Informal Discussion Transcript

Session 4C – Proactive Strategies for Managing Long-Term Care Needs in Retirement

Presented at the Living to 100 Symposium

Orlando, Fla.

January 8–10, 2014

SOCIETY OF ACTUARIES
LT100
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Long-Term Care Needs in Retirement

JACK PADDON: I'm retired from actuarial vice presidency of New York Life, and I've been to all five symposiums since their start here in this hotel in 2002. So I'm very glad to be working in this capacity today.

There are a couple of very interesting, what you might call philosophical, ideas that underlie long-term care, and one of them is kind of quasi-cultural. The idea of long-term care for the elderly is a very ancient one, days of the Babylonians. Respect for elders, and all sorts of parallel things like that. Back in the time of Moses, an element of long-term care got partly embedded in the fourth commandment: Honor your father and mother, and this certainly applies when fathers and mothers are approaching old age. It's also applying as certain unfortunate parents approach old age, and some of their children develop the need for long-term care, or perhaps they've had a child from birth who has been disabled. So long-term care has these additional elements in addition to living to age 100.

I'll give you a self-developed layman's definition of what I see as long-term care. It can be defined as the cost-effective maintaining of one's quality of life with dignity by compassionate, caring caregiving, either paid or unpaid, because if family members assist, they're certainly not paid directly. Care for those too old or too disabled if they're younger people, to adequately care for

themselves. So it's a helping hand to those who need it, and it's always been viewed that way as part of cultural and even religious perspectives over the years, as well as in many public policy and financial environments today.

And, of course, a person's health or his or her money are two very important things that trigger long-term care and make its proper and effective use a real challenge, and that will be the theme of our panel today. We have a very diverse, but I think it will be a very interesting, panel working with me today, and underlying our discussion of some of the various challenges of long-term care, keep in mind that there are some very specialized groups/clientele involved. For example, there are the advocates and the experts that give advice and consult, and we have one of those with us today, Dr. Sandy Timmermann, who is a noted gerontologist. We also have government, federal and state and other levels involved, and with us today is a federal government lawyer from the Human Health and Services Department, John Cutler, who has had a very involved and intensive work in the development of more recent proposals for long-term care insurance. And finally we have the private sector, where insurers like Steve Schoonveld, who has been working in the actuarial profession and other sections of the private sector to make long-term care

products available. So the things we cover will involve all three of these specialties right there firsthand on the panel, and they also will involve all of us directly or indirectly, whether we happen to be potential long care recipients, or potential long-term caregivers. And, a lot of that uncertainty stems from the fact that we all potentially are in that boat, but the actual odds are not terribly high, but there are positive odds nonetheless.

The way we will handle our presentations at this session is each speaker will give opening remarks with just a few slides relating to their area of expertise. Then I've formulated and they've looked at, and kind of OK'd, some other more in-depth questions that they'll answer and talk about themselves. Then we'll open the floor to your questions and then, some time before the end of the session, each of the panelists will get up and give some of their own concluding insights about the subject.

So let me start with introducing our first panelist: Dr. Sandy Timmermann. She is a well-known gerontologist who specializes in the financial-, business-related concerns of the aged. She's done this most, if not all, of her working career. She is now doing her own personal consulting on these topics. For part of her career she was a Met Life vice president, who was the prime mover in founding and directing Met Life's Mature Market Institute, which

operated while she was there. Sandy's also a frequent contributor to the *Journal of Financial Service Professionals* and some other periodicals on the geriatric concerns she is familiar with and expert about. So I turn the floor over to Sandy for her opening remarks.

SANDRA TIMMERMANN: Thank you. What I'd like to do to start us off is to present some slides that will set the stage and get us thinking about some of the issues from a consumer perspective. My area of expertise has focused on individual consumers and how long-term care impacts them not only from a psycho-social and physical point of view, but also financially. So let me start with this slide. We're all familiar with demographics, but this one focuses on boomers and the march of time. You can see the big generation of baby boomers, the youngest age 50 and the oldest age 68—really two separate generations. Now think of this wave moving to the right. Thinking about 2050 when the youngest of the boomers will be 85, it seems obvious that long-term care needs will increase at the same time.

The Gen X cohort is a small one. Are there going to be enough caregivers, the adult children, to take care of all of the boomers? Perhaps we can count on the millennials to provide care; it is a big generation. Someday they too will need long-term care.

Boomers are in transition and many things are on their

minds. Looking at this from a holistic perspective, they are thinking about their children, their grandchildren, their money, their work, and health and long-term care is a part of it. The problem is that most of them believe that they're forever young. You may remember the song that Bob Dylan sang, "We'll Be Forever Young," capturing the desire and hope of many boomers to never grow old. They've been called the Peter Pan generation. Although it is a generalization to make this assumption, I think you'll see it reflected in the surge of anti-aging medical products that probably don't work, the fitness craze and trying to eat well. I think there is a feeling among a lot of us that as long as we keep active and we keep doing the right thing, aging isn't going to affect us the way it did our parents and grandparents. There may be some truth to this, at least for those who maintain their health, but looking down the road we haven't really faced up to the fact that we may need long-term care, even though it is lurking in the back of our minds. Research from the Met Life Mature Market Institute on the oldest boomer cohort, those who have turned 67 last year, indicates that two of the biggest concerns as you can see from this graph are "providing for your own or your spouse's or partner's long-term care needs," and "being able to afford health care in your retirement years." They trumped "living comfortably in

retirement." This was a nationally representative study using longitudinal as well as cross-sectional data. We followed these boomers for three years and then added to the sample as needed.

In my opinion, the greatest need of the boomer generation will be the need for chronic care. Data indicate that the older you are, the more likely you are to develop chronic conditions. The Alzheimer's Association estimates that one out of every two people age 85 or over will develop Alzheimer's disease or some type of dementia. As a result, providing and paying for care and treatment for such a large cohort will be an even bigger issue. The Mature Market Institute conducted studies for 10 years about the cost of care, and you can see from the slide that the costs rose steadily, with private rooms in a nursing home averaging $88,000 annually. Assisted living looks more affordable at $40,000, but we found that the base costs that were quoted were covering fewer and fewer services as time went on. In many facilities, there are additional fees such as medication management or personal care that can really add to the cost. Home care, contrary to what many think, can be really expensive if needed around the clock.

I would say that long-term care is the elephant in the room. We don't want to talk about it, we're worried about it, and it can derail a financial plan. These last two days

we've heard a lot about the need to generate income, but what happens to your income flow if you have to pay for your spouse's long-term care? You become impoverished yourself, and can find yourself relying on the government safety net with few choices. I will leave you with that thought and turn the microphone back to Jack. Thank you.

JACK PADDON: Let me introduce Steve Schoonveld, FSA, representing work in the private sector. Steve is the vice president for long-term linked products and their related solutions that they struggle with currently at his employer, Lincoln Financial. Steve has also been active over the years in the SOA section work, where he has chaired the long-term care and also the social insurance, public finance sections. Steve, the floor is yours.

STEVE SCHOONVELD: Thank you, Jack. I agree it's a very big elephant in the room and I was very taken aback by the 31 percent that Sandy just shared with us. It seems like it's an elephant in the room that everyone knows about, but no one wants to do anything about it, and it indeed is one of those things that you simply can't recover from.

Long-term care is a risk that you really can't recover from, you can't adjust from once you pay $40,000, $80,000 out of your estate. You can't get it back, it's gone. Timing risk, market risk, inflation risk, all those things, your expenses going up are things you can do in retirement.

You can slow down your rate of expense. You could wait until you divest some of those investments until a later point in time when the markets have returned.

Long-term care is a permanent episode that happens to your retirement plans and devastates your retirement plans without any chance of recovery. So it's amazing why it's the big elephant in the room and no one wants to deal with it, because it's the biggest risk to someone's retirement plan and it's pretty frequent.

I'm not going to go on and on about the private insurance market until we get into the questions, but I wanted to talk first about what is the current state of the long-term financing mechanism particularly in this country. I was sitting in a session much like this probably about a year and a half ago with a notepad next to me, and I love going to sessions, because sometimes you zone out and you get to think about other things. So if anyone in the room is zoning out, keep doing it, it works for me too, but look up every once in a while. I drew this while I was in a session and I thought about the three kind of different segments of household income for middle mass, affluent. I thought about some of the approaches that we have in aggregate to deal with some of our societal risks. We have the welfare of the public safety net. We have social insurance programs, and I emphasize insurance in that

statement, not the welfare aspect of social insurance programs or the myriad in between that they can be. Then we have private insurance or private solutions.

I said, well, in long-term care, what do we have? Well, we've got Medicaid long-term care that's out there. It's intended to be for the poor. It is a safety net. It often goes beyond just the poor. It helps those who become poor as well. Then we have private insurance that's out there, long-term care insurance, in many different formats, which I'll share with you in a moment. Finally, we have self-insurance. A lot of people that are looking at that elephant are thinking I can handle it, "I've got four daughters that will take care of me." That's not my plan; it's my father's plan, actually.

"I still have a wife that will take care of me for those incidental needs, and if I had that catastrophic episode of a lengthy nursing home stay, Medicaid is there and it is fairly viable for many in the population." So as you can see from how this chart is organized, the cross sections are kind of the intended mechanism within the overall financing system. So there's this vast emptiness in the middle. I call it the green box that typically is filled by a social insurance program. It doesn't have to be, but it is something that the middle mass is relying on to fill that void. There really isn't a straight-forward

solution for the middle mass that is affordable and meets a lot of other goals.

The arrows indicate that the Medicaid long-term care really does reach further into the household levels, so that middle mass market, and some would say up to half the population, their plan for that elephant is Medicaid, and some might argue that's perfect.

Then there is the long-term care insurance market and the self-insurance opportunity. There is that desire, the holy grail if you will, of finding a product or finding a solution that can reach down to the middle mass—a robust and comprehensive solution. So those arrows are indicative of that.

I put some arrows on the side as well, and I thought well, if we're looking for a robust financing system, we'd want to have participation enhanced across the households. That's why those arrows are on the right. Then we would want some type of collaborative system and not the three separate silos to deal with the three separate markets. You'd want something much more collaborative, because not everyone lives either in the same household segment throughout their retirement, or not everyone participates in each of the three types of solutions within the financing system.

So again about a year and a half ago I sat exactly

where you were in some other session at some other hotel that I can't remember and just drew this. It has been a pretty good way to introduce what a long-term care financing system ought to be, and then therefore, how do we optimize success in that system.

I wanted to ask a question though, because I want to make this a little more participatory. What's wrong with this picture? First, people can't count on it. Across the board, we're not just talking one of the individual boxes. There's a big green box in the middle, that doesn't encourage heavy participation. Second, what's right about it? What actually seems to work in this? Every last person in the country has a floor catastrophic plan called Medicaid. I'm not saying it's efficient. I'm not saying it's the right way to go about it. But it's there. Everyone has long-term care insurance. Everyone has something to address the elephant in the room. It's just not the best way to do it. Agreed? OK.

A little bit of background because Sandy touched on this already. The common statistic we always hear is 70 percent of people age 65 will one day have some long-term care need. That's the biggest lie I've ever heard because it doesn't really look at the actual data behind it. It implies that that care needs to be paid. It's not always paid. In fact, that same study pointed out that 80 percent

of home health care that is performed with the general population is done informally and in an unpaid manner. Eighty percent of all home health care being provided is done informally and unpaid by family members. There's nothing wrong with that. We should appreciate it, enjoy it, reward it, encourage it, help educate it so it can become effective care. It allows for some of the personalization of a long-term care financing system. So it's an important thing to note the 70 percent includes people with one or less ADL [activities of daily living] dependencies. That's not traditionally HIPAA [Health Insurance Portability and Accountability Act] qualified paid care, but it's a good tool to start with when it comes to planning. It helps identify the color of the elephant in the room, if you will, and then becomes something that individuals think about. Well, what if I have a modest level of ADL dependency? How can I be taken care of in that case? Can I rely on my spouse? Can I rely on my other family members? Do I need to start finding some ways to fund that? The same with the other levels of care. This is a very good study. I would read it two or three times if I were you.

The home health care claims are predominant, of course, and 80 percent of them are usually done informally or by an unpaid family member. When you look at some of the insurance data, and this comes from the SOA intercompany

study, half of home health care claims end up in recovery. So half of the insured home health care claims end up in recovery. They don't end up in death. Generally, if someone's planning for that first death, there's a death benefit involved, and there might be some recovery of assets, or replenishment of assets after that first death, but people have to plan for actually recovering from their long-term care episodes. It's miraculous that a third of nursing home claims end up not in death, but in life.

Let me step back a bit. This is a big tent. This is the biggest tent I could find on the Internet. It costs $1,400. My point here is that the long-term care market of long-term care solutions is indeed a big tent. What are the solutions that come from the insurance side? What are the solutions that come from all other sources? I'll focus on the insurance ones now, but we do have a big tent right now, and it's filled with many participants. It could take more capacity. It could take more capacity both from the consumer side as well as from the insurer side. It could take other robust ideas that fill that green box.

Here is what I see as being the product solutions that address that long-term care need. We often hear most about individual long-term care, but we don't often hear about combination products of which I spend a significant amount of time working on. We don't often hear about hybrid

products or critical illness products serving that need. We, of course, hear about Medicaid as a solution, and it is indeed a solution that everyone participates in, in some form or the other, but it's inconsistent across states. Some do home health, some don't. Some have higher levels of ADL requirements; some have lower levels of ADL requirements. We'll often talk about Medicare and potentially expanding Medicare to help with custodial long-term care needs, which has its potential and plusses and minuses. Long-term care is custodial, it's not just health care. Then we have self-insurance. There's nothing wrong with self-insurance as long as you're consciously making the decision to go this route, and as long as it's done so in a limited way. None of us can self-insure 20 years of a nursing home stay and then if the last speaker during lunch extends their life another 30 years, you can't afford that. Self-insurance has its place in many things.

Going back to my initial slide, let's say we're talking about developing a long-term care financing system with all those different mechanisms out there. We're not just filling the green box, but we're trying to enhance Medicaid, we're trying to enhance long-term care insurance. What are the goals we're going to have in mind when we do that? Are we just going to say OK, it has to be sustainable? Or these days we talk about affordable health

care. I looked up affordable health care. I often question who is it affordable for? At the height of the high deductible health plans we're facing right now, $12,700 family out-of-pocket costs, is that really affordable for a middle mass person? So affordability is, I would say, kind of primary in this case, but it's affordable for everyone, for all participants, the households, individuals, the private, the public entities, the providers as well. Two, obviously financially sound and sustainable. You want to obtain broad coverage and provide comprehensive levels of benefits, but they ought to be making efficient use of funds, whether it be insurance funds, taxpayer dollars or whether it be personal funds. Then appropriately lined incentives are very important because in many products we see today, the incentives just aren't there to use the dollars efficiently. We'll talk about that more during the Q&A time. Thanks.

JACK PADDON: Let me introduce John Cutler, J.D., Esq., with our federal government. Yet he's very much a friend of all of us as we've gotten to know him in recent days, and because he's just as concerned from the government standpoint as the rest of us, about the viability and ability for folks to have the proper coverages, the proper resources to take care of what could be a very big problem and very much like a college cost. When my children were in

college, and that was some time ago, but the average tuition, room and board at their private college was $12,000, $14,000 a year, but those costs, as well as nursing home costs, have escalated. And so one of the things I will be asking the panel to talk about and give their thoughts on later on in the question and answer, but just to introduce you to the discussion type thing we are happy to be taking today, is what if there's a bubble in long-term care, that it is like the college loan bubble that might be emerging, and where literally millions of users of this service are still in debt tens or hundreds of thousands of dollars. Too long an introduction, John. Let me go on with your part of it here. It's just so you get some thoughts in mind as we progress today.

John has been really a very prime mover, right at the heart and inside of the federal government's recent efforts to come up with a long-term care insurance plan. He'll have some things to add about that from his own personal vantage point, and you're welcome to ask in the question and answer anything he might be able to clarify for you all.

John has worked in the Health and Human Services Department policy office in this capacity, and he's currently now with the U.S. Office of Personnel Management, grappling with some of the aftermath and the public relations questions associated with where the CLASS

legislation, which was part of Obamacare, but which isn't right now as of now. So, John, take it from there.

JOHN CUTLER: Thanks, Jack. He said I was friendly and all I can think of was, if you fall asleep while I talk, I have friends in the IRS. And also the caveat for those that can't read it: Nothing in these remarks is meant to implicate the government to the United States in any way. I do have to give the disclaimer. I am here in my personal capacity, but what has been valuable, and Steve knows this, as does Sandy, from their various interactions [is that] coming into Washington, you really are in a different environment. And I think it's probably also mirrored in the state houses for the governors that are dealing particularly with Medicaid and other long-term care issues, to see the implications of a population that doesn't really understand what's going on, their knowledge about whether they're at risk for long-term care needs, what the programs are that would support them. We know from studies Medicare is what they think will cover long-term care, because it covers their health insurance, and they're not wrong. The program does exist as a back stop. So all this stuff gets mixed together, and occasionally the government moves forward with some solutions at the federal level.

The reason I left HHS to go to OPM was to set up the federal government's long-term care insurance program, an

employee-pay-all benefit. At HHS, I had helped construct that, and OPM is the HR agency for federal government activities, federal government employees and retirees, so OPM is the entity that runs that program. So that was a major initiative in the second Clinton administration, an attempt to change the dynamic, pick up on where employers were with offering long-term care insurance and see if we could drive the debate. Right now, the federal government's employee program has about 270,000 enrollees. It's the largest single program out there, but it's dwarfed by the population that's not covered. Our take up is about 5 percent, which is typical in the employer market. So, we haven't done anything? What I like to say is it's a program success, it's a product success, it's a market place success. But what the Clinton administration had hoped was for a social policy success, and that's not what it is. And then you fast forward a couple more years and we'll get to it later, the CLASS Act—Community Living Assistance Supports and Services Act, something that Sen. Kennedy added to the health care legislation that President Obama was moving through. That was another major initiative and that, for a variety of reasons, hasn't gone anywhere, but we'll get into that later.

I would like to thank the SOA. This is a wonderful approach to the session. It's a little bit different than

what they do with the other ones where you're talking about particular studies and research people have done. But all the stuff we're talking about, just put a little footnote in your head. If it sounds like a statistic, footnote, there's probably something out there, definitely something out there that proves that point.

My slides are also … Being from the government, we're not allowed to have fancy slides, so they'll all look like this, but basically when we were trying to put together the program, we had a couple conference calls, and there were so many different ways you could approach something like this. Do you want it focused on government? Do you want it focused on individuals? Would it be on financing? More skewed toward actuarial? So we all took a different take on that, and what I think is interesting is you'll see us addressing the same issues to a large extent, but [with a] completely different way of analyzing or looking at it. But we all end up coming at the same answers or the same concerns.

Basically what I wanted to conceptualize was that there are public and private approaches. Everything's going on and they feed back and forth. On the public side, you've got government programs, and we typically think of things like Medicare, Medicaid, Social Security and income support program. It's critical at older ages that you have money.

Money equates to better health. The more money you have, health status is more likely to be improved. But there are also social mechanisms in place, and the filial responsibility laws are something I identified as maybe coming. I think Pennsylvania's passed something like this, where if you've got a parent that needs care, you, as an adult child, have to come forward and take care of that person.

Another one, Texas, and I think a number of other states, if you wish to apply for Medicaid, they'll look and see if you have life insurance, and so one of the things that the government's doing there in those states is looking at whether you have assets that could be used to take care of your long-term care needs. So they actually make you sell your life insurance policy so that you have some cash for your long-term care needs.

On the private side, you've got individual actions, the decision to buy a home versus renting. Caregiving: We're going to get into that more, particularly Sandy, when we get to it. Insurance decisions: Why are some people risk takers, and some not? Why are some people planners, why are some not? Some people will like to insure. I should have also included, of course, saving and investment. Other people do that as their mechanism: self-insurance.

So if you follow up in terms of the personal actions,

you've got these different things going on, and I could have probably done a lot more.

The reason I mentioned homeownership is because you've got actually two things going on really. One is psychological. If you're in a home, you may be less likely to go to assisted living or want to leave. Your place of residence becomes very important to you, so decisions about whether you should leave the home or not are skewed by the psychology of that. But the other big thing obviously is if you've got a home, you are sitting on some X amount of money.

Studies have shown though, as the boomers get older, that's going to be a smaller amount of money, because there's more people trying to sell a home than buying it. So what happens when you have more sellers than buyers? Prices go down. I've seen some studies that show maybe a loss of about a third of home equity for individuals. Now, that's not true across the country. If you have a place in Florida, an attractive area like that, you may see how values stay up. But if you're in a place that's not attractive, people trying to sell their home, they're not going to get the rate of return that people in the previous generations have gotten off of their house. And that doesn't even count the fact that, of course, they probably tapped the equity already through second mortgages.

Caregiving will be a big one, and we'll get into that. I put the tax planning in estate planning. Everybody thinks it's OK to do tax planning. This is a Supreme Court decision. You do not have to pay any more taxes than you're responsible for paying. So if there's a legal way not to pay taxes, you do it. You pay less taxes; everybody thinks you're smart. For some reason on the estate planning side, if you were to give your money away to your child, so you look poor and go on Medicaid, that's considered a bad thing. The problem is, how can you tell the difference? Some of the things you do for tax planning end up being estate planning. So there's some interesting issues there when you get into it, particularly with annuities and some of the other products that people are looking at, as well as trusts that do some of this planning.

On the government side, of course, the big programs, Medicare, Medicaid. The CLASS Act. We'll have some questions on that later, I think. It was basically something that Steve had talked about. You've got a public/private approach. All the solutions pretty much now incorporate both public and private. The people that advocate for governmental solutions realize that they A) don't want opposition by the private sector, but, B) they can't fill the universe. They can't take care of everybody's need. Adding a private component has value to

that, and by the same token, I think the private sector, particularly the long-term care insurance industry, is well aware that they can't sell this product to everybody, that there's a need for a governmental program for some people. I think there's a lot of consensus around that one issue. It doesn't necessarily play out in any particular product design. And product here means both a governmental product as well as a private sector product. But there's a lot of coherence at least that both sides have to be at the table.

Again Social Security and income support programs [are] critical at older ages. The tax policy issue: I mentioned homeownership. Obviously there's a tax break for homeownership. You've got it with retirement accounts. There's been some proposals to allow people to tap their retirement accounts for long-term care services or long-term care insurance. So again there's some thinking about different ways to address the long-term care issues with tax policy, which is very popular in Washington, because it doesn't look like you're doing anything horrible and big and scary like Obamacare, which is a wonderful program, Steve. Everybody loves Obamacare because it covers people. That was my plug. So I think we should probably want to exit those slides. Thank you.

JACK PADDON: By the way, it goes far back enough for me to recall that the "Me worry?" picture was not only a Peter

Pan-type of response, but also Alfred E. Newman of *Mad Magazine*. I see a few smiles. We'll go to the internal question part of this now, and starting with Steve and John first, because the question about what primary factors seem to be causing the long-term crisis to become worse, they're going to have their own answers from their vantage point, but for Sandy, who will come third on this question, that will be your opportunity to talk about the caregiver shortage. So you have your topic all picked out, but we'll have Steve and John go first with the points available there.

STEVE SCHOONVELD: OK. Well, obviously the first answer to the long-term care crisis being accentuated is the fact that the demographics are focusing on it. Though, I found it interesting … I think it was one of your slides, Sandy. I always thought the boomer generation was much greater than the millennials and those after as well, and that's pretty consistent. It seemed like the boomers are replicating themselves no more, whereas their parents replicated themselves, and a couple additional ones too. So this is something I hadn't seen before and I thought that was interesting. So those demographics are going to be around with us for quite a while.

One of the things that's definitely exacerbating the problem is that the funding is more expensive these days.

Due to the incredibly low interest rate environment we've had over the last four, five years, and at least it's starting to pick up. At least we're seeing some improvement over the last six months, and a little bit more normalcy is happening, but it's not there yet. Then the other thing which I'll put out there is the trial-and-error regulation and public policy approaches we've had. I like that last slide I had, because it talked about what are some of the principles behind a financing program that we should build, and when it comes to principles, I don't tend to hear much about them when I go to Washington, or even goals. That's why I made the comment about the Affordable Care Act as we have policies that if you have a health condition that requires an out of pocket, that's $12,000. Most middle mass families can't afford $2,000, and so if they have two kids that have two broken arms, guess what, impoverishment's pretty close basically. I think when you think about those ambitions or goals of developing a financing system, I wish there was a linear program we could put together and give you the answer, but there isn't. That kind of structure is important. You want to optimize efficient use of funds, you want to optimize coverage, you want to optimize the right levels of incentives in a program, and then decide what combination of private, public policy and other resources could help solve the problem.

JOHN CUTLER: I agree with Steve, as well as Sandy, in terms of the coming demographics. I don't think it's gotten real to people, and I think my take on the problem is that it's … We're losing an opportunity to make changes. This is an ocean liner, and you're trying to change the direction, and it doesn't happen very fast. So what we're doing by stopping and starting policy … I mean we had both health care and long-term care reform in Clinton's first administration proposal, and it didn't happen. Then it comes back into 2008, Sen. Kennedy with the CLASS Act. That actually was passed as part of health care reform, but it wasn't designed well and because of the interaction of the parties, or lack thereof, between the Republican and Democratic parties, there wasn't a willingness to make the changes necessary for CLASS to be successful, and so it had to be eliminated. So it was actually repealed. That means again we've lost an opportunity to go forward with a public or private solution for that matter.

Same thing, I mentioned the retirement accounts. That would be an opportunity to help jump start the private market, but I don't necessarily see that happening any time soon, because it would be something that the Democrats aren't necessarily going to be in favor of a tax policy change that might be perceived as helping the better off, and in the current climate on the Republican party side,

they're not necessarily going to be inclined to want to do a tax break, because that hurts the deficit situation of the country. So something that would in some senses be a rational and logical small step to taking care of long-term financing needs, isn't going to happen. So I think we're losing time each year as we debate nothing or re-debate the issues, and don't move forward with solutions.

SANDRA TIMMERMANN: I'll talk a little bit about the shortage of home care workers. You heard Steve say that families provide 80 percent of the care, which is a good thing. If families didn't provide it, the care recipient would really be in trouble. However, as you look at the changing family structure and consider that women, who have been the primary caregivers and are now in the workforce in big numbers, families are going to need to rely on home care workers, or workers in institutions to supplement their care. The Alliance for Healthcare Reform is projecting 10 to 12 million direct care worker will be needed in the next 10 years, a growth rate of 2 percent per year. The jobs are very low paying. You can work at McDonald's and make more money. Immigrants have been filling the jobs, there is a huge turnover, and there is little regulation of home care, so we don't know the quality of the care. Older people are often victims of elder fraud or elder abuse, due in part to caregivers in

their homes who are not taking care of them properly. Fewer children, more women. In Cindy Hounsell's presentation yesterday, she pointed out that there are more women and men without children or families to rely on for care. We really need, as a country, to come to grips and solve the paid caregiver shortage problem. I do believe that it's not only the consumer with the elephant in the room. This is also a government problem as well, because all of society is going to have to deal with this piecemeal approach until some new thinking occurs. We just haven't cracked the code yet. So looking at my slide, the age boomer wave and considering that the oldest boomer will be 85 in 2037 and youngest boomer will be 85 in 2050, we have a lot of older people coming along the pipeline for many years to come. We have to deal with the long-term care crisis. The government will be paying more and more money and individuals will be at risk if they don't prepare.

JACK PADDON: Steve, back to you in the private sector. There's a perennial problem I'm sure you're very aware of, working with it every day, kind of a two-prong thing. The product acceptance problem: The products are too expensive, they don't do the job, they're only issues to people who don't need them, and then there's also … I know you have a public relations kind of thing. Well, the public sector can do it better, because they include everybody. Even if no

one's lit the match … has just lit the match to their house, they get fire insurance, that type of thing. Insure everybody even if they are already sick, that type of thing. How can you and the folks in the private sector counteract that thing and get your message across that this is … there's a lot more soundness and sureness and guarantees involved.

STEVE SCHOONVELD: Certainly. I do go to Washington frequently to talk about these issues, and I turn my politics off when I get off the plane. I think that's our job as actuaries anyway, to turn off the politics and to get it right, and so that's one of the reason why those five, six principles came about is we want to get this right, we want to get this effective, we want to get this efficient.

But, there are a lot of myths out there that I end up hearing quite frequently when I go to Washington. The biggest myth I hear is that the private insurance market is in shambles. That's being provided by researchers, and I think those same researchers would look at the music industry and say well, there aren't a lot of CDs or eight tracks being sold, so obviously the music industry must be in shambles.

As you saw, there are many different solutions that we have out there. There's individual long-term care, there's

group long-term care insurance, or there was. John's involved in a very active group long-term care insurance program. There's combination products. There's a host of potential solutions that encompass that big tent and we need to talk about all those solutions and not just pick one and use it as a way to demonize an industry. So that is a slowly changing myth. Like I said, the market's much more robust, and yes, there are carrier exits and carrier participation is smaller than it was 10 years ago, but in an evolving industry, there are starts and stops that do occur. The interesting thing is that until this year, sales have been pretty consistent year over year over year despite carriers dropping out. So that's myth No. 1.

Myth No. 2 is that long-term care is a health product or is health care, and it really isn't. It's custodial care, and there are various ways of dealing with custodial care needs. People plan differently for that elephant. Some plan to fully finance that elephant because they can afford it, and some have to naturally plan differently and make trade-offs in their retirement. One of the other things that carriers often do is take a look at the overall retirement planning picture someone has and help design products that allow them to make those trade-offs either in retirement or as they're planning for retirement. One of the new products we have out there, and it's not new, it's

been around 25 years, it's just kind of exploded over the past few years, is a combination life or annuity and long-term care insurance product. Here a person will always get a benefit from this policy, it might be a death benefit, it might be a long-term care benefit, or it might be the cash value of the policy. For the middle mass, that's a solution that they could actually enjoy. For the middle affluent, that's a solution they can enjoy and afford because it's got a dual purpose to it.

I see in the market, the individual long-term care insurance market, as well as some of the other players in that big tent, as really just beginning to evolve around some of those interesting, novel ideas that are a reaction to or a consideration of the clients that they're trying to satisfy.

One of the areas where the individual long-term care insurance market didn't do a good job of is the group long-term care business. There isn't a group market out there anymore, maybe a carrier out there, but this is cheap, affordable coverage. I've got a policy. I spend $200 a year. I bought it when I was 41, because it was provided to me by an employer, and I continued it when I left, and it's three years of coverage. It's going to cover 90 percent of my risk for $200 a year. Last year I got a rate increase of 70 percent. I said great, give me another 70 percent. It's

still $200 a year. So we lost an avenue there on the group side, and I hope the solutions going forward kind of bring that back in some manner. The participation rates, yes, indeed are low, and that was one of the reasons why the market kind of dried out there.

What can we do as a private industry? Well, we can help support that informal care. We can help support it by giving our policyholders the tools to care for one another in the home before they start using that benefit, and that's a win for everyone. If we can help a policyholder and their family delay claim, use that money for more severe episodes in the future, they're better off. The carrier is better off. The adviser looks very good. So it's a win/win/win.

JOHN CUTLER: If I can pick up on that. I'm very pro long-term care insurance, so my negatives are what I would say are the negatives that I've picked up from people that are active in the critique of long-term care insurance. I think from a public policy standpoint, the biggest problem was that long-term care insurance promised a solution that it didn't deliver. It's been around now 30 years. You would think perhaps it would have greater penetration. Other products: The automobile. I mean name something. There's a rapid technological diffusion and long-term care insurance doesn't have that, so policymakers are left adrift.

Now, from a consumer perspective: Rate increases. This is a product that was promised to be level premium, you would pay your money and never see a rate increase kind of thing. It was always in the small print you could get it, and most of the companies have had to do a rate increase. It's all very understandable. They're getting approvals from insurance departments, because they could make a good case that they don't have a clue what long-term care pricing is like. The government doesn't. Medicare, Medicaid, the government's programs aren't in any better fiscal shape than private sector products. But from a consumer perspective that gives you pause. Maybe I should wait until generation two when they figured it out.

Then you look forward to some of the solutions. The combo products, they'll be more expensive. You're putting together two risks. I don't think you can put together two risks and make it cheaper, so we'll have to see if they play out. They may also have the same problems with pricing and lapse assumptions that long-term care insurance had, because you're now introducing a combination that you haven't had before in larger numbers. So there's no guarantee if you're looking at a combo product that it's a better deal.

STEVE SCHOONVELD: John, there is a guarantee. I've priced and filed combination products, and I sell them

noncancelable. I'm not allowed to raise a single rate in any of the policies that we have placed as a signing actuary.

JOHN CUTLER: Well, the life model may be useful and that also, from a product standpoint, more people buy life insurance than long-term care insurance. So people are used to that. It's a risk that they take care of when they're younger, and they can keep the life policy when they get older, and they don't need it for their kids. So there's a lot of things in play, and I don't mean to dismiss the combination. But if I were a consumer, I'd wait for the dust to settle before I jump into the market.

SANDRA TIMMERMANN: That's certainly one reason, but I think the other reason is that consumers don't trust the industry. The 40 percent rate increase, which is basically what it was across the board, is a pretty hefty increase, and a lot of people saw carriers exit the market. They're saying to themselves, "If I buy a policy, it's not only going to go up in price, but the company might not even be there." So I agree with you, John, on that score, but maybe the dust is settling, Steve. That's encouraging.

STEVE SCHOONVELD: Yeah. I think I'm one of the only pricing actuaries in long-term care with a smile on my face. I do write and price and file policies where I have no legal right whatsoever to raise rates, when every other

individual long-term care policy filed on the planet basically was guaranteed renewable, not noncancelable. I think or one of the differences I see evolving within the individual and combination long-term care markets is we're just not going to stand by and wait for people to come buy products from us. When you go out there and you buy something, you're going to use it. You buy it to use it. So there's that moral hazard aspect of someone coming to a carrier, buying a long-term care insurance policy, and then the second they stub their toe and become two of six ADLs, they want to go on claim for a couple reasons. They're going to get something out of their policy, and they're going to go on waiver of premium. So that aspect was something that I don't call a phenomenon, because a phenomenon is something you can't explain. I often hear adverse selection being called a phenomenon. It's not a phenomenon. You know it when you see it, you can explain it, you can price for it and you can mitigate it.

I think as we begin to distribute today's long-term care insurance product and tomorrow's, whether it be short-term care or combination products, just waiting for people to buy from us is not an appropriate risk management technique. Going out there with advisers, discussing the risks to someone's portfolio and then presenting a myriad of solutions including combination products, does help

drive. I'd like to say you can underwrite someone for their health status but you can't underwrite them for their intent with the policy. We need to find policies that are incentivized and there are some that can be done so in the individual long-term care market as well as the dual-purpose combination products space.

JACK PADDON: I'll ask John to wrap up what thoughts he may want to share about the outlook for the CLASS Act or something more viable that might replace it down the road, perhaps in conjunction with some kind of privately designed efforts jointly.

JOHN CUTLER: Right. I'm not sure how many people remember the CLASS Act and the structure. It was basically an employer-based long-term care and disability benefit. And the authors of it had the frustration of trying to combine the disability population with the aging population. So they were trying to craft a product that would be available even for people with current disabilities. So then you're sitting there going like, oh, adverse selection. So what do you do? So they put in a couple different things like a five-year waiting period that may or may not have been sufficient, and Steve was heavily involved, because the Academy and the Society had a group of actuaries critiquing that and identified several things, while the law was moving through, that needed to be fixed. What happened was

they were all ready to go in conference with those fixes, but if you go back a couple years, what happened when Ted Kennedy died, his seat was filled with a Republican. That meant the Democrats didn't have the 60 votes to break the filibuster that the Republicans had promised. So they basically passed the House and the Senate bills unchanged, and then the president signs that and that's the health care reform legislation. So the proposals that would fix the CLASS Act didn't get incorporated. And then, as I mentioned before, the CLASS Act gets repealed.

Now, the interesting thing about that is what you [have] … The impact of private long-term care insurance is more significant, I think, than people realize, and I liken it to go back to 1964, 1965 [when] they're crafting the Medicare program. The Medicare program is basically the Blue Cross Blue Shield standard option of 1964.

So, I think, going forward, if you see a long-term care insurance fix that's a social program, you're going to see it based on private long-term care insurance experience. The good thing about this 25 or 30 years of private experience is the marketplace knows some of these answers, like what's going to happen in a low interest rate environment. Well, they didn't have that until recently—the last five, 10 years—but they've had that. What happens if lapses are less than they thought? Well, when they first

put the product out, they were assuming like Medigap lapse rates: 5, 10 percent. They're like, you know, less than 1 [percent]. So all the things that the private industry has learned will get factored into a governmental program if they create it, and they will probably create one that would combine the private sector as well. It would be like Medigap being part of Medicare. So I think they'll be an attempt at some point to do something like that. I don't see it happening any time soon.

One of the best solutions to adverse selection is to mandate coverage. Everybody has to buy insurance. We've just gone through that with health care. The question during the discussions with the health care bill was for the long-term care component, the CLASS Act, do we mandate CLASS? And that was an active discussion at that one point in time. But they decided they couldn't mandate both health insurance and long-term care insurance coverage. So that dropped out and one of the problems with CLASS Act was, of course, that they didn't think they'd get enough take up.

Now, going forward five, 10—some X number of years—somebody's going to come up with a proposal. It's going to be public/private. It's going to recognize long-term care insurance experience, and there's some hope then that they might address it.

JACK PADDON: Sandy, back to you. You've had quite a bit of

review and study and interest in the reverse mortgage approach to long-term caregiving, and tell us if you—from your experience, the pros and possible cons. I think of one: That assets built into a home could be misallocated by the family or, worst-case scenario, no equity and no roof over your head. Maybe there are safeguards against that, but elaborate on that for the people.

SANDRA TIMMERMANN: I'd like to broaden this a little bit. Let's think about your home not only as a place that you live in, but also the equity in your home as a source of money needed for retirement. Before I talk about a reverse mortgage, there are other ways to think of using home equity. Let's use the example of people who move into active adult 55+ qualified housing, not low-income housing. Many of them have houses that they sold for more money than the cost of the home they're moving into. The home they're moving into is on one floor and has universal design components so is better for aging in place, and they use the proceeds as extra dollars to supplement their income. That's one way to think about your home.

Another way might be to consider renting rather than owning your house. I don't that I totally agree, but as John says, many people are moving to the Sun Belt. Maybe it is time for people to sell and [they] could consider renting, which would save money without worrying about

upkeep and home maintenance costs.

Now for reverse mortgages and forward mortgages, we have to think about these tools in terms of retirement planning. I know we have some people in the room who are financial planners. Those of us in the planning community haven't thought much about using home equity as part of the whole picture. Reverse mortgages have cons to them, but with changes in the product and the dismal savings rates of boomers, they are worth another look.

There have been some problems with reverse mortgages. The Mature Market Institute conducted research with the National Council on Aging, and in the data analysis found that the age that people were pulling equity out lowered considerably during the recession because they were using it primarily to pay off debt. If you take money at 62, you could find yourself in big trouble later on.

Then the other thing that happened was, initially, there was no underwriting requirement, and so anyone 62 or older could get a reverse mortgage, regardless of income and assets. In order to keep your home, however, you needed to keep it in good shape and you need to pay insurance. There were some scandals of Granny being kicked out on the street as a result. But things have changed. The Consumer Protection Finance Bureau has developed regulations that now require that people who are applying for reverse

mortgages have limited underwriting so something like that doesn't happen, and the amount of equity is being decreased.

I have to say that the good reverse mortgage companies, and I'm working with two of them, believe that this is a plus rather than a minus, because they believe that a reverse mortgage should be considered as part of a holistic planning process. They don't see it as the way some of the spokespeople advertise it as a "last resort," appealing to those who are destitute or very old. There are new ways to think about it. One example is to use it as a line of credit that you may or may not use. You can save it for an emergency, you can pay it back, once the upfront fee is paid, you don't have to pay interest when you withdraw it, and it grows in value. It isn't like a forward home equity line of credit loan (HELOC) where you take out a line of credit against your house, you've got to pay it off and the interest rates are high.

I'm not a financial planner, but I think we have to look at home equity in a very different way, including using your home to stay at home and age in place. The money from a reverse mortgage could be used, not to buy long-term care insurance, that's cross-selling, but to pay for a home care worker, which would enable you to remain at home longer. In fact, using reverse mortgages that way could

supplement long-term care policies that could be sold.

JACK PADDON: OK. Thank you, panel, for these observations. We're now in a question-and-answer time and hearing from you all in the audience. If you have a question for one or more of the panel members, please come to the microphone. Just say who you are so we can get your name in the transactions, the proceedings. Fire away. More than one panelist is welcome to answer if desired.

DOUG ANDREWS: Very interesting discussion. In terms of Sandy's slides about what boomers are worried about, the thing that wasn't on the slide, and maybe they didn't ask them about this, but I would have thought it was caring for aging parents and their potential for requiring long-term care. Then John said there's a filial responsibility law, so I would think that would heighten this anxiety. Then you said there's a real shortage of care workers in the next 10 years, and boomers are going to be aging. But while the boomers are aging, one or both of their parents are going to be needing care. So why isn't that one of the items to worry about or is that an elephant in the room?

SANDRA TIMMERMANN: It is an item to worry about. In most cases, the parents of the oldest boomers are no longer living, although those who are require a great deal of care. The younger boomers are the ones with the greatest caregiving responsibilities now. I've done a lot of work in

this area, so thank you [for] asking. It's a good thing that 80 percent of the care is provided by families, but it's a problem because it's important that women stay in the workforce and a lot of them drop out to provide care. The Mature Market Institute looked at how much money people can [lose] over a lifetime if they drop out of the workforce. We worked with the National Alliance for Caregiving, which has done some research in this area, and found that people lose about $400,000 due to lost wages, Social Security and savings.

The caregiving issue is so important now because government is now moving away from institutional care to supporting aging in place, but we don't have the infrastructure yet to handle that, and even with long-term care insurance, there will still be a shortage of paid caregivers. Policy changes in recruiting, training and retaining them … For example, we need career ladders and government can stimulate that. We may need to change immigration policy, because so many immigrants are providing the care. Or could we create caregiver tax credits on a more widespread basis? The aging-in-place movement that Cindy Hounsell described in the general session also involves community action.

There are new models like the Caring Collaborative where volunteers get together and bank hours that they can

use when they need care. There's a national transportation network that was recently set up and is also a time-banking model. Say, I live in Tennessee and my mother lives in Florida. I could provide a ride in my community and that hour is put into a volunteer bank. When my mother needs a ride in Florida, that hour is there for a volunteer to give her a ride. Or older people can sell their cars in exchange for rides. This network was created by an amazing entrepreneur whose principle is to make it self-sustaining without government money. Overall, aging in place will create some problems and it needs to be addressed in a lot of areas.

Many employers offer elder-care programs. However, they're notoriously underutilized and that's been true for the last 20 years. There is more awareness and a coming together of different sectors because 50-year-old boomers are still young and they're caring for aging parents. They will be looking to their kids to provide care, and maybe their kids will care for them and maybe not. So thank you for bringing up filial responsibility; our country may need to adapt that if we can't find other solutions.

JOHN CUTLER: I don't know whether that will go anywhere. Other countries like the Philippines, a woman—a state senator there—just had a bill, because evidently the culture there is to take care of your parents. I don't know

whether that will work. I think what we're seeing is, because the problem is so immense, people are coming up with pinpoint solutions. Sell your life insurance. Require the kids to take care of their parents. See where that goes.

The reason I'm not sure it will go anywhere is there's also a provision in Medicaid that after you've gone through your services and you pass away, the state's supposed to get the house to pay Medicaid back. Well, so how many states do that? They just don't go after the house because the politics of it are so inflammatory. So you could put a filial responsibility law in the books and nobody's going to be crazy enough to enforce it, because it might fly against the community standard of personal sense. The government is too intrusive, making me take care of my parents, even though on the other hand you've got the concept that yes, you should take care of your parents. I can see the reasons why the community would want the law passed, and I can see a reason why the community would want it not enforced.

Another thing from the private sector side, one of the slides that Steve had: Critical illness. I love critical illness. Medigap is my favorite product too, by the way. Critical illness, that's more popular in other countries. So you could see critical illness coming forward as a

potential solution, because if you look at the cost, most of the cost of this long-term care population, there's like 20 percent of the people have 80 percent of the cost of the problem. So if you could focus on it in a post-acute solution, there would be more along those lines. There have been proposals to have long-term care insurance coverage included in a Medigap-style product. And seniors buy Medigap. It's like two out of three seniors buy Medigap insurance when they get on to Medicare, contrasting that to the 5 percent that buy long-term care insurance. So putting a long-term care insurance component into Medigap to get into the Medicare program has some value, even though it does medicalize it. So here you are going away from this concept of long-term care being supports and services, taking care of people's needs that are much broader than just the health care needs.

Speaking of which, by the way, Genworth a couple of years ago started selling theirs. Genworth has got 25 percent of the market. It's the leading carrier in long-term care insurance. They came up with this idea that they're going to sell a long-term care insurance product that looks like health insurance. They're going to pay 80 percent, you pay 20 percent. That's standard in the health insurance field. Why is Genworth doing that? I think they felt that they were tired of going against the market. The

market is saying we don't understand long-term care insurance, but we understand health care. We understand health insurance, so they decided they would just fold their tent and do what works: If people think its health care, sell it as health care.

So there's a lot of experimentation going on, and that's where I'm going with, like, the filial responsibility laws. They may take off, they may become the norm. They may be accepted. I'm not sure. But it's reflective of society, both at an individual level as well as a governmental level, both programmatic as well as using the government as an instrument: Passing laws telling you, you have to do this or that. I think we're at an exciting period of time where there is all this discussion about what to do. My concern going back to the opening comment: I'm worried we're running out of time too. I mean we'll come up with some nifty solution in 2030 and it's like we'll be past half of the population that needs the care.

STEVE SCHOONVELD: So one of the aspects about this discussion I was thinking about as both were talking, were if 80 percent of the people right now receive home health care informally by family, and you add on the social program that would pay for it, what percent of the population is going to continue to provide care for their family members in an efficient manner? Now, granted some of

those should be working or would rather be working, or that it was a choice thrust upon them. It wasn't something they desired to do, but we do have cultures, we do have segments of the population that actually enjoy taking care of their parents. They are not waiting for a Pennsylvania law to tell them to take care of their parents, and when it comes to public policy discussions around this, we need to be a little more equitable in how we design these products. So if you've got a family with, let's say, a cultural background that promises profusely to take care of their parents until they are five and six ADLs, let's say … Well, if you design a program like CLASS, that family is never going to spend the money and never going to use the dollars until they get to at least five or six ADLs, but the neighbor next door who doesn't care about the parents, they are going to go on and claim on the first broken toe. So whether it's a public policy or a social insurance program or whether it's a product by the private insurance market, you've got to be able to design it so that it meets the needs of both of those populations without unduly overly burdening one or the other.

SANDRA TIMMERMANN: You could make it easy for the family caregiver though. I was thinking of one wonderful invention, which is adult day health services. It's very inexpensive. It's less than $100 a day generally speaking.

This enables people to drop off their relative, or in some cases have their loved one picked up. They can go to work, or, if it's part time, they'll be able to have respite so they can continue caregiving, because it is a very stressful situation on the intense levels. And I think we need more experimentation on the community level, which mixes volunteer, you know, all those people I talked about earlier, all those adulthood 2.0 people who could in fact, work in this sector maybe as paid workers, or as volunteers or in some combination.

STEVE SCHOONVELD: Yes. My point was that one-size-fits-all social programs don't work for all, and one-size-fits-all private insurance programs don't work for all. How many would participate in a home insurance program where you had to have a half million dollars of home insurance coverage? No more, no less, only half a million. Half of us probably would think that's too little, half of us probably would think that's too much. Same consideration though to be had within the realms of what's regulatory possible, and I think that's one of the issues with social insurance programs is you can't treat one person different from another, one taxpayer or one participant from another, and so you do get stuck in kind of these one-size-fits-all type programs. We do have to have that in consideration, I'd like to say take advantage of it, and incent people. The

CLASS program, yes, was actuarially unsound, but even if they fixed it, even if … I forget who was running against Scott Brown in Massachusetts, but even if she had won and they were able to change the CLASS Act, it still would have been, it might have been more actuarially sustainable, but it still would have been one size fits all, and it still would have been inappropriate and inefficient. It wouldn't pass the sniff test like I had in my last slide on a lot of those characteristics we're looking to build a sound long-term care policy, a sound long-term care financing system.

DOUG ANDREWS: I'm glad that you're all talking about it, and I think it's very important that families talk about it. Even in those cultures that believe that they have a responsibility, this can be one of the most divisive issues that comes up in the whole family at the end of life, is how is mother going to be cared for and whose responsibility is it and are you doing enough, etc. So it's really important to have these discussions.

JACK PADDON: Just this morning, in the lower left-hand corner of the front page of *USA Today*, there was a little squib with a two-part pie chart. What percent of children with aged parents have conversed with them on potential long-term care? The answer was less than 40 percent: 39 percent, yes; 61 percent, no. So if there isn't even communication within family units, which is not surprising,

there's a lot of reticence to either direction, sometimes both, to bring up the inevitable.

SANDRA TIMMERMANN: I think that's true. It's very touchy. How do you talk to your 80-year-old mother about what her plans are for the end of life? It can sound greedy. Sometimes it's the opposite, like you said, that older parents wants to talk to their children, and the adult child puts it off. They might say, "Oh, Mom, is something wrong with you? Are you sick?" They don't want to bring it up, and in other cases, the aging parent doesn't want to bring it up. How do you get that conversation going? One out of every four American households has a caregiver, and these conversations need to take place.

The Mature Market Institute conducted a number of studies with the National Alliance for Caregiving and I've been chair of the board. It's a consistent finding across the board that caregiving issues won't go away.

JACK PADDON: We have time for one more question and then I'm going to give the panelists whatever time they need, whether it's after five after three or not, to get their concluding statements in. Go ahead.

KWABENA BOAMAH-ACHEAMPONG: My question goes to Steve. In reference to the long-term care private market, combination products in particular, you seem to have products out there with substantial guarantees, and the target market is more

of the older people, so the premiums are pretty high. So obviously the younger people with less disposable money cannot buy such highly priced guaranteed plans. What is the trend to develop and sell long-term care products targeted to younger people?

STEVE SCHOONVELD: I'm glad you asked the question, because you are the trend. Nationwide has entered the combination product market and they're selling to younger people, just like many other carriers. I think we get a new competitor every week. There are more flexible ways of paying that policy. Is it a policy for a 30-year-old? No. Should it be? Perhaps. You know, there are different needs that a 30-year-old has than a 40-, or a 50- or a 60-year-old, and there are different ways of financing that as well. So if you look at the combination space, you've got single-pay type products and you've got multi-pay and a very flexible type chassis as well, all, by the way, still guaranteed, John.

So that gives choice, that gives options. The trick then is if we're successful in the middle affluent and even not so much the affluent space, to build those same products for the less affluent, the middle mass. And I submit to you that building a dual-purpose product for the middle mass is not a siloed approach. A key point in retirement is a middle mass person or family cannot look at

every last risk they have and find a different solution for that silo. You need some more all-encompassing barn-type solutions that gives flexibility at retirement. This is one of those products that do that, and yes, it's an asset they finance, it's not necessarily a premium they pay and lose. It's a key difference because you're building a plan just like whole life used to be a way to build a plan for your family as well. And welcome to the market, by the way.

JACK PADDON: OK, wrap-up statements. There will always be a federal government. We assume there will always be a private sector. There will always be experts and advisers to show us the way. So you first, John.

JOHN CUTLER: Well, actually one thing before closing remarks per se. I do like the experimentation going on with life and long-term care, and it's been around for a while. I mean you could accelerate your life insurance product, for example, for either a serious illness or if you met the HIPAA triggers for long-term care insurance, the two out of five ADLs, or cognitive disability. What I like about the combination is that the reserving rules, they may not be identical, but you've got a product that reserves across time.

Retirement products are also products across time. When you're talking about the health insurance products, they're a term product. Money comes in this year, claims

are paid; you start over. That's true with Medicare and Medicaid as well. So being able to put together a product that's a long-term care insurance kind of product, which takes care of people, moves money across time on to a chassis like a Medicare program or a Medicaid program may be difficult, so I certainly laud the industry for doing experiments. I shouldn't call it experiments, for seeking more growth in those markets, recognizing in some senses the carriers have recognized that true, traditional long-term care insurance isn't going anywhere, but the experience over the last 25, 30 years with that marketplace has been valuable for carriers that are going forward, and will also be valuable if we do have a public/private solution. So I kind of killed my closing remarks with an answer a little while ago.

Basically, I see something happening at some point. The pressure is too great. We have to act or else we're really just going to be killing our country. I don't know what it will be. I don't know when it will be. To my mind, having been in this for decades—the public policy arena for decades—there are times when something comes up that's clearly the decision point, like Clinton health care reform or Obama's or the CLASS Act. What you do then is you're trying to kill it or improve it, but all the focus is on that kind of proposal.

At other times, you're just sitting back and all the ideas are bubbling up. Do we think we want to do it as a financial kind of approach, like allowing retirement accounts to be tapped? Do we want to do it as home equity? And there have been some changes in home equity. Do we want to try to make the caregiver side of things more robust?

One of the proposals that the Clinton administration had that didn't go anywhere, that came back when Hilary Clinton ran for president in 2008—and I'm assuming if she runs again, it will come back again—the caregiver tax credit: $3,000 to people who are caregivers to try to help them economically, because to the extent that we can keep unpaid caregivers in play, you don't need paid support programs from the government. So we're going to see all these little bubbling of ideas, and I have no idea which ones will come forward, but I do see that kind of effort continuing in Washington and in the states to the extent that states have a stake in this, particularly for the state's Medicaid.

SANDRA TIMMERMANN: I'm interested in figuring out how the private market and the government can do together. I'm beginning to think that ultimately there will be a Medicare Part L, and it will be treated like Medigap insurance, with private sector [to] provide that insurance. I do plead for

some sort of national unity policy around long-term care issues. The individuals need it, employers need it, the macroeconomic situation is such that we need it. Individuals are crying for help and maybe now that the debate is going on with health care coverage, there will be more of an opportunity to also consider long-term care solutions. I'm moderately optimistic.

STEVE SCHOONVELD: I'll be the pessimist here. I don't see a snowball's chance anywhere, even in the frozen United States, of a CLASS-like program being implemented. However, I do see something that would reform Medicaid as we see it today. The problem with Medicaid is that no one really knows the pain you have to go through to become eligible for it, and the limitations that it could cover. If that was something clear and present on retirees' or near retirees' mind, they would do a heck of a lot more planning. If they knew what happens to a family when they need to spend down to become eligible for Medicaid, they may very well be much more participatory in their planning for that big elephant.

I also see that solutions becoming more robust for that middle mass market as well, including the combination market as being that dual-purpose type product that meets the needs of the middle mass efficiently. That product has been around for 30 years. It just hasn't really taken off

until the last few years, and we have new carriers coming in every day.

2013 is a tough year for the individual long-term care insurance markets. Sales are down 30 percent because they pivoted to a different pricing framework and I can go into that detail some other time. But like I said, I don't think we're going to have a social insurance-like program for long-term care, but I think we'll have some partnership opportunities including some more robust private market solutions, and I would love to see Medicaid much more clear and conscious type of program on American people's minds. That way they can react appropriately and plan for that elephant. They can plan through self-funding, they can plan through family, they can plan through critical illness products. As long as they plan, that's all that matters.

JACK PADDON: A couple of words of thanks to everyone here. For the panel for being so flexible in the planning stage and in the execution of this discussion, and for all of you who sat in your scattered places all over the room and listened very attentively to everything that was being said. I want to thank Dr. Andrews for being here and participating. This is the every three year renewal of when he presented a paper and I was his discussant. So here we are. Not much has happened to move long-term care solutions forward, but I think we have, especially through all of

this merging and mixing and sharing of different disciplines and viewpoints, a much better perspective. I certainly do than when we first started planning this session. So thank you for coming, take the message to where ever you go and there will always be a viable solution for a real problem, whether it's America or Canada or anywhere else, we will do it. Thank you again.