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Serving Our Seniors

North Carolina Center for Public Policy Research

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The North Carolina Center for Public Policy Research is a nonprofit organization dedicated to strengthening public policy through nonpartisan research, education, and community engagement. We conduct high-quality, objective research and provide insights, analysis, and recommendations on public policy issues of statewide importance. We educate decision makers to help them form sound policy. We inform citizens about how their government operates and help them understand the connection between policy and their daily lives. We encourage engagement by convening diverse voices and providing tools to increase civic participation.

We believe that:

- High-quality, nonpartisan research free from political or philosophical bias is key to informed decision-making.
- Diversity of opinion and voice improves decisions.
- Inclusiveness and collaboration create policy wins.
- Research and information should be informative and accessible.

Therefore:

- Our Board of Directors is designed to mirror the population of the state in terms of political party, geographic location, race and ethnicity, and gender.
- We have a rigorous review process—making sure research is accurate, timely, and unbiased.
- We seek multiple viewpoints and voices, creating partnerships in both the selection of research topics and the dissemination of our information and analysis.

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A Message from the

Executive Director

Donna Futoransky knows personally the difficult decisions associated with the long-term care needs of an aging parent. Following the Great Recession, she built an addition onto her home, and both of her parents moved from an assisted-living facility to Donna's house. Her father died in 2010, and Donna continues to navigate her role as a caretaker for her 93-year-old mother.

Donna recognizes, of course, that not everyone has the ability to provide long-term care to aging parents. "Fortunately, I was in a position where I could do this. I was making the decision for myself. And I signed up for it," explains Donna. "But if you sign up for it or not, it's a challenge. Period. It's a challenge. It's a challenge for my mother, because she doesn't have the privacy she would ordinarily have. It's a challenge for me that I don't have the freedom that I might have had, and that's not a complaint, it's just a fact."

A fact, and a set of difficult decisions, that will face more North Carolinians as our state's population ages.

Today, 20 percent of our population in North Carolina is 60 years old or older, with the number expected to rise by 58.3 percent by the year 2033. Even more significant is the 102 percent increase in individuals between the ages of 75 and 84 expected during the same period.

The distribution of North Carolina's population will also shift drastically over the next decade. In 2012, 60 counties in North Carolina had more residents aged 60 or over than aged 0 to 17. By 2025, 90 counties will contain more residents aged 60 or over, and only 10 counties will have more residents aged 0 to 17 than 60 or over.

As the new Executive Director for the North Carolina Center for Public Policy Research, I invite you to take a closer look at these important issues facing our seniors and our state.

Today, 20 percent of our population in North Carolina is 60 years old or older, with the number expected to rise by 58.3 percent by the year 2033.

For decades, the Center has maintained a focus on policy work affecting our senior citizens, researching subjects ranging from the civic contributions of seniors to financial fraud to attracting retirees to North Carolina. In this edition of North Carolina Insight, we look at how we Serve Our Seniors, including long-term care and our state's aging services plan. We also explain new legislation passed in N.C., designed to increase communication between the financial sector and law enforcement in an effort to prevent financial fraud against seniors, as well as interview a special deputy attorney general on how the new law impacts his work.

As always, we are grateful to our donors, corporate supporters, and foundations for funding this work and research. We want to thank the GlaxoSmithKline Foundation, the Cannon Foundation, the Hillsdale Fund, the John W. and Anna Hodgin Hanes Foundation, and the James G. Hanes Memorial Fund for their support and commitment to issues affecting our seniors.

We also invite you to reach out to the Center. Let us know how you, your family members, your friends, and your neighbors consider and navigate these important and challenging decisions. North Carolina will move forward as a state together, continuing to transform and learn from each other about questions and policies that impact us all.

Linda S. Millsaps

Dr. Linda Struyk Millsaps
Executive Director

Photo by Karen Tam

Photo by Karen Tam

Photo by Karen Tam

Photo by Karen Tam

The Public Price of Growing Old

By John Quinterno

Introduction

North Carolina's population is aging. In 2011, the number of individuals age 65 and older who call the state home began to grow at an estimated rate of 153 persons each day, 56,000 persons each year. If this projected rate of growth continues, approximately 20 of every 100 North Carolinians—some 2.3 million individuals in all—will be age 65 or older by 2030.[1]

Population aging is a dynamic hardly unique to North Carolina; rather, the entire country is traveling down the same demographic road due to the aging of the "Baby Boomers," the 76-million person cohort born between 1946 and 1964.[2] Thanks to advancements in medicine, public health, and socioeconomic conditions, Baby Boomers are poised to enter the last third of their lives enjoying degrees of health and independence far surpassing those experienced by prior generations.[3]

Viewed in one light, this is a stunning social achievement. A century ago, few Americans—and even fewer North Carolinians—lived to 65 years of age, and those who did were apt to live only for a few more years. In 1900, the typical American man reaching age 65 was likely to survive for another 11.5 years, the typical woman 12.2 years. By 2008, the average 65-year-old man would live another 17.3 years, a woman 20 years.[4] Moreover, the average American who reached age 65 in 1900 was likely to be financially insecure, evidenced by the fact that 65 percent of older men were in the labor force; jump ahead to 2010, and just 22.1 percent of older men held jobs or were seeking work.[5] Altogether, the rise in life expectancies over the last century and the increasing financial security of older adults led American society to re-conceptualize old age as a distinct phase of life known as "retirement."

Today, lengthening lifespans and the retirement ideal are presenting individual American households and society as a whole with unprecedented challenges. Never before has the country had a population structure like the one now taking shape.[6] How will large numbers of older Americans finance their later years? Can the health care system handle the costs associated with serving a sizable older population, most crucially the provision of expensive long-term care? Will enough workers be available or be productive enough to replace the labor provided by Baby Boomers? These are the kinds of policy questions with which citizens, organizations, and civic leaders will grapple over the next two decades.

This article examines a specific issue indivisibly linked to the aging population and the implications for our state: North Carolina's pension system. Even in states that have paid attention to aging issues, states that include North Carolina, uncertainty about potential

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John Quinterno is a frequent contributor to *North Carolina Insight*. He is a principal with South by North Strategies, Ltd., a public policy consulting firm in Chapel Hill, N.C., and the author of *Running the Numbers: A Practical Guide to Regional Economic and Social Analysis* (New York: Routledge, 2014).

aging-related costs abounds. Conceptually, population aging should present state and local governments with two types of costs: those incurred by governments as employers (e.g., employee pensions) and those incurred by governments as providers of public services (e.g., health and human services). Some of these costs are within state and local control, but others are not. State governments determine the pension benefits offered to their employees, for instance, but the federal government sets the Social Security payments upon which most older adults depend for the bulk of their incomes.

Retirement Security: Private-Sector Weakness, Public-Sector Strength

Financial insecurity long has troubled older Americans. Early in the 20th century, all but the richest older adults worked, and those who could not work became impoverished or "were generally forced to rely on the generosity of their children to maintain them in old age."[7] Growth in the older population thus created popular political pressures for government action.

Photo by Karen Tam

In response, a few dozen states experimented with establishing old-age pensions, followed by the federal government, which established Social Security in 1935 and then the Medicare and Medicaid health insurance programs in 1965. The federal government further used tax preferences to foster private pensions, and consequently, the share of the private, nonagricultural labor force covered by a pension plan rose from 14 percent in 1929 to some 50 percent by the mid-1970s.[8] Additionally, all levels of government established pension plans for their employees. Such policy actions collectively reduced older poverty by insuring a basic level of financial security. Explains economist Edward Wolff of New York University:

> The poverty rate among elderly persons (aged 65 and older) has declined dramatically, from 35.2 percent in 1959 to 12.2 percent in 1993 and then to 10.1 percent in 2005. In 1959, the incidence of poverty among the elderly was greater than that among children and more than twice that among nonelderly adults . . . By 2005 it was still slightly lower than the adult poverty rate and 57 percent of the child poverty rate. This reduction in elderly poverty was tied to increased social security benefits and was therefore accomplished without requiring the elderly to work more.[9]

When combined with secularly rising incomes, public policies fostered the idea of retirement as a distinct, leisurely phase of life earned as a reward for a lifetime of productivity—the very kind of retirement enjoyed by many of the parents of today's Baby Boomers, expected by many Boomers, and marketed to those Boomers. Consider changes in labor force participation rates among older white men. In 1954, some 40 percent of older white men were in the labor force, but by 2005, just 20 percent were.[10] Yet economic security is not the same as affluence. In 2010, half of all North Carolina households led by an older adult had annual incomes of less than $31,694.[11] That same year, 94 percent of older Tar Heels drew Social Security benefits averaging $13,818 annually.[12] Between 2010 and 2012, some 29.9 percent of older North Carolinians derived at least 90 percent of their household incomes from Social Security, while 58.5 percent relied upon Social Security payments for at least half of their incomes.[13] Absent Social Security, many older North Carolinians—particularly those who are racial minorities, rural residents, or quite elderly—would have little household income.

Aging and the Problem of Financial Security

Conventional wisdom holds that retired Americans draw their incomes from a three-legged stool of pensions, personal assets, and Social Security. This assumption likely will not hold for Baby Boomers, as many possess few guaranteed retirement income streams apart from Social Security.

Baby Boomers generally began their careers during the 1970s, a time when the expansion of private pension plans was ending. Since then, the share of private sector workers ages 25 to 64 with access to an employer-sponsored plan has fallen from 57.8 percent in 1979 to 52 percent in 2011; put differently, nearly half of all Americans employed in the private sector work for organizations that do not offer any kind of retirement plan.[14] Moreover, the nature of the available plans has shifted from defined-benefit (DB) plans to defined-contribution (DC) plans.

Under DB plans, employees earn a guaranteed benefit based on wages and years of service. Contributions are tax-advantaged for employees and employers, and by pooling resources from all participants in a firm, DB plans spread risks across a large population. On the flip side, such plans are complex, tightly regulated, legal commitments tied to specific firms. In contrast, the DC plans (e.g., 401(k) plans) that have replaced DB plans are portable ones that allow employees and employers to make tax-advantaged contributions to individual accounts.[15] DC plans are cheaper and simpler for employers, but they expose "workers to a host of risks that they are ill-equipped to bear as individuals:

inadequate contributions, poor investment choices, financial market volatility, and outliving their retirement savings."[16]

Today, DC plans (including hybrid DC-DB ones) are the private sector norm. A survey by the U.S. Bureau of Labor Statistics found that 47 percent of private establishments in the South Atlantic sponsored retirement plans in 2013, but just 7 percent of those establishments offered DB plans.[17] Available evidence suggests that the spread of DC plans has not benefited workers. Apart from shifting all risks to participants, DC plans are expensive and offer ordinary workers many more chances to make expensive investment mistakes.

A related problem is that such plans are costly to the taxpayers despite providing coverage that is less than universal. The staff of the U.S. Congress Joint Committee on Taxation estimated that preferential tax treatment of employer-sponsored retirement benefits will cost the federal treasury an estimated $101.2 billion in foregone revenue in federal fiscal year 2013.[18] (These tax expenditures "flow" through to the state income tax code, resulting in an estimated loss of $786.5 million to North Carolina during state fiscal year 2014–2015.)[19] Despite the sizable cost, only 41.8 percent of private sector workers in North Carolina had access to a plan between 2008 and 2012.[20] And low-income workers—arguably those in greatest need of help in saving for retirement—are much less likely to have access to an employer-sponsored retirement plan than other workers. In 2009, only 38 percent of private sector workers in the lowest wage quartile had access to an employer retirement plan compared to 85 percent of those in the top wage quartile.[21] Other research has found that 72 percent of the lowest-income American households reach retirement age without ever having had access to an employer-sponsored retirement plan.[22]

Perhaps the greatest flaw of DC plans is that households with them have not amassed enough savings. According to the Federal Reserve System's triennial Survey of Consumer Finances, 61.2 percent of American families headed by someone near retirement age (ages 55–64) in 2010 had a retirement account, and of those families, half possessed less than $104,800 in savings.[23] That is far below conservative minimum recommendations of the amount of savings needed for retirement. By one estimate, 95.4 percent of all American households approaching retirement age in 2010 simply had saved too little for retirement and likely would rely on Social Security payments for the bulk of their retirement incomes.[24]

Inadequate retirement savings is a problem for people all along the income spectrum. Calculations from the Center for Retirement Research at Boston College indicate that 53 percent of all households in 2010 stood "at risk" of reaching age 65 unable to maintain their living standards. While 61 percent of low-income households were at risk of saving too little, 54 percent of middle-income households and 44 percent of high-income households were in the same situation. And the share of households at risk of saving too little for retirement has increased for every income group since 2007 as a result of the destruction of wealth that occurred during the "Great Recession."[25] The loss of housing wealth was particularly problematic for Baby Boomers, as illustrated by a 2009 study by the Center for Economic and Policy Research in Washington, D.C. that found that the typical household headed by an Early Boomer experienced a 50 percent decline in its net worth between 2004 and 2009, while the typical household headed by a Late Boomer experienced a 45 percent decline.[26]

Although state-level data on retirement savings are not generally available, patterns in North Carolina likely mirror national ones. A 2014 study by the National Institute of Retirement Security in Washington, D.C. found that 41.6 percent of private sector workers between the ages of 21 and 64 in North Carolina participated in an employer-sponsored retirement plan in 2012, with the average participant possessing an account worth $38,330.[27] Compared to other states, North Carolina ranked worse than average in terms of the overall level of financial security facing future retirees measured in relation to potential retirement income, major retirement expenses, and labor market conditions for older workers.[28]

Photo by Karen Tam

Such facts contradict the popular view of Baby Boomers as being a relatively affluent cohort. Even before the recession, few Boomer households were on track to reach retirement age with significant sources of income apart from Social Security benefits, and even then, the value of those benefits was eroding due to the rise of the full-retirement age to 67.[29] Many Baby Boomers therefore may look to the state for services designed to help them meet their needs. Such demands could take forms ranging from tax credits for long-term care to direct spending on services like home energy assistance to laws mandating flexible leave policies so younger workers can provide eldercare. Younger people, meanwhile, might look to state leaders to address some of the increasingly visible problems related to retirement savings, such as by offering incentives to help low-income households save or by—as a number of states are considering and California and Massachusetts are doing—establishing publicly sponsored savings vehicles for private sector employees who lack access to employer-sponsored retirement plans.[30] In that respect, states could reprise their historic role in modeling forward-looking retirement policies for the nation as a whole.

Public-Sector Retirement Systems

The specific costs that North Carolina may face owing to Baby Boomers' insufficient retirement incomes are difficult to gauge because they hinge upon federal policies and personal circumstances. Costs related to the pension plans offered to public-sector employees, in contrast, are firmly within the state's control, and thanks to a tradition of prudent fiscal management, North Carolina's public-sector pension systems are in overall sound condition.

The very concept of pensions originated in the public sector. The national government has offered military pensions since the Revolutionary War, and during the 19th century, large municipalities began to offer benefits to police officers, firefighters, and teachers. In 1911, Massachusetts established the first plan for state employees, and in 1920, the federal government created a system for its civilian employees.[31] Such plans quickly spread and became the template for private industry.

Photo by Karen Tam

Public-sector plans typically are DB plans, not DC ones. The U.S. Bureau of Labor Statistics estimates that 89 percent of all state and local employees had access to a retirement plan in 2013 and that 83 percent of all state and local government employees could access a DB plan. While 32 percent of public employees also had access to a DC plan, those plans were, more often than not, supplemental in nature. Unlike in the private sector, state and local employees generally must contribute to their core retirement plans. Some 86 percent of all state and local DB plans in 2013 required employee contributions, typically a percentage of annual earnings, and in 2013, the average employee contribution totaled 6.4 percent of earnings.[32]

North Carolina has offered public-sector pensions since the Second World War. A framework for local government pensions took form in 1939, one in 1941 for state employees; both pension plans became DB ones that coordinated with the larger Social Security system in 1963.33 Today, the N.C. Department of State Treasurer administers four major retirement systems—the Teachers' and State Employees' Retirement System (TSERS), the Local Governmental Employees' Retirement System (LGERS), the Consolidated Judicial Retirement System (CJRS), and the Legislative Retirement System (LRS). Additionally, the Department administers several smaller pension plans, including the Register of Deeds' Supplemental Pension Fund, (RDSPF), the North Carolina National Guard Pension Fund (NGPF), and the Firefighters' and Rescue Squad Workers' Pension Fund (FRSWPF), along with a number of supplemental retirement savings, death, disability, and other benefit plans and programs (see table 1).[34]

The N.C. General Statutes authorize the major retirement systems and entrust their governance to various boards of trustees. Governance of TSERS, the Consolidated Judicial Retirement System, and the Legislative Retirement System rests with a 13-member board that the State Treasurer chairs and that has members drawn from active and retired State teachers, employees, and members of the public. Nine members are appointed by the Governor, two members are appointed by the General Assembly, and two members serve ex-officio (the State Treasurer and the Superintendent of Public Instruction). The LGERS board contains five of the same individuals who serve on the TSERS board, along with seven members with various ties to local governments and one active or retired member

Table 1. Summary of Plans Overseen by Retirement System Division of the N.C. Department of State Treasurer, 2012–13 Annual Report

	Name	Purpose	Active Members	Inactive Members	Beneficiaries
Pension Plans	Teachers' and State Employees Retirement System (TSERS)	Defined benefit pension for full-time teachers and state employees	310,370	125,513	187,448
	Local Governmental Employees Retirement System (LGERS)	Defined benefit pension for employees of participating local government entities	123,455	50,998	57,405
	Firefighters' and Rescue Squad Workers' Pension Fund	Defined benefit pension for certified firemen and rescue squad workers	42,464	N/A	12,445
	Consolidated Judicial Retirement System	Defined benefit pension for judges and sworn court officials	566	53	584
	Legislative Retirement System	Defined benefit pension for members of the General Assembly	170	94	311
	National Guard Pension Plan	A trust fund for eligible National Guard personnel	5,535	5,117	4,354
	Legislative Retirement Fund	An abolished trust fund for members and elected officers of the General Assembly	N/A	N/A	7
	Registers of Deeds' Supplemental Pension Fund	A supplemental LGERS benefit for registers of deeds	100	2	95

Source: Valuation Reports, N.C. State Treasurer, *https://www.nctreasurer.com/ret/Pages/Valuation-Reports.aspx*

of the Firefighters' and Rescue Squad Workers' Pension Fund (FRSWPF). Note that LGERS and FRSWPF differ from the other systems in that participation is not mandatory. All agencies eligible for participation, with the notable exception of charter schools, must participate in TSERS, whereas local units of government or fire and rescue agencies may opt into LGERS or FRSWPF, respectively. A separate Board of Trustees governs the three supplemental retirement income plans.[35]

TSERS is what most people have in mind when they think of the state pension system. The largest system in terms of members and assets, TSERS covers "all full-time teachers and State employees in all public school systems, universities, departments, institutions, and agencies of the state."[36] As of December 31, 2013, TSERS had 310,370 active members, 125,513 inactive ones, and 187,448 beneficiaries.[37] Some 64.2 percent of active members work in education (of whom 76.4 percent are classroom teachers).[38] Women account for 68.9 percent of active plan participants, and 66.9 percent of all active members are age 40 or older; additionally, the average annual compensation of active TSERS members is $41,351.[39]

TSERS members earn benefits based on a formula linked to average final compensation and years of service. The current annual benefit is equal to 1.82 percent of average final compensation (average of four-highest paid years) for each year of service completed.[40] So, a retiring employee with 30 years of service and an average final compensation of $50,000 would receive a lifetime annuity worth $27,300 per year, subject to possible future cost-of-living adjustments. That benefit would replace 54.6 percent of the employee's average annual final compensation. Employees may qualify for unreduced benefits in three situations: 1) upon reaching age 60 and having completed 25 years of creditable service; 2) upon reaching age 65 and having completed five years of creditable service; and 3) upon completing 30 years of creditable service at any age.[41]

TSERS members can retire with a reduced benefit if they meet certain combinations of age and service length criteria, such as reaching age 50 and having completed 20 years of creditable service or reaching age 60 with five years of creditable service.[42] The calculation for determining reduced benefits is the same one used to determine full benefits with the difference that the benefit amount is reduced by an age- and service-adjusted factor to account for the fact that the early retiree will receive payments over a longer period of time than someone who retires at the normal time. For example, an employee who retires at age 60 with 20 years of service and an average final compensation of $50,000 would receive a lifetime annuity worth $15,470 per year (subject to possible future cost-of-living adjustments). This amount is 15 percent less than the unreduced benefit amount of $18,200.[43]

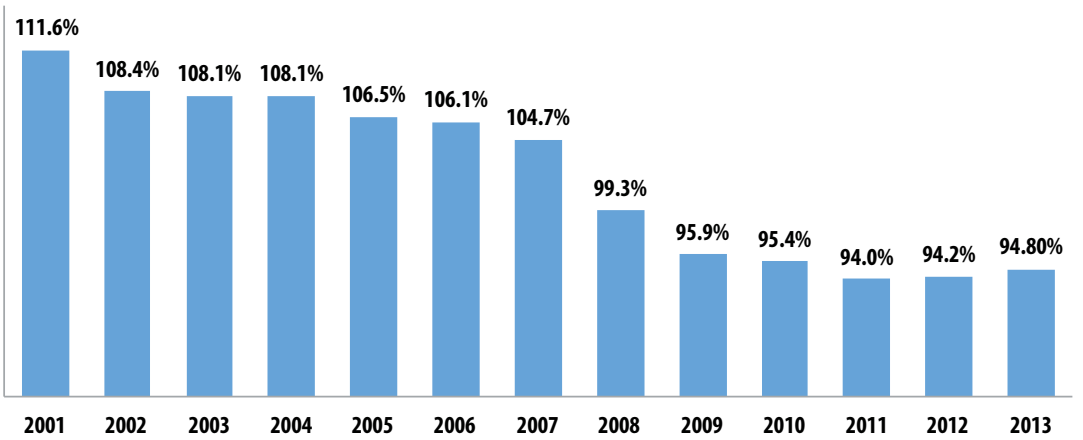
While Baby Boomers constituted 38 percent of active TSERS members at the end of 2013, North Carolina is not facing a retirement wave.[44] Because state employees can draw an unreduced benefit immediately upon completing 30 years of creditable service, Baby Boomers have been retiring steadily from the workforce since 1994, while others must continue to work before qualifying for an unreduced benefit. Employees between the ages of 55 and 64 who were eligible for a reduced or unreduced benefit accounted for 11.2 percent of the active TSERS membership.[45] Given that the average age of a TSERS member in 2013 was 45 and the average period of service was 10.6 years, the overwhelming majority of TSERS participants will not be eligible for any type of benefit

for years.[46] And the retirement of Baby Boomers, in and of itself, will not impose any additional costs on TSERS since the plan's actuarial models already have accounted for the associated obligations.[47]

North Carolina operates TSERS on a pre-funded basis, meaning that the system receives regular contributions for each covered employee over the course of the employee's career. The advantage of pre-funding is that it allows for investment earnings to finance the bulk of the benefits rather than employee and employer (taxpayer) contributions. TSERS derives its funding from three sources: employee contributions (6 percent of annual salary), employer contributions related to the plan's actuarial value (the actual annual funding decision rests with the General Assembly), and investment earnings.

In recent years, many states have shifted from pre-funding their pension plans to "pay-as-you-go" approaches that use current contributions to pay current benefits. Some states also stopped making annual employer contributions to their pension funds. Such policy choices have caused many plans to become underfunded, which occurs when the actuarial value of a plan's liabilities exceeds that of its assets. Underfunding does not mean that a plan is in danger of collapsing, but it creates fiscal pressures for plan sponsors. North Carolina fortunately has avoided these temptations, and TSERS is one of the nation's best-funded plans; in fact, it was in overfunded status for most of the last decade (see Figure 1). The severe investment losses that occurred during the recession hurt the plan, but even with those struggles, TSERS ended 2013 with a funding ratio of 94.8 percent, a ratio that is especially strong compared to those of most public pension plans in the United States.[48]

Figure 1. Funded Ratio of Teachers' and State Employees' Retirement System, 2001–2013 (as of December 31)



Note: Scale doesn't start at zero to better illustrate trends.
Sources: N.C. Department of State Treasurer and Buck Consultants.

Photo by Karen Tam

The strong funding position of TSERS has insulated the state from problems facing other states. That said, the greatest threat to the plan's health would be for the state to stop making its annual required contributions—a significant temptation during tough budget times that merely raises future costs. Prior to fiscal year 2010–2011, the General Assembly never had failed to make the full actuarially recommended contribution to TSERS; that year, however, North Carolina contributed only 73 percent of the required amount. In fiscal year 2011–2012, the state again fully contributed the required amount, followed by a contribution in 2012–2013 that was larger than required.[49]

Provided the state continues to make employer contributions, the comparatively strong health of TSERS provides the state with an opportunity to better the system, particularly since the basic design of the plan, including the benefit structure, has not changed since 1963. For guidance, interested state leaders could look to the recommendations and analysis contained in the 2010 report of the Future of Retirement Study Commission, a 13-member advisory commission named by the boards of TSERS and LGERS. That commission undertook a comprehensive review of issues pertaining to benefit adequacy, risk management, workforce management, participant decision making, and administration, and offered numerous recommendations aimed at strengthening the two retirement systems' accountability to the public and their abilities to manage responsibly the assets held in trust on behalf of public employees.[50]

Photo by Karen Tam

Conclusion

In 2011, the oldest members of North Carolina's Baby Boom generation celebrated their 65th birthdays, in the process inaugurating an era of rapid growth in the size of the older population. If current demographic projections hold, North Carolina will gain older residents at a rate of 153 persons per day, or 56,000 persons per year, each year from 2011 until 2029, which is when the youngest Baby Boomers will turn age 65. By the end of that period, approximately one of every five North Carolinians will be age 65 or older. Such an older population structure is unprecedented, and as a result, citizens, civic organizations, and public officials will confront important policy questions. Those challenges, while serious, are not unmanageable, but addressing them will require state leaders to pay heightened attention to issues of aging and to champion wise public policies focused on improving the well-being of all North Carolinians, young and old.

The Center gratefully acknowledges Carol Woods of Chapel Hill, the Warrenton Senior Center, the Center for Creative Retirement in Asheville and the Fearrington Village for the opportunity to photograph the wide range of activities and services offered in our state. Photographs appearing in this Insight series on Aging are by Karen Tam.

Endnotes

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Caring for Our Seniors:
Rebalancing Long-Term Care Services in North Carolina

By Todd Brantley and Amy Brantley

Introduction

Donna Futoransky never expected to be looking for a part-time job. She never expected to be personally caring for her elderly parents well into her own retirement. She never expected that she would one day have to move her mother and father into her own 869-square-foot home.

But that's what happened when her parents' life savings and thoughtful planning became another victim of the Great Recession.

"They lost a tremendous amount of money," says Donna, a 70-year-old former physical therapist and director of nursing home public relations.

Donna decided to move to North Carolina in 2006 to be closer to her daughter, son-in-law, and grandchildren. Her parents moved into an assisted-living facility nearby, as well.

"I had figured with what they would pay a month, including inflation, with the money they had, they would be able to live there until they were 96," Donna says.

But then the recession hit in 2008, gutting her parents' life savings and the careful plans for their long-term care. It became clear to Donna that her parents would not be able to stay in the assisted-living facility.

Donna decided she would have to move her parents in with her. After speaking with her parents, they decided to build an apartment extension on to Donna's house, keeping the family close together. They took what was left of her parents' savings, combined with Donna's own savings, and began construction.

In 2009, with construction complete, Donna's parents moved in with her. Her parents managed well, helping each other with daily activities. This gave Donna peace of mind when she was away, knowing they were together in the event of an emergency.

Then in 2010, her father passed away, one month shy of his 90th birthday. Initially, Donna still worked full time. She was fortunate to have an employer that understood her situation and was willing to be flexible with her schedule.

"When you don't have anyone else to think about, you really don't think about, 'Well, I have to make an appointment, but the doctor's not there on Monday or Friday. Oh well, I'll go Tuesday,'" says Donna. "Well, if you are working, and Monday and Friday are your best days then you have to make some kind of arrangement to change your work schedule or whatever. Fortunately, I was in a situation that it wasn't critical that I be there at a certain hour, but I still had to put my hours in."

Eventually, Donna retired, but with her parents' depleted savings and the cost of caring for an aging mother, she needed to look for a part-time job to help make ends meet.

Todd Brantley is a researcher and writer from Raleigh. Amy Brantley is a medical instructor and physician assistant at Duke Family Medicine Center in Durham.

Figure and Chart designs by Carol Majors

Photo by Karen Tam

"My mother gets social security. She gets Medicare taken out, and then she has to pay for her secondary insurance, and for the dentist," says Donna.

"We had to use the money. We had to provide a place [for them]," Donna says. "If we hadn't, and then my mother and father's money had run out, and we had this little house, then what? We used up what we had in order to accommodate all of us, and now, now we're in a position where we need money. I'm 70 years old and now I'm in a place where I have to look for a job."

"There aren't a lot of people looking for someone 70 years old for work."

Yet Donna and her mother Sophia are upbeat and optimistic about their situation. They know that not everyone has extended family close by who can help care for an aging parent when the primary caregiver needs a break. They know that not everyone has the means—financial, physical, and emotional—to live with an aging parent and instead must consider institutionalized care.

"There are so many people that have this same situation but that are not as fortunate as we are," says Donna. "They don't have family supports; they don't have a nice place to live."

An Aging Demographic

In North Carolina and across the nation, long-term care for the elderly is increasingly becoming a social, economic, and political issue. The growing population aged 65 and older, as well as budget constraints at the state level, are central to this issue.

Nationally, the first wave of Baby Boomers are entering retirement at a time when their parents are living longer and both generations have witnessed an erosion in their savings due to the Great Recession. It has been described as a "Silver Tsunami," a demographic shift that will swell the ranks of those 65 years old and over, with a Baby Boomer turning 65 every eight seconds in this country.[1] Currently, there are more than 40 million Americans aged 65 and older, 13 percent of the total population.[2] Of those seniors, 34 percent live at 200 percent below the poverty level and five million need long-term care services.[3]

A U.S. Census Bureau report projects that, by 2050, more than 88 million Americans will be aged 65 and over, a more than 48 million person increase from 2010.[4] By 2030, all of the Baby Boomer generation will be aged 65 and older, increasing the nation's older population from 13 percent of the total population in 2010 to 19 percent by 2030.[5] The number of those aged 85 years and older, a group that is most likely to need long-term care and assistance with activities of daily living (ADLs), will increase by 70 percent between now and 2033.[6] See Figure 1.

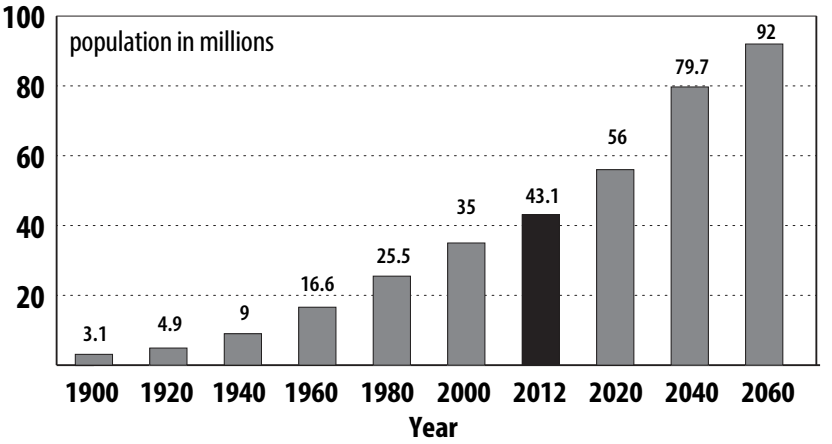
In 2013, 14 percent of the state's residents were 65 and over.[8] By 2033, 20 percent of the state's population will be over the age of 65 and the percentage of residents 85 years and older will grow to 2.6 percent of the state's total population (see Figure 2, page 24). That translates to a nearly 54 percent projected increase in the 65- to 74-year-old age bracket between 2013 and 2033, a 102 percent increase in the 75- to 84-year old age group, and an 88 percent increase in residents 85-years old and over.[9]

Of the population aged 65 and over in the state, the age group of 75- to 84-yearolds will grow more rapidly in the next two decades. Beyond 2030, the growth will shift into the ages 85 and over bracket, as the 2.4 million baby boomers move into this age group. However, 41 counties in the state are already projected to have more growth in the 85 and over population between 2013 and 2033.

In 2013, North Carolina had 60 counties with a larger population of residents 60 years and older than 17 years and younger. By 2025, that number is projected to jump to 90 counties.[11] By 2018, the state as a whole will have more residents 60 and over than 17 years and younger (see Figure 3, page 25).

Another way to measure the impact of the increase in the nation's elderly population is through a "dependency ratio," or "the ratio of the dependent-age population (young or old) to the working age population."[13] Between 2010 and 2030, the nation's dependency ratio is projected to experience a sharp increase due almost entirely to the aging of the Baby Boomer generation.[14]

Figure 1: Number of Persons in U.S., Aged 65+ from 1900–2060, in Millions



Source: Administration on Aging and Administration for Community Living, U.S. Department of Health and Human Services[7]

A 2011 *News & Observer* editorial by demographer James Johnson, a professor at the University of North Carolina–Chapel Hill's Kenan-Flagler Business School, noted that as of 2010 there were 66 dependents for every 100 employed workers.[15] Johnson has described the state's growing elderly population and the resulting economic ramifications as a "huge dependency problem for the state,"[16] with the state's uneven population growth as "a fiscal train wreck in the making."[17]

Photo by Karen Tam

The Financial Impact of Long-Term Care

An investment company's survey noted that Baby Boomers are ill-prepared for retirement and are increasingly relying on credit cards to make ends meet, with as many as 74 percent of respondents saying they will need to "rely heavily on Social Security in retirement."[18] And a separate survey conducted by Nationwide Financial noted that only a quarter of respondents over age 50 said they had purchased long-term care insurance and about 22 percent indicated they would use retirement savings to pay for any long-term care services they might need.[19]

The financial issues facing future retirees is compounded by the effects of the Great Recession, meaning depleted savings, retirement, and, in cases of unemployment, lost wages. In addition, many continue to financially support adult children who are themselves trying to recover from the economic downturn.

"A lot of the baby boomers are staying in the workforce longer to assist their adult children and using their savings," says Dr. Peggye Dilworth-Anderson, Interim Co-Director of the University of North Carolina at Chapel Hill's Institute on Aging and Co-Director of the Institute's Aging and Diversity program. "That means less retirement for them."

North Carolina's dependency problem is compounded by the fact that many seniors move into poverty as they age,[20] a trend that is likely to continue and increase as Baby Boomers live longer and spend down their retirement and other savings.

Figure 2: Current Population and Projections for North Carolina

Age groups	Growth (2013-2033)
65-74	54%
75-84	102%
85+	88%

Ages	2013		2033		% Change 2013–2033
	#	%	#	%	
Total	9,861,952		11,856,858		20.2%
0–17	2,289,304	23.2%	2,366,913	20.0%	3.4%
18–44	3,591,059	36.4%	4,220,841	35.6%	17.5%
45–59	2,012,238	20.4%	2,151,309	18.1%	6.9%
60+	1,969,351	20.0%	3,117,795	26.3%	58.3%
65+	1,402,321	14.2%	2,411,960	20.3%	72.0%
85+	164,848	1.7%	309,807	2.6%	87.9%

Source: N.C. Office of State Budget and Management [10]

Also, many aging Boomers and those recently retired are forced to care for aging parents who are living longer and will increasingly need supports for activities of daily living.

The "sandwiched" nature of the generation also means that more and more Boomers are faced with the difficult decision of how to spend time with and money on aging parents, adult children, and grandchildren.[21]

Long-Term Care Spending

In 2010, spending in the United States for long-term care totaled $342 billion dollars. More than 40 percent of that amount was covered by Medicaid. In 2009, Medicaid spent $34,579 on average per elderly enrollee who was receiving some form of long-term care service, such as nursing home care, community care, in-home health care, home modifications, or transportation. That same year, only "32 percent of elderly Medicaid enrollees used long-term care services, but they accounted for 74 percent of all Medicaid spending on the elderly."[22]

While institutional care, such as nursing home care,[23] still accounts for the majority of long-term care spending in most states, there is a growing trend toward rebalancing Medicaid spending to include more home- and community-based services (HCBS). The trend toward a more equal rebalancing of long-term care spending is based in part on a realization that the cost of nursing home care usually exceeds that of home- and community-based care, as well as an increased consumer demand for services outside the institutional setting. The U.S. Supreme Court's ruling in the 1999 *Olmstead vs. L.C.* case, which declared that states have to provide treatment for individuals with mental disabilities in the least restrictive setting, forced states to expand access to community-based care.[24]

In the 10-year period between 1999 and 2009, HCBS spending increased substantially, and HCBS expenditures now account for 19 percent of Medicaid long-term care spending nationally.[25] Between 2000 and 2010, annual Medicaid spending on HCBS as a proportion of total Medicaid long-term care services and supports spending increased from $19.5 billion to $52 billion nationally.[26]

In many ways, North Carolina has made good progress toward rebalancing its Medicaid long-term care spending. A 2013 national analysis of Medicaid spending for fiscal year 2009 shows that 32 percent of the state's long-term care expenditures for elderly

Medicaid enrollees went to home- and community-based care, ranking the state eighth highest in the country for the fiscal year and well above the national average of 19 percent.[27]

Additionally, North Carolina ranked 11th in the nation in total Medicaid spending on elderly enrollees ($1.946 million) and was 7th in total enrollment for Medicaid-eligible elderly enrollees (182,522), ranking the state 17th in the country in terms of elderly Medicaid enrollment as a percent of total Medicaid enrollment (10 percent).[28]

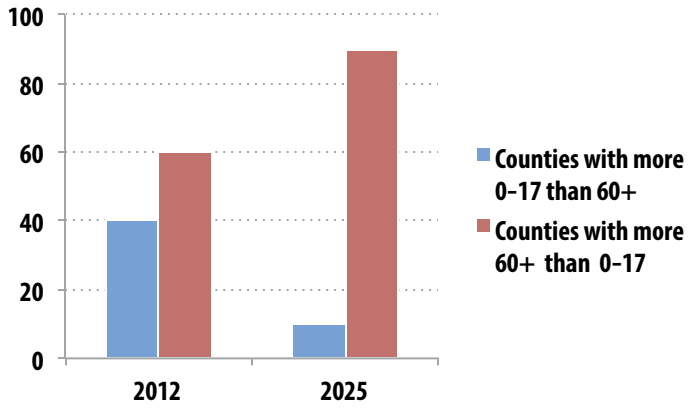
By other measures, however, North Carolina lags behind other states in spending on its elderly Medicaid enrollees. For example, in terms of total expenditures for elderly enrollees as a percentage of total Medicaid expenditures, the state ranked 40th (18 percent), falling below the national average of 23 percent, and the spending of neighboring states such as Virginia (20 percent) and South Carolina (20 percent), as well as other regional neighbors like Georgia (19 percent) and West Virginia (22 percent).[29]

In the 2009 fiscal year, the state ranked 10th in total number of elderly Medicaid enrollees in a nursing home (30,391), yet spent only $24,569 per elderly long-term enrollee, placing it sixth from the bottom in national rankings and well below the national average of $34,579.[30]

Based on state expenditures[31] for individuals 60 years and older, almost 43 percent of the state's spending went to institutional care in fiscal year 2012–13, a slight increase from 40 percent in 2003–04. And the state spent 15.5 percent on home health and in-home care and just 6 percent on adult home care in 2003–04, compared to 15.2 percent on home health and in-home care and 4.5 percent on adult home care in 2012–13.[32] The percentages have remained relatively constant over the past ten years, and there has been minimal movement at the state level from institutional care to home- and community-based expenditures. By State Fiscal Year[33] (SFY) 2012–13, institutional care accounted for 43 percent of the state expenditures, yet spending on home health and in-home care and adult home care remained the same or decreased. See Figure 4.

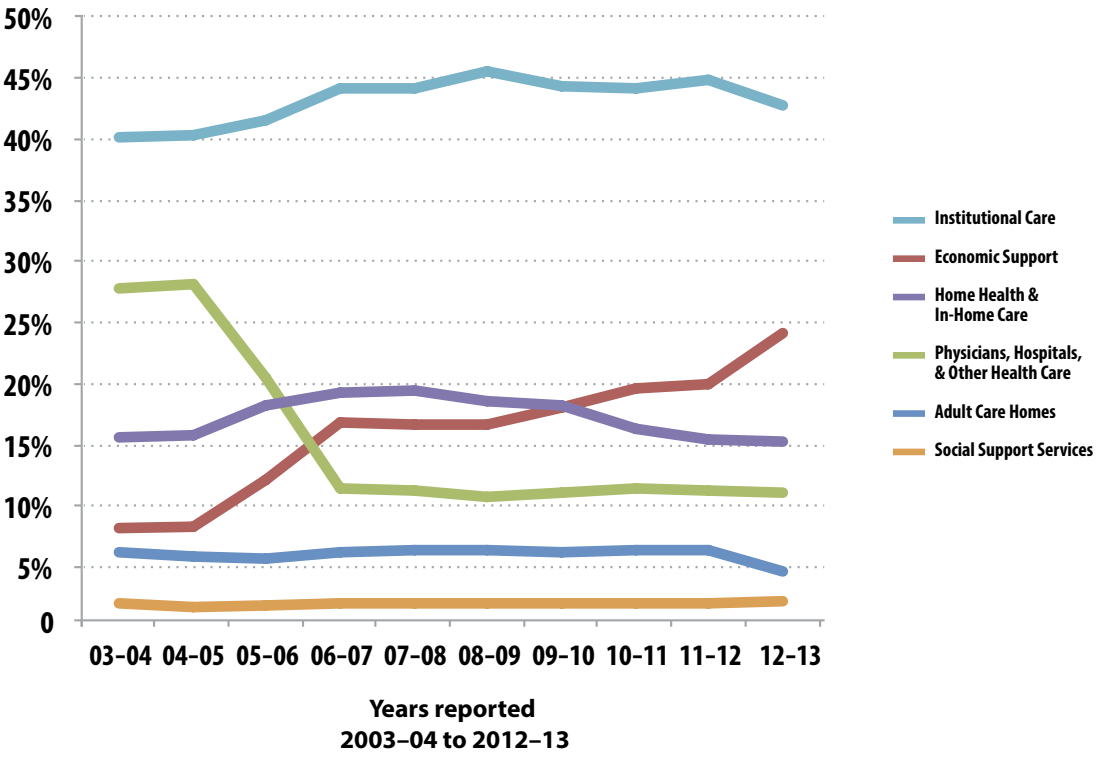
Though spending on institutional care maintained a somewhat steady increase from SFY 2003–2004 to SFY 2012–13, spending on home health and in-home care peaked in SFY 2007–2008 at 19.5 percent of total state expenditures, but declined to 15.2 percent by SFY 2012–13.[34]

Figure 3: Number of Counties in North Carolina with More People 60 Years Old and Over than Ages 0–17, 2013–2025



Source: N.C. Office of State Budget and Management[12]

Figure 4: State Expenditure Data for Adults Aged 60+ from 2004–2013, as a Percentage of Total Spending

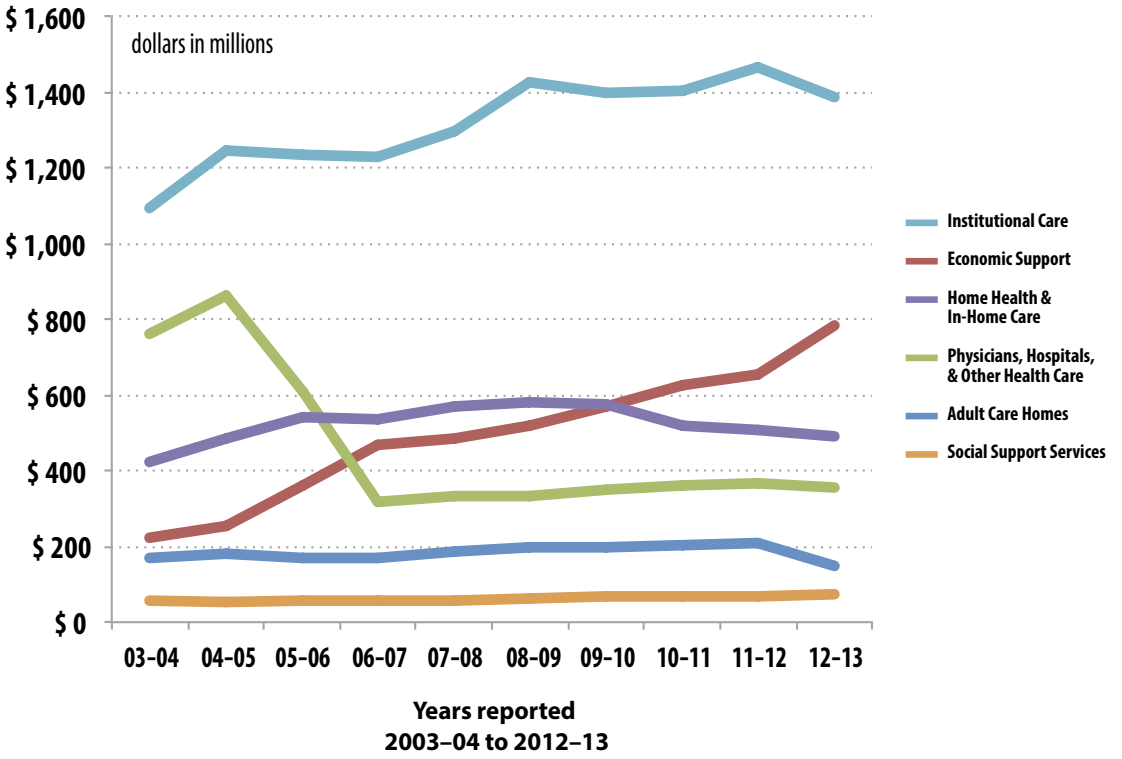


Source: N.C. Division of Aging and Adult Services[35]

In terms of real dollars for state expenditures on individuals 60 years and older, the state spent $1,387,659,583 on institutional care in SFY 2012–13, a $294,318,241 increase from SFY 2003–04 spending of $1,093,341,342. See Figure 5. On average, between SFY 2003–04 and SFY 2012–13, the state spent $1,318,254,066 on institutional care for individuals 60 years and older.[36]

By comparison, the state spent a combined $642,113,247 in the categories of adult-care homes and home health and in-home care in SFY 2012–13, an increase of $47,149,530 from the combined spending of the SFY 2003–04 expenditures of $594,963,717 for those service categories. On average, between SFY 2003–04 and SFY 2012–13, the state spent $707,496,371 on adult-care homes and home health and in-home care for individuals 60 years and older, $610,757,695 less than the amount spent, on average, for institutional care during that same time period.[37]

Figure 5: State Expenditure Data for Adults Aged 60+ from 2004–2013, Total Dollars



Source: N.C. Division of Aging and Adult Services[38]

The Emotional and Financial Impact on Family Caregivers

Health Impact

According to Heather Burkhardt, a planning and evaluation coordinator at the North Carolina Department of Health and Human Services' Division of Aging and Adult Services, family caregivers provide the backbone of the state's long-term services and supports. They will shoulder the greatest burden of meeting the increased demand for long-term care services as more North Carolinians age into the elderly demographic and need assistance with activities of daily living, increasing demand on state resources.

A study by The MetLife Mature Market Institute reported that the "percentage of adult children providing personal care and/or financial assistance to a parent has more than tripled over the past 15 years" and that 25 percent of adults, typically Baby Boomers, are providing care to an aging parent.[41]

"We know that family caregivers provide 80 percent of the long-term care services and supports," says Burkhardt. "They provide a huge resource. Providing supports to family caregivers are the kinds of low-cost solutions that enable them to provide care longer, thereby avoiding or delaying the need for costly institutional care."

Photo by Karen Tam

Burkhardt believes the state can support those unpaid caregivers through education, training, and support groups. And, perhaps most importantly, through respite programs that offer family caregivers a weekly opportunity to step away from their responsibilities. In 2008, Burkhardt's office did a two-part survey of caregivers and those they provided services to. The first survey asked whether caregivers needed a respite from their duties. Then, one year later, the survey followed up with the same caregivers.

"We found that people who needed respite and didn't get it were much more likely to place their loved one in institutional care than those who got the respite they needed," says Burkhardt. "We need programs that enable older adults to remain in the place of their choice with appropriate services and supports and supporting family caregivers is a key feature in making that a reality for many families."

One survey of long-term care providers found that 92 percent of community residents who need long-term care receive unpaid help,[42] usually in the form of family members who are "far and away the principal providers of assistance to the long-term care population living in households."[43] More than 75 percent of community-based adults needing long-term care assistance depended upon a family member for those services. Depending on age, unpaid caregiving responsibilities usually fall on a spouse until about age 74 and then mostly on adult children.[44]

The strain of caring for an aging relative can have a negative effect on the health of the caregiver, including increased levels of anxiety and depression.[45]

"When caregivers don't get respite, whatever form that may take, they have more physical and emotional problems. Meaning they don't get away from the caregiving role," says Dr. Peggye Dilworth-Anderson, Interim Co-Director of the University of North Carolina at Chapel Hill's Institute on Aging and Co-Director of the Institute's Aging and Diversity program. "Caregivers need a lot of education on what it means to be a caregiver. It is about more than love. It is about having skills, respite, resources, and a system of care that supports you. Most people don't realize that."

Employment

For many caregivers, the responsibilities for tending to an elderly loved one can become a life-altering event, often meaning that their own lives and careers are put on hold.

Cecilia Ebron's mother suffered a massive stroke in April 2012, affecting the left side of her body and leaving her with diminished mental capabilities. Rehabilitation at WakeMed Rehabilitation Center helped her regain most of her physical functionality, but the mental deficiencies remained. Her mother now required constant supervision.

Cecilia was facing her own health issues before her mother's stroke and had just taken a leave of absence from her job at CCBI Securities to rehabilitate from knee surgery. After an almost three-month stay in the hospital and in an in-patient rehabilitation center, her mother was discharged. Since Cecilia was the only sibling not working, full-time care for her mother fell on her.

For Cecilia, the former New York City police officer and experienced law enforcement professional, the role as full-time caregiver could not have come at a worse time. She was recovering from her own health issues and actively seeking new employment. At the same time, she was caring for her grandson after school so her daughter could work. Knowing that her mother would require full-time care for the immediate future, Cecilia turned down a potential job at the North Carolina State Bureau of Investigation to assume a new role as a temporary caregiver for her mother.

—continues

Due to her lack of significant physical limitations, Cecilia's mother qualified for only three hours of in-home care per day through Medicaid.

"She does have an aide come in to assist her for three hours a day," says Cecilia, "[But] where does that leave me, to go out and take care of things for myself or for employment?"

"I am sitting here with the same skill set I had years ago, which is decent, however law enforcement is really fast-paced," says Cecilia. "It moves. It doesn't wait for anybody. I could be going to classes, but I am not able to do that because in the timeframe her [in-home] aide is here I am going out washing her clothes or putting the food away—there are all kinds of things that happen, and I am focused 100 percent on her needs."

The day-to-day stress of caring for a loved one with decreased mental capacities can be overwhelming. It is not uncommon for Cecilia's mother to resist taking her medications or forget that she has already taken them. There have been instances of her mother wandering from their apartment in the early morning hours or becoming confused and calling 911.

After almost a year of being out of work and caring for her mother and grandson, Cecilia has made the difficult decision to place her mother in a nursing-care facility. Financially, she is at a point where she can no longer afford to be out of work. Mentally and emotionally, she is drained from constant demands of being a full-time caregiver and the stress of the constant battles with her mother.

The decision, however, has only complicated Cecilia's current situation. In addition to cramming grocery shopping, laundry, and a job search into a mere three hours a day, she now has to find the time to research and visit area nursing homes.

"[Medicaid] gives you 45 days and my 45 days have run out, so I have to start the whole process over," says Cecilia. "I'll be told about a place, then go visit and it is so depressing looking. I don't want her walking into a place where everyone is looking like they are on their last leg. That is not going to help her."

In the three hours Cecilia has in the day, she tries to visit a list of facilities, often not calling beforehand and showing up unannounced to get a better idea of what their day-to-day operations are like. She likes to take the time to sit and watch how the institutional caregivers interact with and care for the residents.

She has found facilities she likes, but they have either been at capacity or do not accept Medicaid or Medicare.

Cecilia is grateful for the in-home aide Medicaid has provided and the time she has been able to spend with her mother and to help ease her transition. However, coming face-to-face with her mother's condition and the reality of someone needing 24-hour care has caused her to worry about her own aging and the future possibility of needing long-term care herself.

"I am probably in a bad place, because I haven't been working," says Cecilia. "The money that goes in for that type of care, I am losing it as we speak, because I am not employed. I've been talking to my sister and I actually need to get an IRA going. Since I don't have money saved, it scares me. It really, really scares me now. I'm on the inside looking out. I see what is available and it is not good."

Financial Impact

In addition to health issues, full-time adult caregivers also face staggering losses in personal wealth and potential income. The MetLife Mature Market Institute study found that the total lost wages and benefits for someone leaving the workforce to act as a full-time caregiver was $274,044 for a woman and $233,716 for a man. When losses to private pension funds are factored in, the amount increases to $324,044 for women and $283,716 for men.[46]

The MetLife report notes that when the average amount, $303,880, of lost wages, benefits, and retirement savings is calculated and "multiplied by the 9.7 million people 50+ caring for their parents, the amount lost is $2,947,636,000,000, or nearly $3 trillion" in lost wages and savings.[47]

In addition to lost income, an individual's caregiving responsibilities can also affect career advancement due to missed opportunities for "promotions, business travel, relocation, and education," as well as lost skills and training.[48]

Family Structure

As more and more seniors need long-term care, and extra strain is put on family members to provide that unpaid care, policymakers and business leaders will need to consider the changing makeup of the modern family structure as they provide supports to their citizens and employees. As the 60+ demographic grows over the next two decades, the families that care for these older adults will include more same sex families, more families with multiple parents, and more families caring for adult children.[49]

"The largest caregiving workforce is the family," says Dr. Dilworth-Anderson. "If the family changes in configuration and structure, then we have to change our structure to engage the needs of the elderly within that structure. Needs are not different, but the families are different."

Not only is the traditional structure of the family evolving, but more families are becoming geographically dispersed, meaning adult children are farther away from aging parents who may need care. One of the benefits of the state's increasingly metropolitanization is that urban centers have more amenities and care centers for seniors, making access to care less of a roadblock.

"When you get out in to the rural areas, you don't have that," says Dr. Dilworth-Anderson. "It is a myth that family members are next door. In fact, rural patients are more likely to be institutionalized."

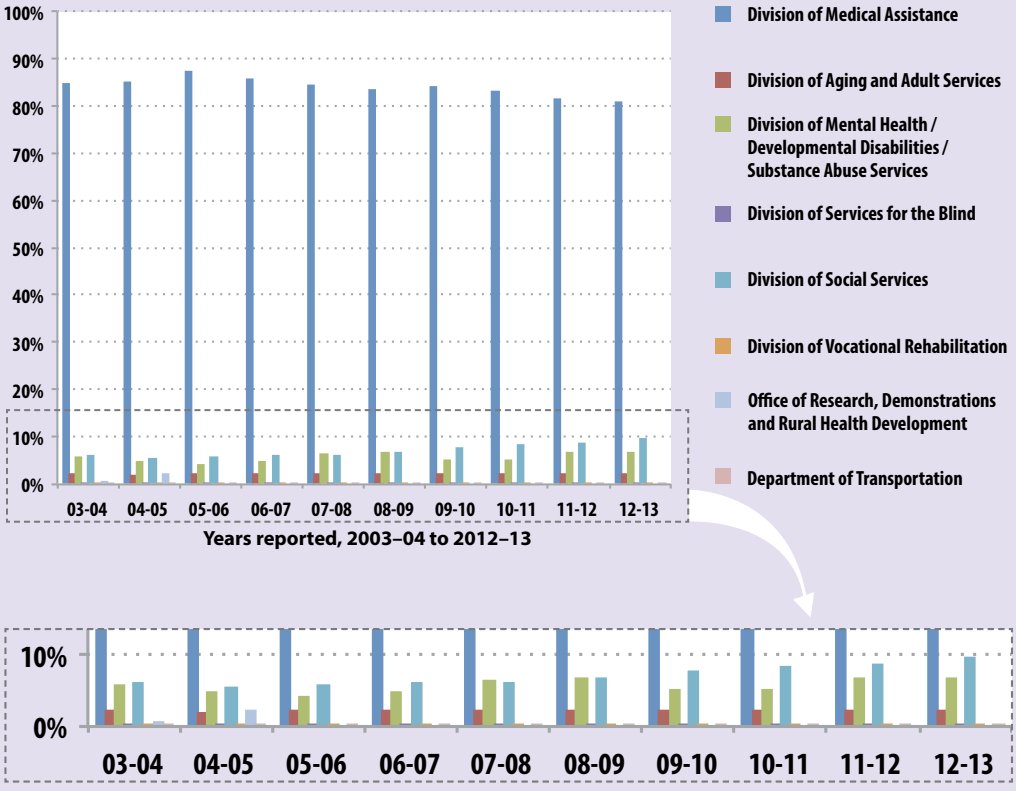
Photo by Karen Tam

Affording the Care

Cost Differences of Institutional Care, Assisted-Living Communities, Adult-Day Services, and Home Care Services

In 2011, the MetLife Mature Market Institute conducted a market survey of the costs of long-term care options in the United States, including institutionalized (nursing home), assisted-living communities, home care, and adult-day services.[50] The findings show a national average increase of 4.4 percent in the cost of institutionalized care. The cost of a private room in a nursing home rose from $83,585 in 2010 to $87,235 in 2011. A semi-private room increased from $74,825 to $78,110 in the same time period.[51] Those costs can increase for the care of those suffering from dementia or afflicted with Alzheimer's. Of those few facilities reporting separate rates based on Alzheimer's and dementia diagnoses, the 2011 average annual rate for a private room was $91,615 per year and $81,030 for a semi-private room.[52]

Figure 6: State Expenditure Data for Adults Aged 60+ from 2004–2013, Percentage of Total Spending by Agency

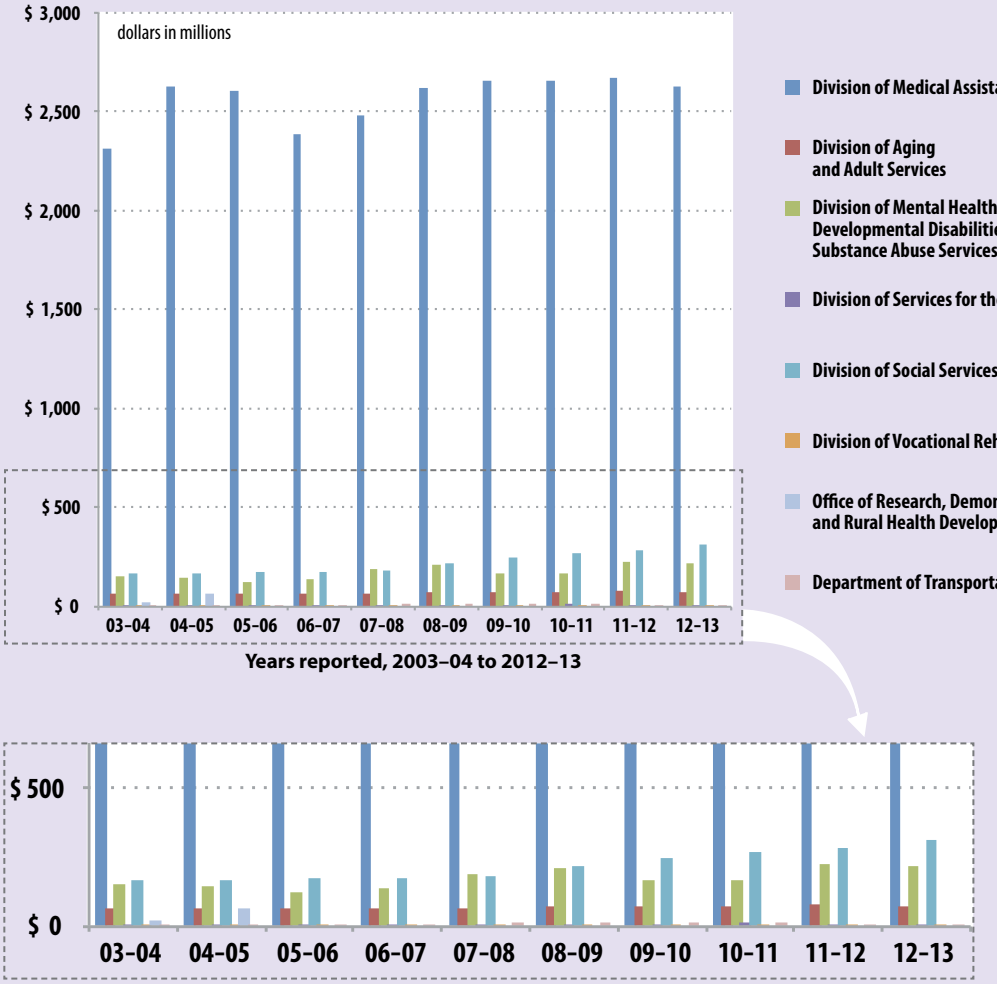


Source: N.C. Division of Aging and Adult Services[39]

The national cost for assisted-living communities, on average, increased 5.6 percent from $39,516 per year in 2010 to $41,724 in 2011.[53] As with nursing home care, the annual cost in an assisted-living community can increase for those with dementia or Alzheimer's. Of those assisted-living facilities reporting separate rates for Alzheimer's and dementia patients, the 2011 average annual rate was $55,428, which actually represents a decrease from the 2010 rate of $57,144; however the cost is still greater than facilities for those without dementia or Alzheimer's.[54]

The cost of community-based care and in-home services, though well below the average annual costs of nursing home and assisted-living care services, increased at a similar rate. The annual costs of adult-day services increased 4.5 percent, from $67 a day in 2010 to $70 in 2011. The cost of home care was $20 an hour for a home-health aide and $19 an hour for a homemaker (non-medical assistance). In terms of annual costs, adult-day services cost $18,200 in 2011, compared to $21,840 for a home-health aide and $19,760 for a homemaker.[55]

Figure 7: State Expenditure Data for Adults Aged 60+ from 2004–2013, Total Dollars by Agency



Source: N.C. Division of Aging and Adult Services[40]

In North Carolina, the average cost of nursing home care for 2011 was $217 per day for a private room ($79,205 per year) and $194 for a semi-private room ($70,810 per year).[57] The average cost for an assisted-living facility in the state was $3,605 per month ($43,260 per year).[58]

Adult-day services cost on average $51 a day in North Carolina ($13,260 per year).[59] The average cost of a home-health aide in the state was $19 per hour for 2011.[60]

A 2014 Cost of Care Survey found the following average rates:

	Average Rate	Average Annual Rate	Five-Year Annual Growth
Homemaker Services *(hourly rate)*	$17	$38,896	0%
Home Health Aide Services *(hourly rate)*	$18	$40,040	0%
Adult Day Services *(daily rate)*	$51	$13,260	1%
Assisted-Living Facility *(monthly rate)*	$2,940	$35,280	4%
Nursing Home *(daily rate for semi-private room)*	$203	$73,913	3%
Nursing Home *(daily rate for private room)*	$225	$82,125	4%

Source: Genworth 2014 Cost of Care Survey[61]

Financial Benefits of In-Home and Community-Based Care

A 2011 survey by the AARP's Public Policy Institute examined existing state-level analyses of the cost savings of rebalancing long-term care spending to include more home and community-based services (HCBS). The studies indicate "cost containment and a slower rate of spending growth as states have expanded HCBS" and "much lower per-individual, average costs for HCBS compared with institutional care."[62]

The report was a literature review of 38 reports from 25 states with published data on long-term care funding for the elderly and disabled. According to the report, North Carolina had no published studies and was not included in the review.[63]

Examples of potential cost-effective approaches include a 2008 analysis of transitioning "low-care need" nursing home residents to community-based programs in Arkansas. The report found the state spent approximately $59 million on its 12,399 institutionalized low-care Medicaid recipients, an amount that could be reduced by transitioning those individuals to a community-based setting. A 2011 analysis of the state's Community Connector Program, a program "that targets individuals at risk for entering nursing homes and links

them with appropriate community-based services and supports," found that HCBS services resulted in "a 23.8 percent average reduction in annual Medicaid spending per participant" and net savings of "$2.619 million for the 919 individuals included in the study's intervention group, or a return on investment of $2.92 per dollar invested in the program."[64]

A California study found the state spent three times more on Medicaid recipients in institutionalized care than in home- and community-based care, more than $32,000 for institutionalized care per recipient compared to just over $9,000 for those receiving care in a home- or community-based setting.[65]

A 2011 Maryland assessment of the state's Money Follows the Person program, a federal demonstration grant to transition eligible individuals out of institutional care and back into their homes and communities, found that the state's Medicaid system saved more than $3,000 per member, per month after transitioning from institutionalized care to home- and community-based care.[66]

Ohio experienced a 114 percent increase in individuals claiming the state's HCBS Medicaid waivers, resulting in a savings of $100 million from 1997 to 2009. An analysis of New Jersey's efforts to rebalance its long-term care spending found the state saved $138 million from 2008 to 2011. Another study found Rhode Island's rebalancing efforts saved the state more than $35 million over a three-year period.[67]

The AARP policy brief notes that some of the state-level studies cited the difficulty in evaluating a comprehensive cost-benefit analysis of institutional care and home- or community-based care, due in part to the difficulties of gathering and analyzing data dispersed across multiple state and federal agencies.

In-Home Health Care Aides

According to the U.S. Bureau of Labor Statistics' Occupational Handbook, the growth rate for home-health and personal-care aides will increase by 48 percent and 49 percent, respectively, between 2012 and 2022.[86] Home-health aides provide basic medical services in the home and personal-care aides assist elderly and disabled clients with the basic activities of daily living, such as bathing, housekeeping, and cooking.[87] Combined, changes in employment for both professions is expected to increase by 1,005,000 positions by 2022. The potential growth in both career fields could provide jobs for millions left unemployed due to the Great Recession, particularly those with only a high-school diploma or less. A high-school diploma or less is generally sufficient education for home-health and personal-care aides, with employers often willing to provide on-the-job training.[88]

According to the U.S. Bureau of Labor Statistics, the median average annual salary of a home-health aide as of 2012 was $20,820 and $19,910 for a personal-care aide. That is an annual salary that translates into a median hourly compensation of less than $10.00 per hour for a full-time job.[89] A CNNMoney article notes that "it's no surprise that about 40% of home aides rely on public assistance, such as Medicaid and food stamps, just to get by."[90]

The same article states that home health aides are not covered under federal laws governing minimum wage and overtime compensation, due to an exemption in the 1974 Fair Labor Standards Act.

The results of the 1974 law classified home health aides as companionship workers, the same categorization as babysitters, meaning that in some cases employers do not have to pay them minimum wage or time-and-a-half for overtime. In September 2013, the United States Department of Labor announced a change to the exemption in the 1974 Fair Labor Standards Act. Effective January 2015, employers will be required to pay direct-care workers a minimum wage and compensate for overtime.[9]

Figure 8: Rates for Nursing Home, Assisted-Living, Home Health, and Adult-Day Services, 2011

	Nursing Homes		Assisted Living Communities	Home Care		Adult Day Services
	Semi-Private Room	Private Room		Home Health Aide	Home-maker	
Rate Type	**Daily**	**Daily**	**Monthly**	**Hourly**	**Hourly**	**Daily**
2011 Average Rate	$214	$239	$3,477	$21	$19	$70
2010 Average Rate	$205	$229	$3,293	$21	$19	$67
Dollar (Percent) Increase from 2010	$9 (4.4%)	9	$184 (5.6%)	$0 (0%)	$0 (0%)	$3 (4.5%)
2011 Median Rate	$l99	$224	$3,243	$20	$19	$65
2011 Highest Average Rate	$678	$655	$5,757	$34	$29	$148
Location	AK Statewide	AK Statewide	DC Washington	MN Rochester Area	MN Rochester Area	VT Statewide
2011 Lowest Average Rate	$128	$141	$2,156	$14	$13	$29
Location	OK, TX Rest of State	LA Rest of State	AR Rest of State	LA Shreveport Area	LA Shreveport Area	AL Montgomery Area
2011 Annual Rate	$78,110	$87,235	$41,724	$21,840	$19,760	$18,200

*Costs are rounded to the nearest dollar.
Source: The MetLife Mature Market Institute[56]

A report by the National Domestic Workers Alliance on domestic workers, which includes personal caregivers, found that those professions are also disproportionally female and minority, with 95 percent of all domestic workers being female and 48 percent being Latino and African American.[92] The job of a health aide is the "single most common job for black women."[93] Additionally, most of these positions do not provide benefits, including retirement and insurance. The report notes that 65 percent of domestic workers do not have health insurance, only 2 percent receive retirement benefits or a pension, and nearly half do not earn a wage that can support a family.[94]

The CNNMoney article notes that the home health care industry is struggling to keep its services affordable at a time of rising demand and when states are cutting Medicaid services to trim their budgets.[95]

"There is a high turnover rate in terms of certified nursing assistants," says Dr. Peggye Dilworth-Anderson. "We need to educate the workforce, train the existing workforce, and pay people more money."

"The high turnover rate is due in large part to the low wages and lack of job security and benefits on the job," says Dr. Dilworth-Anderson. "The industry is disproportionately skewed toward poor women, immigrant women, and women of color. It is a barnacle workforce taking care of a barnacle population. That is a risky situation. It does speak to how we are not valuing individuals—the older people and the workforce. It is a varied gender situation because we are talking about poor women taking care of other sick women. That is very political in the sense of who we value in society. Some would argue we don't value women in the workforce. Some would say we don't value the elderly. There is a lot of evidence to say both are true."

Conclusion

Over the next two decades, the state of North Carolina will be faced with a growing cohort of older residents, many of whom will need assistance with activities of daily living and more intense long-term care services. The increasing demand on state resources will inevitably strain the state's Medicaid system and place demands on other governmental agencies that provide economic supports and human services.

"We can't meet the demand we have now," says Heather Burkhardt, with the North Carolina Department of Health and Human Services' Division of Aging and Adult Services. "We need more creative solutions and to support public/private partnerships. It can't be just more government funding."

To meet the demand for increased long-term care, the state will need to focus on all the forms of caregiving available to an individual and their families, including better governmental supports for private caregivers, training and education for employers on how to support employees caring for aging loved ones, and a more strategic use of Medicaid long-term care expenditures to make sure costly institutional care is provided only for those who need it most. For older adults who can stay in their homes and communities, programs like PACE, Just for Us, and Money Follows the Person, should provide the support and resources instead.

"It is not simply that North Carolina or other states spend too much money on institutional care," says Dr. Gregory Boyer, a research associate at the University of North Carolina at Chapel Hill's Institute on Aging. "With Medicaid, it is a required benefit under law since it has been enacted, whereas home- and community-based care is at the mercy of the economy. We know there are people being institutionalized who could be served better in the home or community, but if there aren't the appropriate funding or policies [in place], they will be institutionalized."

The growing demographic of seniors means the state, as well as families and businesses, will need to reconsider how the aged and medically frail are cared for as illnesses and disabilities affect their independence. It means moving beyond a linear path of retirement to aging to illness to nursing home and instead to a more dynamic continuum of care where nursing homes are available for those who need them but systemic policies are in place for those who don't. These seniors can then transition back into homes and communities as they heal. It can be a more cost-efficient model, and one that is more individual-centered rather than system-driven.

"I like to think about care on a continuum and with transitions," says Dr. Dilworth-Anderson. "People can go from home to hospital to sub-acute care to back home again. It is not home and institution. All this care is being given at the same time."

"North Carolina needs to maintain a strong continuum of care that includes high quality community options as well as high quality institutional care," says Heather Burkhardt. "If we have all the options, people will have a choice in which setting best meets their preference and needs. We need to have a long-term service and support system that is person-centered and provides various levels of care and settings."

For Donna Futoransky, who is caring for an aging loved one and navigating her own retirement, the day-to-day obligations of her caregiver role have caused her to reflect more on her own future care.

"Every day that I get older, I think about it [long-term care]," says Donna. "I don't know if it scares me, but I do think about it. And I have thought about it more when I see what is happening with other people and where they have to put their parents."

Donna's time working in the nursing home industry helped her appreciate how important the nursing home option is for families who can no longer afford to care for a sick family member, despite their desire and willingness to do so.

"I was crying right along with the people who were bringing their family members in," says Donna. "They were so devastated. [These were] large families with sons and daughters who would have opened their homes in a minute, but didn't have the capability to take care of them [anymore]."

"Some of the nursing homes I worked at were wonderful—some were ok," Donna says. "But I don't want to have to visit my mother in a nursing home, so we will do everything we can to make sure she doesn't have to do that [move to a nursing home]."

Photo by Karen Tam

Yet Donna often wonders how others in similar situations manage, especially those whose families weren't as well prepared as hers.

"Fortunately, I was in a position where I could do this. I was making the decision for myself. And I signed up for it," says Donna. "[But] if you sign up for it or not, it's a challenge. Period. It's a challenge. It's a challenge for my mother, because she doesn't have the privacy she would ordinarily have. It's a challenge for me that I don't have the freedom that I might have had, and that's not a complaint, it's just a fact."

For now, she's enjoying the time she has been given with her mother and the chance for her grandchildren to know their great grandmother.

"I'm so glad we have the opportunity to be able to have her here."

Her mother, Sophia, agrees. "She's such a loving daughter. She's been so good to me. I've got a happy life."

Policy Recommendations

1. **Establish a statewide study to analyze the cost-benefit of transitioning more abled Medicaid recipients from institutionalized care to adult-day services and other forms of home- and community-based care.** The study should include a quantitative analysis of fiscal savings and improvement in patients' health status, as well as a qualitative analysis of improvements to quality of life and benefits of staying in home and community. The study should also focus on rebalancing expenditures to increase nursing home diversions and access to long-term services and supports.

2. **Examine expanding models that offer patient-centered, integrated care and long-term services for North Carolina seniors throughout the state.** Explore ways to make these models of care more effective for less-population dense rural communities where transportation may not be as readily available.

3. **Increase state services to private caregivers, including educational services and respite opportunities, and engage with businesses and employers about demands on private caregivers and workplace supports.** Examine innovative programs and partnerships for planning, execution, and promotion of caregiver support programs, including respites, training, and supports.

4. **Explore ways to increase public awareness of long-term care planning, including savings, caregiver assistance, and home- and community-based care options.** Include increased promotion of programs that assist North Carolinians to transition, when appropriate, from nursing homes back to their homes and communities.

Program for All-Inclusive Care for the Elderly (PACE)

One example is the Program for All-Inclusive Care for the Elderly, commonly known as PACE. The PACE program started as a pilot in California in the 1970s and has since grown to 105 organizations covering 31 states as of 2014.[68] The PACE program provides a coordinated approach to health care for very frail, most often financially needy, seniors who choose to remain in their homes and communities. In North Carolina, there are nine active PACE programs, with 1,097 enrolled, and more are scheduled to open.[69]

Piedmont Health SeniorCare oversees the administration of the PACE program in Burlington, which serves residents of Alamance and Caswell Counties. Like most PACE programs, the Burlington PACE site primarily serves a senior population that is financially needy and physically frail. Through the PACE model of a coordinated approach to health care, an interdisciplinary team based at the program's day-health center manages individual plans of care for each enrollee. The team, which meets every morning to review case plans, is composed of a physician, pharmacist, nurse, social worker, dietitian, recreational therapist, rehabilitation staff member, home-care coordinator, and even a driver, who provides transportation to and from the center and to medical appointments as needed.[70]

While the program is not restricted to Medicare and Medicaid recipients, the vast majority of program participants are dually eligible for both Medicare and Medicaid.[71] Dual eligibility means participants pay nothing to participate in the program. Medicare and Medicaid pay a capitated payment per member, per month to the PACE administrator.

A capitated payment is a flat rate paid for the care provided to Medicare- and Medicaid-eligible individuals.[72] For Medicare, the rate varies based on the health care needs of the individual. A patient with comorbidity of two or more conditions means the provider receives a higher capitated payment for more complicated medical care. Under the capitated payment system, the provider assumes all the financial risk involved with each individual's care. If the services provided exceed the individual capitated amount, the PACE administrator must cover the cost. For Medicaid, the PACE program receives a flat rate per month that does not fluctuate based on the health conditions of the individual patient, as the rate does change under Medicare.[73]

According to Marianne Ratcliffe, Executive Director of Piedmont Health SeniorCare, there is financial risk and accountability that is inherent in a capitated model, due to the chronic conditions and frailty common with the population served by the PACE program.

"We have $3,310 a month for each member from Medicaid, and on average we get about $2,000 from Medicare for parts A, B, and D," says Ratcliffe. "We get about $5,300 per month for someone's care."

Ratcliffe explains that the Piedmont Health SeniorCare program serves a typical demographic of PACE patients, with some

In North Carolina, several programs and initiatives are underway to provide more community-based long-term care options for those individuals who want to stay in their homes. Here are three such examples of programs operating in our state.

patients having up to eight medical conditions and needing assistance with activities of daily living like bathing and grooming.

"We are a managed-care program with a contract with different area providers who provide services that we cannot provide directly," says Ratcliffe. "The majority of services are rendered at our adult day-care center. Then other services are provided in the patient's home or in the community."

"We have contacts with all those different providers and we still coordinate and authorize those services through our interdisciplinary team and we also pay for those services. So if someone goes to the cardiologist, they're going to bill us instead of Medicare or Medicaid."

Analysis has shown that the PACE model can lower Medicare costs by as much as 38 percent and Medicaid costs by as much as 15 percent for comparable patient populations.[74] It can also decrease nursing home admissions and mortality rates, and participants have indicated "better self-reported health and quality of life compared to non-PACE populations."[75]

At the PACE program in Burlington, the staff of Piedmont Health SeniorCare have seen similar improvements in their own patients and think the better outcomes are due, at least in part, to the community setting.

"After 12 months, 54 percent of the patients had an improvement in their geriatric depression score from the time they enrolled," says Ratcliffe. "That is largely due, not to medication, but from coming into the center, developing friendships, having the support network of the interdisciplinary team to coordinate and address their health care needs."

Given the age and medically frail nature of the patient population base at the Piedmont Health SeniorCare's senior day center, success is often measured in terms of maintaining the status quo, so any measurable improvement is encouraging.

"The other thing we look at is mental statuses. At three years into the program, we have 46 percent of patients who have seen improvement from enrollment, and 65 percent improvement at 12 months," says Ratcliffe. "Maintaining would be success, but the fact that we're seeing improvement in some of these scores is quite rewarding."

Though the PACE model has shown promising results in terms of lowered costs and improved health outcomes, the widespread adoption of the model has been slow in some parts of the country, due in part to a lack of public awareness about the service, limited state-level support in some areas, high initial start-up costs for nonprofit centers, a hesitation by some seniors to participate in the adult day care model, transportation issues in rural communities, and out-of-pocket costs for middle-income individuals who are not eligible for Medicaid.[76]

Money Follows the Person

The Money Follows the Person demonstration program was created by Congress in 2005 to assist states in rebalancing their long-term care spending to give more Medicaid-eligible recipients the option of transitioning from institutional care to home- and community-based care.[77] To qualify for the program, participants must have been in an institution for at least 90 days and must express a desire to transition back into their homes and communities.[78]

Money Follows the Person participants are eligible for up to $3,000 in transitioning supports, funds that can be used to cover the costs of moving back into a community setting, such as "security deposits, utility startup expenses, furniture, accessibility modifications or other one-time items and services that may be required to transition."[79]

The Money Follows the Person demonstration program has been shown to reduce Medicaid long-term care expenditures in other states by transitioning more individuals away from expensive institutional care and back into communities.

An assessment of Maryland's Money Follows the Person program found that it saved the state's Medicaid system more than $3,000 per member, per month and resulted in a higher quality of life for those who transitioned back into their communities.[80]

A West Virginia projection of potential cost savings in implementing the state's Money Follows the Person project forecasted savings of more than $50 million dollars over 10 years from transitioning only 75 to 110 individuals.[81]

To entice states to participate, the demonstration grant provides an increased federal matching rate toward the state's Medicaid spending on enrollees in the program.[82] The grant, in effect, increases the state's available funding for future participants and expands the scope of the program.

"Once an individual goes in to a community, the services that they receive—those services pull down extra federal funding and get pulled in to what is called a rebalancing fund, which allows you to continue serving other individuals who you wouldn't otherwise have been able to serve," says Jessica Keith, a special advisor on the Americans with Disabilities Act in the North Carolina Department of Health and Human Services.

"The more transitions that you do and the more services that the person receives, the more federal funding you will have," says Keith.

Keith believes the key to expanding Money Follows the Person is breaking through cultural biases of institutional care, a belief that a person needing long-term assistance is best served in institutional settings. The objective includes explaining to paid caregivers and families that not all individuals need to live in a nursing home and that some can remain in their homes, receive care, and still be active members of their communities. It's more cost-efficient for the state and, as the PACE program has shown, beneficial to the health and well-being of the individual.

"Everyone in a human services position wants to support an individual and believe in individuals and truly cares for individuals. Sometimes in more congregate settings, people are used to caring for people and the idea of somebody transitioning really scares them," says Keith. "One of the greatest challenges is taking the time and making sure we have all of the information about what is possible for individuals, so that we can get the individuals who are currently serving the individuals away from the assumption that all individuals need 24/7 care and supervision."

Just for Us

Since 2001 a unique program has been underway in Durham to connect more low-income, "medically fragile" seniors and disabled adults with in-home health care in an effort to better manage chronic disease and provide services.[83]

As part of Duke University Medical Center's Department of Community and Family Medicine, the "Just for Us" program offers a range of health care services to the elderly and disabled adults, the majority of whom reside in Durham's public housing complexes. Much like the PACE program, individual care is managed by a team of providers, including the patient's primary-care provider (PCP), as well as a social worker, and nutritionist, all with the goal of keeping the patient in their community, better coordinating their care, and sustaining their independence.

"Initially, the focus of the program was to coordinate care for the patient and follow up on plans made by the primary care provider," says Dr. Robin Burnette, former medical director of Just for Us. "However, they found that patients were not returning to their PCP regularly. Thus, Just for Us was started to deliver those basic primary-care services."

Just for Us operates through a partnership between multiple agencies, including county-level health departments, the city housing authority, a nationally-recognized research hospital, and a community-health center. The partnership allows the program to execute a multifaceted approach to in-home care for medically frail seniors and better coordinate services to support and maintain their independent living.

Cost of care is mitigated because the concentration of medically frail and low-income seniors in public housing allows for a centralized delivery of services. Likewise, the interdisciplinary approach to care and case management helps to identify and connect elderly and disabled adults to the benefits for which they are eligible. In 2002, at the start of the program, only 28 percent of participants were enrolled in Medicaid, despite the fact that many more were eligible. Physical barriers, such as transportation and long waits, discouraged enrollment. Two years later, due to more efficient and integrated case management, Medicaid enrollment was more than 90 percent for program participants, meaning more financial assistance was available to support care.[84]

The Just for Us program has shown promising cost rebalancing in expenditures for Medicaid recipients enrolled in the program, such as decreased spending on ambulance usage by participants, fewer emergency department visits, and a significant drop in spending on inpatient hospitalization between fiscal years 2002–03 and 2003–04.[85]

"Going into the home gives the provider a better idea of the patient's experience than you are able to achieve in the clinic," says Dr. Burnette. "In particular, you see a patient's accessibility, medication related issues, caregivers, food, and cleanliness."

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[18] Rodney Brooks, "Retirement Living: Debt holds many Boomers back," USA Today, Oct. 21, 2013. Available at http://www.usatoday.com/story/money/columnist/brooks/2013/01/28/retire-debt-crisis-retirement-boomers/1840225/.

[19] "Children's Inheritance First to Go When Paying for Long-Term Care Costs," Nationwide Financial Press Release, Mar. 4, 2013. Available at http://www.nationwide.com/newsroom/030413-NF-LTC-Inheritance.jsp. The Long-Term Care Study was conducted online between Sept. 17–24, 2012, and the respondents comprised 813 adults ages 50+ having $150,000 or more in annual household income/investable assets.

[20] "North Carolina's Aging Profile, 2013," North Carolina Division of Aging and Adult Services. Available at http://www.ncdhhs.gov/aging/cprofile/2013Profile.pdf.

[21] "The MetLife Study of Caregiving Costs to Working Caregivers: Double Jeopardy for Baby Boomers Caring for Their Parents," The MetLife Mature Market Institute, The National Alliance for Caregiving, and the Center for Long Term Care Research and Policy at New York Medical College, June 2011, p. 15. Available at https://www.metlife.com/assets/cao/mmi/publications/studies/2011/Caregiving-Costs-to-Working-Caregivers.pdf. The study analyzes data from the 2008 panel of the National Health and Retirement Study combined with estimates to determine the extent to which older adult children provide care to their parents, the roles gender and work play in that caregiving, and the potential cost to the caregiver in lost wages and future retirement income as a result of their support. After cases with missing data were eliminated from the 2008 panel, the sample was restricted to 1,112 men and women who had a parent living.

[22] Reaves and Young, note 2 above, p. 2.

[23] Andrea Wysocki et al, "Long-Term Care for Older Adults: A Review of Home and Community-Based Services Versus Institutional Care," Effective Health Care Program: Comparative Effectiveness Review, No. 81, Nov. 2012. Available at http://effectivehealthcare.ahrq.gov/ehc/products/369/1277/CER81_Long-Term-Care_FinalReport_20121023.pdf. Nursing homes are defined as "State-licensed institutional facilities offering 24-hour room and board, supervision, and nursing care. . . . services may include personal care, activities of daily living (ADL) support, medical management, nursing management, medication management, restorative nursing, palliative care, physical rehabilitation (either as a short-term service associated with postacute care or as maintenance rehabilitation), social activities, and transportation."

[24] Ibid., p. ES-2.

[25] Reaves and Young, note 22 above.

[26] Terence Ng, Charlene Harrington, MaryBeth Musumeci, and Erica L. Reaves, "Medicaid Home and Community-Based Service Programs: 2010 Data Update," The Kaiser Commission on Medicaid and the Uninsured, Mar. 2014, p. 1. Available at http://kaiserfamilyfoundation.files.wordpress.com/2014/03/7720-07-medicaid-home-and-community-based-services-programs_2010-data-update1.pdf.

[27] Reaves and Young, note 22 above, p. 6.

[28] Ibid.

[29] Ibid.

[30] Ibid.

[31] "North Carolina County Data Package Introduction," North Carolina Division of Aging and Adult Services, Jan. 2014. Available at http://www.ncdhhs.gov/aging/ExpendData/CountyDataReport2013.pdf. Note that these expenditures represent the federal, state, and minimum local share for services provided to individuals age 60 and older.

[32] "State Expenditure Data for 60+ from 2004–2013 for North Carolina," North Carolina Division of Aging and Adult Services. Available at http://www.ncdhhs.gov/aging/expenddata.htm. Data compared from 2004 Table III-B Report and 2013 Table III-B Report.

[33] The state fiscal year runs from July 1 through June 30.

[34] "State Expenditure Data for 60+ from 2004–2013 for North Carolina," North Carolina Division of Aging and Adult Services. Available at http://www.ncdhhs.gov/aging/expenddata.htm. Data obtained from Table III-B Reports.

[35] Ibid. The Division of Aging and Adult Services defines the service categories as follows:

- Adult Care Homes—Includes: Special Assistance payments for residents of adult care homes; Medicaid expenditures for: personal care services (PCS-basic and enhanced), care management and screening, and transportation associated with adult care homes.
- Economic Support—Programs and services that provide an indirect financial support, without which a cash outlay by the recipient would be required.
- Hospitals, Physicians, and Other Health Care—Services that provide a variety of health care to recipients outside their home.
- Home Health and In-Home Care—Services that provide health and related care to recipients in their home.
- Institutional Care—Services provided to residents of nursing homes, mental health facilities, and hospitals.
- Social Support—Services that provide social and/or other support to recipients inside or outside their home.

The report notes that: "The Schedule of Reported Expenditures by Funding Source and Major Service Category (Table III-B) summarizes the expenditures by the contributing funding sources based on the six service categories. These expenditures represent the federal, state and minimum local share for services provided to individuals age 60 and older."

[36] Ibid.

[37] Ibid.

[38] Ibid.

[39] Ibid.

[40] Ibid.

[41] "The MetLife Study of Caregiving Costs to Working Caregivers: Double Jeopardy for Baby Boomers Caring for Their Parents," The MetLife Mature Market Institute, The National Alliance for Caregiving, and the Center for Long Term Care Research and Policy at New York Medical College, June 2011, p. 2. Available at https://www.metlife.com/assets/cao/mmi/publications/studies/2011/Caregiving-Costs-to-Working-Caregivers.pdf.

[42] H. Stephen Kaye, Charlene Harrington, and Mitchell P. LaPlante, "Long-Term Care: Who Gets It, Who Provides It, Who Pays, and How Much," Health Affairs 29, No. 1 (2010) p. 11. Available at http://content.healthaffairs.org/content/29/1/11.full.pdf+html. The survey included analyses of data sets from five nationally representative federal surveys: The Survey of Income and Program Participation; the 2007 National Health Interview Survey; the 2007 American Community Survey; the 2004 National Nursing Home Survey; and the Medical Expenditure Panel Survey.

[43] Ibid., p. 15.

[44] Ibid.

[45] MetLife Study of Caregiving Costs to Working Caregivers, note 41 above, p. 16.

[46] Ibid., pp. 14–15.

[47] Ibid., p. 15.

[48] Ibid., p. 12.

[49] Interview with Dr. Peggye Dilworth-Anderson, Interim Co-Director of the University of North Carolina at Chapel Hill's Institute on Aging and Co-Director of the Institute's Aging and Diversity program, and Dr. Greg Boyer, Research Associate, University of North Carolina at Chapel Hill's Institute on Aging and Co-Director of the Institute's Aging and Diversity program, Mar. 22, 2013.

[50] "Market Survey of Long-Term Care Costs: The 2011 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs," The MetLife Mature Market Institute and LifePlans Inc., Oct. 2011, pp. 6–14. Available at https://www.metlife.com/assets/cao/mmi/publications/studies/2011/mmi-market-survey-nursing-home-assisted-living-adult-day-services-costs.pdf.

The MetLife survey defines these categories as:

- Nursing home: A "facility which provides residents with a room, meals, personal care, nursing care, and medical services" for both short- and long-term care.
- Assisted-living communities: "It provides services for those who are not able to live independently, but do not require the level of care provided by a nursing home. Residents of assisted living communities may need personal care, assistance with meal preparation, activities of daily living, and household chores, and/or require supervision due to cognitive impairment related to disorders such as Alzheimer's."
- Home-care services: "Homemakers or companions provide services that include light housekeeping, meal preparation, transportation, and companionship. This type of care is often appropriate for those with Alzheimer's disease or other forms of dementia who may be physically healthy but require supervision. Homemakers and companions are not trained to provide hands-on assistance with activities of daily living such as bathing and dressing."

  > "Most home care is non-medical care provided by paraprofessionals. However, some home care can only be delivered by licensed health care professionals. Typically provided by nurses, physical and occupational therapists, or specially trained home health aides under the direction of a physician or nurse, skilled care services at home are most often needed after an acute event such as a hip fracture, when follow-up rehabilitation services are needed at home after discharge from a hospital."

- Adult-day services: "Adult day services provide health, social, and therapeutic activities in a supportive group environment for individuals with cognitive and/or functional impairments. Some are freestanding centers or programs; others are affiliated with a facility or organization such as a nursing home, assisted living community, senior center, or rehabilitation facility."

[51] Ibid., p. 4.

[52] Ibid., p. 7. The survey results do not provide an average annual cost for these services in 2010.

[53] Ibid., p. 4.

[54] Ibid., p. 9.

[55] Ibid., p. 5.

[56] Ibid., p. 5.

[57] Ibid., p. 23.

[58] Ibid., p. 31.

[59] Ibid., p. 47. Annual rates for adult-day services were calculated by multiplying the average daily rate by the number of weekdays in a year (260).

[60] Ibid., p. 39.

[61] "Genworth 2014 Cost of Care Survey," CareScout and Genworth Financial, Inc., 2014, p. 52. Available at https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/130568_032514_CostofCare_FINAL_nonsecure.pdf.

[62] Wendy Fox-Grage and Jenna Walls. "State Studies Find Home and Community-Based Services to Be Cost-Effective," AARP Public Policy Institute, Mar. 2013. Available at http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/state-studies-find-hcbs-cost-effective-spotlight-AARP-ppi-ltc.pdf.

[63] Ibid.

[64] Ibid., pp. 4–5.

[65] Ibid., p. 7.

[66] Ibid., p. 11. $9,114 for recipients in a nursing care facility compared to $5,957 for those transitioned back into their communities.

[67] Ibid., pp. 14–16.

[68] Sandra Terrell, "Program of All-Inclusive Care for the Elderly (PACE) Report," Report to the Joint Legislative Oversight Committee on Health and Human Services, N.C. General Assembly, Oct. 14, 2014. Available at http://www.ncleg.net/documentsites/committees/JLOCHHS/HandoutsandMinutesbyInterim/2014-InterimHHSHandouts/October2014,2014/Va-Report_on_PACE-DHHS-2014-10-14-AM.PDF.

[69] Ibid. There are nine programs in North Carolina at ten sites: Carolina SeniorCare-Lexington, Elderhaus-Wilmington, St. Joseph of the Pines-Fayetteville, PACE of the Southern Piedmont-Charlotte, PACE of the Triad-Greensboro, PACE@Home-Newton, Piedmont Health SeniorCare-Burlington, Piedmont Health SeniorCare-Pittsboro, Senior Community Care of North Carolina-Durham, and Senior Total Life Care-Gastonia. Data as of 9/1/14.

[70] Interview with Marianne Ratcliffe, Executive Director of Piedmont Health SeniorCare, Mar. 1, 2013.

[71] Ibid.

[72] Tanaz Petigara and Gerard Anderson, "Program of All-Inclusive Care for the Elderly," Health Policy Monitor (13) 2009. Available at http://www.npaonline.org/website/download.asp?id=3034&title=PACE_-_HealthPolicyMonitor_-_2009.

[73] Interview with Marianne Ratcliffe, note 70 above.

[74] Petigara and Anderson, note 72 above.

[75] Ibid.

[76] Ibid.

[77] Debra J. Lipson and Susan R. Williams, "Money Follows the Person Demonstration Program: A Profile of Participants," National Evaluation of the Money Follows the Person (MFP) Demonstration Grant Program, Mathematica Policy Research, Inc., No. 5, Jan. 2011. Available at http://www.mathematica-mpr.com/publications/PDFs/health/mfpfieldrpt5.pdf.

[78] Interview with Jessica Keith, Special Advisor on the Americans with Disabilities Act, N.C. Department of Health and Human Services, Apr. 11, 2013.

[79] "Money Follows the Person," N.C. Department of Health and Human Services. Available at http://www.ncdhhs.gov/dma/moneyfollows.

[80] Wendy Fox-Grage and Jenna Walls. "State Studies Find Home and Community-Based Services to Be Cost-Effective," AARP Public Policy Institute, Mar. 2013, p. 11. Available at http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/state-studies-find-hcbs-cost-effective-spotlight-AARP-ppi-ltc.pdf.

[81] Ibid., p. 18.

[82] Lipson and Williams, note 77 above.

[83] SD Yaggy et al, "Just for Us: An Academic Medical Center-Community Partnership to Maintain the Health of a Frail Low-Income Senior Population," The Gerontologist, Vol. 46, No. 2, pp. 271–276.

[84] Ibid.

[85] Ibid. Between fiscal years 2002–2003 and 2003–2004, ambulance spending dropped by 49 percent, spending on emergency department visits dropped by 41 percent, spending on inpatient hospitalization dropped by 68 percent, and spending on outpatient hospital visits dropped by 24 percent, while at the same time spending increased for CAP-DA (Community Alternatives Program for Disabled Adults) services, prescription drugs, and in-home health care.

[86] U.S. Bureau of Labor Statistics Occupational Outlook Handbook, Home Health and Personal Care Aide entries. Available at http://www.bls.gov/ooh/healthcare/personal-care-aides.htm and http://www.bls.gov/ooh/healthcare/home-health-aides.htm.

[87] Ibid.

[88] Ibid.

[89] The Bureau of Labor Statistics 2012–2013 Occupational Handbook, Home Health and Personal Care Aide entry, http://www.bls.gov/ooh/healthcare/home-health-and-personal-care-aides.htm#tab-1, retrieved on August 22, 2014.

[90] Annalyn Kurtz, "America's Fastest Growing Job Pays Poorly," CNNMoney.com, Mar. 11, 2013. Available at http://money.cnn.com/2013/03/11/news/economy/fastest-growing-job/index.html.

[91] "Minimum wage, overtime protections extended to direct care workers by US Labor Department," U.S. Dept. of Labor News Release, Sept. 17, 2013. Available at http://www.dol.gov/opa/media/press/whd/WHD20131922.htm.

[92] Linda Burnham and Nik Theodore, "Home Economics: The Invisible World and Unregulated World of Domestic Work," National Domestic Workers Alliance, 2012. Available at http://www.domesticworkers.org/pdfs/HomeEconomicsEnglish.pdf.

[93] Kurtz, note 90 above.

[94] Burnham and Theodore, note 92 above.

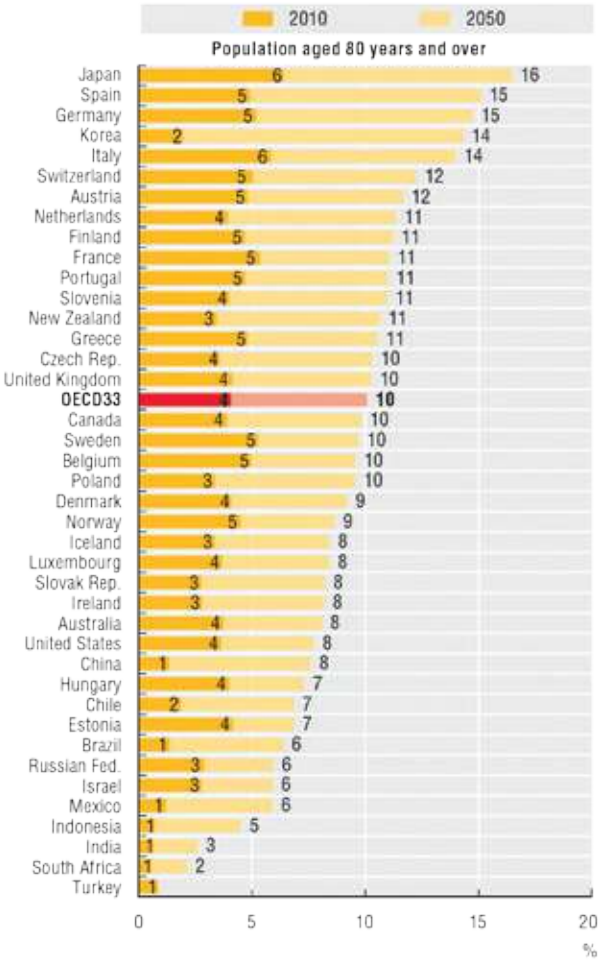
[95] Kurtz, note 90 above.

Comparing the Aging Population and Long-Term Care Across OECD Countries

By Paige C. Worsham

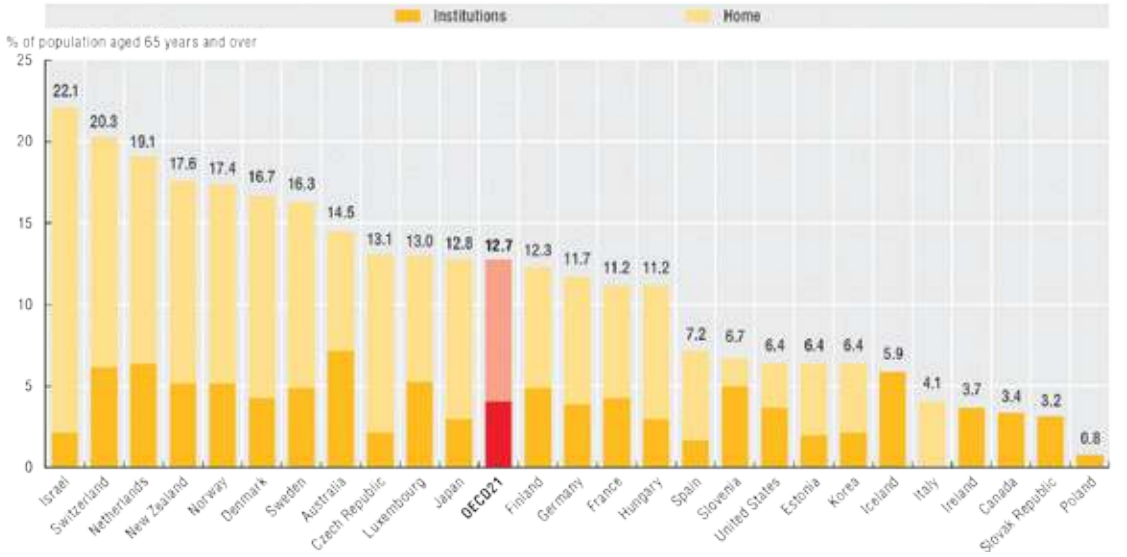
Across the Organisation for Economic Cooperation and Development (OECD) member and partner countries included in the data, the share of the population over 80 years old will increase, on average, from 4 percent in 2010 to 10 percent by 2050. At 16 percent, Japan will see the largest percentage among the member countries, and Mexico, at 6 percent, the smallest. The percentage of the population aged 80 years and older rises from 4 percent in 2010 to 8 percent in 2050 in the United States.

OECD: Share of the Population Aged Over 80 Years, 2010 and 2050



At almost 3 percent, the Netherlands spends the most, as a share of GDP, on long-term health care across OECD countries. The United States spends 0.5 percent, and the OECD countries spend just under 1 percent on average. According to a 2013 OECD report on health indicators across member and partner countries, 6.4 percent of the United States population, aged 65 and older, received long-term care services in 2011, with approximately half of that population receiving institutional care and the other half receiving home-based care. Among the OECD countries, 12.7 percent received long-term care services, with 4 percent in institutional care, and 8.7 percent at home. Home-based care has increased in the U.S. between 2000 and 2011, but still lags behind other OECD countries.

OECD: Population Aged 65 Years and Older Receiving Long-term Care, 2011 (or Nearest Year)



Source: "Health at a Glance 2013: OECD Indicators," Organisation for Economic Co-operation and Development. Available at *http://www.oecd.org/els/health-systems/Health-at-a-Glance-2013.pdf.*

Photo by Karen Tam

Above, the Taptations of Carol Woods Retirement Community in Chapel Hill in 2008. Their introductory chorus begins: "We're the Taptations with white hair / We'd rather dance than rock in a rockin' chair!"

North Carolina's Aging Services Plan:
Are We on Track?

By Dr. Linda S. Millsaps

Today, 20 percent of our population in North Carolina is 60 years old or older, with the number expected to rise by 58.3 percent by the year 2033. Even more significant is the 102 percent increase in individuals between the ages of 75 and 84 expected during the same period.[1]

Policymakers and state administrators have been focused on the unique challenges related to North Carolina's growing senior population for some time. While the methods used to address these challenges have changed, one of the most targeted efforts has been the creation of four-year Aging Services Plans. In February 2011, the N.C. Division of Aging and Adult Services (a part of the N.C. Department of Health and Human Services) released the 2011–15 North Carolina Aging Services Plan. Based on input from approximately 1,200 citizens and community leaders, and seven separate conferences and roundtables, this plan outlined eight separate strategic goals to guide the work of state and local agencies and organizations as it related to the aging population.

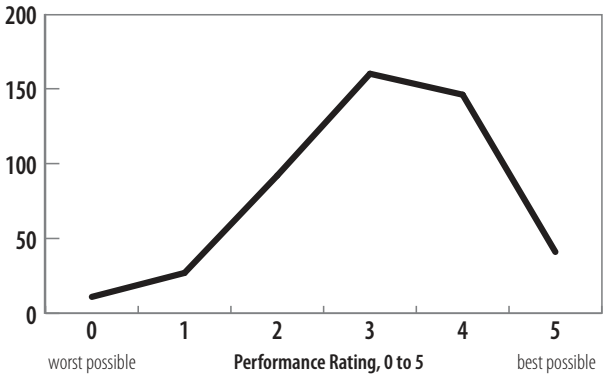
The close of 2014 offers a perfect opportunity to examine how well those most involved in directing local services believe we are meeting the goals laid out in the plan,

Dr. Linda S. Millsaps is the executive director of the North Carolina Center for Public Policy Research.

as well as provide input on the statewide primary area of focus for 2015. To that end, the Center surveyed 151 aging and adult services professionals from across the state. Of those contacted, 31 replied, a response rate of 20.5 percent. We include the results of the survey responses here. In each category, an answer of "0" represented the "worst possible" performance, while "5" suggested the "best possible" performance. Respondents were not asked to give specific examples or their rationale. Rather, the focus was on a general sense of the respective county and overall state performance under each aging services plan goal.

In general, respondents tended to answer that both the state and local governments were performing in the mid-range, with 52.8 percent of the survey questions receiving a score of two or three, out of the zero- to five-point scale. However, on the outer ends of the scale, respondents were far more likely to indicate that the state and county were performing very well, with 39.2 percent of responses falling in the four- or five-point range. By contrast, only 8 percent of responses fell in the bottom (zero- or one-point) categories. See Figure 1.

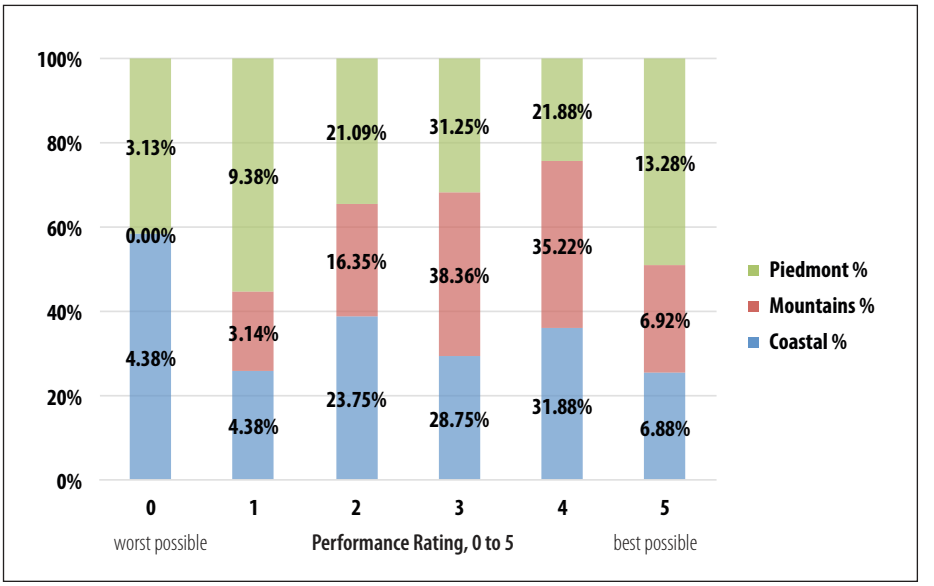
Figure 1:
Survey Responses for All Goals, Combined



From the Mountains to the Coast: Responses by Region

Some interesting patterns develop when the data is dissected by region. As indicated in Figure 2, there are no responses from the mountain region that answered goal performance in any category is the "worst possible." Overall, respondents in the mountain region tended to trend more positively in reply to goals at both the state and local level, with an average response of 3.24 on the 0–5 scale. However, the piedmont region actually generated the greatest proportion of "best possible" responses, with 13.3 percent of those who answered the survey indicating a "best possible" perception.

Figure 2:
Survey Responses by Region



Interestingly, there was not a substantial difference between the general perception of statewide and local performance. When considering total responses, the statewide performance received an average score of 3.05, while the average local score was 3.11. Reflecting the overall trend, the respondents from the mountains again saw things as more positive at both the statewide and local level.

Rural or Urban Community?

One of the more interesting findings relates to urbanization and performance. Respondents who indicated they are in a "rural" area generally indicated the greatest satisfaction, with an average response of 3.26. Self-identified "suburban" respondents showed the least satisfaction, with an average score of 2.85. "Very rural" and "urban" respondents both generated average performance scores of 3.0. When asked to identify the level of urbanization in their community, most respondents in this survey selected "rural" out of the five options: very rural; rural; suburban; urban; very urban.
So what does this all mean?

- First, it means that aging services leaders who responded to the survey believe that on both a statewide and local level we are performing in the mid-range in terms of meeting the goals laid out in the 2011–15 Aging Services plan. In addition, while responses about the county level performance tended to be more positive, they are not substantially different than the perception of how we are doing as a state as a whole.
- Second, it means that the mountain representatives who responded, on average, have a more positive view of progress in these areas than their counterparts. (Interestingly, this seems to apply for all mountain respondents, including those from both rural and urban areas).
- Third, it may mean that more work needs to be done in suburban areas, as respondents seemed less satisfied with performance at all levels.

What Should Be the Focus in 2015?

Before we examine responses to each individual goal, it's important to look ahead. Respondents were very thoughtful as they opined on what our focus as a state should be going into 2015. The most frequently cited concerns relate to limited funding for services for the aging population. As one respondent noted, "The capacity to serve an increasing population of economically vulnerable older adults is seriously in jeopardy." Both federal and state funding reductions are noted in the answers, with particular attention to the cost of transportation currently and the potential future cost as the number of seniors grows significantly in proportion to the overall population.

However, the concerns are not limited to budget issues. Many respondents focused on the need to allow seniors to age in place, while providing the transportation, medication, and food support necessary to maintain a high quality of life.

The non-budgetary policy implications are two-fold. First, several respondents cited a growing concern about the ability of the state to have enough workers to support the services needed by our aging citizens. As one respondent noted, "the senior population is currently on course to surpass the forty to sixty age group, leaving nobody to care for our seniors." Others noted a different but related problem. They indicated a growing trend for working family members to drop out of the workforce at a younger age so they can care for their aging parents. This decreases the overall income of the home and potentially increases financial instability while increasing demands for supportive services. Second, a call for citizen (and legislative) education and understanding as to the financial implications of aging is evident in the survey. To quote one reply, "many citizens continue to believe that Medicare will take care of them in a health crisis and don't understand the burden that many families face with regard to financial costs and caregiver burden."

Goals of the North Carolina Aging Services Plan, 2011–2015

Goal 1: Empower older adults, their families, and other consumers to make informed decisions and to easily access existing health and long-term care options.

Goal 2: Enable older adults to age in their place of choice with appropriate services and supports.

Goal 3: Empower older adults to enjoy optimal health status and to have a healthy lifestyle.

Goal 4: Ensure the safety and rights of older and vulnerable adults and prevent their abuse, neglect, and exploitation.

Goal 5: Empower older adults to engage in the community through volunteerism, lifelong learning, and civic activities.

Goal 6: Prepare North Carolina for an aging population.

Goal 7: Ensure an adequate direct care workforce for an aging population and opportunities for older workers.

Goal 8: Maintain good stewardship of publicly funded services.

Source: North Carolina Department of Health and Human Services (DHHS)
http://www.ncdhhs.gov/aging/stplan/NC_Aging_Services_Plan_2011-2015.pdf

Of course, some respondents shared a few creative ideas to address aging needs. One suggested a meal card that would allow homebound seniors to order from nutritious menus at local restaurants. Another suggested changes to local building codes that could facilitate the development of more adult day health facilities. And, others indicated that additional community education about existing services would be helpful.

The N.C. Division of Aging and Adult Services is on schedule to publish a new aging services plan in March of 2015. That plan will, we understand, reflect the need to continue to move forward in some of these important areas of support and education. It will also reflect the needs of a different period of time and a new administration.

As explained by the Division, the plan was developed "In collaboration with the Governor's Advisory Committee on Aging (GACOA) and the 16 regional Area Agencies on Aging who support older adults and their caregivers. The 2015–2019 State Aging Services Plan bears the title 'Booming Forward: Working Together to Improve Lives.' It is a title that acknowledges North Carolina's baby boomers have begun to reach retirement age and that a collective response is required to foster and support creative ideas, leverage resources, and build both public and private partnerships to ensure positive outcomes for the diverse needs of our citizens. The Plan has six goals that take into account the multi-faceted nature of what is required to work together to improve lives. The next four years will see increased efforts on the part of state agencies that serve these older adults and their families to enhance collaboration, streamline service administration, target available resources, and emphasize accountability for improved person-centered outcomes."

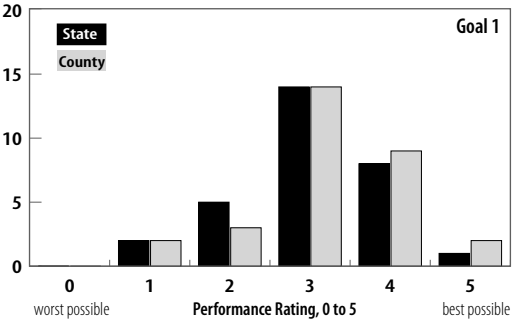
The Division also explains that while the Plan is their responsibility, "It is a collective effort of many partners and organizations to help shape our priorities and set an aging agenda for the state. The implementation of the Plan will require the work of many, including individuals, local organizations, advocates, policy makers and government. Together we can improve the lives of North Carolina's older adults and caregivers."

Current and previous aging services plans are available on the N.C. Department of Health and Human Services website at *http://www.ncdhhs.gov/aging/plan.htm.*

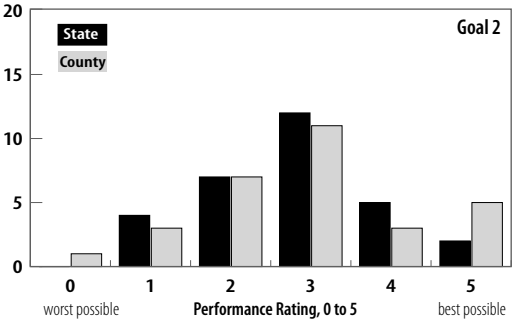
Eight Goals in the 2011–15 Aging Services Plan

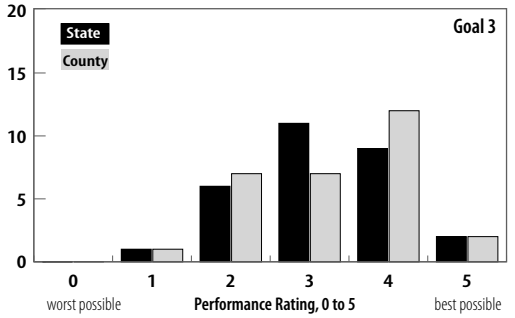
Here's a look at responses related to each of the eight major goals outlined in the 2011–15 aging services plan. As you will note from the goals, the plan is expansive and addresses a broad array of issues as they relate to North Carolina's aging population. Each chart that follows displays ratings of state performance and the respondent's county performance. Largely, the most positive responses appear in the areas of public stewardship (Goal 8) and volunteerism (Goal 5). County services tended to garner the most positive scores in the areas of empowering seniors for optimal health (Goal 3), senior safety (Goal 4), and volunteerism (Goal 5). And, reflective of the overall findings, the average response to each goal was more likely to be middle of the road progress.

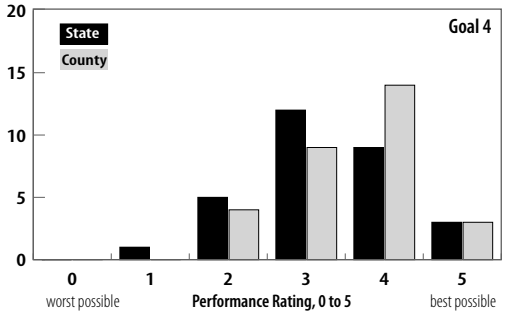
Goal 1: *Empower older adults, their families, and other consumers to make informed decisions and to easily access existing health and long-term care options.* Specific goal objectives in the 2011–15 plan focused on educating the public, streamlining and strengthening access to service and support, and ensuring the inclusion of diverse cultures and abilities. Much of the effort suggested by the plan was often tied to better use of technology, partnerships, and training opportunities. In this survey, respondents often had a slightly more positive view of local efforts as compared to statewide performance, although the greatest number of respondents hovered around the middle of the spectrum.

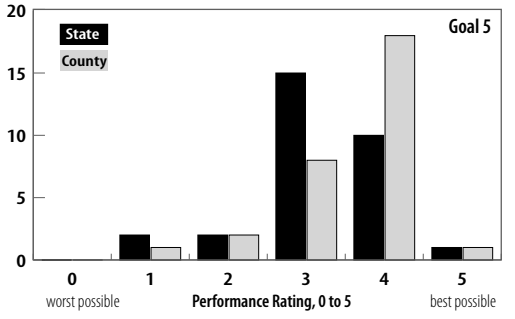


Goal 2: *Enable older adults to age in their place of choice with appropriate services and supports.* Objectives in this area included greater flexibility in publicly funded supports, expanding community-based services, and transforming the existing long-term care system to reflect greater collaboration, linkages, and a person-centered philosophy of care. The value statement associated with this goal is "the best support is the right assistance, at the right time, in the way the consumer prefers to receive it." For this goal, the county responses were more distributed, with some respondents putting their county's performance in the "worst possible" category, while others placed their community in the "best possible" grouping.







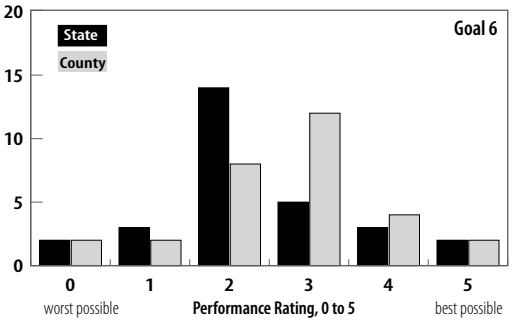


Goal 3: *Empower older adults to enjoy optimal health status and to have a healthy lifestyle.* This goal is centered around the issues of health and healthy living, with a particular focus on encouraging seniors to take responsibility for their health and behaviors. Most objectives and strategies under this goal targeted both creating infrastructure and opportunities, as well as encouraging participation in health promotion and disease prevention programs. Individual elements of the plan addressed such varied needs as dental care access, fall prevention, and mental health.

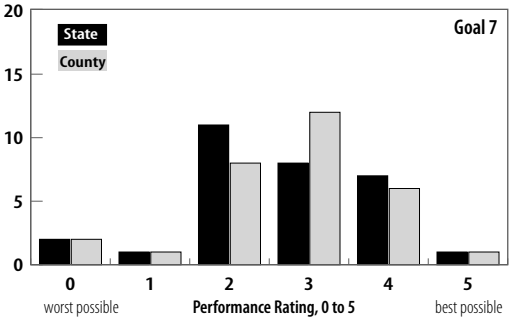
Goal 4: *Ensure the safety and rights of older and vulnerable adults and prevent their abuse, neglect, and exploitation.* Much of the work suggested in this area revolves around better use and expansion of existing programs to fit different types of elder abuse and exploitation. However, the strategy also moves farther into the public policy realm, encouraging the appointment of a legislative study commission, passage of legislation to prevent fraud against the elderly (discussed elsewhere in this issue of *Insight*), and new partnerships with the business community to fight fraud against seniors and the disabled.

Goal 5: *Empower older adults to engage in the community through volunteerism, lifelong learning, and civic activities.* Personal growth, social engagement, and volunteerism are the focal points for this goal—one of the areas where those surveyed believed there has been the greatest success. Again, more progress is seen at the local level, although the view of statewide advancement is not quite as positive. Specific policy-related strategies in this area relate to the continuation of the Senior Tar Heel Legislature and the Senior Leadership program offered through the University of North Carolina Institute on Aging, although more local strategies are also included to harness older volunteer experience.

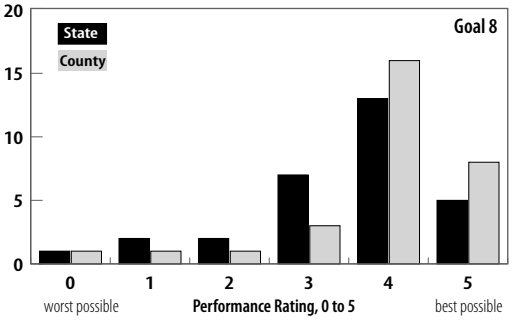
Goal 6: *Prepare North Carolina for an aging population.* While the stated, overarching goal is rather broad, the strategies associated with it are specifically targeted to the state and local governments and the use of their resources to inform and educate. The survey results suggest local governments are doing a little better in this regard. However, unlike the previous goals, the responses are more dispersed, with respondents indicating very positive and very poor performance at both the state and local level.



Goal 7: *Ensure an adequate direct care workforce for an aging population and opportunities for older workers.* The strategies associated with this goal fall into two distinct categories. The first strategy is a focus on the need to ensure the presence of an adequate and appropriately trained workforce to support our aging population in their later years. The second strategy is an emphasis on making sure seniors have access to and the ability to maintain gainful employment. In this goal, respondents tended to rate both the state and local governments in the middle, with some indications of high satisfaction and high dissatisfaction in some areas.



Goal 8: *Maintain good stewardship of publicly funded services.* In particular, strategies were centered on increasing efficiency and effectiveness through use of better management and performance-based practices. Overall, the respondents gave both the state and local governments high marks in this area.



Endnotes

[1] "North Carolina's Aging Profile, 2013," North Carolina Division of Aging and Adult Services. Available at *http://www.ncdhhs.gov/aging/cprofile/2013Profile.pdf*.

Photo by Karen Tam

Examining New Legislation to Combat Elder Fraud

By Paige C. Worsham

On July 23rd, 2013, Governor Pat McCrory signed Senate Bill 140, "Financial Exploitation of Older Adults," into law as N.C. Session Law 2013–337. The new law is the culmination of several years of work and research on fraud committed against the elderly, a resulting Task Force comprised of legislative, state agency, law enforcement, and financial sector representatives, and a bill introduced by one of the legislators serving on the Task Force.

This new legislation is designed to increase the communication between the financial sector, social services departments, and law enforcement in potential cases of financial fraud against seniors in North Carolina. The existence of fraud committed against the elderly was prevalent when the Center began focusing on the issue years ago, and the problem continues today. The Federal Trade Commission's most recent data rank North Carolina 23rd out of the 50 states in the number of fraud complaints per capita and 24th in the number of identity theft complaints per capita. More than 48,000 consumer complaints related to identity theft and fraud were reported in North Carolina in 2013. The FTC says that people over 50 account for almost one-half of all consumer fraud complaints, and more than a third of all identity theft complaints.

As background, in 2011, the Center presented research and recommendations to the N.C. General Assembly's Legislative Study Commission on Aging. During the 2011 legislative session, the N.C. General Assembly passed legislation citing the Center's research on fraud against older adults and establishing the Task Force.

Co-chaired by Senator Stan Bingham (R-Davidson) and Representative Hugh Blackwell (R-Burke), this Task Force on Fraud Against Older Adults includes key stakeholders from the financial industry including the N.C. Bankers Association, the State Employees Credit Union, and the Commissioner of Banks; state agencies such as the Division of Aging and Adult Services, the Attorney General's Office, and the State Treasurer's Office; advocacy groups including AARP and the Senior Tar Heel Legislature; and law enforcement groups such as the FBI, the N.C. Conference of District Attorneys, and the N.C. Chiefs of Police.

Two representatives from the N.C. Center for Public Policy Research also served on the Task Force. The Task Force convened for meetings during 2011, 2012, 2013, and 2014, and produced a Task Force Report that included recommendations to submit to the N.C. General Assembly.

Near the beginning of the 2013 legislative session, Sen. Bingham used the recommendations and introduced Senate Bill 140, a bill "to increase the recognition, reporting, and prosecution of those who would defraud or financially exploit older adults, and to continue the Task Force on Fraud Against Older Adults." After hearings in two Senate committees and one House committee, the bill passed the Senate 47–0 and with a vote of 111–1 in the House. Governor Pat McCrory signed the bill into law as N.C. Session Law 2013–337.

Under the new legislation, an older adult is defined as any person 65 years or older and protected against exploitation under the law. Previously, the older adult had to meet an age threshold *and* be unable to safeguard their own rights and resources.

The new law encourages financial institutions to maintain a list of individuals for any disabled or older adult customer that the institution can contact in the case of suspected financial exploitation. Financial institutions now have a duty to report suspected fraud against a disabled or older adult customer to local law enforcement or the department of social services, and good faith reports are protected from liability. The legislation sets out a process for law enforcement or social services to obtain the older or disabled adult's financial records following a credible report of suspected fraud.

Through education and awareness about this new legislation and accompanying tools in the financial sector, court system, and law enforcement agencies, North Carolina has a new mechanism to combat potential crimes against our seniors.

A Q&A with David Kirkman

Special Deputy Attorney General, Consumer Protection Division

The Consumer Protection Division in the N.C. Department of Justice is home to the Elder Fraud Unit, a group of four individuals dedicated to preventing and assisting elderly victims of internet, phone, and home repair fraud. David Kirkman, a Special Deputy Attorney General with the Consumer Protection Division, answered a few questions about the Unit's work and the new legislation.

What is the role of the Elder Fraud Unit in the N.C. Attorney General's Consumer Protection Division?

The Governor's Crime Commission grant that funds the Unit is called "Elder Fraud—Break Re-victimization Cycle Project 2013." As the name implies, the Unit's mission is to identify elderly victims of fraud and prevent their re-victimization. Re-victimization is a major feature of elder fraud, something that differentiates it from almost all the other types of scams and frauds addressed by the Attorney General.

What types of scams has the Unit confronted in North Carolina recently? Have scammers changed the way they target older adults over the past few years?

Mostly, we are still seeing the sorts of repeat victimization scams that we saw 8–10 years ago. Elderly North Carolinians continue to suffer heavy losses to home repair scammers, who patrol older residential neighborhoods looking for targets. As for the frauds perpetrated against seniors from overseas, 2014 saw only a slight decrease in heavy losses to sweepstakes, lottery, grandparent, and sweetheart scams. With respect to the overseas scammers' targeting techniques, they still seem to work from lists of older consumers who have good credit. What was new in 2014 was the widespread and high-tech IRS and Treasury Agent phone scam. Millions of us across the country got those ominous-sounding robocalls warning about our pending arrest for outstanding tax liabilities or other government debts. We were told that we needed to press a certain number on our phone or dial a specific number in order to talk to an IRS or Treasury Agent.

The targeting technique for the IRS scam was rather clever. They robocalled everybody. Consumers who might be vulnerable to the scam essentially self-selected and took steps to speak to the "agent." The rest of us ignored the robocalls or simply reported them to authorities. Guess who responded the way the scammers wanted? They tended to be older consumers.

The sweetheart scams and grandparent scams continued to plague older North Carolinians in 2014, just as they did the previous two years. Reports of the scam died down somewhat during the second half of the 2014. We did notice the scammers resorting more and more to threats or reports of violence against the grandchild or online love interest

who supposedly was in trouble overseas. Some of our victims even reported phone calls featuring what they thought was their grandchild or their boyfriend/fiancée screaming and being beaten up in the background. These tactics probably extended the series of money transfers the scammers could extract from their victims. As for targeting techniques, those scammers utilized social media (Facebook, singles websites, etc.) to spot their targets.

The N.C. General Assembly passed legislation in the 2013–14 session designed to increase protections against elder fraud. What changes in procedure and impact has the Elder Fraud Unit seen as a result of the law?

Financial institutions began contacting us almost immediately about cross-border scams that were afflicting their customers. Local law enforcement officials seem to be receiving reports of home repair fraud directly and in real time, which is the key to foiling it.

Within days of the statute going into effect, we were contacted by a large national bank and told of a man in the Charlotte area who had been in the throes of a Nigerian money transfer scam for almost two years. His losses totaled $3.2 million, according to the bank. The scammers told him that a wealthy distant relative of his had died in that country. They repeatedly persuaded him to send funds for things like attorneys' fees, probate fees, inheritance taxes, administrative fees, litigation costs, bribes for government officials, customs duties, and similar expenses. We immediately contacted the victim, initiated counseling, and got him some much needed support. The losses stopped. Prior to the effective date of SB 140, the bank felt that it could do nothing more than file a Suspicious Activity Report with the federal government and contact the local Adult Protective Services office.

One thing that jumped out when we ran the Unit's 2014 statistics was a drop in the average loss per victim served. During the preceding five years, the average loss per victim seemed to be stuck at $10,000 per victim. In 2014, it was just over $7,500. It will take some time to determine whether and how SB 140 might have contributed to that decrease. Perhaps certain changes in the wire services industry contributed to the drop. Perhaps it was just a statistical anomaly. My hunch is that SB 140 is causing elder fraud incidents to be spotted and broken up much earlier in the repeat victimization cycle.

Have other changes in policy or procedure impacted the way the Elder Fraud Unit identifies and pursues exploitation of older adults in our state?

Yes. Financial institutions contact us with much more regularity. In addition, we also hear of more and more instances where bank personnel have been quite proactive in spotting and thwarting the scams themselves, freezing transactions, and contacting us so that we might work with the victims and their families. This appears to be a direct consequence of SB 140, which encouraged, but did not mandate, training for financial institution personnel to help them address suspected elder fraud incidents.

Have attitudes toward financial fraud committed against older adults changed?

Yes, without question. It is rare anymore that we hear a financial, medical, or legal professional express the sentiment, "They haven't been declared incompetent. It's their money. It's none of our business!" I remember when similar sentiments were expressed regularly about domestic violence. For example, 35–40 years ago, it was, "We shouldn't get involved in matters between a husband and wife. It's their business." Then, North Carolina adopted the Domestic Violence Act. Attitudes started to change significantly. Communities adopted a holistic approach to the problem, creating DV shelters and special DV courts, and training professionals of all stripes to recognize the problem and address it. I think the passage of SB 140 represents a tipping point in the fight against Elder Fraud, not unlike the passage of the Domestic Violence Act three and a half decades ago.

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