

## The Forgotten Middle: Middle Market Seniors Housing Study

A conversation with the authors who highlight their research findings, its importance and next steps.

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NIC Chief Economist **Beth Mace** recently discussed the study with some of its authors:

- **Charlene Quinn**, associate professor, University of Maryland, School of Medicine
- **Caroline Pearson**, senior vice president, NORC at the University of Chicago
- **David Grabowski**, professor of healthcare policy, Harvard Medical School.

*Here is a recap of their conversation.*

**Beth Mace:** This is one of the first studies to look at housing and healthcare needs including mobility limitations, cognitive impairment and chronic conditions. Why is this important?

**Charlene Quinn:** Traditionally, impairments in activities of daily living, or what we call ADLs, such as needing assistance with bathing and eating, as well as instrumental activities of daily living (IADLs), have been assessed for eligibility for public programs. What we know in reality is that older adults and their families are focused more on questions of mobility, such as 'can I climb stairs?' So we decided to focus on how to measure mobility and cognitive status because that reflects what is going on in the real world, although we include measures of impairments of ADLs and IADLs in the study as well as the number of chronic conditions.

**Beth Mace:** What do we gain by looking at these attributes and estimates by income group?

**Charlene Quinn:** We gain a better understanding of the heterogeneity of both needs and resources within the middle income group. It's sometimes easy to think of older adults as a general group from a policy perspective, as well as from an industry and care provider perspective. But by looking at the attributes and estimates within the income group as we did, it gives us a better understanding of just how heterogeneous this population of middle income older adults is and how that will change over time.

**Beth Mace:** How did you define middle market? Was there much discussion on this definition?

**Charlene Quinn:** Yes, we spent a lot of time determining a definition of the middle income group. We reviewed other studies and discussed this with experts and industry practitioners. We considered policy and scientific definitions and looked at data estimates for lower and upper income thresholds. We ultimately defined middle-income as people in the 41st to 80th percentile, based on financial resources (income and annuitized assets). For seniors 75-84, that range is \$25,001 - \$75,025.

We set a conservative minimum threshold at which an individual would qualify for Medicaid. We were thinking in this study not only of the impact on housing needs but what might be the policy implications for a Medicaid population at that threshold.

**Beth Mace:** Caroline, what are some of the key findings of the research conducted by you and your NORC colleagues?

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Middle income seniors include those 75-84 with financial resources of \$25,001 - \$75,025.

**Caroline Pearson:** We set out to model how the aging population would look in 10 years, forecasting out to 2029. We wanted to understand how the size, demographics and health conditions of that population would change as well as what their financial resources would look like in the future. It is that combination of health, mobility and cognitive needs that govern the degree to which people can live independently. We combined that with their financial resources to understand what sorts of housing and care options will be available to them.

The biggest takeaway of the study is the sheer growth we will experience in the size of the senior population. Looking specifically at middle income seniors, their population will nearly double from 8 million seniors over age 75 today to 14.4 million by 2029. As we think about this cohort that might not have been traditionally served by Medicaid or private seniors housing options, the size of that underserved population is going to grow dramatically.

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## The middle-income senior population will nearly double by 2029, to 14.4 million.

We will also see a higher percentage of seniors who are female. And they are going to be more ethnically and racially diverse with significant growth in the proportion of Hispanics and African Americans. These seniors will be more educated. Fewer won't have completed high school and more will have completed college. All those demographic features have a big effect on people's health as well as their financial conditions in the future.

**Beth Mace:** Charlene, any other findings that you found interesting or surprising?

**Charlene Quinn:** Despite our efforts in the U.S. to promote health and the fact that we have a better understanding of chronic conditions, I was surprised that 20 percent of middle income seniors in 2029 will be high need, which we define as having three or more chronic conditions and at least one activity of daily living impairment. More than 8 million seniors age 75+ will have mobility limitations. It points out the level of need in the middle income group.

**Caroline Pearson:** Building on Charlene's point, our model assumes that current rates of chronic conditions, cognitive impairment, and mobility limitations will remain steady into the future. There is literature that suggests some chronic conditions, such as obesity, are becoming more common, and some conditions such as cognitive impairments might be less common in the future. We don't have enough information to really tell us how those trends are changing, so we held them steady. Those assumptions suggest that 67 percent of seniors will have three or more chronic conditions in 2029 and 60 percent of seniors will have mobility limitations. Those seniors are very likely to need support from caregivers and may need more appropriate housing options.

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## Two-thirds of middle-income seniors will have three or more chronic conditions in 2029.

**Beth Mace:** Any other findings that you found surprising?

**Caroline Pearson:** Given the large and quickly growing population of middle income seniors, many of whom will have chronic and cognitive and mobility conditions that may make it difficult for them to remain in their homes, we wonder what their financial resources will look like. We started with real attributes of the actual population who will be seniors in 2029 and took into account differences in savings patterns and sources of income, such as pensions and 401(k)s. We found that 81 percent of seniors over age 75 are not going to have annual financial resources that would cover medical and housing costs of \$60,000 a year. This is a relatively conservative cost estimate based on the typical rent in private pay seniors housing and what medical costs will be for these folks. The vast majority of those seniors would likely not be served by that private pay seniors housing market today. If we include their housing equity in their financial resources, the number of middle income seniors who still would not be able to afford those housing options is 54 percent. It speaks to the gaps in our existing patchwork quilt of how we care for seniors. We have these middle income folks who will not have a lot of options available to them in a community setting.

**Beth Mace:** Why is it important that this study is being published?

**Caroline Pearson:** It's critical [we study this issue] because it is an emerging challenge for our country which will probably be solved through a combination of public and private partnerships. The issue of seniors housing hasn't been core to the policy discussion other than for those seniors covered by Medicaid. It's important to raise awareness of the issue and draw policymakers into the discussion to find policy solutions for the future.

**David Grabowski:** This study is an important contribution in that it brings the housing component to the broader study of long-term care and health policy.

**Beth Mace:** What are some of the limitations of the study?

**Caroline Pearson:** Besides the fact that we assumed a consistent rate of occurrence of health and mobility limitations over time, the other limitation is that individual medical out-of-pocket costs are highly variable based on a person's health status as well as their insurance coverage. Also, seniors housing rent costs vary dramatically across the country. Our study is a national view using some reasonable averages for the country. The story on an individual or local level may be very different and that is not captured in our analysis.

**Beth Mace:** Would you consider the results to be conservative or aggressive in terms of the number of seniors in the future who can access seniors housing?

**Caroline Pearson:** The definition of middle market was intentionally conservative. We set the middle income threshold to be conservative, and we probably excluded some people at the lower end who may not qualify for Medicaid and may still be in this under-served middle market population. Also, the assumptions we made on rent and medical costs were conservative, so if anything we were probably understating the proportion of folks who have insufficient resources to cover the seniors housing

**Beth Mace:** Were you surprised that there were more middle income seniors who could afford senior housing than we may have thought because we typically think of seniors housing as geared toward the higher end of the wealth cohort?

**Caroline Pearson:** It was interesting that more middle income seniors could afford seniors housing if they were willing to sell their homes and contribute that housing equity to their monthly expenses. But the bigger story is that lots of folks are and will be underserved.

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More middle-income seniors could afford seniors housing if they sold their homes and used that equity.

**Beth Mace:** David, you're a professor at the Harvard Medical School, what is your interest in this topic?

**David Grabowski:** My research looks at the economics of long-term care and healthcare for older adults. Typically in our study of long-term care and health care, we've put housing to the side and have not integrated it into our research on aging Americans. We often view

housing as a family issue, and health and long-term care as a shared family and policy issue. That's a mistake because housing is also a family and policy issue, but more importantly, housing is necessarily interrelated to health and long-term care and other services seniors are receiving. If my housing is supportive, then might have a positive impact on my health and functioning and vice versa. If I have good function and good health, then I'll be living in a less restrictive housing environment. These are all jointly determined and they should be studied in a more integrated framework. Historically, we in the research community and the policy community have thought about each of these in a siloed fashion. What I like about this study is that it considers health and long-term care in a more integrated environment. That is

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Fifty-four percent of middle-income seniors will not be able to afford housing and care even with all of their financial assets committed, including housing equity.

an important and necessary step toward thinking about policy solutions that address this issue.

**Beth Mace:** Can you provide a big picture of the significance of this research?

**David Grabowski:** Middle income individuals, as the title of our piece suggests, have been forgotten and left out of the discussion of how they will pay for housing and long-term care. Middle income adults are in an odd spot. They are not wealthy enough to self fund their senior housing but not poor enough to qualify for subsidized housing. One contribution of our research is that we do identify more of these individuals in this middle market that can afford housing options. However, we know there are a growing number of individuals in the “middle income” gap and a key issue of this research is identifying this problem and suggesting that there is a role to develop policies along with the private sector to help middle income older adults to find housing options.

**Beth Mace:** What are some of the policy implications from this study?

Middle-income individuals have been left out of the discussion of how they will pay for housing and care.

**David Grabowski:** At a high level, any policy solution will be a mix of private sector ideas along with a complementary set of policies from the public side. Some of the areas we discuss in the paper are to take on this issue at the federal health policy level. There’s been work around how income tax credits can help get individuals into different housing options and we give some thought to changing the eligibility limits for those programs to target middle income older adults. Another idea is to have housing communities start their own Medicare Advantage plans. Some assisted living companies are doing this now. But you need sufficient resident participation to have the ability to offer services. The idea is to have an interesting medical model to leverage some of those Medicare Advantage dollars to offset some

of the cost of seniors housing. We also discuss in this paper that this year Medicare Advantage began allowing plans to use some dollars to offer supplemental benefits for non medical services such as long-term care. It’s another way to leverage Medicare dollars and make the model more tractable. The final policy implication involves the role of Medicaid, the dominant payer of long-term care services in the U.S. When it comes to assisted living however, Medicaid only pays for care not housing. That’s a real barrier to finance this model. Maybe we could figure out how to leverage more Medicaid dollars, allowing individuals to retain more of their income to pay for housing or allowing families to put in more dollars while they still qualify for Medicaid, or changing the rules around what communities can charge Medicaid for housing. Medicaid is such an important payer on the long-term care side and we have not leveraged the program when it comes to seniors housing. Medicaid is really invested in home and community-based services on the one hand and institutional nursing home care on the other. How can we leverage more Medicaid dollars to make seniors housing more available for older adults?

**Beth Mace:** Charlene, any other policy implications from this study?

**Charlene Quinn:** In our study, individuals at the lower end of the middle income group are very close to the definition of Medicaid eligibility and will be resource constrained.

We haven’t talked much about our idea for a Medicare Part E that would address non-health needs to support older adults, such as housing, nutrition, transportation and non-acute care. Though the Centers for Medicare & Medicaid Services (CMS) is expanding the rules around what can be covered by Medicare Advantage plans, a large portion of Medicare beneficiaries remain in fee-for-service plans and coverage of additional benefits are the decisions of private Medicare Advantage Plans. We know Medicare Part A finances an acute healthcare system and not housing. So I really hope the upcoming policy and investor summits will foster some discussions about how a new Medicare Part E could address the future needs of older adults and shift the focus from acute care to the social determinants of health.

Any policy solution will be a mix of private sector ideas and public policies.

**Beth Mace:** David, what are the implications for further research suggested by this study?

**David Grabowski:** I think this research has done a great job of identifying a problem. Now we know there will be a big group of middle income older adults who want to stay in the community and could have different housing options. How can we make that happen? We know it will take a shared public-private solution. So what is the next step? I would like to see models that integrate housing and health, and long-term care. What works and what doesn't? We need to get the financing and payment models right. Maybe it involves Medicare Advantage plans, senior housing communities, Medicaid programs, and HUD or some other group on the housing side. How do we get all the players to the table to try some demonstrations and pilots? The next step is to learn what works and then determine how we employ this model as part of broader policy changes.

**Charlene Quinn:** We should also look at the impacts of supportive services on health care costs and utilization. There are some preliminary studies that have been done in HUD buildings that show some interesting impacts on healthcare costs.

**Beth Mace:** What are some next steps?

**David Grabowski:** We need to continue to educate. Far too many of us view housing and healthcare in a siloed way. The session in Washington, D.C., is a great first step to educate the policy and research communities. The engagement of stakeholders is important. It would be a powerful step to do a pilot with stakeholders and make this happen on the ground.

**Caroline Pearson:** The other next step, because there is so much regional variation, is to take this model down to a regional or local level to give people a better sense of what the population in their area will look like and how that compares to costs and financial resources specific to that geography.

**Charlene Quinn:** The next step might be thinking about innovations in health provisions that would combine a housing and health approach in new senior living models. It's a great opportunity.

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**NEXT STEPS: Educate, analyze and innovate.**