers different aspects of a patient's medical care, services, and needs, with varying additional costs to the patient.¹¹⁹ Essentially, Medicare provides payments to the medical providers of basic catastrophic and some preventative, rehabilitative, and maintenance medical care, but if the consumer decides to pay extra, then he or she may be eligible for a wider variety of services. In order to keep costs down, many Medicare supplemental insurance providers also require frequent deductibles and co-pays.¹²⁰

Medicare Part A

Medicare Part A is technically referred to as "Hospital Insurance Benefits for Aged and Disabled."¹²¹ Medicare Part A is available to most individuals without payment of a premium if they:¹²² are age 65 or over, have received social security or railroad retirement disability benefits for 25 months, or have end-stage renal disease. This part of Medicare is truly "free" without the need to pay premiums during retirement, but only if the individual has paid premiums (in the form of "payroll taxes") during his or her working years.¹²³ If an individual has not earned the right to enjoy free Part A Medicare benefits because of insufficient funding (through payroll taxes) while working, then if he or she wants to enjoy the benefits of Medicare Part A coverage, or to enjoy any other benefits of Medicare, then a monthly premium must be paid during retirement to purchase Medicare Part A.¹²⁴ Additionally, if a beneficiary waits to enroll in Medicare Part A until needed, as opposed to when he or she was originally eligible to enroll, then the beneficiary will also pay a 10 percent penalty for twice the number of years the beneficiary could have had Part A, but didn't sign up.¹²⁵

Medicare Part A pays for:¹²⁶ inpatient care in hospitals (such as critical access hospitals, inpatient rehabilitation facilities, and long-term care hospitals), inpatient care in skilled nursing facilities (but generally only for the first 100 days immediately following a hospital stay), or inpatient care in a Religious Nonmedical Health Care Institution; hospice care services; and some limited home health care services (although, based on a 2005 federal law, each state is required to find ways to cover more home-care costs). Please note that "inpatient" means a doctor has admitted the Medicare beneficiary, not just because that individual stays overnight.¹²⁷

The general categories of medical care covered under Medicare Part A:¹²⁸

- **Inpatient Hospital Care**—for each benefit period in 2013, the beneficiary is responsible to pay a deductible of \$1,156, but no co-payment for days 1–60, then \$289 for days 61–90 of each benefit period, and then \$578 per “lifetime reserve day” after day 90 each benefit period (up to 60 days over the beneficiary’s lifetime),¹²⁹ and finally all costs for each day after the lifetime reserve days. These out-of-pocket deductibles and co-pays cover semiprivate rooms, meals, general nursing, and drugs as part of the beneficiary’s inpatient treatment, and other hospital services and supplies (including care provided in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, inpatient care as part of a qualifying clinical research study, and mental health care), but do not cover private-duty nursing, a television or phone in the room if there is a separate charge for these items, personal care items like razors or slipper socks, a private room unless medically necessary, or doctor’s services a beneficiary receives while in a hospital.¹³⁰
- **Inpatient Care in a Religious Nonmedical Health Care Institution**—nonreligious health care items and services (like room and board) if the beneficiary qualifies for hospital or skilled nursing facility care, but where his or her medical care isn’t in agreement with personal religious beliefs.
- **Home Health Services**—all “medically-necessary” part-time or intermittent skilled nursing care, and/or physical therapy, speech-language pathology services, and/or services for beneficiaries with a continuing need for occupational therapy will be provided at no cost to the beneficiary; however, the beneficiary will be responsible to pay 20 percent of the “Medicare-approved amount” for durable medical equipment. There is generally no limitation on the length of time that these services are provided, as long as the attending physician reorders the services every 60 days.
- **Hospice Care**—if a Medicare-approved facility’s hospice medical team determines that a beneficiary needs short-term inpatient stays for pain and symptom management that can’t be addressed at home, and that the patient is terminally ill and is statistically determined to have 6 months or less to live, then the beneficiary will pay nothing for the hospice care including room

and board at a hospice facility, but will be responsible to pay \$5 per prescription for outpatient prescription drugs for pain and symptom management and 5 percent of the “Medicare-approved amount” for inpatient respite care (to allow the patient’s usual caregiver to enjoy up to 5 days of rest and relief from the care duties).

- Blood—there is no charge for blood obtained by the hospital for free from a blood bank, but the beneficiary might be charged for the first three pints of blood that the hospital purchases specifically for that beneficiary.
- Skilled Nursing Facility (Nursing Homes)—Medicare Part A will cover a short stay in a Skilled Nursing Facility for rehabilitation and certain “long-term care” services needing skilled care (including physical and other forms of therapy). It will generally pay for semiprivate rooms, meals, skilled nursing and rehabilitative services, and other services and supplies that are medically necessary, but if and only if they follow a 3-day minimum medically-necessary inpatient hospital stay for a related illness or injury. The beneficiary will pay nothing for the first 20 days each benefit period, will pay \$144.50 per day for days 21–100 of each benefit period, and will pay all costs for each day after day 100 in a benefit period.

To summarize, out-of-pocket costs for Medicare Part A in 2013 are:¹³¹

- Monthly premiums are:
 - \$-0- for those who qualify for enrollment;
 - \$441 for those who do not otherwise qualify for enrollment but who decide to enroll on the first date they are eligible to enroll; and
 - \$485 for those who do not otherwise qualify for enrollment and who wait to enroll until the coverage is actually needed (after the penalty period ends it drops to the regular monthly rate).
- For each “spell of illness”¹³² while an inpatient in a hospital (whether due to physical or mental illness):¹³³

- \$1184 deductible before Medicare Part A pays any other expenses;
- If the hospital stay extends beyond 60 days, then \$296 per day for each day from the 60th day until the 90th day, and then \$592 for each day after the 91st day until any individual's "lifetime reserve days" have been depleted,¹³⁴ and then all costs for each additional day;
- All costs for private-duty nurses, in-room phones or televisions, and a private room if it is not medically necessary; and
- If the reason for the spell of illness is for a mental health issue rather than a physical health issue, then 20 percent of "mental health services" that can be separated from normal hospital services.
- For home health care:
 - \$-0- for home health care services;
 - 20 percent of all Medicare-approved amounts for durable medical equipment
- For a short stay in a skilled nursing facility:
 - \$-0- for the first 20 days;
 - \$148 for each day from the 21st day until the 100th day; and
 - All costs for each day after the first 100 days.
- For hospice care:
 - \$5 co-payment for each prescription drug and other similar products for pain relief and symptom control;
 - 5 percent of the cost of respite care (*i.e.*, the amount needed to provide a rest period for a full-time family caregiver);
 - Normal Medicare Part B costs (*i.e.*, 20 percent of the costs) for doctor's services if hospice is provided at home, or if hospice care is provided at an institution but that

particular doctor is not affiliated or employed by that institution); and

- Normal room and board expenses that can be separated from true hospice care costs.

Medicare Part B

Medicare Part B is technically referred to as “Supplementary Medical Insurance Benefits for Aged and Disabled.”¹³⁵ It is a voluntary insurance program “to provide medical insurance benefits in accordance with the provisions of this part for aged and disabled individuals who elect to enroll under such program, to be financed from premium payments by enrollees together with contributions from funds appropriated by the Federal Government.”¹³⁶ Many individuals who are age 65 or over, and certain individuals under age 65, may obtain the benefits by paying a premium of between \$104.90 and \$335.70, based on income.¹³⁷ If the individual is already receiving Social Security old age, survivors, or disability insurance, then the premiums will generally be deducted directly from the monthly benefit checks.¹³⁸ There is a permanent penalty of 10% of the normal Part B premium for each full 12-month period that the beneficiary fails to timely apply for Part B coverage, which is assessed for individuals who enroll in Part B after the enrollment period.¹³⁹

Medicare Part B provides two general categories of benefits:¹⁴⁰ medically-necessary services (which are services or supplies that are needed to diagnose or treat a beneficiary’s medical condition and that meet accepted standards of medical practice); and, preventive services (which is health care to prevent illness, like the flu, or detect it at an early stage, when treatment is most likely to work best).¹⁴¹ In addition to the monthly premium, beneficiaries will generally also need to meet the annual deductible limit of \$147, plus a typical remittance of 20% of the Medicare-approved amount for any service.¹⁴² Note that after passage of the Patient Protection and Affordable Care Act of 2010, certain screenings and preventative services are provided before the annual deductible and without any co-pay.¹⁴³

To summarize, out-of-pocket costs for Medicare Part B in 2013 are:¹⁴⁴

- Monthly premiums are:
 - At least \$104.90 (and a sliding scale up to \$335.70 based on income); and

- At least \$115.39 (and a sliding scale up to \$369.27 based on income) for those who wait to enroll until the coverage is actually needed.
- \$147 deductible before Medicare Part B pays any other expenses.
- For home health care:
 - \$0- for home health care services;
 - 20 percent of all Medicare-approved amounts for durable medical equipment.
- For medical and other services
 - 20 percent for most doctor services, outpatient therapy, and durable medical equipment;
 - Clinical laboratory services are generally covered entirely by Medicare Part B, but if certain services are not covered, then 100 percent of those costs; and
 - There might be limits on physical therapy, occupational therapy, and speech language pathology services, so once those limits are hit, then 100 percent of those costs.
- For outpatient hospital services:
 - 20 percent for most doctor and health care provider's services; and
 - Additional costs that would normally be paid for services in a doctor's office will need to be paid for services in a hospital as an outpatient.

“Medigap” Policies if no Medicare Part C Policy is Purchased

If an individual only enrolls in Medicare Parts A and B, and not in Medicare Part C (as discussed *infra*), and if the individual wants to pay a single monthly premium that best anticipates the total out-of-pocket expenses, which can be higher than expected in years that the individual has more health problems than others, then the individual can purchase a Medigap policy.¹⁴⁵ Medigap policies are sold by private

insurance companies, and for a monthly premium, they pay some of the out-of-pocket expenses incurred through a Medicare Part A and Part B plan (annual deductible, co-pays, and coinsurance), and they can cover services not available through Medicare Parts A and B. However, a Medigap plan offers less than an actual Medicare Part C plan (as described *infra*), and if an individual is enrolled in a Medigap plan, then he or she is barred from enrolling in a Medicare Part C plan, and *vice versa*. Medigap policies are generally called “Medicare Supplemental Insurance” Plans, and although not completely standardized, as each state regulates insurance, many Medigap policies are standardized.¹⁴⁶

While “the cost of Medigap policies can vary widely,” the range seems to be:¹⁴⁷

- \$165 per month for any Medicare beneficiary if they purchase a “Community-Rated” policy (*a.k.a.* a “Non-Age-Rated” policy);
- A sliding scale cost of \$145 per month if purchased at age 65 but \$175 per month if purchased at age 72 if the Medicare beneficiary purchases an “Issue-Age-Rated” policy; and
- A sliding scale cost for each individual of \$120 per month if purchased at age 65, but then \$126 when he or she turns 66, then \$132 when he or she turns 67, ..., but \$165 per month if first purchased at age 72, but then \$171 when he or she turns 73, then \$177 when he or she turns 74, ..., if the Medicare beneficiary purchases an “Attained-Age-Related” policy.

Medicare Part C

Medicare Part C is possibly the most difficult of the four parts to comprehend (although the technical rules of Medicare Part D might be more complicated). Under its most recent iteration, Medicare Part C is titled “Medicare Advantage.”¹⁴⁸ If an individual is enrolled in Medicare Parts A and B, and if that individual wants to enroll in Medicare Part C, then he or she will find a private Medicare Advantage plan developed and offered through a private insurance company, and pay whatever premiums are charged by that policy or plan.¹⁴⁹ There are some basic requirements of any policy in the federal law (such as the requirement that the plan must cover all benefits covered under Medicare Parts A and B), and the insurance company submits the plan or policy to the Centers for Medicare & Medicaid Services to provide advanced approval, but once approved by the Center, then the federal government has literally no further regulatory authority over the private plan.¹⁵⁰ Individuals should only need to purchase Medicare Part C if they have no other means to

cheaper coverage for all other health maintenance costs not covered by Medicare Parts A and B (such as retiree health benefits through an employer, union or association or a private insurance policy, or other Medicare Gap insurance already purchased or otherwise available).

Individuals who wish to enroll in a Medicare Part C plan must do so timely within the open enrollment period of any calendar year.¹⁵¹ The open enrollment period is crucially important, and a major stumbling block, since a selection of a Part C plan is irrevocable for the following calendar year. So, say, in 2013, an individual has a certain number of known health issues and a certain universe of known or preferred service providers, and based on that information and costs (explained *infra*), a certain Part C plan is selected and the individual becomes properly enrolled for the entire 2014 calendar year. Anytime in 2014, however, a new health issue might surface and/or new service providers might be sought out. However, until the open enrollment period in 2014, the individual is stuck in the Part C plan until December 31, 2014, and cannot enjoy enrollment in an alternate Part C plan until January 1, 2015.

The federal rules governing each individual private insurance policy purporting to be Medicare Part C compliant do not primarily relate to the benefits to be covered or to the premiums charged for those benefits; rather, the federal rules primarily limit the model of delivering the health care to the beneficiaries (and how the medical professionals and institutions will be paid by the private insurance company). As to the business model of a Medicare Advantage part C plan, it must be one of the following¹⁵² (which ostensibly mirror the business models generally seen in employer provided group health plans):

- Medicare Preferred Provider Organization (PPO) Plans—The beneficiary (patient) is able to see any doctor or specialist that he or she chooses within the PPO (if those doctors are not in the PPO network, then the beneficiary's cost will increase), but the beneficiary can usually see a specialist without a referral;
- Medicare Health Maintenance Organizations (HMO) Plans—The beneficiary (patient) is able to visit doctors in the HMO network only, and in most cases, the beneficiary will be required to have a referral to visit a specialist;
- Medicare Private Fee-for-Service (PFFS) Plans—the beneficiary (patient) is able to see any doctor or specialist (but those doctors or specialists must be willing to accept the PFFS's fees, terms, and conditions), but the beneficiary generally does not need a referral to see a specialist;

- Medicare HMO Point of Service (HMOPOS) Plans—An HMO plan that may allow the beneficiary (patient) to get some services out-of-network for a higher cost;
- Medicare Special Needs Plans (SNP)—these plans are designed for people with certain chronic diseases or other special health needs, and generally must include Medicare Part A, Part B, and Part D coverage; or
- Medicare Medical Savings Account (MSA)—there are two parts to this plan: a high-deductible plan with which coverage won't begin until the annual deductible is met, and, a savings account plan where Medicare deposits money for the beneficiary to use for health care costs.

Since these Medicare Part C plans must provide at least all of the medical benefits, services, and procedures covered under Medicare Parts A and B, a good starting point is to look at those benefits specifically not covered under Parts A or B. The general categories of important medical services *not* covered by Medicare Parts A or Part B include: routine dental or eye care, dentures, cosmetic surgery, acupuncture, and hearing aids and exams for fitting them.¹⁵³ Therefore, many individuals need additional health insurance coverage, and if they can't find a nonMedicare part C plan (either while an employee, pursuant to COBRA coverage after a qualifying event, or as an individual on the open market), then the only real option is the selection and purchase of a compliant Medicare Advantage Part C plan.

To summarize, out-of-pocket costs for Medicare Part C in 2013 are:¹⁵⁴

- Monthly premiums are:
 - Whatever is charged by the private insurance company offering a compliant Medicare Part C plan (which would at least be the monthly premiums that individual would need to pay to enroll under Medicare Parts A and B).¹⁵⁵
- Deductibles and co-pays:
 - Whatever the monthly premium covers (however, the minimum out-of-pocket expenses for any Part C plan is generally at least the amount of out-of-pocket expenses they would

have had if only enrolled in Medicare Part A and Part B plans).

Medicare Part D

Medicare Part D is the newest addition to Medicare,¹⁵⁶ and is titled “Voluntary Prescription Drug Benefit.”¹⁵⁷ An individual can enroll in a Medicare Part D plan whether or not that individual is enrolled in a Medicare Advantage plan (*i.e.*, a Medicare Part C plan). Similar to selecting a Medicare Advantage plan, the individual will find a private Voluntary Prescription Drug Benefit plan developed and offered through a private insurance company and pay whatever premiums are charged by that policy or plan.¹⁵⁸ The insurance company has two choices when setting up the pricing structure: the first, which includes the colloquially named “donut hole” and which does not need approval from the Secretary of Health and Human Services through the Center for Medicare & Medicaid Services, or the second, which is commonly referred to as the actuarial equivalent method and which does require approval from the Secretary.¹⁵⁹

A “Covered Part D” drug is a drug: “that may be dispensed only upon a prescription; is approved by the FDA; is commercially used or sold in the United States or which is identical, similar or related to a drug commercially used or sold in the United States; and, for which there is a compelling justification for its medical need, or is identical, similar or related to such a drug.”¹⁶⁰ There are some protections for consumers of Part D plans, including the communication of drug specific information and other relevant information, the assurance of pharmacy access, and the mandate for the use of standardized technology.¹⁶¹

Here’s how the pricing structure, with the “donut hole” works:¹⁶²

- First, the Part D beneficiary, in addition to paying premiums to the private insurance company, must first meet an annual deductible of \$325 (in 2013, as adjusted for inflation) before the Part D plan provides and coverage;¹⁶³
- Second, the Part D beneficiary will pay 25 percent of all prescription drug costs, and the insurance policy will pay 75 percent, until the gross cost of prescriptions (*i.e.*, the beneficiary’s deductible plus 100 percent of the cost of drugs during this period), has reached \$2,970 (in 2013, as adjusted for inflation);¹⁶⁴
- Third, the infamous donut hole:¹⁶⁵

- Before the enactment of the Patient Protection and Affordable Care Act, the beneficiary was required to pay 100 percent of all additional costs, until the beneficiary had paid a total out-of-pocket expenses to the pharmacy of \$4,750 (in 2013, as adjusted for inflation) for the calendar year,
- After the enactment of PPACA, the beneficiary pays a percentage less than 100 percent until his or her out-of-pocket expenses to the pharmacy total \$4,750 (in 2013, as adjusted for inflation) for the calendar year, depending on whether he or she is purchasing generic drugs or prescription drugs, and by 2020, the percentage will have been reduced to 25 percent,¹⁶⁶ and
- Finally, any remaining prescription drug costs in the calendar year are considered “catastrophic,” and the beneficiary will pay 5 percent of all remaining costs and the insurance company will pay 95 percent, but there will likely be a minimum co-pay for generic prescriptions (either \$2 or \$5).

The manner in which a Medicare beneficiary selects a policy during an open enrollment period¹⁶⁷ is similar to the problems with a Medicare Part C policy:¹⁶⁸ an individual might find and be happy with the currently selected Part D plan that covers all or most of his or her current prescription regime, but if a new chronic illness is diagnosed during this year, or if a physician wants to change the mix of drugs, then the individual might be stuck in the current plan for the remainder of the year, even if it doesn’t provide subsidies for the new medications.

To summarize, out-of-pocket costs for Medicare Part D in 2013 are:¹⁶⁹

- Monthly premiums are:
 - Whatever is charged by the private insurance company offering a compliant Medicare Part D plan.¹⁷⁰
- Deductibles:
 - \$325
- Co-pays:
 - \$661 during the coinsurance period (25 percent of the costs of all drugs until the deductible, the co-pay, and the portion

paid by the Part D insurance total \$2,970, so the beneficiary already paid the first \$325 of costs, and then up to an additional \$661, and the insurance company paid the pharmacy \$19.84, so the deductible, the co-pay, and the portion paid by the Part D insurance total \$2,970).

- \$3,764 during the coverage gap period (*i.e.*, the donut hole period as it exists for 2013). The \$3,764 is comprised of every dollar spent by the beneficiary, which will be the sum of 47.5 percent of the plan's cost for the covered brand-name prescription drugs plus 79 percent of the plan's cost for covered generic drugs
- If the beneficiary has already had total out-of-pocket expenses for the calendar year of \$4,750 (*i.e.*, \$325 + 661 + 3,764), then for the remainder of the calendar year, 5 percent of all drug costs plus a co-payment of up to \$5 for generic drugs (which can be a large sum of out-of-pocket money).
- There is some relief, however, and an individual who has limited resources¹⁷¹ can receive assistance with out-of-pocket costs for Part D plans of up to \$4000.¹⁷²

Summary of Medicare Out-of-pocket Costs

On one end of the out-of-pocket cost spectrum is that for any year that a Medicare beneficiary is absolutely and totally healthy, and only pays premiums:¹⁷³

- Medicare Part A will not cost anything (assuming the individual paid payroll taxes as advanced premiums for at least 40 quarters);¹⁷⁴
- If the individual is enrolled in Medicare Part B, it will cost 12 monthly premiums of \$104.90 for a total of \$1,258.80 in 2013 (but if the individual is charged the 10% penalty because he or she did not enroll in Medicare Part B when eligible, then \$1,384.68 in 2013);¹⁷⁵
- If the individual purchased either a Medigap policy or a Medicare Advantage Part C-compliant policy, then at least the monthly premiums that the individual would have paid if he or she had enrolled in Medicare Parts A and B, plus an additional amount, which varies based on the desired “bells and whistles” selected by the beneficiary.

- If the individual purchased a Medicare Part D-compliant prescription drug policy, then it will cost whatever monthly premiums are charged by the private insurance company.¹⁷⁶

On the other end of the out-of-pocket cost spectrum is that for any year that a Medicare beneficiary is quite unhealthy, although there does not seem to be a maximum out-of-pocket cost, in addition to the premiums outlined immediately above:

- Medicare Part A will generally cost \$1,184 (in 2013) for each “spell of illness” where he or she is admitted to a hospital. If he or she is so unhealthy that the inpatient stay in a hospital extends beyond 60 days, then \$296 per day (in 2013) for up to 30 days, and then if the hospital stay extends beyond 90 days, then \$592 (in 2013) per day for each of his or her 60 “lifetime reserve days” and then 100 percent of the costs for each day after his or her “lifetime reserve days have been used up.” After the hospital, if he or she goes to a Skilled Nursing Facility for rehabilitation, then his or her out-of-pocket costs begin after the 20th day, and he or she will be responsible for \$148 per day (in 2013) for days 21 through 100, and then 100 percent of the costs for each day thereafter. On the other hand, if he or she goes home after the hospital, then the rehabilitation will generally not cost anything for medical services, but he or she will need to pay 20 percent of the total costs of all medical equipment that is medically necessary.
- Other than the annual wellness check, the Medicare Part B beneficiary will always be responsible for the first \$147 in expenses (in 2013), plus 20 percent of the cost of medically necessary medical equipment, plus 100 percent of the cost of services or equipment which, even if medically necessary, are not specifically covered under Medicare Part B.¹⁷⁷
- Medicare Advantage Part C-compliant plans, or any other private insurance that provides supplemental medical care services, will cost in terms of co-pays and deductibles, whatever the individual contract states for the individual beneficiary based on the monthly premiums the individual chose to pay for Part C coverage. There is no upper limit of costs in the statute, so unless the private Part C policy has either an annual or lifetime out-of-pocket limit, then it will cost the beneficiary whatever it costs.

- Medicare Part D-compliant plans, or any other private insurance that provides prescription drugs, will cost \$325 (in 2013), plus up to \$661 (in 2013) while he or she is in the co-insurance period, plus up to \$3,764 during the coverage gap period (*i.e.*, donut hole period as it exists for 2013),¹⁷⁸ plus 5 percent of the costs of prescription drugs for the remainder of the year (there is no upper limit of costs in the statute, so unless the private Part D policy has either an annual or lifetime out-of-pocket limit, then it will cost the beneficiary whatever it costs).

So, the costs of medical services are totally unpredictable in advance, without knowing how healthy or unhealthy an individual will be in any given year. Premiums are generally predictable, or at least budgetable, and therefore should hopefully be paid out of the retiree's annuity and income stream. Arguably, the deductibles for Parts A, B, and D can be planned for ahead of time and paid from an annuity stream; and, in years that a deductible is not needed, the savings can be invested back into the individual's endowment.

However, in years that a chronic illness emerges and can be ameliorated, there will be very high costs, and the individual might need to pay a good portion of those costs out-of-pocket. Even with a chronic illness, however, in subsequent years, as the illness is being maintained (but not ameliorated), the out-of-pocket costs might be a lot less. These costs are generally unbudgetable, in that it is generally impractical to try to plan which years they will actually be high and which years they might be lower. Therefore, all of these medical care expenses (*i.e.*, the co-pays of 20 percent of all medical equipment that is medically necessary, the co-pays agreed upon in the Medicare Part C-compliant plan or the Medigap plan, and the co-pays for prescription drugs) should all be paid from the spend-down of the individual's endowment as they are incurred.

Note that this discussion does not try to summarize the out-of-pocket costs for long-term care services, which are not medical services, and which, will either be paid totally out of pocket to an in-home caregiver or to a Skilled Nursing Facility (*i.e.*, a nursing home), or will be paid for by Medicaid and/or Veterans Aid and Attendance benefits if, through means testing, the individual is determined to be needy at the time the individual enrolls in such program.¹⁷⁹

Paying for Long-Term Care Expenses: Self-Pay Unless Indigent

As illustrated, other than some rehabilitation after a hospital stay, Medicare generally pays for care that requires someone in the medical profession to prevent, ameliorate, rehabilitate, or at least

maintain, a physical health or mental problem. However, long-term care only requires a caretaker, not necessarily a medical professional, to assist an individual with activities of daily living or instrumental activities of daily living.¹⁸⁰ If a family member assumes the responsibility of being a caregiver for another individual, then they are not allowed to be paid for their services, either directly or indirectly.¹⁸¹ While this might be the cheapest option for the elderly and infirmed individual in need of caregiving assistance, it might lead to financial, emotional, or physical stress on the family member(s) who volunteer to become caregivers. So, while a family member is desirable, sometimes it makes sense for the payment to go to an adult daycare center, an in-home caretaker professional, an assisted living facility, or a nursing home facility—as discussed, each of these options could become very expensive.

Medicaid for Needy Individuals

Established in 1965 in the same law that enacted Medicare, Congress added Subchapter XIX to the existing Social Security Act titled “Grants to States for Medical Assistance Programs.”¹⁸² Basically, Medicaid is not a single program, but a grand idea, where each State voluntarily experiments (within broad federal statutory guidelines) to efficiently “provide medical and health related services for individuals and families with low incomes through direct payment to suppliers of the program.”¹⁸³ If a State voluntarily joins Medicaid by submitting a plan to the Center for Medicare and Medicaid Services (CMS)¹⁸⁴ and agrees to be regulated by CMS once approved and implemented, then the State will receive matching dollars from the federal government.¹⁸⁵

First, each state must agree to cover “categorically needy” individuals.¹⁸⁶ Then, each State can voluntarily choose to cover additional groups of individuals who are “medically needy.”¹⁸⁷ Under the Affordable Care Act, as interpreted by the U.S. Supreme Court, states can now further expand Medicaid coverage in order to receive additional federal funding.¹⁸⁸ The original Medicaid statute only required states to cover medical care or long-term care provided in an institutional setting, but over time, the statute has been amended to first encourage, and then to mandate, that states to find ways to provide the services in the community (generally in-home care).¹⁸⁹ As the various state programs have evolved over time, and as many have been either expanded during periods of budgetary surpluses or curtailed during periods of budgetary deficits, each respective state program generally has different eligibility criteria, different delivery models, and different regulation; thus, there is no national standard (just minimum groups of people who must be

covered and minimum benefits that must be provided or paid for). As the Affordable Care Act starts taking effect, placing some new demands and opportunities on the various state programs, the existing nuances between each state's eligibility requirements (*i.e.*, who is needy and who is covered) will only be intensified. Therefore, general definitions will be provided herein, but any individual needing assistance with understanding or enrolling in Medicaid is cautioned to hire a good attorney who is knowledgeable about the Medicaid program for the state within which he or she resides.¹⁹⁰

The common thread to all respective state Medicaid programs is that the programs are means-tested, are considered welfare, and are only available to indigent persons.¹⁹¹ "An individual is entitled to Medicaid if he fulfills the [financial] criteria established by the State in which he lives."¹⁹² This article will only be concerned with medical care and long-term care programs for needy elderly individuals.¹⁹³ Individuals who need assistance with medical care costs or long-term care costs need to apply for Medicaid through each state's respective agency, must disclose financial information, and attest to questions under penalty of perjury. Generally, there is a limit to the amount of assets "owned" and available to the prospective Medicaid beneficiary. Assets, in terms of Medicare, include both the endowment and the income stream, as those terms have been used in this article.

As to the endowment, a single elderly individual can have the following "countable resources" and still generally qualify as "needy" to immediately enroll in Medicaid on the date he or she is admitted into a nursing home or on the date he or she qualifies for in-home long-term care services:¹⁹⁴

- Cash and equivalents (such as cash surrender value of a whole life insurance policy and lines of credit) up to \$2,000;
- Personal equity in a primary residence up to \$536,000 (in 2013, although states can allow equity of up to \$802,200 if they choose);
- One automobile;
- A pre-purchased funeral or memorial arrangement (or, if not a preplanned package, then up to \$1500 in a separate bank account ostensibly for purposes of burial or interment);
- Any real or personal property that is essential to self-support and general household belongings;

- Properly established Medicaid disability trusts (as long as the state can recover expenses paid during the individual's life from the individual's estate upon his or her death);
- An actuarially sound annuity.¹⁹⁵

The state Medicaid rules generally will require any resources above and beyond these "allowable resources" to be liquidated and spent-down before Medicaid will begin paying for the beneficiary's medical care and long-term care services. The Commissioner of Social Security is granted the authority to require that the individual sell any resources and use the proceeds to pay for the long-term care (either directly to the State, directly to the nursing home, or directly to the in-home professional care giver).¹⁹⁶

As to the income stream, which is generally limited to about \$2000 per month, the sum from the following income sources for any individual will be considered (whether defined as earned income or unearned income):¹⁹⁷

- Wages and net earnings from self-employment;
- Royalties and other types of remuneration;
- Support and maintenance furnished in cash or kind;¹⁹⁸
- "[A]ny payments received as an annuity, pension, retirement, or disability benefit, including veterans' compensation and pensions, workmen's compensation payments, old-age, survivors, and disability insurance benefits, railroad retirement annuities and pensions, and unemployment insurance benefits;"¹⁹⁹
- Prizes and awards;
- "[P]ayments to the individual occasioned by the death of another person, to the extent that the total of such payments exceeds the amount expended by such individual for purposes of the deceased person's last illness and burial;"
- Other rents, dividends, interest, and royalties;
- Interest from trusts established by the individual and which names the individual as a beneficiary of the trust income; and
- Certain housing payments to members of the uniformed services.

Since income streams are generally purchased or elected on an irrevocable basis, states cannot require the beneficiary to spend down the annuity streams, but they can require the Medicaid recipient to pay for part of the cost of long-term care. If the individual is in a nursing home, and is not married, then almost all expenses for daily living, including room and board, are included in the monthly charges of the nursing home, and all but about \$30 per month of the income stream (the allowance for personal needs) will be used to share the cost of long-term care.²⁰⁰

There are special considerations for married couples,²⁰¹ especially when one spouse needs the long-term care services provided by Medicaid (whether in an institutional setting or at home), but the “healthy” spouse does not need the services and will remain in the “community” (*i.e.*, stays at home). As to the resources, the community spouse is allowed to keep up to 50 percent of the couple’s “Community Spouse Resource Allowance,” (which is basically the couple’s combined resources, but only up to \$115,920 in 2013).²⁰² As to the income, the community spouse can generally receive up to the “Monthly Maintenance Needs Allowance,” of \$2,898 in 2013, without jeopardizing the enrollment of the institutional spouse into Medicaid.²⁰³

When given the choice of using accumulated wealth to pay for long-term care until they become indigent and a ward of the state, or gifting away assets to their family, friends, and charities to become indigent should they need long-term care, most individuals will choose the latter. Many elder-law and estate-planning attorneys, understanding the rules and limitations for assets and income on the date an individual applies to Medicaid, can provide Medicaid planning services to spend down wealth so that an otherwise non-needy family unit will be considered needy when Medicaid is needed.²⁰⁴ Due to actual or perceived abuses with this type of planning, Congress enhanced the penalty for Medicaid planning, and extended the “look-back period” to the preceding five years, starting on the date that the individual applies for Medicaid.²⁰⁵ All transfers for less than fair market value (*i.e.*, gifts of any kind) made by the Medicaid applicant during the look-back period are totaled, and the applicant will then be ineligible to receive Medicaid for a period of time, determined by the ratio of the total gifted assets to the average monthly cost of nursing home care in the area or State. For example, if a person gifted \$60,000²⁰⁶ and the average monthly cost of a nursing home in that particular region was \$6,000,²⁰⁷ then the ratio is 10, meaning that if the individual applied for Medicaid today, he or she would be ineligible and would need to pay all long-term care expenses for the next 10 months, and therefore the state Medicaid agency will not pay any expenses for 10 months (assuming that the family, friends or charities who improperly received the transfers will gift them back to

the applicant, thus allowing the applicant to pay his or her own way for those 10 months).²⁰⁸

In summary, if an individual plans on not paying for long-term care, and having the state pay for it through the state's Medicaid program, then the individual must generally be indigent (or, as expressed through the statute, "needy.") The determination is made on the summation of available resources and available income streams, and if available, resources are sold off or gifted away at less than fair market value, then the applicant will be denied Medicaid funding for a penalty period. If the Medicaid applicant is married, then resources and income streams available to the spouse are included; however, if the spouse does not also need assistance with long-term care (*i.e.*, is a healthy spouse staying in the community), then the amount of available resources and income stream available to the healthy spouse are considerably higher so as to not impoverish that healthy spouse.

Special Aid and Attendance Benefits for Needy Veterans

In addition to the normal pension a veteran receives for his or her services to the country, veterans and survivors who are eligible for pension benefits, and who are housebound or require the aid and attendance of another person, may be eligible to receive additional monetary amounts.²⁰⁹ Similar to eligibility for Medicaid, veterans generally must prove limited assets and income for the veterans' additional pension benefits.

The Aid & Attendance (A&A) increased monthly pension amount may be added to a veteran's monthly pension amount if he or she meets one of the following conditions:²¹⁰

- The veteran requires the aid of another person in order to perform personal functions required in everyday living, such as bathing, feeding, dressing, attending to the wants of nature, adjusting prosthetic devices, or protecting himself or herself from the hazards of their daily environment;
- The veteran is bedridden, in that his or her disability or disabilities requires that he or she remains in bed apart from any prescribed course of convalescence or treatment;
- The veteran is a patient in a nursing home (or an assisted living facility) due to mental or physical incapacity; or
- The veteran's eyesight is limited to a corrected 5/200 visual acuity or less in both eyes or concentric contraction of the visual field to 5 degrees or less.

Generally, any veteran credited with 90 days of active duty, of which at least 1 day during a period of war, is eligible to apply for the Aid & Attendance Improved Pension.²¹¹ Additionally, a surviving spouse of an eligible veteran (had he or she not died) may also apply.²¹² The individual applying must qualify both medically and financially. To qualify financially, an applicant must have on average less than \$80,000 in assets, excluding their home and vehicles.²¹³ The maximum monthly benefits for 2013 are:²¹⁴ \$1,732 for veterans without dependents; \$2,045 for veterans with one dependent; \$2,676 for two veterans married to each other; and \$1,113 for the surviving spouse of a veteran. These benefits might be enough to cover medical care and long-term care expenses without the need to apply for Medicaid.²¹⁵

Only attorneys specifically trained and in receipt of a certificate from the Veteran's Administration are allowed to represent veterans in claiming or negotiating benefits with the VA (issues arise such as whether Medicare is accepted by a VA hospital).²¹⁶

Self-Pay—Either in Advance Through Long Term Care Insurance or in Real Time

As illustrated, if an individual needs long-term care, either at-home or in an institution, then the costs are quite high (but are at least budgetable).²¹⁷ If indigent, whether as part of due course or by means of Medicaid planning, then the state Medicaid program will likely cover the major costs. If the individual is a veteran who is disabled because of wartime service, then he or she might be entitled to aid and attendance benefits from the Veterans Administration. Otherwise, the individual will need to self-pay. If advance planning is properly done, then the purchase of a long-term care insurance contract might cover the costs if and when they are incurred.

There has been a private market for individuals to purchase long-term care insurance for a while, but the problems with the private market include:²¹⁸ adverse selection²¹⁹ and the resulting high cost of premiums; insurance underwriting,²²⁰ complexity of the private long-term care insurance market,²²¹ and the use-it-or-lose-it syndrome.²²² There have been some income tax advantages²²³ for an individual when he or she purchases a "qualified long term care insurance contract," but many argue that even these tax advantages have not improved the private market.

Since the amendments to the Internal Revenue Code have not seemingly opened the market for long-term care insurance, Congress tried to allow employers to provide a floor long-term insurance employee benefit plan, but that attempt has since floundered, and has ultimately been repealed. It was through the CLASS Act, enacted as

part of the Affordable Care Act of 2010,²²⁴ which would generally allow employers to voluntarily set up a benefit program, where employees would voluntarily enroll and pay a premium.²²⁵ The individual would be entitled to cash benefits to pay long-term care expenses once he or she could not perform at least two of the Activities of Daily Living DLs.²²⁶ However, the statute left all of the machinations up to the Secretary of Health and Human Services, who was supposed to determine premium levels, benefit levels, and coordination with other public benefits, all within statutory parameters, but in a manner that would not permit “general federal revenues to subsidize the program.”²²⁷ However, before the Secretary of Health and Human Services could develop the program within the statutory constraints, politics interfered. First, Secretary Sebelius announced that the Obama Administration would not attempt to implement the CLASS Act because she does “not see a viable path forward for Class implementation at this time.”²²⁸ Then, the American Taxpayer Relief Act of 2012²²⁹ formally repealed the CLASS Act. However, since it was one of the final legislative goals of former Sen. Ted Kennedy,²³⁰ and since the private market does not seem to move towards equilibrium without governmental intervention, it might be reintroduced in altered form in the future.

Without a general employer program as a base, the data indicates that long-term care insurance products purchased in the private market currently cover less than 12 percent of total long-term care costs for all Americans,²³¹ but for those 7 to 9 million individuals who hold such policies, between 60 percent to 75 percent²³² of their individual costs were covered.²³³ Financial institutions are looking at innovative ways to include long-term care insurance in other products (such as riders in regular life insurance, and other hybrids),²³⁴ and professionals are still advocating for younger and healthier individuals and married couples to purchase some form of long-term care insurance to allow a legacy to pass to the children, family, and charities without the risk of spending down all available resources in order to qualify for Medicaid or paying for long-term care as it is consumed (which will similarly spend down all or most of the endowment.)²³⁵ However, as women generally live longer, and have different health issues and financial goals, couples might choose separate gender-based policies.²³⁶

THE NECESSARY ENDOWMENT NEEDED AT THE BEGINNING OF RETIREMENT AND THE NECESSARY INCOME STREAM NEEDED DURING RETIREMENT

Going full circle in this article, we are back at putting a single dollar value on the out-of-pocket costs each individual Medicare beneficiary

will be responsible for paying throughout retirement. In other words, in the planning for the right endowment amount at the start of retirement and the right annuity stream during retirement, some individuals, and their financial planners, try to transform the unexpected, unbudgetable, and uncalculable costs of health care into a nice and neat magic number. This article has hopefully demonstrated that a magic number for any family unit is either wholly impossible to determine or is based on an average that does not reflect the true expenses for any particular family unit. And, in reality, even if a particular family unit bucks the odds and determines a magic number actually needed, chances are that this family unit's actual endowment at any point in time, based on a pattern of savings versus consumption during the working years, is far less than the magic number targeted, expected, or needed.

The Necessary Income Stream

While this article can use a whole range of life expectancies and discount rate assumptions to equate a lump sum (*i.e.*, an account balance) and the annuity stream it can purchase in the current market, the best neutral place to go is through published governmental figures. In its Advanced Notice of Proposed Rulemaking for ERISA retirement plan benefit statements, the US Department of Labor uses current market rates (or what they refer to as the proposed safe harbor assumptions) to convert an account balance of \$125,000 for a 45 year old plan participant as of December 31, 2012 into a deferred monthly annuity of \$625, starting when the participant attains his 65th birthday and retires, and then continues for the remainder of his life.²³⁷ By projecting the participant's account balance forward to his expected normal retirement age, again using a proposed set of safe harbor assumptions, then at age 65 the participant's account balance is expected to be \$557,534, and then the annuity that account balance is expected to purchase is an immediate monthly annuity of \$2,788, continuing for the remainder of his life.²³⁸

The point is that if an individual can match annuity streams with fixed and budgetable expenses during retirement, then along the way, either a higher income stream can be generated or a diminishment in life style can be anticipated. Upon retirement, which might come on unexpectedly due to uncontrollable forces in the workforce or labor market, or because of sudden physical or mental impairment, it might be too late to change either the income or the fixed expenses. For planning purposes, the individual should start figuring out what type of retirement lifestyle can be afforded. There are many varied opinions as to the salary and wages replacement ratio needed in retirement to continue the preretirement lifestyle.²³⁹ In thinking about income streams, there are

certain issues that affect women:²⁴⁰ women live longer than men on average and most often outlive their husbands, and a few will live beyond age 100; for each year [women] work between age 62 and age 70, they will receive higher monthly benefits from Social Security. This can make a big difference later in life when out-of-pocket health costs often soar. Defined benefit pension plan rates and benefits must be unisex, but annuities purchased outside of such plans from the private insurance market typically have prices that vary by sex, with women paying more than men because women live longer (couples should keep this in mind when deciding between taking a DB lump sum or an annuity).

However, this article argues that all budgetable, fixed, and planned expenses during retirement should be paid through the predictable income stream, and if the income stream does not cover all such expenses, then the individual should strongly investigate whether a portion of the endowment should be liquidated and used to purchase an appropriate annuity to cover those expenses, or the individual should see if there are ways that general living expenses can be reduced to the level that they will be covered by the income stream. The information about the income stream that should therefore be included on ERISA retirement plan benefit statements (and other communications) should be about properly budgeting all fixed expenses and matching annuity streams.

The Necessary Endowment

The best anyone can do is look at averages and then try to realistically assess where they lay on the normal curve. Fidelity determined that a married couple, each aged 65, retiring in 2010, should have a separate source of endowment of \$250,000, which the couple would spend down \$12,500 each year for the couple's combined premiums, deductibles and co-pays for their medical care and services for the year.²⁴¹ However, this is a statistically average couple, whose out-of-pocket costs are uniform throughout the remainder of their respective lives, who will die as expected (he on his 82nd birthday and then she on her 85th birthday), and that the "account" holding this single sum is invested prudently and properly so that the balance continually earns an annual rate of return of 4 percent (and that the actual cost of living adjustment for the statutory premiums and deductibles, as well as the general inflation rate on medical services and equipment upon which are co-pays, is 6.6 percent each year). But, they caution that by pure mathematics, out of millions of couples who are each age 65 and who retire in 2010, only 50 percent will be average or, in this case, below average (*i.e.*, on the left side of a normal curve) and that \$250,000 will be exactly enough, or more than enough, leaving any unspent portion upon the second death as part of their legacy estate. For example, if that same couple were to live longer

(the male would not die until his 92nd birthday and the female would not die until her 94th birthday), then instead of needing \$250,000 as a single sum in 2010, they would statistically need \$430,000.²⁴²

Remember, however, that under the planning system suggested in this article, consisting of withdrawals and the spend-down of an endowment for all unbudgetable expenses, and the use of income and annuity streams to immediately pay fixed and budgetable expenses, the out-of-pocket costs for health care should be bifurcated. The predictable premiums and annual deductibles should be part of the annuity stream (any unused amounts, such as planned deductibles that never need to be spent, will be invested in the endowment), and the unexpected co-pays, depending on how healthy or unhealthy any Medicare beneficiary happens to be in any given year, should be paid from a draw-down of the endowment. Therefore, Fidelity's now-3-year-old conservative calculation of \$430,000 needed by the 65-year-old couple who will live to 92 and 94, respectively, should be divided between the endowment and annuity.

Unfortunately, the studies show that while many baby boomers will have adequate wealth, many will not. For example, after an empirical study, some academics have concluded:²⁴³

First, many households reach retirement with relatively little financial wealth to support their retirement needs. Half of all households headed by someone between the ages of 65 and 69 in 2008 had total financial assets, including assets in IRAs and 401(k)s, of less than \$52,000. Many providers of single-premium immediate annuities require minimum investments. Forty-three percent of the households aged 65 to 69 would not be able to make a \$25,000 minimum investment even if they liquidated all of their financial assets, including personal retirement accounts.

...

Third, most households appear to treat their houses as a source of reserve wealth that can be tapped in the event of a substantial expense—for example, a healthcare need—rather than a source of annual income. The potential to sell one's home and to redeploy the proceeds, which offers a precautionary wealth stock, may also contribute to the limited demand for private annuities.

Therefore, planning for a target endowment is a good idea during the accumulation period (personal savings that maximize the deferrals into retirement plans, investment strategies that diversify portfolios in

a manner that minimizes the risk of large losses while maximizing the growth and income potential, and consumption patterns that allow the largest possible endowment in the future when salary and human capital potential diminishes). However, sometimes retirement comes on forcefully at an inconvenient time, such as being laid off or fired, or after a period of short-term disability and the depletion of all available sick days and vacations days that could have otherwise been converted into cash, and the individual loses the ability to continue working if the endowment accumulated is not enough.

As explained, this article posits that the best strategy includes both an endowment (*i.e.*, “nest egg” at the beginning of retirement) and an income stream (whether fixed or variable). With the endowment/“nest egg,” most economists agree that a certain percentage of principal should be targeted as a withdrawal each year. Since 1994, the accepted theory was to withdraw 4 percent per year, thus the greatest chance of endowment lasting at least 30 years.²⁴⁴ However, since 2008, several noted economists have challenged the 4 percent per year rule, by proving through stochastic analyses that inefficiencies are generated due to surpluses in some years and over payments in others, and concluding that individualized plans might be better.²⁴⁵

However, this article argues that if the withdrawal and spend-down of the endowment is intended be used to pay for budgetable, fixed, and planned expenses during retirement, then the individual should strongly investigate whether a portion of the endowment should be liquidated and used to purchase an appropriate annuity to cover those expenses; thus, the retiree does not need to invest the principal, manage the withdrawals, and worry about longevity and the depletion of the endowment. This will eliminate the need to choose a spend-down strategy and follow it, and allows only for *ad hoc* distributions.²⁴⁶ The information about the endowment that should therefore be included on ERISA retirement plan benefit statements (and other communications) should be about being conservative with the endowment and only spending down the available resources for unbudgetable and unplanned expenses, which will primarily be the unexpected out-of-pocket expenses associated with health care, but which will also cover emergency spending, pleasurable spending, and legacy planning for any part of the endowment not consumed during retirement.

COMMUNICATIONS TO PARTICIPANTS REQUIRED UNDER THE CURRENT ERISA RULES

Most for-profit employers that sponsor employee benefit plans must comply with the labor rules under ERISA²⁴⁷ and the income

tax rules under the Internal Revenue Code.²⁴⁸ Part of this compliance involves reporting to the government and disclosure to the participants and beneficiaries.²⁴⁹ The government controls the forms that it publishes for reporting, but disclosure notices and other communications to plan participants are generally drafted by each plan sponsor, even if the regulatory agencies provide model notices or suggested language.²⁵⁰

Three major assumptions made in this article, whether justified or not, are that all employers that sponsor employee benefits plans: (1) primarily establish such plans to attract, retain, or reward its valued employees, and not primarily because of income tax advantages; (2) have internal employees or outside ERISA advisors that competently understand all of the complex rules and nuances of ERISA and the Code; and (3) actually operate the plans in complete adherence to the written plan documents and the law. Providing proper notices to participants and beneficiaries becomes much more difficult when any of these assumptions is absent.

Summary Plan Descriptions

Generally, the first plan-related communication that an employee will see about the benefits promised under an employer sponsored retirement plan is a Summary Plan Description (SPD) any time before he or she is eligible to participate in the plan or within 90 days after he or she becomes a participant.²⁵¹ Following that, a participant may anticipate receiving an updated SPD at least every five years (or a Summary of Material Modifications when the plan is materially amended in the interim).²⁵²

While there are certain content requirements for the SPD,²⁵³ the form and style are totally in the discretion of the plan sponsor,²⁵⁴ as long as it is “written in a manner calculated to be understood by the average plan participant and shall be sufficiently comprehensive to apprise the plan’s participants and beneficiaries of their rights and obligations under the plan.”²⁵⁵ The regulations state further that:²⁵⁶

[i]n fulfilling these requirements, the plan administrator shall exercise considered judgment and discretion by taking into account such factors as the level of comprehension and education of typical participants in the plan and the complexity of the terms of the plan. Consideration of these factors will usually require the limitation or elimination of technical jargon and of long, complex sentences, the use of clarifying examples and illustrations, the use of clear cross references and a table of contents.

An SPD is generally required for all ERISA plans,²⁵⁷ and is supposed to be a nice summary, in understandable language, of the official written plan document. However, over time, some courts have determined that the provisions of the SPD will control where there are inconsistencies with the actual provisions in the plan document. Although a recent U.S. Supreme Court case has arguably held that these courts were incorrect in their interpretations and that the terms of the plan's SPD and other summary documents do not supersede the provisions of the actual plan document,²⁵⁸ it will likely take several years before plan administrators, through their plan attorneys and consultants, actually start drafting new SPDs in simpler and more explanatory form, without the fear that any inconsistent or missing information in the SPD will not be viewed by the courts as the legally binding provisions.²⁵⁹

Even if attorneys did not worry about conflicts between the SPD and the document, however, plan sponsors are still arguably not drafting the SPDs in the style and format required by the ERISA regulations.

Although not crucial for this particular discussion of SPDs for a retirement plan, a holistic approach including how to think about communications from an employer's group health plan might be appropriate. Participants in a group health plan governed by ERISA have the need for different information. Basically, they need to know if a certain medical procedure or treatment will be covered by the plan, as well as how their coverage will be continued or will become portable after they cease to be an employee or incur other major life events, like the involuntary termination of employment or marriage or divorce. The SPD for the employer's group health plan has the same requirements as for a retirement plan and must also be "written in a manner calculated to be understood by the average plan participant and shall be sufficiently comprehensive to apprise the plan's participants and beneficiaries of their rights and obligations under the plan."²⁶⁰

In 2006, a study looked at the readability of health care plans and found that:²⁶¹

[t]he average readability level for important information concerning eligibility, benefits, and participant rights and responsibilities in summary plan descriptions is written at a first year college reading level. The average level of readability for SPDs is higher than the recommended reading level for technical material. Some of the SPDs in the study sample use language written at a 9th grade reading level. Other SPDs use language written at nearly a college graduate (16th grade) reading level.

The study concludes that fundamental improvements are needed in the readability of written SPDs and that employers and plan administrators should explore the use of alternative methods of communication to plan participants beyond the written SPD.²⁶² Whether or not a plan administrator agrees with the conclusions of this study, it seems that they should arguably first try to draft a legally compliant SPD in an understandable manner before exploring alternate methods of communication beyond the SPD.

Unlike a retirement plan sponsor, however, the plan sponsor of a group health plan is not required to provide statements along the way; therefore, the participant generally will not know with certainty that the expenses incurred in any particular medical procedure will be covered. All that the participant can do is: seek preapproval from the plan sponsor (usually through the human resources department of the sponsoring employer); bring an action against the plan to clarify her rights to future benefits under the terms of the plan;²⁶³ or simply undergo the procedure and incur the expense, and then make a claim for benefits and follow the plan's claims procedures if the benefit claim is denied.²⁶⁴ Because both of these remedial procedures are burdensome, especially with many of the urgent life or death decisions that are made with respect to one's medical treatment, a clear and readable SPD is especially crucial.

Benefit Statements

In ERISA retirement plans, after the individual becomes a participant in the plan and has received the SPD, he or she will receive notices along the way with information about the benefits that have vested and accrued under the plan. Under current rules, the participant will receive such notice:²⁶⁵

- At least quarterly if a participant in a self-directed defined contribution plan,²⁶⁶
- At least annually if a participant in any other type of defined contribution plan,²⁶⁷ and
- At least once every three years if a participant in a defined benefit plan.²⁶⁸

Like the SPDs, these benefit statements “shall be written in a manner calculated to be understood by the average plan participant.”²⁶⁹

Other statements that must be communicated to plan participants with information about their respective retirement plan benefits include:²⁷⁰

- If the individual is a participant in a defined benefit pension plan, then he/she will receive a statement of accrued and nonforfeitable benefits;²⁷¹ a suspension of benefits notice;²⁷² a notice of plan amendments that provide for a significant reduction in the rate of future benefit accruals or the elimination or significant reduction in an early retirement benefit or retirement-type subsidy;²⁷³ and if the plan is terminated under a standard termination with the PBGC, then a notice of intent to terminate²⁷⁴ and a notice of plan benefits.²⁷⁵
- If the individual is a participant in a defined contribution plan with individual accounts, where he/she can self-direct investments, then he/she will receive a notice of complete information to allow him/her to exercise control;²⁷⁶ a notice in advance of any blackout period;²⁷⁷ a qualified default investment alternative notice;²⁷⁸ an automatic contribution arrangement notice;²⁷⁹ and a notice of the right to divest.²⁸⁰

Collectively, these other notices and forms of communication regarding benefits under either a defined benefit plan or under a defined contribution plan where participants self-direct their investments, suggest different aspects of education that can be integrated into a single method of communication that could be delivered to every participant in every defined benefit or defined contribution plan (at various points in time before and during their participation in the plan) that helps an individual understand financial and investment strategies and expectations and the value of an account (described in this article as an endowment) and the value of annuities and associated accruals (described in this article as an income stream).

Distribution Information and Election Forms

In the life-cycle of a participant in a retirement plan, after the participant initially learns about the plan through the SPD, and after the participant receives benefit statements and other ancillary notices, the participant will eventually be owed benefits (due to death, disability, termination of employment, retirement, or otherwise). When the participant retires or is otherwise entitled to plan benefits from a retirement plan, he or she will receive a notice that explains the taxation and roll-over treatment allowed under the Code.²⁸¹ While the contents of such a notice are described through Treasury Regulations and can be drafted in any manner and any style,²⁸² the Regulations clearly state that the IRS has the authority to publish a model section 402(f) notice, and that “[t]he plan administrator will be deemed to have complied with ... [the

notice requirements] if the plan administrator provides the applicable model section 402(f) notice.”²⁸³ Since the IRS has published an appropriate model notice,²⁸⁴ almost all plan sponsors blindly use the model notice—sometimes not aware that the model language can become outdated²⁸⁵ and that they are required to amend it to comply with current law even in the absence of further guidance from the IRS; sometimes not aware that they are still responsible for altering the model language to comply with the actual provisions of the controlling plan document; and, more importantly for this discussion, arguably the act of blindly using a model notice without any stylistic changes whatsoever could easily be seen as a violation of their requirement that the tax information notice “must be designed to be *easily understood* and must explain the [relevant information].”²⁸⁶

If the plan is subject to the Qualified Joint and Survivor Annuity rules,²⁸⁷ then a participant will also receive a disclosure of the relative values of different distribution options.²⁸⁸ The Treasury applied the familiar standard, requiring that the disclosure of relative values notice “must be written in a manner calculated to be understood by the average participant.”²⁸⁹ If a plan subject to these requirements offers both annuity and lump sum distribution options, then the disclosure of relative values might actually help the average plan participant to inherently understand the difference between the two different methods of receiving plan benefits, and as is demonstrated later in this article, might be a good starting point for statements from 401(k) plans and profit sharing plans,²⁹⁰ regardless of whether the plan actually offers any distribution options that include an immediate or deferred annuity option.

Proposed Best Practices for Drafting All Communications

As discussed, most of the important disclosure notices that inform plan participants of their benefits under a retirement plan, as opposed to the notices that provide general financial information about the plan or that merely convey ERISA rights, have as a basic premise that they are “written in a manner calculated to be understood by the average plan participant.” Although this phrase is a statutory requirement for the SPD, and is merely a regulatory requirement for the other notices in the life-cycle of a participant, the term is not defined anywhere. Neither the Departments of Treasury nor Labor has provided guidance. A few courts have reviewed specific language of communications but have not provided any bright-line tests.²⁹¹

How does a plan sponsor meet its primary threshold of drafting notices and summary plan descriptions in a manner calculated to be understood by the average participant? Although not controlling, a source that might provide some insight and possibly even a level of

security might be an alternate federal agency, the Department of Health and Human Services. HIPAA privacy notices²⁹² are required to be drafted in “Plain Language.”²⁹³ Because group health plans are considered covered entities under HIPAA’s privacy rule,²⁹⁴ there is arguably at minimum a link between HIPAA covered entities and ERISA employee benefit plans.

In its “Plain Language Principles and Thesaurus for Making HIPAA Privacy Notices More Readable,” the Department of Health and Human Services, through its Agency for Healthcare Research and Quality, suggests:²⁹⁵

- Layering the notice, where the first layer is a short notice that summarizes individual’s rights and other information, and then the second layer would be a more comprehensive notice satisfying the statutory elements of the notice;
- Arranging the required information in the order that would be in the reader’s best interest (including appropriate preambles and appendices);
- Drafting the notice at a 9th grade reading level;
- Making the notice easier to read by using a conversational style rather than a formal style, using common words, using short sentences, avoiding hyphens and compound words, providing examples to explain problem words, using lower case rather than all capital letters;
- Making the notice look easier to read by allowing more white space by using wider margins, chunking long lists into smaller bites, by inserting pictures, graphs, or other visuals where appropriate, using large fonts and high contrasts, giving the context first before supplementing with new information;
- Making it suitable for the culture by matching logic, language, and experience; and
- Preparing in some situations to draft all or some of the notices in an even simpler manner for those plan participants and beneficiaries with limited reading skills.

Again, there is no guarantee that following the guidance set forth by the Department of Health and Human Services for “Plain English”

HIPAA privacy notices will fulfill the ERISA notice requirements that they be drafted in a “manner calculated to be understood by the average plan participant.” However, every plan sponsor must start somewhere, and why not start with those suggestions (at least until the Departments of Treasury or Labor issue more pertinent and helpful guidance).

The stylistic approach to communications is relevant in the proposal of this article—although it proposes a model benefit statement with generic summaries about how the retirement benefits are only part of the individual’s nest egg (which has been referred to as an endowment throughout this article) and income stream in retirement and that there are predictable and unpredictable expenses that should be considered before any elections are made on the form of distribution from the plan, there is still a statutory requirement that a benefit statement, in general, “shall be written in a manner calculated to be understood by the average plan participant.”²⁹⁶ After all, how can an individual be expected to understand what he/she does not know?

CONCLUSION: A PROPOSAL FOR INFORMATION THAT SHOULD BE INCLUDED IN FUTURE ERISA RETIREMENT PLAN BENEFIT STATEMENTS

Basic Education Needed in All Communications

General Information

“By providing more ongoing and meaningful notification to participants as to the value of their retirement funds, Congress hopes that participants will take more of an active role in planning and saving for their retirement.”²⁹⁷ However, this article suggests that the average individual who participates in an employer-provided retirement plan can only assess the “value” of his or her retirement funds if it is put in the context of how much retirement will cost, and the cost of retirement includes the budgetable expenses for room, board, and general living, as well as the unbudgetable expenses, such as the out-of-pocket expenses for medical care, especially in years that the individual happens to be unhealthy.

Yes, the statutory requirements of ERISA must be met, and benefit statements must include the appropriate disclosures of total benefits accrued²⁹⁸ (for pension plans) and the value of each investment to which assets in the individual account have been allocated²⁹⁹ (for individual account plans). However, as indicated, these benefit statements “shall be written in a manner calculated to be understood by the average plan participant.”³⁰⁰ This article posits that the “average plan participant”

needs a basic education in order to have any understanding at all about how the accumulated account balances in individual account plans, or how accrued life annuities that will commence in the future, fit into their endowment and annuity streams that will be accumulated while working and available later in retirement. Further, this article proposes that the “average plan participant” also needs an education in what kind of budgetable expenses can be paid from the retiree’s annuity stream and what kind of unbudgetable expenses can be paid from the retiree’s endowment.

The sample benefit statement (*infra*, “The Proposed Model Benefit Statement for an ERISA Plan”) represents what the author hopes is at least a conversation starter within the Department of Labor as to: the usefulness of including such information about retirement on ERISA benefit statements; whether they have the statutory authority to suggest or demand such general information in benefit statements under ERISA §105; and, if so, which information about the financing of retirement is actually relevant. Then, if some general educational information is suggested or required on benefit statements, hopefully the conversation within the Department of Labor will expand to similar information within Summary Plan Descriptions and within benefit election forms. Further, this author hopes the Department of Labor, especially through its Employee Benefits Security Administration, will use their Web site to educate plan participants further, by posting information and links to sister federal agencies (such as the Social Security Administration and the Center for Medicare and Medicaid Services).

Before the author’s sample notice, however, this article discusses the whole concept of financial literacy separately (in the next subsection), since that is a wholly different conversation. The Department of Labor should consider including financial literacy education on ERISA plan communications.

Financial Literacy

In 2009, the Financial Industry Regulatory Authority (FINRA) Investor Education Foundation, undertook a detailed telephone survey known as the National Financial Capability Study, with the purpose of benchmarking key indicators of financial capability and linking these indicators to demographic, behavioral, attitudinal, and financial literacy characteristics. The key findings relating to retirement are that “the majority of Americans do not have ‘rainy day’ funds set aside for unanticipated financial emergencies and similarly do not plan for predictable life events, such as ... their own retirement.”³⁰¹ More specifically, “even among those in the 45–49 age group, only 51 percent have attempted to calculate how much they need to save for retirement.”³⁰²

Another study asked the following three questions to a random group of Americans.³⁰³

1. Suppose you had \$100 in a savings account and the interest rate was 2% per year. After five years, how much do you think you would have in the account if you left the money to grow?
 - A. More than \$102
 - B. Exactly \$102
 - C. Less than \$102
 - D. Do not know
 - E. Refuse to answer

2. Imagine that the interest rate on your savings account was one per year and inflation was 2% per year. After one year, how much would you be able to buy with the money in this account?
 - A. More than today
 - B. Exactly the same
 - C. Less than today
 - D. Do not know
 - E. Refuse to answer

3. Please tell me whether this statement is true or false. ‘Buying a single company’s stock usually provides a safer return than a stock mutual fund.’
 - A. True
 - B. False
 - C. Do not know
 - D. Refuse to answer

Although the study builds the regression analyses controlling for age, sex, education, employment status, and race/ethnicity, it concludes, generally, that there is “a troubling picture of the current state of financial knowledge in the United States. Many respondents lack key knowledge of financial concepts and fail to plan for retirement, even when retirement is close at hand, only 5–10 years off. This is important since being able to develop and implement retirement plans is key to retirement security: those who do not plan reach retirement with half the wealth of those who do.”³⁰⁴

In addition, President Obama has taken several steps in bridging the financial literacy gap. His administration created the President’s Advisory Council on Financial Capability “to assist the American people in understanding financial matters and making informed financial decisions, and thereby contribute to financial stability. It is composed

of nongovernmental representatives with relevant backgrounds, such as financial services, consumer protection, financial access, and education. The Council will suggest ways to coordinate and maximize the effectiveness of existing private and public sector efforts and identify new approaches to increase financial capability through financial education and financial access.”³⁰⁵ In their first interim report, published in early 2012, they decided that the second of three themes would be to “build a financially capable workforce and retiree community, which is necessary for a stable and globally competitive economy.”³⁰⁶ In addition, the Obama administration has set up a dedicated educational Web site through the US Securities and Exchange Commission, which includes basic tabs titled: “Introduction to Markets;” “Investing Basics;” “Researching & Managing Investments;” “Employment to Retirement;” and “Life Events.”³⁰⁷ The most recent step taken by the current administration was the creation of the President’s Advisory Council on Financial Capability for Young Americans, which will “advise the President and his Administration on ways to improve the financial skills of young Americans so that they can make smart decisions about going to college, using financial products, and even saving for their retirement.”³⁰⁸

Therefore, the author of this article is not going to assume or present a superior methodology of educating plan participants on basic financial literacy than is being explored by economists and the President’s advisory boards. However, in order for an individual plan participant to properly choose between an annuity or lump sum form of distribution from an ERISA-governed retirement plan, in addition to understanding the difference between an annuity and an endowment, the sources and uses of each during a typical retirement and the expected out-of-pocket costs of medical care and long-term care, as suggested herein, the individual will probably also need a general understanding of basic financial terms, issues, and concepts. This article encourages coordination throughout all federal agencies on an education campaign that starts in public school and that follows all individuals throughout their careers and retirement, and that the same information on an individual’s benefit statement from a retirement plan is the same information on an individual’s benefit statement from Social Security³⁰⁹ (and although states regulate the insurance and financial industry, possibly even the same information on any insurance or financial product).³¹⁰

The Proposed Model Benefit Statement for an ERISA Plan

Dear Polly Participant,

You are a participant in the XYZ, Inc. 401(k) Retirement Plan, and as of December 31, 2013, your account balance is \$125,000, which

is the sum of all of your salary deferrals, the company matches and other profit sharing contributions, and investment earnings (net of fees), based on the investment portfolio you have requested (or based on the plan's default investment portfolio if you have failed to affirmatively communicate a request).

As long as you remain an employee in XYZ, Inc., and as long as XYZ, Inc. maintains the plan, you will continue to participate in the plan. Based on some safe harbor assumptions approved by the Department of Labor, in 20 years, when you have attained age 65 and are eligible for "normal retirement" under the plan, your account could possibly total \$557,534. Please be keenly aware that this is a very rough estimate, and is not a guarantee.

However, you should start planning for your retirement now and see if you believe you are accumulating enough through this 401(k) plan, which will be added to all of your other accumulated wealth and other income sources. Under current market rates, you could possibly turn your full current account of \$125,000 into a deferred annuity of \$625, where you will receive \$625 on the first day of the month coincident with or following your 65th birthday and then continuing monthly for the rest of your life (*i.e.*, the last payment will be on the first day of the month coincident with or preceding your death). Again, based only on those same current market rates and safe harbor assumptions, you could possibly turn your full expected account of \$557,534 into an immediate annuity of \$2,788, where you will receive \$2,788 on the first day of the month coincident with or following your 65th birthday, and then continuing monthly for the rest of your life.

We have provided some education about how to think about the true cost of retirement, and some useful governmental resources, in the Supplemental Materials attached to the XYZ, Inc. 401(k) Retirement Plan Summary Plan Description, which we encourage you to read more carefully, but here are some highlights that you should always be considering:

First, although you might think you can control if and when you retire, there are risks, including the possibility that if your physical or mental health deteriorates, you might need to leave the workforce earlier than planned (meaning more time in retirement with less money to cover all expenses).

Second, you should determine your total assets available in your retirement (which includes all sources of income plus all of your accumulated property and wealth, including the benefits from this plan).

You should have two separate components of your retirement portfolio: first, a steady stream of income (which includes any annuitization of your account balance, as described above, plus Social Security,

plus things like rental income, income generated by bonds, and reverse mortgages which provide income to you); and, second, an endowment (which means all real, personal, and intangible property, which can be transferred, closed, or sold for cash, including a lump sum distribution from this plan or an IRA, your house and its furnishings, collectibles, investment accounts, reverse mortgages, or home equity loans).

The monthly income stream should be used to cover all of your monthly expenses that you can budget (such as, for each home, the mortgage or rental payments, property taxes, utilities, cable and phone bills, homeowners, insurance, community assessment dues, alarm systems, landscaping and cleaning services, and other planned and expected maintenance costs; federal and income taxes; state and local income taxes, sales taxes, renewal and licensing fees, and other required remittances; credit card and other personal debt obligation payments; for each automobile, the maintenance and tune ups, insurance, and fees for parking passes, city stickers, and disability vehicle placards; insurance premiums for life insurance, long-term care insurance, homeowners or rental insurance, and health insurance; food and clothing; and all other discretionary expenses that can be budgeted ahead of time, such as vacations, hobbies, gifts, charitable contributions, dues for clubs and other organizations, securing professional services such as house keepers, barbers, attorneys, and accountants, and general entertainment).

If you don't think you have enough income, see if you can: use part of your endowment to purchase an annuity, plan for a simpler and less expensive retirement lifestyle, or continue earning wages and salary (if you can).

The endowment should be liquidated and spent-down for all other expenses that you can not budget, whether pleasurable for you or for emergencies (such as unexpected medical emergencies; other health care expenses; retrofitting expenses in the home due to a disability; moving expenses if the current home cannot be retrofitted; assistance and gifts to a family member who is out of work, has a new baby, gets married, moves, goes to college, or other pleasant or emergency needs; and large donations to charities or for funding of a legacy). You need to maintain and continually invest the remaining endowment to last at least as long as you anticipate living.

Note that even if you will be covered by Medicare for your medical care and services, there are still out-of-pocket costs, including monthly premiums, annual deductibles, and co-pays. Medicare is extremely complicated, but if you spend some time reviewing www.medicare.gov, and if you find a competent attorney or advisor to answer your specific questions, then it is somewhat manageable. The information about Medicare contained in this notice is only a summary of the current rules.

Medicare Part A basically provides hospital benefits. There will not be any monthly premiums for Part A if you paid payroll taxes in at least 40 quarters over your careers (either “FICA” taxes while you were an employee somewhere, including XYZ, Inc., or “SECA” taxes if you have ever been an independent contractor or self-employed). However, if you are admitted to a hospital in any year, then your out-of-pocket costs will be a deductible of the first \$1,184 billed (for each “spell of illness”), plus some substantial daily co-payments if you stay in a hospital for an extended period of time or if you stay in a rehabilitation facility after being released from a hospital for an extended period of time;

Medicare Part B basically provides preventative care and medically necessary care. Premiums for Part B are at least \$1259 each year (if you have high levels of income in any year, then the premiums can be higher). The only thing you get for free is a once a year “wellness” visit with your doctor. After that, if you need certain additional preventative care or medically necessary care outside of the hospital, then your out-of-pocket costs will be a deductible of the first \$147 billed, plus 20% of all additional medically-necessary costs (with no upper limit) and 100% of some other medically-necessary costs not covered by Medicare Part B (again, with no upper limit). Please note that if you do not enroll in Medicare Part B as soon as you are eligible (basically on your 65th birthday), then your premiums will include a late enrollment penalty charge.

You can voluntarily find a private insurance company and either purchase a “Medigap” policy or a compliant Medicare Part C plan, but not both.

With a “Medigap” policy, for a set premium, the plan will pay your out-of-pocket costs for Medicare Parts A and B. Like any insurance, at the end, you will have either “won” or “lost.” In years that you are healthier than expected by both you and the insurer, your total premiums paid might actually exceed the out-of-pocket costs they pay on your behalf, and you will have “lost;” on the other hand, in years you are unhealthier than expected, then your total premiums will be less than your out-of-pocket costs, and you will have “won.” Other than the gamble, a good reason to consider a “Medigap” policy is to convert a totally un-budgetable expense into a totally budgetable expense.

On the other hand, with a “Medicare” Part C policy (officially called a “Medicare Advantage” plan), the plan will cover all of the benefits offered under Medicare Parts A and B, plus any additional medical care services and choice of doctors or hospitals you are willing to pay for. Note that Medicare Parts A and B do not cover routine eye, ear, or teeth care (which, statistically, are problematic for a great majority of

adults as they age). The premiums charged will be similar to the way you choose an insurance policy for your automobile—the more you are willing to pay out-of-pocket as medical care expenses are incurred, the less the insurance company will charge as monthly premiums. Please note that once you enroll in Medicare, in each calendar year, you will be locked into the specific Part C plan that you selected during the “open enrollment” period of the preceding calendar year, regardless of your dis-satisfaction with your choice or if you develop a new chronic illness which is not properly covered with your choice. For example, in 2025, if you are enrolled in Medicare, then between October 15 and December 7, 2025, you need to choose whether you are happy with your current Part C plan and reenroll for the full 2026 calendar year, or whether you want to enroll in a different plan for 2026.

Finally, you can voluntarily find a private insurance company and purchase a compliant Medicare Part D plan to cover your prescription drug costs. Unless you qualify for a government subsidy due to low income, your out-of-pocket costs can be up to about \$4,000 (there is an initial deductible, then a period where you pay 25% of the costs, then the “donut hole” period where you pay a higher share than 25% until the year 2020, when you will only be responsible for 25% of the costs); however, if your prescription drugs are so expensive and you need to pay more than about \$4,000 each year, then you will generally be responsible for about 5% of all additional costs. If you cannot afford your out-of-pocket costs for your prescription drugs in any year, then you can apply to the Center for Medicare & Medicaid Services for a subsidy. Please note that the same issue for enrollment periods from Part C plans apply to Part D plans, and you will be locked into your selected Part D plan for the entire calendar year, regardless of your dis-satisfaction or if new drugs are prescribed but are not covered under your plan.

Please note that if you have long-term care expenses, as opposed to medical care expenses, you will likely need to pay them yourself, unless you are “needy” under your state’s Medicaid program. Long-term care means that you need assistance with activities of daily living, such as eating, bathing, dressing, toileting, and transferring from a bed to a chair. If you go into a nursing home, then expect to pay about \$70,000 per year (which is the national average); and if you want to stay at home, then a professional caregiver is about \$12 per hour (again, then national average). Please note that while a family member might volunteer to be a caregiver to assist in your activities of daily living, most states prohibit you from paying that family member.

You can privately purchase a long-term care insurance policy while you are young and healthy.

If you meet the “needy” requirement for Medicaid (generally, if single, then you must have less than \$2000 in wealth and less than \$30 per month as an income stream, and if married, then the “healthy” spouse must have less than \$115,920 in wealth and less than \$2,898 per month as an income stream), then the state will pay for your long-term care needs. Each state administers its own Medicaid plan, and applying for Medicaid in any state is very complicated. Therefore, you should contact a competent attorney or advisor to answer your questions on how to apply for Medicaid and possibly how to do some Medicaid planning.

If you are a disabled veteran, who served at least one day during war-time, then you might be entitled to aid and assistance benefits from the Veterans Administration.

Additional considerations regarding retirement are the advanced directives you can execute now, while you still have complete mental capacity to legally enter into these contracts. Most states allow you to name an agent to make decisions over your property and/or over your health care, should there come a point in your retirement when you no longer have the mental or physical capacity to make or communicate your decisions. If these advanced directives are done properly, with the advice and assistance of a competent attorney, then the court will generally not need to become involved. However, in the absence of properly executed advanced directives, then a local court will have an adult guardianship hearing, and if the judge determines that you no longer have the mental capacity to make or communicate decisions over your property or body, then the judge will appoint a guardian to make legally binding decisions on your behalf.

Please note that neither the officers of XYZ, Inc., nor the administrator of the XYZ, Inc. 401(k) Retirement Plan, are providing individual advice. We are trying to educate you to see where the money accumulated through this plan while you work, and payable to you when you retire, fits in with all other available resources you will have during retirement to pay for your general living, housing, medical care, and long-term care expenses and the total endowment you will have during retirement to pay for pleasantries and emergencies. We strongly advise you to seek personal legal advice or other retirement counseling. –

NOTES

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3. WikiHow, “Managing Your Money: Retirement” series, available at <http://www.wikihow.com/Calculate-How-Much-Money-You-Need-to-Retire>.
4. To be fair, the author also “BING”ed those same key words, which yielded similarly titled articles.
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6. Skinner, 21 J. Economic Perspectives 59 (2007).
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11. United States Government Accountability Office, Report to the Chairman, Special Committee on Aging, U.S. Senate, GAO-11-400 (June 2011), available at <http://www.gao.gov/assets/320/319390.html>.
12. The calculator and instructions are available at <http://www.dol.gov/ebsal/regs/lifetimeincomecalculator.html>.
13. Even if there were a single number, it would be a different number for each family unit.
14. Based on reported information by employers, in 2010, there were 1,297,000 total participants in all ERISA retirement plans sponsored by private sector employers. Department of Labor, Employee Benefits Security Administration, “Private Pension Plan Bulletins: Abstract of 2010 Form 5500 Annual Reports,” Table of Highlights, available at <http://www.dol.gov/ebsal/publications/form5500dataresearch.html>, click on “2010” under “Private Pension Plan Bulletins Abstract of Form 5500 Annual Reports.”
15. See, *infra* “Communications to Participants Required under the Current ERISA Rules.”
16. This article, even before being accepted for publication, had been submitted to the Office of Regulations and Interpretations, Employee Benefits Security Administration, US Department of Labor, as *personal* comments of the author, as requested under their advance notice of proposed rulemaking for Pension Benefit Statement, as published in 78 FR 26727 (5/8/2013), and *not* as a part of larger comments prepared by any professional association in which the author is a member.
17. See, e.g., Coe, Khan, & Rutledge, “How Important is Medicare Eligibility in the Timing of Retirement?” Center for Retirement Research at Boston College (May 2013, Number 13-7), available at crr.bc.edu/wp-content/uploads/2013/05/IB_13-7.pdf; Stern, “Is Now the Worst Time to Retire? Not Even Close,” Reuters Business & Financial News (7/25/2013), available at <http://www.cnbc.com/id/100911237>, and “Big Question: When Should I Retire?” Society of Actuaries, Managing Retirement Decisions Series (2012), available (along with all other Issue Briefs) at <http://www.soa.org/managing-retirement>.
18. See, e.g., IRS Publication 1779, “Independent Contractor or Employee” (revised March, 2012); and Harned, Kryda & Milito, “Creating a Workable Legal Standard for Defining an Independent Contractor,” 4 J. Bus. Entrepreneurship & L. 93 (2010).
19. See IRC §183 for deductions allowed on personal income tax returns after a hobby is converted into an activity engaged in for profit. Before any individual uses the proceeds from a qualified plan or IRA to start a business, they should investigate the concerns expressed by the

Employee Plans group of the IRS in what they call Roll Overs as Business Startups (ROBS) at <http://www.irs.gov/retirement/article0,,id=249181,00.html>.

20. According to Hiemstra, "The End of Retirement is Near," the Futurist (1999), available at <http://www.futurist.com/articles-archives/the-end-of-retirement-is-near/>, after making the opening statement,

One invention of the 20th century that is likely to disappear early in the 21st century is the concept of retirement. Retirement has come to mean that after a period of income-generating work lasting until age 65 or, in recent times, age 60 or even 55, one should cease income-generating work. The "final" phase of life is expected to be one dominated by leisure, paid for by savings and benefits accumulated in the employment phase of life.

It concludes:

Now however, it seems likely that most 21st century elders will not retire. They will slow down, work less, work at new things, have some leisure, but continue to engage in useful, income-producing work in a variety of arrangements and patterns, perhaps for all of their lives. It is safe to say that the first quarter of the 21st century will see a great re-invention of the third phase of life, away from classic retirement and toward something like "life fulfillment." The end of retirement and beginning of life fulfillment may be a kind of liberation.

The author of this article agrees with those general predictions.

21. A qualified plan is a retirement plan sponsored by a for-profit private employer that satisfies all of the requirements set forth in Internal Revenue Code (hereafter IRC) §401(a). Under the current rules, there are exactly two types of qualified plans, a defined contribution plan or a defined benefit plan. Under IRC §414(i), "the term 'defined contribution plan' means a plan which provides for an individual account for each participant and for benefits based solely on the amount contributed to the participant's account, and any income, expenses, gains and losses, and any forfeitures of accounts of other participants which may be allocated to such participant's account." Under IRC §414(j), "the term 'defined benefit plan' means any plan which is not a defined contribution plan."
22. The U.S. Department of Treasury published proposed regulations that would have added Treas. Reg. §1.401(a)-3, allowing pension plans to add a "bona fide phased retirement program" for full-time employees otherwise eligible to commence plan benefits. Treasury Regulations are codified at Title 26 of the Code of Federal Regulations (CFR). Under the proposed rules, all such employees who voluntarily elected to participate in the program, as long as they have attained age 59½, would receive a pro rata portion of accrued benefits from the plan, which would be tied in to a reduction in service hours and the associated reduced current salary as active employees. A corresponding rule was proposed at Treas. Reg. §1.401(a)-1(b)(1)(iv), to hold that the addition of a bona fide phased retirement program would not violate the definitely determinable benefits rule for pension plans. See 69 FR 65108 (Nov. 10, 2004).

The Proposed Regulations have never been finalized, nor have they formally been retracted, and they specifically indicate that they cannot be relied upon before publication of final regulations.

23. Treas. Reg. §1.401-1(b)(1)(ii) (a profit sharing plan “must provide a definite predetermined formula for ... and for distributing the funds accumulated under the plan after a fixed number of years, the attainment of a stated age, or upon the prior occurrence of some event such as layoff, illness, disability, retirement, death, or severance of employment.” As per Rev. Rul. 71-295, 1971-2 CB 184, a fixed number of years means at least 2 years (holding that a profit sharing plan that a plan which permits any employee to withdraw any portion of his share of the employer’s contribution 18 months after it has been made without regard to the attainment of a stated age or the occurrence of some event is not a qualified profit-sharing plan).

Note that participants in 401(k) plans are generally prohibited from receiving a distribution of their elective deferrals (*i.e.*, contributions) while still employed, unless “upon hardship of the employee.” IRC §401(k)(2)(B)(i)(IV). *See* Treas. Reg. §1.401(k)-(d)(3) for further definitions of an acceptable hardship distribution and some safe harbors available for plan documents and plan administrators.

24. IRC §401(a)(36), as added by the Pension Protection Act of 2006, P.L. 109-280. Under Treas. Reg. §1.401(a)(1)-b(3), unlike the Proposed Regulations for bona fide phased retirement programs had suggested, “retirement does not include a mere reduction in the number of hours that an employee works. Accordingly, benefits may not be distributed prior to normal retirement age solely due to a reduction in the number of hours that an employee works.” Under Treas. Reg. §1.401(a)(1)-b(2), a pension plan document can define any age as its normal retirement age, but it “must be an age that is not earlier than the earliest age that is reasonably representative of the typical retirement age for the industry in which the covered workforce is employed.” A plan’s normal retirement age can only be set below 62 if such age “is not earlier than the earliest age that is reasonably representative of the typical retirement age for the industry in which the covered workforce is employed is based on all of the relevant facts and circumstances” and, if such age happens to be below 55 (unless the employees are qualified public safety employees), then it will be presumed to violate the requirement, “unless the Commissioner determines that under the facts and circumstances the normal retirement age is not earlier than the earliest age that is reasonably representative of the typical retirement age for the industry in which the covered workforce is employed.”
25. “Managing Post-Retirement Risks: A Guide to Retirement Planning,” Society of Actuaries (2011), available at <http://www.soa.org/ccml/content/areas-of-practice/special-interest-sections/pension/post-retirement/>.
26. *See, e.g.*, Mitchell, “Retirement Risk Management in Times of Turmoil,” 17 Elder L.J. 439 (2010); Heffernen, “Beating the Retirement Odds,” 31-OCT Pa. Law. 26 (2009); and Gordon, “The ‘Prudent Retiree Rule’: What to Do When Retirement Security is Impossible,” 11 Lewis & Clark L. Rev. 481 (2007).
27. Many of the risks listed have been expressed by Michael Callahan, President of Edu4Retirement, Inc. The author copresented with Mr. Callahan at a session titled “So Now You Have Retired: What Risks Do You Face With Your Retirement” at the 2012 American Society of Pension Professionals and Actuaries Annual Conference, and the author learned a lot about how to

think of retirement risks during the preparation of their combined materials, and from other conversations with, and reading materials shared by, Mr. Callahan.

28. See, e.g., “The Global Financial Stability Report: Chapter 4, The Financial Impact of Longevity Risk,” the International Monetary Fund (April 2012), available at www.imf.org/external/pubs/ft/gfsr/2012/01/pdf/c4.pdf; Tweel, “Retirement Savings in the Face of Increasing Longevity: The Advantages of Deferring Retirement,” 14 N.C. Banking Inst. 103 (2010); Perun, “Retirement Savings: Confronting the Challenge of Longevity,” The Aspen Institute Initiative on Financial Security (2010), available at www.aspeninstitute.org/sites/.../ConfrontingLongevity_AspenIFS.pdf; and Pratt, “Retirement in a Defined Contribution Era: Making the Money Last,” 41 J. Marshall L. Rev. 1091 (2008).
29. Inflation, and associated cost-of-living adjustments, are especially important in regards to Social Security checks. According to the Social Security Administration, until 1975, Social Security benefit increases were *ad hoc* adjustments set by legislation, but since 1975, increases have been automatically calculated based on statutory cost-of-living adjustments or COLAs. Further, for Social Security, the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) is used. The CPI-W is an index of prices of goods and services typically purchased by urban wage earners and clerical workers, which is different than the standard Consumer Price Index for All Urban Workers (CPI or CPI-U). Note that in the President’s Fiscal Year 2014 Budget, President Obama has indicated that he is “willing to accept Republican proposals to switch to the chained CPI” but only if the two following conditions are met: “The change is part of a balanced deficit reduction package that includes substantial revenue raised through tax reform” and “it is coupled with measures to protect the vulnerable and avoid increasing poverty and hardship.” See <http://www.whitehouse.gov/omb/budget/factsheet/chained-cpi-protections>.
30. Note that as interest rates rise, the value of bonds generally diminish, and vice versa.
31. Part II of this article explains how individuals can best anticipate the true cost of health care during retirement.
32. Long-term care generally means the expenses for assistance in performing the Activities of Daily Living or the Instrumental Activities of Daily Living. See, *infra* “Long-Term Care.”
33. See, e.g., Quinn, “Do You Need Help Making Financial Decisions? Don’t Be Afraid to Ask for Assistance,” AARP Bulletin (1/11/2012), available at <http://www.aarp.org/work/retirement-planning/info-01-2012/incapable-of-managing-money-financially-speaking.html>; and Kolata, “Taking Early Retirement May Retire Memory, Too,” NY Times (10/11/2010), available at http://www.nytimes.com/2010/10/12/science/12retire.html?pagewanted=all&_r=0.
34. See, e.g., Wong & Earl, “Towards an Integrated Model of Individual, Psychosocial, and Organizational Predictors of Retirement Adjustment,” 75 J. Vocational Behavior 1 (2009); and Reitzes and Mutran, “The Transition to Retirement: Stages and Factors That Influence Retirement Adjustment,” 59 Int’l. J. Aging and Human Development 63 (2004).
35. See Duane, “Spotlight on scams that target older adults,” Consumer Financial Protection Bureau (June 13, 2013), available at <http://www.consumerfinance.gov/blog/spotlight-on-scams-that-target-older-adults/> (“Older Americans lose an estimated \$2.9 billion annually to financial exploitation, and it’s estimated that for each case that is reported, 43 others go unrecognized.

- With 50 million older people in this country, and 10,000 more reaching retirement age every day, we cannot afford financial predators or practices that victimize our elder citizens.”).
36. See “Elder Abuse: The Size of the Problem,” Department of Health and Human Services, available at <http://www.ncea.aoa.gov/Library/Data/index.aspx> (“The most recent major studies on incidence reported that 7.6%–10% of study participants experienced abuse in the prior year. ... One study estimated that only 1 in 14 cases of elder abuse ever comes to the attention of authorities.”) (citations omitted).
 37. Kozak, “Employee Benefit Plans” at 246, Carolina Academic Press (Durham, 2010).
 38. *Id.*
 39. However, one of the ways that elderly individuals are financially exploited or abused is by purchasing inappropriate annuities or other income or insurance products. See, e.g., Frolik, “Protecting Our Aging Retirees: Converting 401(k) Accounts Into Federally Guaranteed Lifetime Annuities,” 47 San Diego L. Rev. 277 (2010); Catalano and Lazaro, “Financial Abuse of the Elderly: Protecting the Vulnerable,” 15-Fall PIABA B.J. 1 (2008); and Passaro, “Claims of Exploitation of the Elderly in the Sale of Financial Products,” 80-Oct Fla. B.J. 81 (2006).
 40. However, “a study has now confirmed our worst fears: 46 percent of people die with either no financial assets, or less than \$10,000. Many of these households didn’t own a home (or gave up ownership later in life) and relied almost entirely on Social Security benefits for income, according to the recent analysis of households with people in their last years of life” according to Fleck, “Half of Americans Die With Virtually No Money,” AARP Blog (8/7/2012), available at <http://blog.aarp.org/2012/08/07/half-of-americans-die-with-virtually-no-money/>.
 41. In most states, while an individual has the requisite legal mental capacity, the individual can name an agent to make decisions over property and/or health at the point the principal no longer has the requisite mental capacity to make decisions over property or to consent to or deny medical treatment. Unlike common law agency relationships that terminate once the principal lacks capacity, however, the states have individually developed these durable powers of attorney contracts that actually spring into effect upon, and last through, the incapacity of the principal. Generally, if the advanced directives are not properly executed while an individual has mental capacity and a decision must be made over his or her property or health at a point when the individual lacks mental capacity, then a suit for adult guardianship must be filed so the appropriate state court with jurisdiction can appoint an individual (usually called a guardian or conservator), to make decisions on behalf of that individual. See, e.g., Seal, “Power of Attorney: Convenient Contract or Dangerous Document,” 11 Marq. Elder’s Advisor 307 (2011).
 42. See *supra* n.11, GAO Report (2011) at 10 (citations omitted).
 43. Horneff, Maurer, Mitchell & Dus, “Optimizing the Retirement Portfolio: Asset Allocation, Annuitization, and Risk Aversion,” University of Michigan Retirement Research Center, Working Paper 2006-124 (2006), available at <http://141.213.232.243/bitstream/handle/2027.42/49336/wp124.pdf?sequence=3>.
 44. <http://www.riia-usa.org/about/default.asp>.
 45. Franklin, “Change the Conversation About Retirement Planning: Evolving Models go Beyond Generating Cash Flow,” Investment News (6/23/2013), available at <http://www.investmentnews.com/article/20130623/REG/306239997?template=printart>.

Note, for full disclosure purposes, the author currently serves as a Special Adviser to the Board of Trustees of RIIA.

46. *Id.*

47. *See supra* n.21.

48. IRC §411(a)(7)(A)(i) (“in the case of a defined benefit plan, the employee’s accrued benefit determined under the plan and . . . expressed in the form of an annual benefit commencing at normal retirement age”). Note that although the statutory requirement is an annual benefit, most defined benefit plans generally divide that annual benefit by 12, thus expressing the annual benefit in the form of a monthly benefit commencing at normal retirement age.

A life annuity is paid until the participant dies, commencing on his or her annuity starting date (which, under IRC §417(f)(2)(A)(i), is “the first day of the first period for which an amount is payable as an annuity.”). The most common optional forms of benefits in a defined benefit plan include a joint and survivor annuity, a term certain annuity, and/or a lump sum distribution. A joint and survivor annuity will be paid as long as the participant is alive, and upon his or her death, if the named second life is still alive, then the annuity will be paid until the death of the second life. In order to take advantage of this protection for the second life, the participant must pay a “premium” in the form of a lesser monthly annuity. If the second life, which is irrevocably selected before distributions begin, dies before the participant, then the participant “loses” out on the premium paid. If the participant needs a certain term that the annuity will be paid, regardless of whether he or she is alive, then a premium must be paid in order to receive the protection of the desired term certain (again, the premium is a lesser monthly dollar amount, and the participant “loses” if he or she lives beyond the term certain). A lump sum distribution represents the actuarial present value that is mathematically equivalent to the life annuity, based on the plan’s actuarial equivalents (such as life expectancies and interest rates). Under IRC §401(a)(25), if a defined benefit plan document allows the conversion of the normal form of benefit into any optional forms, then the plan document must state the actuarial equivalents used to convert the life annuity into any other form of distribution in a manner that prevents any type of discretion on the part of the plan administrator. For a more in depth discussion, *see* Kozak, “Employee Benefit Plans and Issues for Small Employers,” T.M. 353-4th, BNA Tax Management Portfolios (2010), at III.A.3.b.(4)(e).

49. Under IRC §417(b), a qualified joint and survivor annuity is an annuity for the life of the participant with a survivor annuity for the life of the spouse which is not less than 50 percent of (and is not greater than 100 percent of) the amount of the annuity which is payable during the joint lives of the participant and the spouse, and which is the actuarial equivalent of a single annuity for the life of the participant. But, Congress recently determined that upon the death of a spouse under normal circumstances in retirement, the surviving spouse will generally need about 75% of the pre-death joint annuity, so they added IRC §417(g) through the Pension Protection Act of 2006, and now every pension plan needs to have a 75% “Joint and Survivor Annuity” option if it does not already include that option (or does not at least offer the choice between a 50% J&S option and a 100% J&S option).

50. Think of a married hetero-sexual couple, both about the same age and in roughly the same health, who need the income to cover expenses and who have no other dependents.

51. As to participation in private sector pension plans, there were a total of almost 41 million total participants in all defined benefit plans that filed a form 5500 in 2010. *See supra* n.14.
As to the participation in public sector pension plans, which are not qualified retirement plans and therefore do not file form 5500, the GAO concluded that “Over 27 million employees and beneficiaries are covered by state and local government pension plans” but noted that “[s]ince 2008, the combination of fiscal pressures and increasing contribution requirements has spurred many states and localities to take action to strengthen the financial condition of their plans for the long term, often packaging multiple changes together. ... 35 states have reduced pension benefits, mostly for future employees due to legal provisions protecting benefits for current employees and retirees. ... Half of the states have increased member contributions, thereby shifting a larger share of pension costs to employees.” *See* “Economic Downturn Spurs Efforts to Address Costs and Sustainability,” GAO-12-322 (2012), available at <http://www.gao.gov/products/GAO-12-322>.
52. “Social Security forms the foundation of income for nearly all retiree households, providing 36 percent of aggregate income for households with a member aged 65 and older; however, it provides a much greater portion of income for low and middle income households. Pensions and assets together provide 31 percent of aggregate income. However, many older adults lack any pension; 44 percent of full-time workers in their 50s have neither a defined benefit nor a defined contribution pension from their current employer; and the number of active defined benefit plan participants has declined since 1990. In 2007, before the recession began, the median level of financial assets for households approaching or entering retirement was around \$72,000. Using a 4 percent withdrawal rate in retirement, this amount would replace about 5 percent of these families’ \$55,000 median annual household income. Although most retirees would also receive Social Security benefits, for many retirees even these will not be sufficient to maintain their standard of living. Older Americans’ income varies widely. In 2008, annual income for households with a member age 65 and older ranged from \$7,466 for those in the lowest of five income groups to \$109,543 for the highest of five income groups.” according to “Income Security: The Effect of the 2007-2009 Recession on Older Adults,” Testimony by Barbara D. Bovbjerg before the Subcommittee on Primary Health and Aging, Committee on Health, Education, Labor and Pensions, U.S. Senate, GAO-12-1272T, October 18, 2011, available at http://www.gao.gov/browse/topic/Retirement_Security!/?rows=10&o=&now_sort=issue_date_dt+desc,title_sort+asc&o=10.
53. IRC §414(i). Under IRC §411(a)(7)(A)(ii), in the case of a plan which is not a defined benefit plan, the “accrued benefit” is the balance of the employee’s account.
54. 75 FR 5253 (Feb. 2, 2010).
55. 77 FR 5443 (Feb. 3, 2012). The proposed regulations would primarily amend portions of the minimum distribution rules currently in final form at Treas. Reg. §1.401(a)(9)-5 and -6.
56. *See supra* n.16.
57. For a complete discussion of Social Security benefits, *see, e.g.*, Altman, “The Striking Superiority of Social Security in the Provision of Wage Insurance,” 50 Harv. J. on Legis. 109 (2013); and Zimmerman, “Incentivizing Work at Older Ages: The Need for Social Security Reform,” 19 Elder L.J. 485 (2012).

If an individual was determined to be disabled and is receiving disability insurance benefits from Social Security, then by definition, when the individual attains his or her Social Security Normal Retirement Age, then the disability insurance payments cease and old age insurance payments begin.

Note that individuals might not be able to use the total expected amount to cover expenses for two reasons: first, under IRC §86, individuals with a certain level of income during retirement might need to pay income taxes on 50% or even 85% of the amount received from Social Security; and, second, as discussed *infra*, at “Medicare Part B”, if an individual elects to pay premiums for coverage under Medicare Part B, then such premiums will likely be taken at the source by the Social Security Administration, thus reducing the amount of the check mailed (or, these days, directly deposited).

58. Social Security Administration Reg. §404.110(b)(1) (an individual needs at least 6 quarters of coverage but not more than 40 quarters of coverage to be fully insured); and §404.115. *See also* §§ 404.111 and .112 for special rules for veterans of World War II or certain employees of private non-profit organizations, respectively.
59. *See generally* IRC §3101, Federal Insurance Contributions Act (FICA payroll taxes for wages earned by common law employees) and IRC §1401, Tax on Self-Employment Income (SECA payroll taxes for earned income of self-employed individuals).
60. 42 USC §416(l)(1)(E) (the full retirement age is 67 for those born in or after 1960, which has been ratcheted up from age 65 for those born before 1937).
61. 42 USC §402(q)(1). *See* Social Security Reg. §§ 404.410 through 413 for methodology of calculating early retirement benefits.

This article does not provide strategies and philosophies for determining whether to accelerate or delay the enrollment in Social Security; for such advice, *see, e.g.*, Baxendale and Coppage, “Should Taxpayers Repay Social Security Benefits to Increase Future Benefits?,” 84 PRACTXST 334 (2010); Pollard, “When is the Better Time to Start Receiving Social Security Benefits?,” 35 ESTPLN 32 (2008); Kaplan, “Top Ten Myths of Social Security,” 3 Elder L.J. 191 (2005); and Baxendale, “Is Postponing Social Security Benefits the Better Choice?,” 77 PRACTXST 330 (2004).

62. Social Security Administration Reg. §404.313.
63. Social Security Administration Reg. §404.330.
64. Social Security Administration Reg. §404.331.
65. Social Security Administration Reg. §404.335.
66. IRC §453.
67. *See infra*, “Self-Pay—Either in Advance Through Long Term Care Insurance or in Real Time.”
68. Per Instructions to the 2012 IRS Form 1040, Chart A, available at <http://www.irs.gov>, for 2012, federal income tax returns were required to be completed and filed: if single, over age 65, and gross income was at least \$11,200; if married filing jointly, both over age 65, and gross income was at least \$21,800; if married filing separately, over age 65, and gross income was at least \$3,800; if head of household, over age 65, and gross income was at least \$13,950; and if qualifying widower, over age 65, and gross income was at least \$16,850. Further, “Gross income means all income you received in the form of money, goods, property, and services that is not exempt from tax, including any income from

sources outside the United States or from the sale of your main home (even if you can exclude part or all of it). Do not include any social security benefits unless (a) you are married filing a separate return and you lived with your spouse at any time in 2011 or (b) one-half of your social security benefits plus your other gross income and any tax-exempt interest is more than \$25,000 (\$32,000 if married filing jointly). If (a) or (b) applies, see the instructions to figure the taxable part of social security benefits you must include in gross income.”

69. *See, infra*, “Life Expectancy.”
70. IRC §401(a)(9). *See, e.g.*, Sigler, “The Impact of Required Minimum Distributions from Retirement Plans and the Taxing of Social Security Benefits,” 19 J. Benefits & Comp. 6 (2003); and Kozak, “The New Required Minimum Distribution Rules: Simpler than the Old Rules, But Still Not Simple,” The Carolina Business Journal (July 2002).
71. Health Savings Accounts were created in 2003 when Congress added IRC §223. Under the rules, an account can be established and funded through tax-deductible employee contributions or tax-exempt employer contributions, and as long as distributions are used “exclusively for the purpose of paying qualified medical expenses of the account beneficiary,” then the distributions are not subjected to income tax. Under the statutory rules, at IRC §223(d)(1)(E), since the “interest of an individual in the balance in his [Health Savings] Account is nonforfeitable,” then any amounts not spent on medical expenses while the individual is young and healthy or otherwise wealthy will be available to be used for medical expenses incurred later in life. As per Rev. Proc. 2012-26, the inflation-adjusted amounts for 2013 were annual deductions limited to \$3,250 for individuals with self-only coverage and \$6,450 for individuals with family coverage, but only if the individual only participated in a “high deductible health plan” which must have an annual deductible of at least \$1,250 for self-only coverage or \$2,500 for family coverage, and which must have the total out-of-pocket expenses (other than premiums) of at least \$6,250 for self-only coverage and \$12,500 for family coverage.
72. Viatical agreements allow a noninterested third party to purchase a life insurance product owned by an individual who is critically and terminally ill. Note that some states regulate the viatical market by requiring that the brokers are licensed (*see, e.g.*, M.G.L. Chapter 326, available at <http://www.mass.gov/ocabr/shared/doilproducer-viatical-req.html>).
73. A life insurance policy is a worthwhile asset, but it is there primarily to provide income to one’s heirs upon death. Generally, with a whole life insurance policy, the insured individual can sometimes receive a distribution of the policy’s cash surrender value or a loan, but the withdrawal of the full cash surrender value will terminate the policy and outstanding loans will decrease the face amount payable upon death.
74. After several discussions with colleagues and students, the term “unbudgetable” seems more appropriate than terms such as “uncontrollable” or “unexpected.”
75. OECD, Glossary of Statistical Terms, available at <http://stats.oecd.org/glossary/detail.asp?ID=1530>. Note that there is no definition of “life expectancy” in the definitional sections of the Code (either at IRC §§ 414 or 7701) or in ERISA (at §3).
76. Bowman and Freeman, “Mortality Comparisons and Risk Exposures in the Older Age U.S. Financial Services Market,” Society of Actuaries Report 1 (2011) (finding, at p. 15, “For

- example, historically the mortality for a \$5,000 burial expense product is very different from that of a \$5 million individual life policy. The socioeconomic status of the insureds, the additional protective underwriting tools utilized for the higher face amount policies, and the health selection criteria for each product contribute to the mortality differences between the products.”).
77. *See, e.g.*, “Deaths: Preliminary Data for 2010,” National Vital Statistics Report, Center for Disease Control, Table 6 titled “Expectation of life at selected ages by race, Hispanic origin, race for non-Hispanic population, and sex: United States, final 2009 and preliminary 2010” (2012), available at <http://www.cdc.gov/nchs/fastats/lifexpec.htm>.
 78. *Los Angeles Dept. of Water & Power v. Manhart*, 98 S. Ct. 1370, 1377 (1978). The Court stated that “[just] because women as a class live longer than men, an employer may *not* adopt a retirement plan that treats every individual woman less favorably than every individual man.” *Id.* at 1379-80 (emphasis added).
 79. *Arizona Governing Committee, Etc. v. Norris*, 463 U.S. 1073, 1081 (1983) (quotations in original).
 80. *Id.* at 1085.
 81. 2012 Annual Report of the Social Security Trustees, page 90, Table V.A3, “Period Life Expectancy.”
 82. *Id.*
 83. <http://www.medicare.gov/NHCompare/Static/tabSI.asp?language=English&activeTab=3&subTab=3>.
 84. <http://www.medicare.gov/NHCompare/Static/tabSI.asp?%20language=English&activeTab=3&subTab=18&version=>.
 85. *See, e.g.*, Carlson, “Trends and Tips in Long-Term Care: Who Benefits - or Loses - From Expanded Choices,” 18 *Elder L.J.* 191 (2010); Klein, “Top Ten Elder Law Myths,” 38 *AUG Md. B.J.* 26 (2005); and Kling, “Zoned Out: Assisted-Living Facilities and Zoning,” 10 *Elder L.J.* 187 (2002).
 86. <http://www.medicare.gov/NHCompare/Static/tabSI.asp?language=English&activeTab=3&subTab=3&Alternatives=HCAHPS10>.
 87. According to the National PACE Association, available at <http://www.npaonline.org/websitel/article.asp?id=12> (click on “List of PACE Programs by State”), the 29 states with PACE programs are: Alabama, Arkansas, California, Colorado, Florida, Iowa, Kansas, Louisiana, Massachusetts, Maryland, Michigan, Missouri, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Virginia, Vermont, Washington, and Wisconsin.
 88. Note that due to the terminology of Medicare and Medicaid, both enacted in 1965, the term “community” means any place of residence which is not an “institution” (like a hospital or a nursing home).
 89. <http://www.medicare.gov/NHCompare/Static/tabSI.asp?language=English&activeTab=3&subTab=3&Alternatives=HCAHPS1>.
 90. <http://www.medicare.gov/NHCompare/Static/tabSI.asp?language=English&activeTab=3&subTab=3&Alternatives=HCAHPS5>.
 91. <http://www.medicare.gov/NHCompare/Static/tabSI.asp?language=English&activeTab=3&subTab=3&Alternatives=HCAHPS6>.

92. <http://www.medicare.gov/NHCompare/Static/tabSI.asp?language=English&activeTab=3&subTab=3&Alternatives=HCAHPS7>. See http://www.alfa.org/alfalState_Regulations_and_Licensing_Informat.asp.
93. <http://www.medicare.gov/NHCompare/Static/tabSI.asp?language=English&activeTab=3&subTab=3&Alternatives=HCAHPS8>. See also www.carf.org.
94. <http://www.medicare.gov/NHCompare/Static/tabSI.asp?language=English&activeTab=3&subTab=3&Alternatives=HCAHPS9>.
95. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Nursing-Facilities-NF.html>.
96. See, e.g., Brisk, “Medicare Benefit for Skilled Nursing Care Can Continue Even After ‘Plateau,’” (2011), available at <http://www.briskelderlaw.com/pdfs/MEDICARE%20FOR%20SNF%20AFTER%20PLATEAU.90518.pdf>.
97. Private insurance contracts will generally categorize the medical care in a similar manner. This article does not discuss the federal income tax implications of medical care expenses that, if not compensated for by insurance or otherwise, under IRC §213, are deductible from a taxpayer’s gross income if they were paid for the taxpayer, his spouse or dependent, and if the total expenses exceed 7.5% of his adjusted gross income. For federal income tax purposes, “medical care” means, under IRC §213(d)(1), “amounts paid (A) for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body; (B) for transportation primarily for and essential to medical care referred to in subparagraph (A), (C) for qualified long-term care services; or (D) for insurance (including amounts paid as premiums under [Medicare] part B . . .) covering medical care referred to in subparagraphs (A) and (B) or for any qualified long-term care insurance contract.” The definition is a moving target, and the IRS publishes an annual alphabetical listing of costs that are and are not considered medical expenses through Publication 502, “Medical and Dental Expenses (Including the Health Coverage Tax Credit) (2012), available at <http://www.irs.gov/pub/irs-pdf/p502.pdf>.

Note that this definition under the Code is broader than the definition under ERISA §3 for an employee welfare benefit plan which provides “for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services.”

98. “There are many definitions of “chronic condition”, some more expansive than others. We characterize it as any condition that requires ongoing adjustments by the affected person and interactions with the health care system” according to http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2.
99. See, e.g., the definition for purposes of Medicare, at 42 USC §1395x(n), which is likely similar to many private insurance policy definitions. (“The term “durable medical equipment” includes iron lungs, oxygen tents, Nebulizers, CPAP, catheters, hospital beds, and wheelchairs (which may include a power-operated vehicle that may be appropriately used as a wheelchair, but only where the use of such a vehicle is determined to be necessary on the basis of the individual’s medical and physical condition and the vehicle meets such safety requirements as the Secretary

may prescribe) used in the patient's home (including an institution used as his home other than an institution that meets the requirements of subsection (e)(1) of this section or section 1819(a) (1)), whether furnished on a rental basis or purchased, and includes blood-testing strips and blood glucose monitors for individuals with diabetes without regard to whether the individual has Type I or Type II diabetes or to the individual's use of insulin (as determined under standards established by the Secretary in consultation with the appropriate organizations); except that such term does not include such equipment furnished by a supplier who has used, for the demonstration and use of specific equipment, an individual who has not met such minimum training standards as the Secretary may establish with respect to the demonstration and use of such specific equipment. With respect to a seat-lift chair, such term includes only the seat-lift mechanism and does not include the chair.”).

100. When used exclusively, and no other medical services are used to attempt to ameliorate or maintain the chronic illness itself, then it becomes different than palliative care. *See, infra* n.102.
101. Such laws exist in Oregon (The Oregon Death With Dignity Act is available at <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ors.aspx>, and was held Constitutional in *Gonzales v. Oregon*, 546 U.S. 243 (2006)); Washington (The Washington Death With Dignity Act is available at <http://apps.leg.wa.gov/RCW/default.aspx?cite=70.245>); and Vermont (The Patient Choice at End of Life, available at <http://www.leg.state.vt.us/docs/2014/Acts/ACT039.pdf>).
102. *See, e.g.*, “What Is Palliative Care?” available at <http://www.getpalliativecare.org/whatis/>. (“Palliative care is specialized medical care for people with serious illnesses. It focuses on providing patients with relief from the symptoms, pain, and stress of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses and other specialists who work together with a patient’s other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.”). When used in conjunction with other medical services that attempt to ameliorate or maintain the chronic illness itself, then it becomes different than hospice care.
103. Most states allow individuals, while they still have mental capacity to do so, to express their health goals, through what are colloquially and collectively called “end of life” directives: Durable Power of Attorney for Health contracts, living wills, declarations of mental health treatment, and Do Not Resuscitate Orders. The newest form of end of life directive is a Physicians Ordered Life Sustaining Treatment order, which details to all attending medical professionals the preplanned wishes of an individual as his or her chronic disease proceeds through its final stages. *See* National POLST Paradigm, at www.polst.org, for more information.
104. U.S. Department of Health and Human Services, from their 1990 report titled “Measuring the Activities of Daily Living: Comparisons Across National Surveys,” available at <http://aspe.hhs.gov/daltcplreports/meacmpes.htm>.
105. *Id.*
106. However, “[a]s useful as they are, ADLs do not measure the full range of activities necessary for independent living in the community. To partly fill this gap in disability classification, the ‘instrumental activities of daily living,’ or IADLs, were developed. The IADLs capture a range of activities that are more complex than those needed for the ADLs, including

handling personal finances, meal preparation, shopping, traveling, doing housework, using the telephone, and taking medications” according to Weiner, Hanley, Clark & Van Nostrand, “Measuring the Activities of Daily Living: Comparisons Across National Surveys,” U.S. Department of Health and Human Services (1990), available at <http://aspe.hhs.gov/daltcp/reports/meacmpes.htm>.

107. U.S. Department of Health and Human Services, available at <http://longtermcare.gov/the-basics/who-needs-care/>.
 108. *Id.*
 109. *Id.*, at <http://longtermcare.gov/the-basics/how-much-care-will-you-need/>.
 110. *Id.*
 111. Available at <https://www.metlife.com/mmilresearch/2012-market-survey-long-term-care-costs.html#keyfindings>. The rates in bold are from the survey, and all other rates have been interpolated by the author for purposes of this article.
 112. Available at <https://www.metlife.com/assets/cao/mmilpublications/studies/2012/studies/mmi-adult-day-services-table.pdf>. Note that the lowest average rate is \$31 daily in Mobile, Alabama, and that the highest average rate is \$141 hourly in Vermont.
 113. Available at <https://www.metlife.com/assets/cao/mmilpublications/studies/2012/studies/mmi-home-care-costs-table.pdf>. Note that the lowest average rate is \$13 hourly in Shreveport Area, Louisiana, and that the highest average rate is \$32 hourly in Rochester Area, Minnesota.
- It is quite difficult under most existing state laws for family members who act as caregivers to be paid, so the rate is for professional caregivers who are properly licensed and bonded, and who enter into formal employment contracts with the patient needing the caregiving services. *See, e.g.*, Knox, “Eldercare for the Baby-Boom Generation: Are Caregiver Agreements Valid?,” 45 Suffolk U. L. Rev. 1271 (2012), and Porter, “Why Care About Caregivers? Using Communitarian Theory to Justify Protection of ‘Real’ Workers,” 58 U. Kan. L. Rev. 355 (2010).
114. Available at <https://www.metlife.com/assets/cao/mmilpublications/studies/2012/studies/mmi-assisted-living-costs-table.pdf>. Note that the lowest average rate is \$2,447 monthly in Mississippi, anywhere other than Jackson Area, and that the highest average rate is \$5,598 monthly in Wilmington, Delaware.
 115. Available at <https://www.metlife.com/assets/cao/mmilpublications/studies/2012/studies/mmi-nursing-home-costs-table.pdf>. Note that the lowest average rate is \$131 daily in Texas, anywhere other than Austin, Dallas/Ft. Worth, or Houston, and that the highest average rate is \$388 daily in New York, New York.
 116. Available at *id.* Note that the lowest average rate is \$147 daily in Oklahoma, anywhere other than Oklahoma City or Tulsa, and that the highest average rate is \$396 daily in New York, New York.

Whether in a semiprivate room or a private room, due to the extra attention needed, patients with Alzheimer’s disease or other forms of dementia will generally be exposed to higher daily rates, especially in nursing homes that specialize in such heightened caretaking. Some of the additional attention relates to human sexuality. *See, e.g.*, White, “The Eternal Flame: Capacity to Consent to Sexual Behavior Among Nursing Home Residents With Dementia,” 18 Elder L.J. 133 (2010) and Tenenbaum, “To Be or To Exist: Standards for Deciding Whether

- Dementia Patients in Nursing Homes Should Engage in Intimacy, Sex and Adultery,” 42 *Ind. L. Rev.* 675 (2009).
117. The Social Security Act of 1965, P.L. 89-87, created Medicare under Title XVIII of the Social Security Act, titled “Health Insurance for Aged and Disabled,” codified 42 USC §1395 *et. seq.*
 118. P.L. 111-148. As per the decision in the consolidation of *National Federation of Independent Business v. Sebelius* and *Florida v. United States Department of Health and Human Services*, 132 S. Ct. 2566 (2012), the Patient Protection and Affordable Care Act is, in fact, Constitutional, except that the Secretary of Health and Human Services will not have the authority to withhold current federal matching funds to states that do not amend their respective Medicaid programs to cover more individuals, as required under the Act for those states to receive additional federal matching funds.
 119. See “Medicare & You: 2013,” available at www.medicare.gov/publications/pubs/pdf/10050.pdf (especially the chart on page 14 of the publication).
 120. See <http://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-a-glance.html>.
 121. 42 USC §1395c.
 122. *Id.*
 123. As per IRC §3101, the employee portion of “payroll taxes” under the Federal Insurance Contributions Act is comprised of: 6.2% of compensation earned up to the Social Security Taxable Wage Base to fund the Old Age, Survivors, and Disability Insurance part of Social Security, plus 1.45% of all wages (plus, starting in 2013, an additional 0.9% of all wages in excess of a threshold of \$250,000 in the case of a joint return; \$125,000 in the case of a married taxpayer filing a separate return; and \$200,000 for single taxpayers) to fund the Hospital Insurance part of Social Security (*i.e.*, Medicare Part A). As per IRC §3111, the employer portion of “payroll taxes” is the same amount as the employee’s portion. As per IRC §1401, since a self-employed individual is both an employee and an employer, the tax on self-employment income is basically the sum of the “payroll taxes” determined under IRC §§ 3101 and 3111, by substituting “self-employment income” for “wages” (although individuals might be eligible for certain income tax credits to otherwise reduce the total contribution).
 A separate Federal Hospital Insurance Trust Fund is established under 42 USC §1395i; thus, actually bifurcating the funding, and projected sustainability, of the Social Security and Medicare trust funds. See “A Summary of the 2013 Annual Reports: Social Security and Medicare Boards of Trustees,” available at <http://www.ssa.gov/oact/TRSUM/index.html> (“Each year the Trustees of the Social Security and Medicare trust funds report on the current and projected financial status of the two programs.”).
 124. The monthly premium for 2013 is \$441, see <http://www.medicare.gov/cost/>.
 125. 42 CFR §406.32(d).
 126. 42 USC §1395d.
 127. See 42 USC §1861(b); and “Are You a Hospital Inpatient or Outpatient? If you have Medicare? Ask!” (Revised Feb. 1, 2011), Medicare Publication 11435, available at

128. “Medicare & You: 2013,” available at www.medicare.gov/publications/pubs/pdf/10050.pdf.
129. Each individual has a total of 60 “lifetime reserve days,” and each day that an individual pays a higher co-pay for an inpatient hospital stay in excess of 60 days per each spell of illness reduces the remaining “lifetime reserve days,” and once any individual has paid a total of 60 “lifetime reserve days” then the individual will be responsible for all costs, without any assistance from Medicare Part A. The term “lifetime reserve days” is used for the first time in Regulations promulgated by the Center for Medicare and Medicaid, and the explanation of such lifetime reserve days, without use of the term, is at 42 USC §1395d(a)(1).
130. But such services *might* be covered under Medicare Part B, *if* they are determined to be medically necessary.
131. <http://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-a-glance.html#collapse-4808>.
132. As per 42 USC §1395x(a), the term “spell of illness” with respect to any individual means “a period of consecutive days - (1) beginning with the first day (not included in a previous spell of illness) (A) on which such individual is furnished inpatient hospital services, inpatient critical access hospital services or extended care services, and (B) which occurs in a month for which he is entitled to benefits under part A, and (2) ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital or critical access hospital nor an inpatient of a facility.”
133. Note, there is a lifetime limit of 190 days of mental health care; whereas, there is no such maximum number of days of physical health care over an individual’s life. *See, e.g.,* Tovino, “All Illnesses are (Not) Created Equal: Reforming Federal Mental Health Insurance Law,” 49 *Harv. J. on Legis.* 1 (2012).
134. *See supra* n.129.
135. 42 USC §1395j.
136. *Id.*
137. 42 USC §1395r; *See* <http://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-a-glance.html#collapse-4808>. The sliding scale is: \$146.90 monthly premium if income is between \$85,000 and \$107,000 (or \$170,000 to \$214,000 for individuals who file their federal income tax returns as Married Filing Jointly); \$209.80 monthly premium if income is between \$107,000 and \$160,000 (or \$214,000 to \$320,000 for individuals who file their federal income tax returns as Married Filing Jointly); \$272.70 monthly premium if income is between \$160,000 and \$214,000 (or \$328,000 to \$428,000 for individuals who file their federal income tax returns as Married Filing Jointly); and \$335.70 monthly premium if income exceeds \$214,000 (or \$428,000 for individuals who file their federal income tax returns as Married Filing Jointly).
138. “Medicare Part B premiums must be deducted from Social Security benefits if the monthly benefit covers the deduction. If the monthly benefit does not cover the full deduction, the beneficiary is billed” according to “Hospital and Medical Insurance Benefits Provided,” Social Security Handbook §127, the Social Security Administration, available at http://www.ssa.gov/OP_HomeIhandbookIhandbook.01Ihandbook-0127.html.
139. *See* “Medicare & You: 2013,” available at www.medicare.gov/publications/pubs/pdf/10050.pdf (in preparation for the 2013 calendar year, beneficiaries had from October 1 through October 15, 2012, to compare policies and options, and from October 15 to December 7, 2012, generally,

to make changes or to enroll, and if already enrolled, inaction would allow continued coverage as of January 1, 2013).

140. 42 USC §1395k. *See also* “Medicare & You: 2013 (pages 33-50),” available at <http://www.medicare.gov/pubs/pdf/10050.pdf>.

141. *See* <http://www.medicare.gov/Coverage/Home.asp>.

142. “Medicare & You: 2013,” available at www.medicare.gov/publications/pubs/pdf/10050.pdf. There is no maximum annual or lifetime limit, so in years that an individual is unhealthy, his or her out-of-pocket expenses will be 20% of a very large number.

Note, under the Affordable Care Act, a limitation on out-of-pocket costs under group health plans offered by employers to employees would be capped at \$6,250 for an individual and \$12,700 for a family; however, there is no similar limiting provision for out-of-pocket spending by Medicare beneficiaries. Although the limit for employer plans was supposed to be effective in 2014, the U.S. Department of Labor extended the compliance deadline until 2015. *See* “FAQs About Affordable Care Act Implementation Part XII,” U.S. Department of Labor (Feb. 20, 2013), available at <http://www.dol.gov/ebsa/healthreform/>, click on “Part XII” under “Frequently Asked Questions.”

143. *See* <http://www.medicare.gov/coverage/preventive-visit-and-yearly-wellness-exams.html>. Within the first 12 months of Medicare Part B enrollment, any beneficiary can have a free “Welcome to Medicare” preventative visit (“which includes a review of the patient’s medical and social history related to his or her health and education and counseling about preventive services, including certain screenings, shots, and referrals for other care, if needed. It also includes: height, weight, and blood pressure measurements; a calculation of the individual’s body mass index; a simple vision test; a review of the individual’s potential risk for depression and his or her level of safety; an offer to talk with the patient about creating advance directives; and, a written plan letting the patient know which screenings, shots, and other preventive services might be needed.”). Then, once a beneficiary has been enrolled in Medicare Part B for at least 12 months, then a Yearly “Wellness” visit (“a beneficiary can use this annual visit to develop or update a personalized prevention help plan to prevent disease and disability based on his or her current health and risk factors, which might require the completion of a “Health Risk Assessment” questionnaire, and also includes: a review of his or her medical and family history; developing or updating a list of current providers and prescriptions; height, weight, blood pressure, and other routine measurements; detection of any cognitive impairment; personalized health advice; a list of risk factors and treatment options for that patient; and, a screening schedule (like a checklist) for appropriate preventive services, even if such services are not free.”).

144. <http://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-a-glance.html#collapse-4808>.

145. *See* “Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare: 2013,” available at <http://www.medicare.gov/Pubs/pdf/02110.pdf>.

146. 42 USC §1395ss.

147. “Cost of Medigap Policies,” Medicare.gov, available at <http://www.medicare.gov/find-a-plan/staticpages/learn/how-insurance-companies-price-policies.aspx#;return%20false;>.

148. 42 USC §1395w-21. Note, recent amendments to the statutory provision are titled “Medicare Advantage Program” even though the name in the statutory provision remains titled “Medicare+Choice Program.”

149. *See supra* n.138. Section 127.5 of the Social Security Handbook continues (“Beneficiaries may elect deduction of Medicare Part C (Medicare Advantage) from their Social Security benefit. Some Medicare Advantage plans include a reduction in the Part B premium. Social Security takes that reduction into account, as soon as we are notified of the reduction by CMS. Beneficiaries may also elect deduction of their prescription drug plan premium from their Social Security benefit.”).
150. Note that insurance companies are regulated by each individual state.
151. *See* “Understanding Medicare Part C and D Enrollment Periods” (Revised October 2012), available at <http://www.medicare.gov/Publications/Pubs/pdf/11219.pdf>.
152. 42 USC §1395w-21(a)(2).
153. *See*, “Medicare & You: 2013 (page 52),” available at www.medicare.gov/publications/pubs/pdf/10050.pdf.

According to a 2012 report produced by the Federal Interagency Forum on Aging-Related Statistics, available at http://www.agingstats.gov/Main_Site/Data/2012_Documents/Health_Status.aspx, three of these medical issues, hearing, vision, and dental, respectively, are among the most common causes of poor health, and yet they are not generally covered under Medicare Part A or Part B plans (“In 2010, 46 percent of older men and 31 percent of older women reported trouble hearing. The percentage of older Americans with trouble hearing was higher for people age 85 and over (59 percent) than for people age 65–74 (31 percent). Eleven percent of all older women and 18 percent of all older men reported having ever worn a hearing aid. Vision trouble affected 14 percent of the older population, 13 percent of men and 15 percent of women. Among people age 85 and over, 23 percent reported trouble seeing. The prevalence of edentulism, having no natural teeth, was higher for people age 85 and over (33 percent) than for people age 65–74 (19 percent). Socioeconomic differences were large. Forty-two percent of older people with family income below the poverty line reported no natural teeth compared with 22 percent of people above the poverty threshold.”).

154. “Your Medicare Costs,” [medicare.gov](http://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-a-glance.html#collapse-4808), available at <http://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-a-glance.html#collapse-4808>.
155. It seems almost impossible to find an actual average premium, or even a comparison of premiums, through the Internet (the author spent about 30 minutes after Googling “average monthly premium Medicare Part C 2013” and found no useful information).
156. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. 108-173, added Medicare Part D effective as of January 1, 2006.
157. 42 USC §1395w-101.
158. *See supra* n.149.
159. 42 USC §1395w-102(a).
160. 42 USC §1395w-102(e).
161. 42 USC §1395w-104.
162. 42 USC §1395w-102(b). *See, also*, “Medicare & You: 2013 (page 57),” available at www.medicare.gov/publications/pubs/pdf/10050.pdf.
163. This is technically called the “Yearly Deductible.”
164. This is technically called the “Copayment Period.”
165. This is technically called the “Coverage Gap Period.”

166. Under §1101 of the Patient Protection and Affordable Care Act of 2010, the “donut hole” is gradually reduced from 100% payment by the beneficiary to 25% co-payment by the beneficiary, effectively extending the “copayment period,” which requires a 25% co-payment, until the “Catastrophic coverage” period, and thus effectively eliminating the “Coverage gap” period (*i.e.*, the “donut hole.”). Under 42 USC §1395w-102(b)(2)(C)(ii), as amended, the generic-gap coinsurance percentage is 93% for 2011 (meaning the beneficiary is responsible for 93% of costs during the coverage gap period for generic drugs), is decreased by 7% for each calendar year from 2012 through 2019, and remains at 25% for 2020 and each subsequent year. Under 42 USC §1395w-102(b)(2)(D)(ii), as amended, a different sliding scale is used, and the coverage gap for applicable drugs (*i.e.*, not generic drugs, but otherwise eligible prescription drugs), is 97.5% for 2013 and 2014 (meaning that the beneficiary pays only 2.5% of the total costs during the coverage gap period for non-generic prescription drugs), 95% for 2015 and 2016, 90% for 2017, 85% for 2018, 80% for 2019, and remains at 75% for 2020 and each subsequent year.
167. 42 USC §1860D-1(b).
168. *See supra* text accompanying and following n.151.
169. “Your Medicare Costs,” Medicare.gov, available at <http://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-a-glance.html#collapse-4808>.
170. However, depending on the individual’s income in 2 calendar years prior to the current calendar year, and the individual’s filing status in that previous year, there is an additional “income adjusted monthly adjustment amount,” ranging from \$11.60 (if single and 2011 income was between \$85,000 and \$107,000; or if married filing jointly and 2011 income was between \$170,000 and \$214,000) to \$66.60 (if single and 2011 income was above \$214,000; if married filing jointly and 2011 income was above \$428,000; or, if married but filing separately and 2011 income was above \$129,000).
171. Resources must not exceed \$13,300 for individuals or \$26,580 for a married couple living together (resources do not include the value of a primary residence, a car, and life insurance policies), and annual income must not exceed \$17,235 for individuals or \$23,265 for a married couple living together).
172. *See* “Apply online for Extra Help with Medicare prescription drug costs,” available at <http://www.ssa.gov/pubs/EN-05-10525.pdf>.
173. The summary in this section has been calculated by the author for this article. For an interesting quantitative comparison of individual expectations of the total cost of healthcare (either in terms of annual spending or lifetime spending) to experts’ expectations, *see* Hoffman & Jackson, “Retiree Out-of-Pocket Healthcare Spending: A Study of Consumer Expectations and Policy Implications,” 39 Am. J.L. & Med. 62 (2013).
174. For an individual who pays monthly premiums for Medicare Part A because he or she did not have 40 quarters of payroll taxes, then 12 * \$104.90, for a total of \$1,258.80 in 2013, and if that individual did not enroll when first eligible, then on an annual basis, 12 * \$115.39, for a total of \$1,384.68 in 2013.
175. Depending on income, the highest level of premiums that can be charged is 12 * \$335.70, for a total of \$4,028 in 2013, but if the individual is charged the 10% penalty because he or she did not enroll in Medicare Part B when eligible, then \$4,431.24 in 2013.

176. *See supra* n.158. Depending on the Medicare Part D beneficiary's income two years prior to the current year, then in addition to the monthly premiums charged by the private insurance company, which varies based on the desired "bells and whistles" selected by the beneficiary, there might be a surcharge of up to 12 * \$66.60 per month, for a total of \$799.20 in 2013.
177. A good starting point is entering a test, item or service in the appropriate spot titled "Your Medicare Coverage" on <http://www.medicare.gov/coverage/your-medicare-coverage.html>.
178. *See supra* n.165, under the Affordable Care Act, this donut hole decreases and is ultimately eliminated in 2020.
179. For a reminder of the costs of long-term care services, *see supra* "Long-Term Care."
180. *Id.*
181. *See supra* n.113.
182. *See supra* n.117.
183. "Social Security Programs in the United States," Social Security Administration, available at <http://www.ssa.gov/policy/docs/prodesc/sspus/>, click on "Medicaid." Under 42 USC §1396d(a), the term "medical assistance" means "payment of part or all of the cost of the following care and services or the care and services themselves, or both . . ."
184. 42 USC §1396a. Currently, all States have voluntarily developed compliant Medicaid systems.
185. 42 USC §1396b. *See*, "The Medicaid Program at a Glance," Kaiser Family Foundation (March 4, 2013), available at <http://kff.org/medicaid/fact-sheet/the-medicaid-program-at-a-glance-update/> ("The federal government matches state Medicaid spending according to a formula in federal law. The federal match rate, known as the Federal Medical Assistance Percentage, or FMAP, varies based on state per capita income. The FMAP ranges from a federal floor of 50% to 73.4% currently in the poorest state, Mississippi. The federal government funds about 57% of Medicaid costs overall.").
186. Under 42 USC §1396a(a)(10)(A)(i), "all states must make medical assistance available to all individuals who are "categorically needy." As summarized in "Medicaid Made Simple," American Medical Association, available at <http://www.ama-assn.org/resources/doc/rfs/medicaid-made-simple.pdf>, the "categorically needy" include "Low-income infants, pregnant women, and children aged 1-5 with income below 133% of the Federal Poverty Limit; Low-income families who meet certain pre-welfare reform AFDC eligibility requirements (e.g., income and resources); Low-income children aged 6-18 with income below 100% of the Federal Poverty Level; and, Aged, blind and disabled individuals receiving Supplemental Security Income through Social Security." In addition, the applicant must: be a U.S. citizen or meet certain immigration rules; be a resident of the state where he or she applies; and have a Social Security number.
187. 42 USC §1396a(a)(10)(A)(ii). One of the most relevant groups of individuals who might be covered under any given State's Medicaid program are those, under §1396a(a)(10)(A)(ii)(V), who remain in medical institutions for periods in excess of 30 days, provided that the resources and the income stream for any of those individuals do not exceed the federal threshold amounts.
- See "Eligibility," Centers for Medicare & Medicaid Services, available at <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Eligibility.html>, which states:

In order to participate in Medicaid, federal law requires states to cover certain population groups (mandatory eligibility groups) and gives them the flexibility to cover other

population groups (optional eligibility groups). States set individual eligibility criteria within federal minimum standards. States can apply to CMS for a waiver of federal law to expand health coverage beyond these groups. . . . Many states have expanded coverage, particularly for children, above the federal minimums. For many eligibility groups, income is calculated in relation to a percentage of the Federal Poverty Level (FPL). For example, 100% of the FPL for a family of four is \$23,550 in 2013. The Federal Poverty Level is updated annually. For other groups, income standards are based on income or other nonfinancial criteria standards for other programs, such as the Supplemental Security Income (SSI) program.

Another important financing problem with Medicaid is the phenomenon commonly referred to as “dual eligibles,” where a Medicare beneficiary is too indigent to pay all of the required out-of-pocket costs so the state Medicaid program will cover those out-of-pocket costs. *See* 42 USC §1936(p), providing a definition of a “Qualified Medicare beneficiary; Medicare cost-sharing.” *See also* “Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles) At a Glance, Centers for Medicare & Medicaid Services, available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medicare_beneficiaries_dual_eligibles_at_a_glance.pdf.

188. *See* National Federation of Independent Business v. Sebelius and Florida v. United States Department of Health and Human Services, 132 S. Ct. 2566, especially Part IV of the majority opinion.

As summarized in “Affordable Care Act,” Center for Medicare & Medicaid Services, available at <http://www.medicare.gov/affordablecareact/affordable-care-act.html>, the Act, among other things to improve the entire system, “creat[es] a minimum Medicaid income eligibility level across the country,” will allow those newly eligible Medicaid beneficiaries to “receive a benchmark benefit or benchmark equivalent package that includes the minimum essential benefits provided in the Affordable Insurance Exchanges,” and “includes a number of program and funding improvements to help ensure that people can receive long-term care services and supports in their home or the community.”

189. 42 USC §1396n(c).
190. The starting point should be www.medicare.gov, or any state’s official Web site for its governor. Additionally, since elder law attorneys traditionally develop a greater understanding about these rules than do other attorneys, individuals can find elder law attorneys through various state and local bar association Web sites, as well as a national database through www.naela.org (the National Academy of Elder Law Attorneys).
191. *See, e.g.,* Harris v. McRae, 448 U.S. 297, 301 (1980) (“[The Medicaid program provides] federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons.”).
192. *Schwelker v. Gray Panthers*, 453 U.S. 34, 37 (1981).
193. Under the federal rules, an elderly individual is defined at 42 USC §1396d(a)(iii), as being “65 years of age or older.”
194. 42 USC 1382b. Through a cross-reference, “resources,” for purposes of qualifying for Medicaid, have the same meaning as “resources” for purposes of qualifying for Supplemental

Security Income for the Aged, Blind and Disabled. As per 20 CFR §416.1201, “resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance.”

While each state has very specific rules for limits and/or how property must be titled, *for a good summary, see <http://longtermcare.gov/medicare-medicaid-more/medicaid/medicaid-eligibility/financial-requirements-assets/>.*

195. There is not a satisfactory definition of actuarially sound annuities, for purposes of Medicaid, through current federal regulations or other guidance. Therefore, respective state Medicaid agencies are establishing their own rules on what constitutes an actuarially sound annuity. The author posits that the concept of “actuarially sound annuities” from qualified retirement plans might be instructive to those respective state Medicaid agencies.

As to Medicaid, the Centers for Medicare & Medicaid Services Publication #45, “The State Medicaid Manual,” (last revised in November, 1994), available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>, offers a definition, but since it has not been revised to incorporate the amendments made by the Deficit Reduction Act of 2005, it is unclear if this definition is still relevant. The manual, at 3258.9 B, states (emphasis added):

Annuities.--... Annuities, although usually purchased in order to provide a source of income for retirement, are occasionally used to shelter assets so that individuals purchasing them can become eligible for Medicaid. In order to avoid penalizing annuities validly purchased as part of a retirement plan but to capture those annuities which abusively shelter assets, a determination must be made with regard to the ultimate purpose of the annuity (i.e., whether the purchase of the annuity constitutes a transfer of assets for less than fair market value). If the expected return on the annuity is commensurate with a reasonable estimate of the life expectancy of the beneficiary, [then] the annuity can be deemed actuarially sound.

As to ERISA plans, the idea of an “actuarially sound” annuity ties in with the rules for Required Minimum Distributions when someone attains age 70½. If taken out as joint and survivor annuity, and the second life is not a spouse, then the question is whether statistically (*i.e.*, actuarially) it is expected that the worker who earned the benefit will receive at least 50% of the total benefit during his or her life. So, by doing the actuarial mathematics that they do (calculating the present value of future benefits, based not only on interest, but other discounts, such as a reasonable mortality table and other relevant factors, as reflected in Treas. Regs. §1.401(a)(9)-9, Q&A-3), if at the date of the irrevocable election it is expected that at least 50% of the benefit will truly be a retirement benefit, and that less than 50% will truly be a death benefit, then it passes the “Minimum Incidental Death Benefit” under IRC §401(a)(9)(G), and associated regulations at Treas. Reg. §1.401(a)(9)-6, Q&A 2(c). Although the term “actuarially sound” is not used within the Regulations, the Preamble to the Final Regulations, at T.D. 9130 (06/14/2004), states that “[t]he basic purpose of the incidental benefit rule is to ensure that the payments under the annuity are primarily to provide retirement benefits to the employee.” Remember, these are just the Required Minimum Distribution rules for an individual who

turns age 70½ and is “wealthy” enough to not need the benefits accrued under an employer-provided retirement plan to pay living and medical care expenses.

Bottom line, since the Deficit Reduction Act of 2005 amended the Medicaid eligibility rules, a “needy” applicant for Medicaid must prove that he or she did not purposely gift away resources that could have paid the nursing home or in-home caregiver. One of the requirements for such annuity purchase is that it is “actuarially sound (as determined in accordance with actuarial publications of the Office of Chief Actuary of the Social Security Administration),” as defined in 42 USC §1396p(c)(1)(G)(ii)(II). On the other hand, for purposes of receiving favorable income tax treatment under a qualified retirement plan, Congress demands that at some age (here, age 70½,) at least a minimal amount of the accrued benefit must be distributed and is expected to be included in the participant’s gross income while he or she is alive. The two separate uses of the same term likely will, or has, caused confusion and negative consequences for an individual, who made appropriate, irrevocable, and statutorily compliant benefit distribution elections under the qualified retirement plan rules, but who then applies for Medicaid under his or her state rules within 60 months of that election.

196. 42 USC §1382b(b)(1). However, under §1392b(b)(2), the Commissioner may not force the sale of real property that cannot be sold because it is jointly owned, its sale is barred by legal impediment, or if the owner’s reasonable efforts to sell it have been unsuccessful.
197. 42 USC §1328a(a). While each state has very specific rules for limits on income streams, *for good summary, see <http://longtermcare.gov/medicare-medicaid-more/medicaid/medicaid-eligibility/financial-requirements/>*.

However, 42 USC §1382a(b) excludes certain income streams from being counted in determining the \$2000 threshold (such as certain amounts paid to the individual based on being: under age 65 and blind but not otherwise disabled; under age 65 and disabled but not otherwise blind; or, age 65 or older; certain annuity payments to veterans who are age 65, blind, or disabled; and assistance furnished to or on behalf of such individual (and spouse), which is based on need (including assistance received pursuant to a catastrophe declared to be a major disaster by the President, home energy assistance programs, dwelling assistance programs, and relocation assistance programs)).

198. There is a whole list of exceptions at 42 USC §1382a(a)(2)(A).
199. 42 USC §1382a(b)(2)(B).

The author strongly cautions that the reliance upon the term “pensions from employer-provided retirement plans” *might* not harmonize with what ERISA attorneys and other pension consultants understand as “pensions from employer-sponsored retirement plans,” especially those retirement plans that are classified as qualified retirement plans.

Under 42 USC §1396p(c)(1)(G), as added by DRA 2005, the following specific annuities will be considered to be a transfer of assets for fair market value, and thus *not* subject to the Medicaid waiting period penalties:

an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986; or (II) purchased with proceeds from – (aa) an account or trust described in subsection (a), (c), or (p) of section 408 of such Code; (bb) a simplified employee pension (within the meaning of section 408(k) of such Code); or (cc) a Roth IRA described in section 408A of such Code.

For clarification (by the author): IRC §408(b) describes an individual retirement annuity; IRC §408(q) describes a deemed IRA under a qualified plan; IRC §408(a) describes an individual retirement account; IRC §408(c) describes accounts established by employers and certain associations of employees; and IRC §408(p) describes Simple retirement accounts. The author cautions that there is absolutely no specific reference in the statute to annuities and pension distributions to a participant or beneficiary from an employer-sponsored retirement plan, as governed by IRC §§ 401(a), 403(a), 457(b) or 457(f). Similarly, there is a lack of any definitional reference, or statutory cross-reference, to pensions either in the US Code or in federal regulations. There is some relief provided in the Social Security Handbook, at §1317.1, available at http://www.ssa.gov/OP_Home/handbook/handbook.13/handbook-1317.html, which states “1317.1 Do Pension And Retirement Payments Count As Wages? Effective January 1, 1984, your pension and retirement payments generally count as wages. However, they do not count as wages if the payments are made from tax-exempt trusts or qualified deferred compensation plans.” Qualified retirement plans are, indeed, tax-exempt trusts. However, the author’s research yielded no actual statutory or regulatory demand or permission for the Social Security Administration to make this interpretation, and even within the Social Security Handbook’s interpretation, there is no citation or further analysis.

Note that this raises a very interesting question: if a participant in a qualified retirement plan (or even a properly designed and administered non-qualified retirement plan), chooses an annuity optional form of benefit distribution, then that annuitization, especially if the normal form of benefit was a lump sum, *might* be treated as “the disposal of an asset for less than fair market value.” As per 42 USC §1396p(e)(3), as added by DRA 2005, “The Secretary *may* provide guidance to States on categories of transactions that may be treated as a transfer of asset for less than fair market value.” (emphasis added). Since the Secretary of Health and Human Services, through the Center for Medicare & Medicaid Services, has not promulgated regulations on this particular aspect of the amendments to Medicaid made through DRA 2005, then each individual state is left to its own interpretation.

For example, without any verification by the author, the following description of Ohio’s Medicaid rules appears on Michael Millonig’s Web site, available at <http://www.milloniglaw.myelderlawattorneys.com/ohio-medicaid.html>:

The Ohio Medicaid rule sets forth provisions governing ERISA pension plans, IRA’s, any other pension and retirement plans, or “any other similar financial vehicles administered by an individual, employer or union.” The term used in the rule is “Retirement and income supplementing accounts” or RISA.

Even though ERISA and state law provide protection from creditors for such accounts, there is no such provision in the Medicaid rule. The issue for purposes of Medicaid eligibility is whether the account is a countable resource and whether eligibility is approved. This is not a creditor issue and the State does not force a liquidation of any particular asset.

The RISA is a countable resource if the person has an ownership interest and the legal ability to convert it to cash. Thus, if the plan allows withdrawal of any or all

of the plan balance, then it is countable. This may be the case even if the person is still working. Many plans provide for in service withdrawals based upon hardship or other criteria. However, there is no requirement for the persons to terminate employment if this is the only way to obtain a withdrawal. The RISA of both husband and wife will be evaluated to determine availability.

The amount of the resource is the amount available for withdrawal less any penalty imposed by the plan. However, income taxes due cannot be deducted from the amount.

If the RISA is not an available resource, then it may still be considered as income. The person must elect the maximum available amount. If a spousal waiver is required to obtain the maximum amount, the person must prove they made a good faith attempt to obtain this spousal waiver. This provision is in violation of ERISA which of course preempts state law. It is an egregious violation of spousal rights guaranteed under federal law. The result is of course that, by not electing a joint and survivorship pension payment, the CS is left with no pension income after the death of the NHS. What is the point of requiring a good faith effort when there is no right to demand a waiver? The only point of this is for ODJFS to intimidate and coerce a waiver.

This article provides absolutely no opinion as to whether the Departments of Labor, Treasury, and Health & Human Services have coordinated their respective Regulations and other guidance to harmonize the rules for the annuitization or lump sum distribution of accrued benefits from employer-provided retirement plans with the penalty rules which prevent an individual from enrolling in his or her state's Medicaid program if needy. However, if there has not yet been any coordination, then this author *hopes* that there will be coordination, especially as both the Departments of Labor and Treasury are finalizing their respective rules on Lifetime Income Distributions from employer plans and as respective State Medicaid agencies are interpreting the federal mandates for annuities "purchased" after February 8, 2006 as to whether they are proper transfers for fair market value, or by default, are improper transfers for less than fair market value, which causes a penalty period before the State Medicaid agency will pay for the long-term care services of the applicant.

200. <http://longtermcare.gov/medicare-medicaid-more/medicaid/medicaid-eligibility/share-of-cost/>.
201. The effect of *United States v. Windsor*, ___ U.S. ___ (2013), on Medicaid is uncertain. The *Windsor* Court held that Section 3 of the Defense of Marriage Act invalid, because, "[b]y seeking to displace this protection [of marriage] and treating those persons [who have been solemnized as a same-sex couple through a state's marriage laws] as living in marriages less respected than others, the federal statute is in violation of the Fifth Amendment." In "welcoming" the *Windsor* decision, President Obama stated that "I've directed the Attorney General to work with other members of my Cabinet to review all relevant federal statutes to ensure this decision, including its implications for Federal benefits and obligations, is implemented swiftly and smoothly." See, Slack, Supreme Court Strikes Down the Defense of Marriage Act,

The White House Blog (June 26, 2013), available at <http://www.whitehouse.gov/blog/2013/06/26/supreme-court-strikes-down-defense-marriage-act>.

According to H.R. Rep. No. 104-664, at 10 (1996), “The word ‘marriage’ appears in more than 800 sections of federal statutes and regulations, and the word ‘spouse’ appears more than 3,100 times. With very limited exceptions, these terms are not defined in the federal law,” and concluded that “federal law has simply accepted state law determinations of who is married.” (quotations in the original). So, assumedly, the definition of “marriage” and “spouse” at 1 USC §7, will be deleted (as it was added to the U.S. Code in 1996 through P.L. 104-199), and the pre-1996 definitions will resurface (meaning that states that embrace marriage equality and allow same-sex couples to enter into valid marriages, or that accept the marital status conferred by a sister state or foreign jurisdiction, will run their state Medicaid programs to protect the community spouse from dire poverty in all lawful marriages).

202. While each state has very specific rules for limits on income streams, *for good summary*, see <http://longtermcare.gov/medicare-medicaid-more/medicaid/medicaid-eligibility/considerations-for-married-people/>.
203. Note that a phenomenon (which is disturbing in the author’s opinion) has surfaced due to improper advanced planning for the marital assets and income streams – divorce has now become a legitimate tool to allow the infirmed spouse to enroll in Medicaid while keeping the healthy spouse in the community. See, e.g., “Divorce and Medicaid (General Discussion),” available at http://www.decnj.org/articles/Divorce_Medicaid.html, and Heiser, “If I Divorce my Husband, Will he be Eligible for Medicaid?” available at <http://www.agingcare.com/Answers/divorce-husband-eligible-for-Medicaid-153274.htm>.
204. This article does not get into the debate, but there is an issue as to whether Medicaid planning is ethical and moral. See, e.g., Bothe, “The Stigma of Survival: Medicaid Estate Planning,” 51 S. Tex. L. Rev. 815 (2010); Karp and Gershbein, “Poor on Paper: An Overview of the Ethics of Morality and Medicaid Planning,” 79-OCT Fla. B.J. 61 (2005); and Zeman, “Estate Planning: Ethical Considerations of Using Medicaid to Plan for Long-Term Medical Care for the Elderly,” 13 Quinnipiac Prob. L.J. 187 (1998).
205. The Deficit Reduction Act of 2005, P.L. 109-171 (2/08/2006), amending 42 USC §1396p(c)(1)(B)(I) from 36 months to 60 months.
206. Note that it is a pure mathematical summation in the numerator, without any recognition of the time value of money.
207. Each state’s Medicaid agency keeps current averages for different regions within the state.
208. Anecdotally, individuals in need of long-term care who are moved directly into a nursing home from a hospital are generally not expelled from the nursing home upon realization that the patient has no assets to pay, and that Medicaid will not pay for a period of months. This is to avoid bad publicity. However, if the same patient voluntarily goes to a nursing home, then the nursing home simply will not admit him or her until the penalty period ends.
209. See http://benefits.va.gov/PENSIONANDFIDUCIARY/pensionaid_attendance_housebound.asp.
210. *Id.*
211. <http://www.veteranaid.org/eligibility.php>.
212. *Id.*

213. *Id.*
214. See, e.g., <http://www.usawarvet.org/aid-and-attendance.php>.
215. Note, veterans might have more options for health care than nonveterans, but they might also have more conflicts. See, e.g., Jacksonis, Deyton, & Hess, "War, Its Aftermath, and U.S. Health Policy: Toward a Comprehensive Health Program for America's Military Personnel, Veterans, and Their Families," 36 J.L. Med. & Ethics 677 (2008).
216. See, e.g., "Veterans Benefits Law & Advocacy," Lexis Nexis, available at <http://www.lexisnexis.com/veteranslaw/default.page>, ("In December 2006, Congress repealed the 144-year-old law that prohibited attorneys from charging a fee for representing veterans in VA benefits claims. The Veterans Benefits, Health Care, and Information Technology Act of 2006 (Section 101 of Public Law 109-461) took effect on June 20, 2007. The law now allows attorneys to represent veterans much earlier in the VA claims process, and permits them to charge reasonable fees for the representation.").
217. According to "National Clearinghouse for Long-Term Care Information," U.S. Dept. of Health and Human Services, available at http://www.longtermcare.gov/LTC/Main_Sitel/Understanding_Long_Term_Care/Basics/Basics.aspx, ("The Administration on Aging estimates that about 70 percent of Americans over age 65 will need long-term care support.").
218. Wone, "Another Option? The Future Combination Long-Term Care Policies Following the Pension Protection Act of 2006," 3 NAELA J. 207 (2007).
219. *Id.*, at 212 ("Adverse selection is the tendency of those who have reason to expect greater-than-average benefits to be more likely to purchase any insurance-type product priced for the average risk.") (quotation and citation omitted).
220. *Id.*, at 214 ("Insurance underwriting is the process of reviewing medical and health-related questions furnished in an application to determine if the applicant presents an acceptable level of risk and is insurable.") (quotation and citation omitted).
221. *Id.*, at 215 ("Even within the same market, the GAO concluded that prices could vary from \$857 to \$2061 annually for similar policies from different carriers.") (quotation and citation omitted).
222. *Id.*, at 216 (If a person dies without the need for any long term benefits services, or if a person stops paying premiums because of negligence or affordability, then all premiums have been paid wasted).
223. In the Pension Protection Act of 2006, Congress added IRC §7702B to add the definition of a "qualified long-term care insurance contract" and allowed the proceeds to be excludable from gross income; amended IRC §§ 72 and 213 to allow for the premium payments to be deductible; and amended IRC §1035 to allow taxpayers with existing non-qualified long term care insurance contracts to exchange them for qualified contracts without recognizing any gains.
224. The Community Living Assistance Services and Supports Act, P.L. 111-148, Tit. VIII, §§ 8001-8002.
225. See, e.g., Klein, "The New CLASS Act," 7 NAELA J. 35, 37 (2011).
226. *Id.*, at 39.
227. *Id.*, at 37. (citing 42 USC §30011-7(b)).
228. On October 14, 2011, Secretary Sebelius transmitted a report and letter to Congress stating that "the Department does not see a viable path forward for CLASS implementation at this time" according to "Key Features of the Affordable Care Act By Year," U.S. Department of

- Health & Human Services, available at <http://www.hhs.gov/healthcare/facts/timelineline-timeline-text.html>. View a copy of the “CLASS report” at <http://aspe.hhs.gov/daltcp/reports/2011/class/index.shtml>.
229. P.L. 112-240 (Jan. 2, 2013).
230. *See, e.g.*, Volsky, “Judd Gregg: We Included CLASS IN Health Reform to Accommodate Kennedy’s ‘Last Hurrah,’” Think Progress (10/18/2011), available at <http://thinkprogress.org/health/2011/10/18/346873/judd-gregg-we-included-class-in-health-reform-to-accommodate-kennedys-last-hurrah/>, (“I knew we weren’t going to kill the CLASS Act because it was Sen. Ted Kennedy’s proposal, and he was very sick, and most of us were very sensitive to the fact he was sick. This was his last hurrah, legislatively.”).
231. Ujvari, “Long-Term Care Insurance: 2012 Update,” AARP Public Policy Institute (06/2012), available at http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/ltc-insurance-2012-update-AARP-ppi-ltc.pdf
232. *Id.*
233. *Id.*
234. *See, e.g.*, “Annuity LTC Riders,” The Annuity News, available at <http://annuitynews.net/tag/annuity-ltc-riders/>.
235. *See, e.g.*, Curry, Anwuri, Robinson, & Shugrue, “Financial Planning for Long-Term Care: Individual Expectations and Plans ~ A Closer Look at Long-Term Care Insurance,” Connecticut Long-Term Care Needs Assessment Focused Report I, University of Connecticut Health Center (January 2008), available at <http://www.uconn-aging.uchc.edu/LTC%20financing%20report%20FINAL%20REPORT%201-23-08.pdf>.
236. Britt, “Balancing Long-Term Care Solutions for Couples: Important Difference between Men and Women You Should Know,” Society of Financial Service Professionals, Risk Management Section e-Newsletter (July 2013), available (to SFSP members) at <http://www.financialpro.org/members/sections/print/RM0713.pdf>.
237. *See supra* n.16, at 26739, Appendix A, Lifetime Income Illustration, (b) *Example*.
238. *Id.*
239. *See, e.g.*, Powell, “Will You Need 135% of Your Salary in Retirement? Figuring Out Your Income-Replacement Rate is Not an Easy Task,” Market Watch (Sept. 8, 2011), available at <http://www.marketwatch.com/story/will-you-need-135-of-your-salary-in-retirement-2011-09-08>, (where that author actually criticizes a fellow economist for suggesting the 135% replacement rate, but summarizes the other suggestions, such as 60%, 75%, 81% to 84% depending on salary, and 100%); and Krasny, The Notion That You’ll Spend Less In Retirement Is Totally Misguided,” Business Insider (Aug. 29, 2012), available at <http://www.businessinsider.com/the-notion-that-youll-spend-less-in-retirement-is-totally-misguided-2012-8>.
240. “Women Take the Wheel: Destination Retirement,” Society of Actuaries (2012), available at www.soa.org/WorkarealDownloadAsset.aspx?id=30096.
241. Fidelity Viewpoints, “Putting a Price on Health,” available at <https://guidance.fidelity.com/viewpoints-workplace/putting-a-price-on-health-pr> (citing Fidelity Consulting Services, 2010). (“Based on a hypothetical couple retiring in 2010, 65 years or older, with average (82 male, 85 female) life expectancies. Methodology and Information: Estimates are calculated for “average” retirees, but may be more or less depending on actual health status, area, and longevity.

Assumes no employer-provided retiree health care coverage. Assumes retiree has traditional Medicare, elects Medicare Part D, and receives full government Part B subsidy. Assumes a health care cost inflation rate of 6.6% based on various service cost increases, ranging from 4% to 7.5%. Estimates are representative of amount needed in a taxable account. Assumes medical costs are incurred uniformly annually after age 65, and assumes an after-tax rate of return of 4% in retirement. Savings amounts do not include expenses related to over-the-counter drugs, dental care, nursing home care, or long term care insurance.”).

Note that instead of \$250,000, “[t]he Society of Actuaries Decision Brief Securing Health Insurance for the Retirement Journal estimates a couple, both age 65, will need \$230,000 to cover these costs, which doesn’t include the cost of long-term care.” See Dowd, “Boomers Need Health-Care Costs Reality Check (an Interview with Anna Rappaport),” *Fox Business* (Aug. 16, 2012), available at <http://www.foxbusiness.com/personal-finance/2012/08/16/boomers-need-health-care-costs-reality-check/>.

242. *Id.*

243. Poterba, Venti & Wise, “The Composition and Drawdown of Wealth in Retirement,” 25 *J. Economic Perspectives* 95, 113 (2011). Note that the data set for the empirical study is from 2008, which predates the housing bubble burst and economic downturn from late 2009.

244. Bengen, “Determining Withdrawal Rates Using Historical Data,” 7 *J. Financial Planning* 171, 172 (1994). The actual statement was (“Assuming a minimum requirement of 30 years of portfolio longevity, a first-year withdrawal of 4 percent, followed by inflation-adjusted withdrawals in subsequent years, should be safe.”).

245. See, e.g., Scott, Sharpe, & Watson, “The 4% Rule – At What Price?” 7 *J. Investment Management* 1 (Spring 2009); and Pfau, “Choosing a Retirement-Income Strategy: A New Evaluation Framework,” 2 *Retirement Management J.* 33 (Fall 2012), available (to members) at http://ria-usa.org/pdfs/rmjs-pub/RMJ_V2N3.pdf (where the market is divided into high net worth clients, affluent clients, and mass market clients, and that for each, depending on his/her/their lifestyle, they are “overfunded” if less than 3.5% of the endowment is withdrawn in any year, “constrained” if between 3.5% and 7% of the endowment is withdrawn in any year, and “underfunded” if 7% or more is withdrawn in any year).

246. If, however, an individual chooses a formulated and planned spend-down method, then he or she needs to first make a reasonable assumption about his or her life expectancy. See, e.g., “How Much Can I Afford to Spend in Retirement? Plan on Living to 95,” (July 12, 2013), available at <http://howmuchcaniaffordtospendinretirement.blogspot.com/2013/07/plan-on-living-to-95.html>.

247. Most employee benefit plans (health and welfare plans and pension and profit sharing plans) are governed by a federal law, the Employee Retirement Income Security Act of 1974 (ERISA), P.L. 93-406, codified at 29 USCA §1001, *et. seq.* (although references herein are to the sections of ERISA, which do not directly map to the codified sections in Title 29). ERISA was enacted in part to provide employees, who are promised benefits from their employers, with rights to actually receive and enjoy such benefits. As per ERISA §4(b), plans maintained by governments, by certain small businesses without common law employees, and a few other types of employers are not governed by ERISA. Title I, Subtitle B of ERISA requires certain reporting and disclosure by plan sponsors in Part 1; certain vesting and accrual minimums in Part 2;

- certain advanced funding requirements for pension plans in Part 3; duties individuals serving as plan fiduciaries must comply with to avoid personal liability for breaches in Part 4; and, a list of civil actions and remedies, and other enforcement mechanisms, in Part 5.
248. *See supra* n.21. With a qualified retirement plan, the contributions made by the employer to fund the plan benefits are immediately deductible under IRC §404, the income taxation for the participants is deferred until the year that benefits are received from the plan under IRC §402, and neither the employer nor the participants pay income taxes in between since the assets must generally be invested in a special tax exempt trust that meets the requirements of IRC §501(a). By default, since plans sponsored by governmental employers are regulated under IRC §457(b), and since plans sponsored by public schools and certain tax-exempt organization employers are regulated under IRC §403(b), all other retirement plans sponsored by private employers are regulated under IRC §401(a) if the employer desires the immediate deduction and wants the employees to defer inclusion of the benefits into their Gross Incomes until the year received. However, for those employers who choose to promise deferred compensation to a select group of management, or if they promise retirement benefits through a noncompliant qualified plan, the deferred compensation plans are regulated under a myriad of rules in IRC §§ 83(b), 162(m), 409A, 451, and 457A.
 249. ERISA §§ 101 to 111 contain most of the statutory requirements for reporting and disclosure for plans subject to ERISA.
 250. Under Title III of ERISA, as amplified by President Carter's Reorganization Plan No. 4 of 1978 (43 FR 47713, Dec. 28, 1978), the Department of Labor has jurisdiction over the content of most reporting and disclosure requirements, but over time, the Department of Treasury has been given jurisdiction and has issued guidance on the content of some disclosures as well.
 251. ERISA §104(b)(1)(A). Under ERISA §104(b)(1)(B), when a plan is first established and thus becomes subject to ERISA, all eligible participants must receive a copy of the SPD within 120 days.
 252. ERISA §104(b), flush language after (b)(1)(B).
 253. ERISA §102(b); Labor Reg. §2520.102-3. Labor Regulations regarding ERISA are codified at Chapter 25 of Title 29 of the Code of Federal Regulations ("CFR").
 254. Labor Reg. §2520.102-2 (and Labor Reg. §2520.102-4 when there is a reason to draft different SPDs for the same plan).
 255. ERISA §102(a); Labor Reg. §2520.102-2(a).
 256. Labor Reg. §2520.102-2(a).
 257. Under ERISA §3(3), "the term 'employee benefit plan' or 'plan' means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan." The terms "employee welfare benefit plan" and "employee pension benefit plan" are defined at ERISA §§ 3(1) and 3(2), respectively.
 258. *Amara v. Cigna Corp.*, 131 S. Ct. 1866, 1878 (2011) (holding that "[f]or these reasons taken together we conclude that the summary documents, important as they are, provide communication with beneficiaries about the plan, but that their statements *do not themselves* constitute the terms of the plan for purposes of § 502(a)(1)(B).") (emphasis in the original).

259. *Id.* In the author's opinion, the *Amara* decision is not absolutely conclusive for several reasons, and will not immediately resolve the issue of complicated and highly technical SPDs and other summary documents.

First, the holding can reasonably be classified as mere dicta, since the argument begins, at 1877, "[e]ven if the District Court had viewed the summaries as plan 'terms' (which it did not, see *supra*, at 1875–1876), however, we cannot agree that the terms of statutorily required plan summaries (or summaries of plan modifications) necessarily *may* be enforced (under § 502(a)(1)(B)) as the terms of the plan itself." (quotations in the original) (emphasis added).

Second, right before the ostensible holding for part II.A. of the opinion, the Court states, at 1878, "[n]one of this is to say that plan administrators can avoid providing complete and accurate summaries of plan terms in the manner required by ERISA and its implementing regulations." So, this leaves the issue of when has an SPD crossed the line to be considered as negligently or willfully misleading, in which case a court might hold under certain facts that the provisions in the SPD and other summary documents might actually supersede the provisions in the actual plan document.

Third, in a more controversial analysis of the decision, the Supreme Court reminded us, at 1875, that the "[district] court held that ERISA § 502(a)(1)(B) provided the legal authority to enter this relief [ordering the CIGNA Plan to reform the provisions of its plan documents and then to make benefit distributions in accordance with such revision]" and, at p. 1876, that the district court "decided not to answer" whether "ERISA § 502(a)(3) also provided legal authority to enter this relief." Under the two different statutory civil actions, either a participant brings a civil action under ERISA §502(a)(1)(B) "to recover benefits due him under the terms of his plan," or brings a civil action under ERISA § 502(a)(3)(B) to "obtain other appropriate equitable relief" (assumedly only if the remedy available under ERISA §502(a)(3)(A), of "enjoin[ing] any act or practice which violates [ERISA] or the terms of the plan" is unavailable). Therefore, *Amara* seemingly holds that if the terms of a plan document are to be revised under order of a district court, such authority must arise from ERISA §502(a)(3), and not from ERISA §502(a)(1)(B). The author's conclusion is supported by the statement in the concurring opinion written by J. Scalia, at 1882, that "[ERISA § 502(a)(1)(B)] does not authorize relief for misrepresentations in a summary plan description (SPD). I do not join the Court's opinion because I see no need and no justification for saying anything more than that." In the author's opinion, this or other district courts might use the ostensible authority cloaked within ERISA §502(a)(3) to require this particular CIGNA plan, or other plans with similar facts, to revise the terms of the plan document, which might or might not include the terms of the SPD and other summary documents.

Fourth, in its conclusion that it is up to the district court to figure out what the term "other equitable relief" actually means based on the specific facts of a civil action brought under ERISA §502(a)(3), the *Amara* Court blurs the harm that must be proven by either individual participants or the class of participants as a whole, since the Court first states, at 1881, that "[a]ccordingly, when a court exercises its authority under § 502(a)(3) to impose a remedy equivalent to estoppel, a showing of detrimental reliance must be made" but then continues its discussion and concludes section III of its opinion with "[a]lthough it is not always necessary

to meet the more rigorous standard implicit in the words ‘detrimental reliance,’ actual harm must be shown.” (quotations in the original). In this author’s opinion, until there is further clarification of the level of any individual participant’s harm that needs to be proven in a civil action under ERISA §502(a)(3), SPDs and other summary documents might continue being drafted in a complicated manner, since the simpler a SPD is for any participant to understand, the easier it will likely be for that participant to demonstrate some level of harm if a court grants “other equitable relief” (whatever that means and whether it rises to the level of harm or detrimental reliance).

260. *See supra* n.255.
261. “How Readable Are Summary Plan Descriptions For Health Care Plans?” Employee Benefits Research Institute, Notes (October 2006), available at http://www.ebri.org/pdf/notespdf/EBRI_Notes_10-20061.pdf. *See also* “Report Of The Working Group On Communications To Retirement Plan Participants,” United States Department of Labor, Employee Benefits Security Administration (2005), available at http://www.dol.gov/ebsa/publications/AC_1105b_report.html.
262. *Id.*
263. ERISA §502(a)(1)(B).
264. ERISA §503.
265. ERISA §105(a).
266. ERISA §105(a)(1)(A)(i). Under ERISA §404(a), fiduciaries of ERISA plans make all investment decisions over plan assets, but under ERISA §404(c), if the fiduciaries follow certain procedures and stay within certain parameters, then they can allow the individual plan participants to self-direct the investments for their respective accounts.
267. ERISA §105(a)(1)(A)(ii).
268. ERISA §105(a)(1)(B).
269. ERISA §105(a)(2)(A)(iii).
270. For a complete chart prepared by the Department of Labor, titled “Reporting and Disclosure for Employee Benefit Plans” (revised October 2008), *see* http://www.dol.gov/ebsa/compliance_assistance.html#section3, click on “Reporting/Disclosure Guide For Employee Benefit Plans.”
271. ERISA §209. The plan administrator shall provide a statement of total accrued benefits and total nonforfeitable pension benefits, if any, which have accrued, or the earliest date on which benefits become nonforfeitable to participants upon request, upon termination of service with the employer, or after the participant has a one year break in service.
272. ERISA §203(a)(3)(B); Labor Reg. § 2530.203-3. The plan administrator shall provide a notice that benefit payments are being suspended during certain periods of employment or reemployment during the first month or payroll period in which the withholding of benefit payments occurs.
273. ERISA §204(h). The plan administrator shall provide a notice within a reasonable time, generally 45 days, before the effective date of a plan amendment subject to ERISA that is expected to reduce the rate of future benefit accruals. The notice must also be “written in a manner calculated to be understood by the average plan participant and to apprise the applicable individual of the significance of the notice.” *See also* Treas. Reg. §54-4980F-1, Q&A-11 (in order

to add a penalty tax on untimely or ineffective notices, Congress added §4980F to the Code to supplement existing ERISA §204(h) and associated Labor Regulations).

274. ERISA §4041(a)(2). The plan administrator shall provide a notice of intent to terminate within 60 days before the proposed termination date. Under ERISA §4041, the plan can only terminate under a standard termination, meaning the plan has enough assets at the time of termination to cover the present value of all accumulated and accrued liabilities; however, if the employer sponsoring the plan declares bankruptcy, then the PBGC might become trustee over the plan assets and assume the liability to pay out accrued benefits (up to a statutory limit of about \$170,000 per year if paid as a life annuity starting at the beneficiary's attainment of age 75) to the individuals when they attain the retirement age defined under the controlling plan document.
275. ERISA §4041(b)(2)(B). The plan administrator shall provide a notice to each person who is a participant or beneficiary under the plan by the date that the plan submits an actuarial certification to the PBGC, specifying the amount of the benefit liabilities (if any) attributable to such person as of the proposed termination date and the benefit form on the basis of which such amount is determined, and including the following information used in determining such benefit liabilities: the length of service, the age of the participant or beneficiary, wages, the assumptions, including the interest rate, and such other information as the corporation may require. The notice shall be written in such manner as is likely to be understood by the participant or beneficiary.
276. ERISA §404(c); Labor Reg. §2550.404c-1(b)(2). The plan administrator shall provide all information required under the Regulations before the time when investment instructions are to be made, or upon request.
277. ERISA §101(i); Labor Reg. §2520.101-3. The plan administrator shall provide notification at least 60 days in advance of any planned period of more than 3 consecutive business days when there is a temporary suspension, limitation or restriction under an individual account plan on directing or diversifying plan assets, obtaining loans, or obtaining distributions.
278. Labor Reg. § 2550.404c-5. The plan administrator shall provide advance notice the circumstances under which contributions or other assets will be invested on their behalf in a qualified default investment alternative, the investment objectives of the qualified default investment alternative, and the right of participants and beneficiaries to direct investments out of the qualified default investment alternative. The Regulations provide the time frames.
279. ERISA §514(e)(3). The plan administrator shall provide a notice informing participants of their rights and obligations under the arrangement within a reasonable period before the plan year begins.
280. ERISA §101(m). The plan administrator shall provide a notice informing participants of their right to sell company stock and reinvest proceeds into other investments available under the plan and the notice must also describe the importance of diversifying the investment of retirement account assets. The notice must be communicated Not later than 30 days before the first date on which the individuals are eligible to exercise their rights.
281. IRC §402(f).
282. Treas. Reg. §1.402(f)-1, Q&A-1(a).
283. *Id.*, at Q&A-1(b).

284. The IRS published a model notice for compliance with the statutory provisions titled “Special Tax Notice Regarding Plan Payments,” first in Notice 2002-3, and then an updated model notice in Notice 2009-68, 2009-39 IRB 423 (Sept. 4, 2009).
285. *See id.* Notice 2009-68 only modified and superseded the original 2002 model notice after several years of not complying with amendments to the Code that might have been substantial in some participants’ distribution decisions.
286. Treas. Reg. §1.402(f)-1, Q&A-1(a) (emphasis added). Note that the term “easily understood” is a bit looser than the requirements for SPDs and other forms of communication, requiring that they be “written in a manner calculated to be understood by the average plan participant.” In the author’s opinion, the model notice promulgated by the IRS is not easily understood, and therefore, arguably no plan sponsor has actually complied with the mandates under their own Treasury Regulations.
287. IRC §401(a)(11).
288. IRC §417(a)(3).
289. Treas. Reg. §1.417(a)-3(a)(4). Note that the requirement for the disclosure of relative values explanation notice to be “written in a manner calculated to be understood by the average participant” is not a statutory requirement, but only appears at Treas. Reg. §1.417(a)(3)-1(a)(4). Query whether the Departments of Treasury and Labor actually view (or will view) the same phrase in exactly the same manner, should either agency begin to investigate the appropriateness and readability of various ERISA retirement plan communications.
290. Under IRC §401(a)(11)(B), the qualified joint and survivor annuity and qualified preretirement survivor annuity requirements, as further defined at IRC §417, apply to all defined benefit plans, and to all defined contribution plans subject to the minimum funding standards of §412, but, under §401(a)(11)(B)(iii), do not apply to any defined contribution plan that “provides that the participant’s nonforfeitable accrued benefit... is payable in full, on the death of the participant, to the participant’s surviving spouse...” and if a participant cannot “elect a payment of benefits in the form of a life annuity.”
- Since most 401(k) plans and other profit sharing plans provide the full account balance upon death of the participant, and since most 401(k) plans and profit sharing plans do not currently offer annuities as distribution options, they are not subject to the disclosure of relative value requirements. If, going forward, a 401(k) plan or profit sharing plan adds an annuity distribution option, then they will need to comply with the requirements because that second clause will no longer excuse them from the requirements. However, the author of this article argues that the information required under the disclosure of relative values regulations is very relevant to any plan participant in understanding the difference between an annuity and a lump sum distribution, in general, and should be included in all benefits statements, even those from 401(k) plans and profit sharing plans which do not offer annuity distribution options.
291. *See, e.g.,* *Wilson v. Southwestern Bell*, 55 F.3d 399, 407 (8th Cir. 1995) (holding that it “appears to be an objective standard rather than requiring an inquiry into the subjective perception of the individual participants” and that the readability requirement does not extend to other correspondence); and *Hickman v. GEM Ins. Co.*, 299 F.3d 1208, 1212 (10th Cir. 2002) (holding that “the trial court followed the correct procedure in first resolving the question of ambiguity before proceeding to examine the question of an alleged violation of the notice requirements.

- This procedure is appropriate in ERISA cases, where the plan language should be construed first in order to determine whether that language was clear and unambiguous.”).
292. Sections 261 to 264 of the Health Insurance Portability and Accountability Act of 1996, P.L. 104–191; 45 CFR Part 164 (67 FR 53182, Aug. 14, 2002, amending and replacing Final Regulations originally published at 65 FR 82462, Dec. 28, 2000).
 293. 45 CFR §164.520(b).
 294. 45 CFR §§ 160.102(a)(1) and 160.103, definitions for covered entity, health plan, and group health plan.
 295. Available at <http://www.innovations.ahrq.gov/content.aspx?id=2439>.
 296. ERISA §105(a)(2)(iii).
 297. Kennedy, “ERISA’s Participant Benefit Statement Requirements: Current Rules Under PPA ’06 and a Suggested Blueprint for Future Interpretations,” 35 Tax Management Compensation Planning Journal 1, 2 (10/05/2007).
 298. ERISA §105(a)(2)(A)(1)(i)(II).
 299. ERISA §105(a)(2)(B)(i).
 300. *See supra* n.296.
 301. “Financial Capability in the United States,” FINRA Investor Education Foundation (2009), available at <http://www.finrafoundation.org/programs/p123306>.
 302. *Id.* National Survey - Executive Summary at p. 8. The study further concluded, at p. 9, that “[w]hile 66 percent of individuals who are not yet retired acknowledged receiving [Social Security] statements, a large majority of recipients stated they did not use the information contained in those statements when making or adjusting decisions on when to retire or when to claim Social Security benefits.”
 303. Lusuradi & Mitchell, “Financial Literacy and Retirement Planning in the United States,” National Bureau of Economic Research, Working Paper w17108 (2011).
 304. *Id.* at 14-15.
 305. Executive Order 13530, signed on January 29, 2010, available at <http://www.treasury.gov/resource-center/financial-education/pages/advisory.aspx>.
 306. “Interim Report, President’s Advisory Council on Financial Capability,” 7 (January 18, 2012). The report finds that: “What American adults actually know about personal finance and math is sharply lower than what they think they know. Almost half (48 percent) who gave themselves the highest score in math were not able to do two calculations involving interest rates and inflation. Seventy-six percent of Americans say they are stressed about money. Over two-thirds of employers say that financial stress contributes to health costs at their company. Fifty-eight percent say that financial “illness” contributes to employee absences at their companies, and 78 percent also agree that employees are less productive at work when worrying about personal financial problems. Employee Assistance Program providers have seen an 88 percent increase in requests for help with financial matters since the economic downturn began.” (citations omitted).
 307. <http://investor.gov/>. Note, that there is a different Web site at <http://www.mymoney.gov/>, which is run by the 21 federal agencies that compose the Financial Literacy and Education Commission, which is chaired by the Secretary of the U.S. Department of Treasury. Congress established FLEC through passage of the Fair and Accurate Credit Transactions (FACT) Act of 2003.

308. President Obama, Executive Order (June 25, 2013), available at <http://www.whitehouse.gov/the-press-office/2013/06/25/executive-order-establishing-presidents-advisory-council-financial-capab>.
309. In preparing this article, the author actually read through his personal Social Security benefit statement, admittedly for the first time in its entirety. There is very little educational material regarding how to plan for the expected and unexpected costs of retirement.
310. The National Financial Education Network for State and Local Governments is an informal group of state and local government entities and professional and trade associations of government entities, convened by the Financial Literacy and Education Commission, to share ideas and effective practices in financial education. See <http://www.mymoney.gov/Pages/default.aspx>.