Session 1A: Long Term Care Q&A

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Anna Rappaport: I should start by saying I am not a long-term care or a long-term care financing specialist, but I am very interested in this topic and would like to raise some issues for comment by the panelists. Doug mentioned equity release. I chair the Society of Actuaries Committee on Post-Retirement Risks and one of the things that we've been quite intrigued by is the whole question of when will reverse mortgages get good acceptance, and how would they be structured? I'd love to hear comments about equity release and what might make such products work well. Doug also wanted to take a fresh look at long-term care financing and I thought that was great, but I'd like to raise a twist the fresh look. Is there a reasonable way to think about what is a normal level of support that ought to be provided by the family and a cutoff for catastrophic care that might be financed through some sort of a public system and what might be the cutoffs for catastrophic care? Anybody who would like to comment on that, and also comment on thinking should think about the personal role, public role, and insured financial services. The link between those roles and financing is particularly important if we move to explore some different models.

Doug Andrews: Thank you for those questions, Anna. I certainly don't have definitive answers for you, but I can outline some of the areas where answers might be provided. The current mechanism for equity release is the reverse mortgage. In a separate paper I've analyzed the reverse mortgage market and I don't think it is appropriately priced and I have indicated a way in which I think it could be made a more viable mechanism if the state provided an insurance program for the negative equity component, but I think if that market is improved, that may be a method that's viable. But in my paper I do refer to a proposal in the

United Kingdom with respect to long-term care insurance where at the time of reaching say 65, people would be advised as to what their long-term care costs are

expected to be in terms of a premium, not what their actual costs will be in terms of claims but what their share of the premium is. One of the ways that they could pay for that premium is through the equity in their home. That can be based either on some form of immediate payment if they have some way of releasing the equity or it can be on a deferred basis and it can be deferred right up to the time of death, at which time the state would collect from the equity in the home.

So while it's an equity-release mechanism, it doesn't need to be released right away. The argument for this is that the generation that's coming into getting long-term care currently have already done very well inter-generationally because of the great appreciation of their houses and so they should be expected to pay some of their long-term care costs. If you introduce some form of insurance now, it's a little late in collecting costs from them so now is the time to get the money from them and you take it from their home equity that they've built up. So that's one answer there.

In terms of the personal and public split, that is a question that has to be answered country by country, because the attitudes toward social responsibilities and social solidarity are so different just in the countries that I visit and the countries that I live in that you're not going to have a one size fits all. I do like the approach that I mentioned in this discussion that the Germans have used of having a specific charge for individuals that haven't had any children because that is recognizing that children are expected to play some role in providing personal care. In the survey information people did seem to think that there was a responsibility individually and for government to provide care so people are recognizing that there is some personal element. How to quantify that, will take a lot of discussion and the quantification won't be just what people expect to be provided. It will also be the cost associated with providing that level of care.

In terms of the personal and public split from a financing point of view, I'm relying on the figures in the paper from the OECD and that is that the cost for a publicly

provided program should be say in the order of 3 percent of GDP, so that's going to buy you all of the services provided. From a social point of view, catastrophic coverage needs to be present and so that would be one of the things that has to be provided from the 3 percent of GDP. After you've provided that catastrophic coverage, you'll have to see how much more you have left over that can be provided and then you would define minimum levels of care, but you need a basic safety net of care for all the population.

Marc Cohen: Thanks, Anna. When I was starting out in research in the mid-'80s one of the first things we looked at was reverse mortgages and there were all these papers coming out about how these things are going to be taking off. Now it's 25 years later, and they still really haven't taken off much. I think more than anything else it requires a symbolic transformation of what housing actually is. Many people believe that it's an integral part of saving and it's an integral part of inheritance that this is something that when they go it becomes part of their estate and it gets passed onto their kids and so I think we can improve the markets. For awhile there wasn't a secondary mortgage market to help support these. We can improve these and give financial incentives, but I think as much as anything else, it requires a mind-shift of it as a saving mechanism to help pay for care during retirement versus an investment that you get to pass onto your kids, so that's on that point.

On your second point, the conversation about long-term care is quite different than health care because you have the interplay both of health-related issues as well as life-style related issues. You look at the modalities in which people receive care: assisted living, retirement communities, nursing homes, home care and so on. It's very different; there's a lot more preference involved in that. One point I want to make, what Steve Moses said notwithstanding about Medicaid, it is true that it's the largest public payer. However, the vast majority of long-term care in this country and in most countries is provided by families through what is often called informal care networks, maybe family care networks. In the early long-term care surveys 38 or 35percent were receiving formal

paid services. I haven't looked at the data lately, but most people by and large receive it from their families and if there's a consensus about anything, it's that there's a shared responsibility. There is some level of assistance that people expect publicly because the burden associated with long-term care can be very difficult, but we have evidence that it's a shared responsibility actually from the private insurance market.

We looked at family caregivers of privately insured individuals who were receiving benefits under their policies and asked the question: Does this just replace family care? The fact that you've got pretty generous private insurance payments coming in, does that mean the family stops giving care? And what we found in two different studies is that this in fact was not the case. That the nature of the interaction between the family member and the disabled elder may have changed more away from, let's say, hands-on assistance with bathing and dressing and maybe much more time spent with companionship, services, doing chores and so on, but there wasn't an absolute replacement. So it's a really interesting question. Can society decide upon the proper balance? I agree that this is so culture-specific it would be really difficult to do that and we don't have a consensus about the proper balance in this country and even in countries where there are social programs, there are always additional private outlets because so much of this is tied up with preferences and how you want to treat functional disabilities and cognitive infirmities and so on.

Bill Dreher: All of the papers and the comments are valuable to us in terms of understanding the issues but turning scientific findings and good advice into longer and healthier life expectancies ultimately comes down to individual human behavior. As individuals we all have a responsibility to change habits and make life style changes that will benefit ourselves and society over the long run. But spending time and money now for a long term advantage with a greater present value is a tough sale. Investing now to save or gain much more later may have compelling logic, but stubborn human nature puts a low ceiling on the realization of "best possible" outcomes or anything close to them.

Marc Cohen: There's a lot to what you're saying. Steve Moses spoke about the impact of Medicaid as the primary reason why reverse mortgages, private long-term care insurance and so on just haven't really taken off. In my view it's much more complicated than that and much more basic. Survey after survey shows...well, here I'll take a survey right now. How many people believe that at some point in their life they're going to require nursing home care? Raise your hand. A few. How many people think the person sitting next to you is going to require nursing home care? Yeah, everyone raises their hand. There's a fundamental sense of denial. I agree to some degree there are things we can do right now in terms of healthy lifestyle that may help us, but, I mean, this is an insurable risk precisely because we don't know at these ages who is actually going to come down with some of these things. What we can do is plan for that future and the problem is that (1) people deny that it's going to happen, that they're going to actually have a need and (2) that they have misperceptions about what the public is paying and is not paying. If you go out and you do a survey of individuals, most people think that the government will pay for their long-term care. Now, many of them may not be wrong in that respect, but there's an argument about how restrictive or not restrictive those circumstances are. I'll leave it at that. But when you ask people who have been offered, for example, the opportunity to buy long-term care insurance, to take that action for themselves and you ask them, why did you decide not to, very few of them mention Medicaid specifically as the reason. What they say are things like: Well, if I thought the risk was higher (this is music to an actuary in an insurance company's ear, right)...well, if I thought the risk was higher, I'd buy long-term care insurance, or, I'm too young to be thinking about that right now. I have competing demands on my resources. I've got to get the kids through college. I'll worry about that later, and to some degree, doesn't my health insurance already cover that? Doesn't Medicare already cover that?

So there is quite a bit of education I think that needs to be done to get people to take personal responsibility.

Doug Andrews: Those are all extremely good comments that I would agree with and I would like to add I guess some other thoughts along the same line of what we're willing to talk about and what we're willing to think about. You asked the survey question about nursing homes, we could also ask the survey question about how many of us think that we're going to have a period of time where we have Alzheimer's disease or some other severe dementia. That's not something that we like to talk about and mental health tends to be something that we don't talk about in public company, rather it gets swept under the rug. With the population living to 100 and beyond, it is likely going to be a fact of life that there will be periods of mental illness that we will be experiencing either ourselves or our family members and it can be extremely difficult and trying. It's much easier to deal with a family member that has trouble walking across the room or carrying his or her groceries and so on than it is to deal with a family member who is suffering from a mental disability. Mental disabilities are very difficult things.

But because we don't like to talk about those things, we also don't like to think about them, and if we don't think about them we certainly don't take actions to provide for ourselves in the future or to provide for care for ourselves and so that's an extremely difficult situation.

The other thing I would like to say though is that we are talking about people living to 100. We have a period where they're going through education and so on, which may be up to 20 or 25 before they start getting a job. We're talking about working to retirement ages of 65 or 70 and then after that we've got a period from 70 to possibly 100. What makes us think that people have the knowledge, planning, willpower, and vehicles available, to save enough money during that working period to provide for all of the possible contingencies that we may have in our older life? That is an incredible thing for anyone to be able to budget for, not just for actuaries, but how are we going to have the population do that? That's one reason that I argue strongly for a mandatory insurance system because it's beyond most of our capabilities to budget for something like that.

And I would like to comment at this point about the difference country by country and what we are prepared to do for each other or how we think about things.

I have, on most of my visits here, argued for the need for Universal Health Care, so I have been pleased in the last few years that in the United States there has been Universal Health Care Reform. I am disappointed to hear that there are 20 states seeking to have the legislation declared unconstitutional, but be that as it may, I would like to clarify for Jack Paddon the difference in the social context between the protests in Europe that he's hearing about and the protests here about unconstitutionality. I think it's quite a different thing to be talking about Universal Health Care and whether that should be provided than the protests in France which were specifically about raising the retirement age from 60 to 62. That's quite a different thing. And in the United Kingdom where I come from, which was a question of whether tuition should be capped at roughly $5,000 U.S. or whether it should be moved up to be something like $13,000 U.S. as the maximum tuition and even that tuition wouldn't have to be paid for until people were earning about $25,000. Completely different social contexts and that's why, of course, we will need different systems in each country because it needs to fit the population who are going to pay the bill.

Jack Paddon: Yes, as I mentioned in my prepared remarks, the various public street demonstrations in several European cities (against proposed, relatively small reductions in entrenched social programs) … and the constitutional challenges by a majority of states in the United States (to a radical reform by the Federal government of health care programs), were all basically unexpected, and unintended, controversial consequences from so-called "good intentions." This illustrates why major, or even small changes, either to expand or limit these programs, are often difficult to formulate and maintain, let alone to accomplish their intended purposes.

Eric Stallard: You asked how many people think they will need long-term care

during their life. If you're looking above age 65, about two out of three will need TLC. That's easy to remember; two out of three will need LTC. So right next to you, two out of three will need it; one will escape: that is, they will die without needing LTC.

Here is a second key take-away number, which can be related to the comment that about 10,000 people a day are turning age 65 in the United States. I also computed this take-away number in a paper that I did at the last Living to 100 Conference, and I recently updated it for inflation through 2010. It's that the net present value at age 65 of your future long-term care costs is approximately $90,000. That's a general-population value derived from the National Long Term Care Survey which means that it doesn't have a moral hazard component in it. Multiply the $90,000 per person by the 10,000 people per day turning age 65 and you get $900 million a day as the total cost per day for LTC. So the $900 million per day can be paired with the 10,000 boomers per day reaching age 65.

I have one other question. I recognize that participation is mandatory in many countries that have social insurance for LTC, but in the United States participation in CLASS will be voluntary, so I'd like to hear your comments on how you might make a voluntary program work, or if you want to focus specifically on the CLASS Act, how would you make that work as a voluntary program?

Marc Cohen: Eric, I'll just comment on the last. You've written about it and others have written about it. The difficulty of the program is, in fact, the adverse selection issue, and so to my mind unless there are some solutions for that, I see that as the biggest barrier for the success of that program. If you attract early on many more sick people and there's a financial solvency requirement, then necessarily the premiums have to increase. This means that the only people who will find it attractive are those who know they're absolutely going to benefit, and you get into the spiral issues you describe. Some type of risk management on the front end is the only way to make that work. I happen to think

that the CLASS program can, in fact, help spur greater interest and growth in the private long-term care insurance market by raising the level. The big barriers are education and knowledge. The government is going to have to spend a significant amount of money to market the program and educate people about the program, and that will have some spillover effects. If people start to look seriously at the program, start to compare it to private alternatives, in fact, everyone will be better off. I don't really care how people get insured, it's just very important to take personal responsibility and get insured whether through a private mechanism or a public mechanism. But, the only way to improve that program is to have some upfront type of underwriting.

Doug Andrews: I have argued for a safety net of coverage on a mandatory basis. Above that safety net though, voluntary programs could work with underwriting and other measures as discussed. The one thing I could offer you though, if you're looking for an across-the-board program that is also voluntary, is the German system. While it is mandatory it permits opt-outs for the top 10-15 percent of higher income wealthy people that are deemed to be able to afford their care. So, if it's mandatory with opt-outs, in a sense it's voluntary.

Jack Paddon: When Steve Moses briefly referred to "end-of-life counseling" being proposed, and already implemented to a degree in some areas of the Unite States, he underscored a strong personal and professional concern of mine that this process, when involving non-medical people, should net materially interfere with the fundamental, well-established "doctor-patient relationship." This is especially problematical if basic decisions to provide care, or not, become based on whether or not "quality of life," or probability of survival" is sufficiently enhanced, according to some set of arbitrary statistical formulae administered by a government functionary or commission on a "one size fits all" basis.