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THE FUTURE OF LONG-TERM CARE (LTC)

Moderator: DALE C. GRIFFIN
Panelists: HAROLD L. BARNEY
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STANLEY S. WALLACK**
Recorder: DALE C. GRIFFIN

- Brief assessment of future needs for services and financing arrangements for aging baby boomers, including scenarios of the Long-Term Care (LTC) situation in the year 2010
- Discussion of the gap between future needs for LTC and current methods/capabilities of providing it from several perspectives:
  - -- Existing private arrangements (LTC insurance, continuing care retirement communities)
  - -- Managed care ("Social HMOs")
  - -- Public programs
- Analysis of what this implies for future approaches to providing LTC for the elderly

MR. DALE C. GRIFFIN: We are trying to give this session a futurism orientation, and we have an excellent panel, consisting of Hal Barney with Johnson & Higgins, formerly with Prudential; Stan Wallack with Life Plans, Inc., and also with Brandeis University; and Dennis DeWitt, Executive Director of the Health and Human Services Task Force on Long-Term Care Policies.

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** Dr. Wallack, not a member of the Society, is President of LifePlans, Inc. in Waltham, Massachusetts and Director of Bigel Institute for Health Policy at Brandeis University in Waltham, Massachusetts.

PANEL DISCUSSION

This session was organized by the Futurism Section because the Council of the Futurism Section sees the topic of long-term care as a potentially good case study for the use of a futurism perspective by actuaries. For that reason, we have incorporated several futurism techniques into the presentation. One of these is the use of scenarios written by three participants in a workshop at the Chicago fall meeting. A major futurism technique which will be used, although implicitly, is trend scanning and analysis. Each of the panelists has either formally or informally done their own scanning of trends and they will be incorporating those trends into their remarks. Hal Barney includes an explicit use of trend analysis in the form of demographic projections.

The process of consulting experts in the field can be considered a futurism technique. In a more formal process you might survey many experts, feed back the results, and have them reassess their initial positions, which is called the Delphi approach. This session is less formal and a small sample, but it is important because the ideas of these experts are ideas that will probably take on lives of their own. Some of the ideas that we talk about will be the practical realities of 10 or 20 years from now. The problem is guessing which ones.

We hope that the use of futurism techniques will be helpful in pointing out probable futures. We also hope they will to point out alternative choices so that as actuaries we will be clearer on what our options are. A final note before getting to the presentations: I apologize for not representing the Canadian situation directly. I hope the ideas on the demographic trends and possible new products will be of some use to the Canadian situation, although I realize there are other approaches going on there.

Mr. Barney of Johnson & Higgins currently provides actuarial consulting services in the development of long-term care financing arrangements. Previous to that, he was with Prudential for seventeen years working in postretirement areas and most recently in the second generation of the American Association of Retired Persons (AARP) long-term care project. He is truly one of the pioneers in the field and begins with an actuary's view of trends in the long-term care issue.

MR. HAROLD L. BARNEY: We will talk about the future of long-term care. What will the situation be in the year 2010? Who will be the players? What role will insurance play? And who will pay?

THE FUTURE OF LONG-TERM CARE (LTC)

I was recently at a dinner where, prior to sitting down, one actuary complained, "I'll bet tonight's dinner will be rubber chicken." When dinner was presented to us, sure enough, it was rubber chicken. His crystal ball was perfectly accurate, but to him, totally useless. However the actuary on my left had a specially preordered dietary vegetable plate which looked far more appetizing. The moral of this story? Some people worry about what will happen, correctly anticipate, but only complain about the outcome. Others look into the crystal ball and do something about it. We have that opportunity today. In fact, as Pogo once said, "Sometimes I find myself surrounded by insurmountable opportunity!" We can look into the crystal ball, project trends into the future, envision government involvement, barriers to marketable products, lack of data, antiselection, moral hazard, and the like, and complain; or, do something about it.

I would like to take a look into the future, try to discern what we can anticipate in the year 2010 based on present trends, and then sort out some of those things that we can alter from those which we cannot. Let's first look at certain population trends, proportions of the populations in need of assistance with long-term care, and then focus on how those needs may be met in the year 2010.

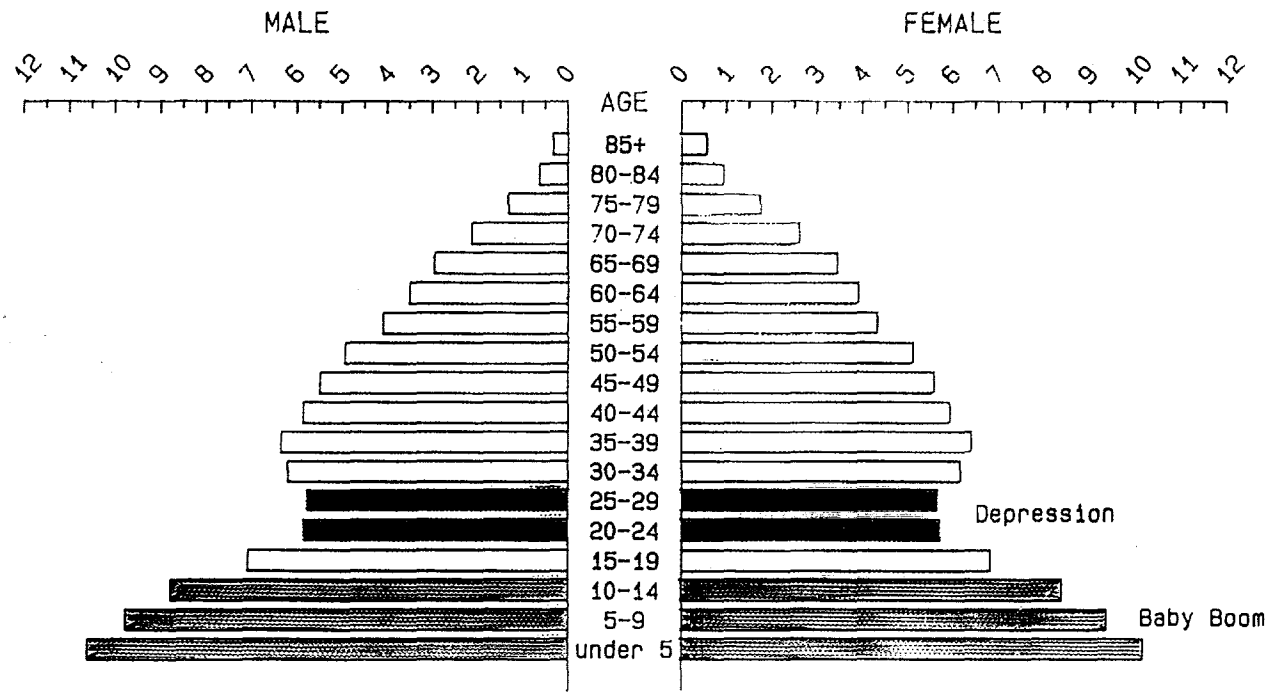
Figure 1 shows the population distribution by age and by sex as of 1960. Note that in 1960 the baby boom generation was just emerging, while the depression cohort was beginning their working careers. The over 65 and over 85 cohorts represented 9% and 1/2% of the total population, respectively.

In Figure 2 the bulge brought about by the baby boom generation has moved into the age brackets 20 to 39.

Twenty-five years later, in the year 2010, the baby boom generation or demographic bulge created thereby appears between ages 45 and 64, while the over 65 lines have grown substantially (Figure 3).

Carrying this out 25 years further, based on the United States Census Bureau middle series projection creates the following illustrated in Figure 4. Now the over sixty-five and over eighty-five cohorts represent 21% and 3-1/2% of the total.

FIGURE 1



U.S. Bureau of the Census, Current Population Reports Series P-25, *Estimates of the Population of the United States, by Age, Sex and Race*, various years and *Projections of the Population of the United States by Age, Sex, and Race: 1983-2080*, U.S. Government Printing Office, Washington, D.C., 1984.

U. S. POPULATION
1985

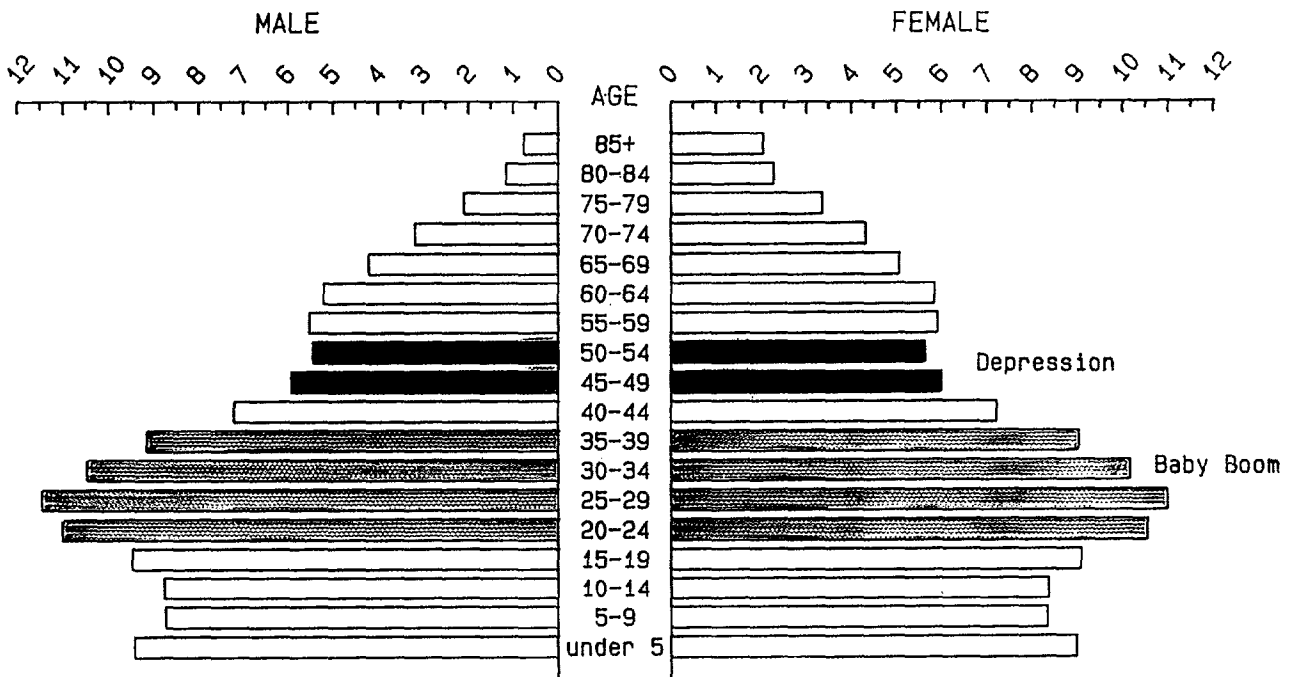


FIGURE 2

U.S. Bureau of the Census, Current Population Reports Series P-25, *Estimates of the Population of the United States, by Age, Sex and Race*, various years and *Projections of the Population of the United States by Age, Sex, and Race: 1983-2080*. U.S. Government Printing Office, Washington, D.C., 1984.

U. S. POPULATION
2010

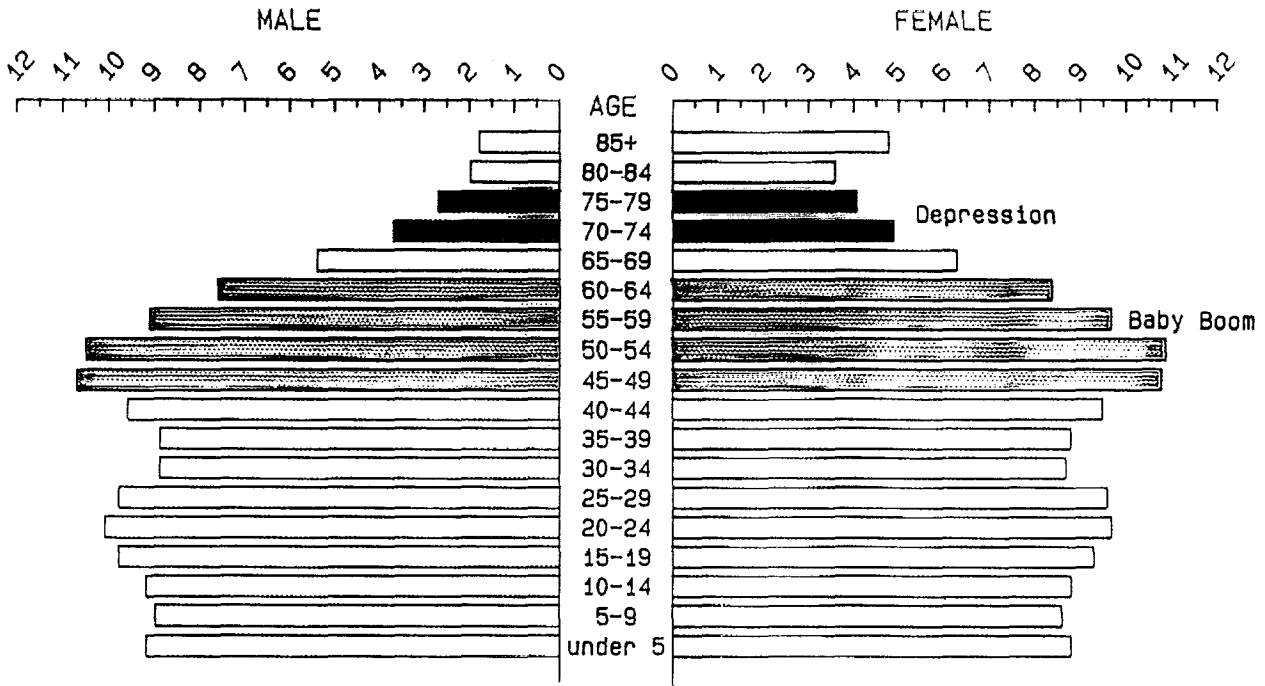


FIGURE 3

U.S. Bureau of the Census, Current Population Reports Series P-25, *Estimates of the Population of the United States, by Age, Sex and Race*, various years and *Projections of the Population of the United States by Age, Sex, and Race: 1983-2080*. U.S. Government Printing Office, Washington, D.C., 1984.

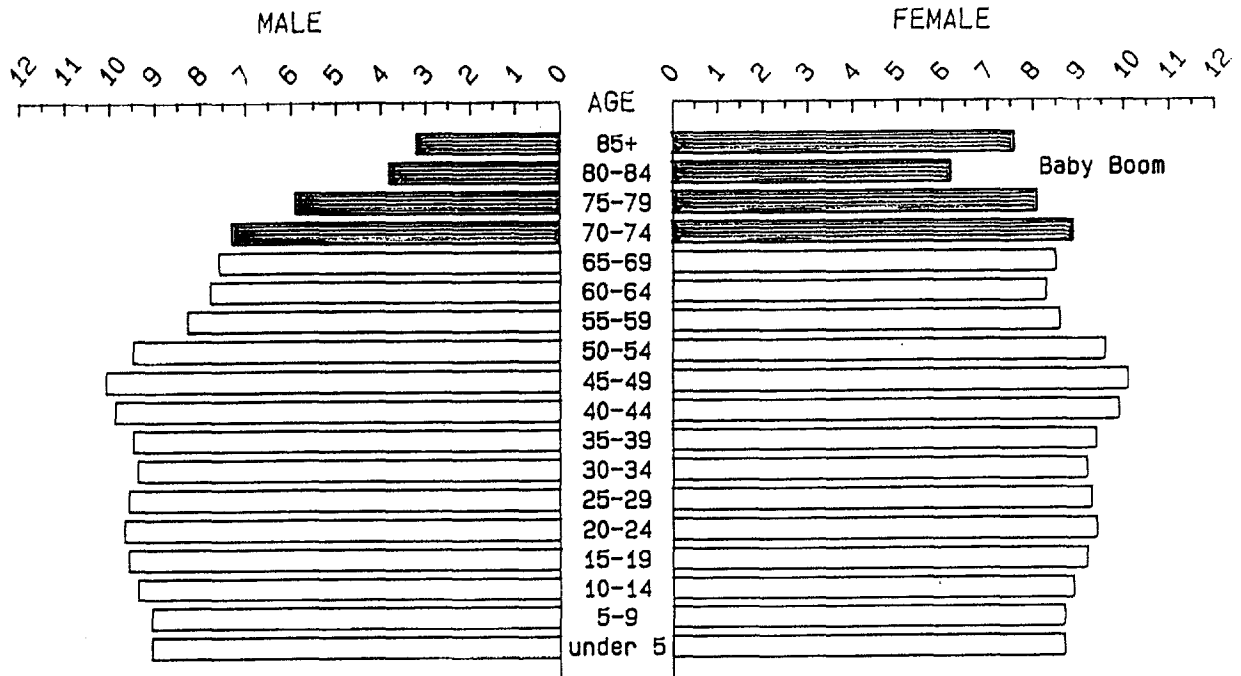


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FIGURE 4

Comparing the century from 1935 to 2035, note the squaring of the population curve (Figure 5).

There are two reasons to begin with this demographic projection. First, age correlates with the risk of utilizing long-term care services. Figure 6 illustrates the proportions of the age groups using nursing home facilities in 1977 and 1985.

Figure 7 illustrates by age group the percent of the populations with impairments and needs for assistance in activities of daily living today. Note the much higher proportions at age 85 and above than we see below that. Hence the importance of the demographics with particular emphasis on the group over age 85. As the growing numbers of elderly meet the age-related incidence of disability, the cost to society of long-term care grows geometrically.

Illustrating this growing cost, the following Figure 8 from the Health Care Financing Administration (HCFA) shows their estimate of future nursing home expenditures.

The second reason demographics are important is that someone will carry the burden of these increased long-term care services. Figures 1 through 5 demonstrate that the ratio of people over age 65 to the working population will increase dramatically over the coming years. If the normal retirement age remains at today's level, there will be fewer people supporting the economy per retiree. Now, either the retiree will pay, or, if the federal government should look to tax the working population, it will require taxation at ever increasing rates because of the relatively smaller base available in the future. This demographic trend argues for a program that prefunds some of the costs of long-term care if we want to avoid mortgaging the futures of our children to support us in old age.

Who is presently paying these costs? While nursing home costs represent a significant portion of the long-term care services utilized by the elderly, it should be noted that for every person in a nursing home, there are two to three with exactly the same needs for assistance living in the community. Their needs are being met by home care and other social services -- some purchased, but 2/3 borne by family and friends. The bulk of the costs for an aging population

FIGURE 5

U. S. POPULATION
1935 - 2035

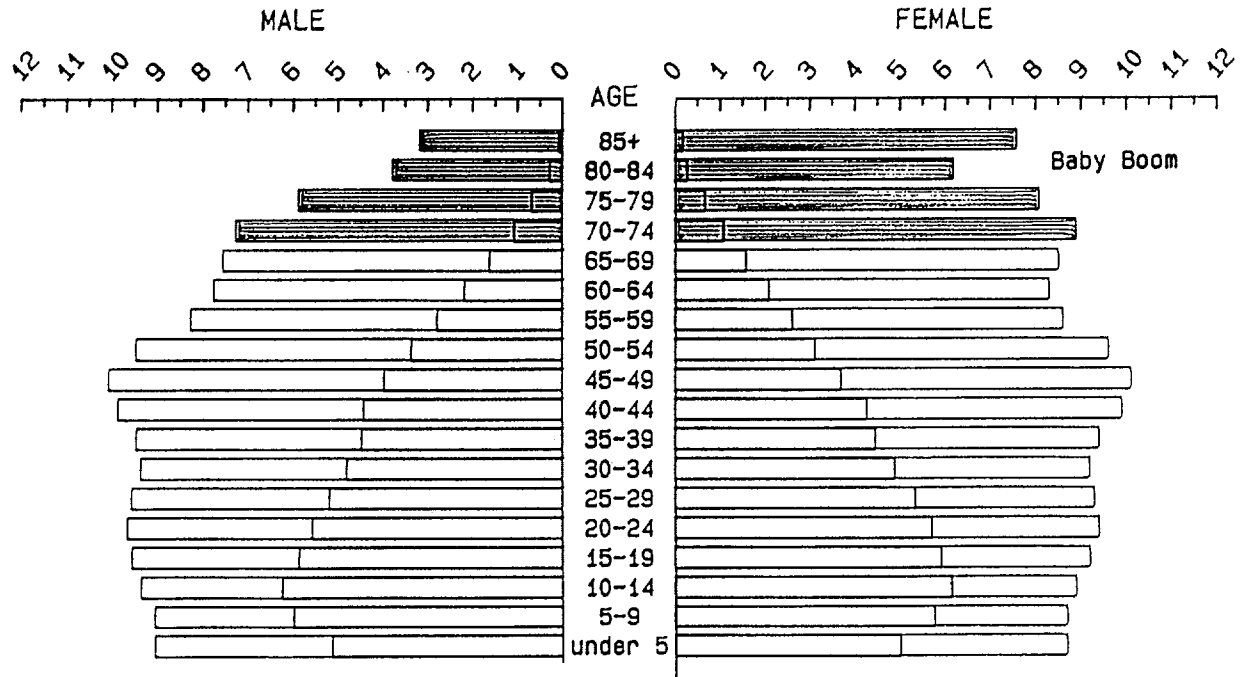

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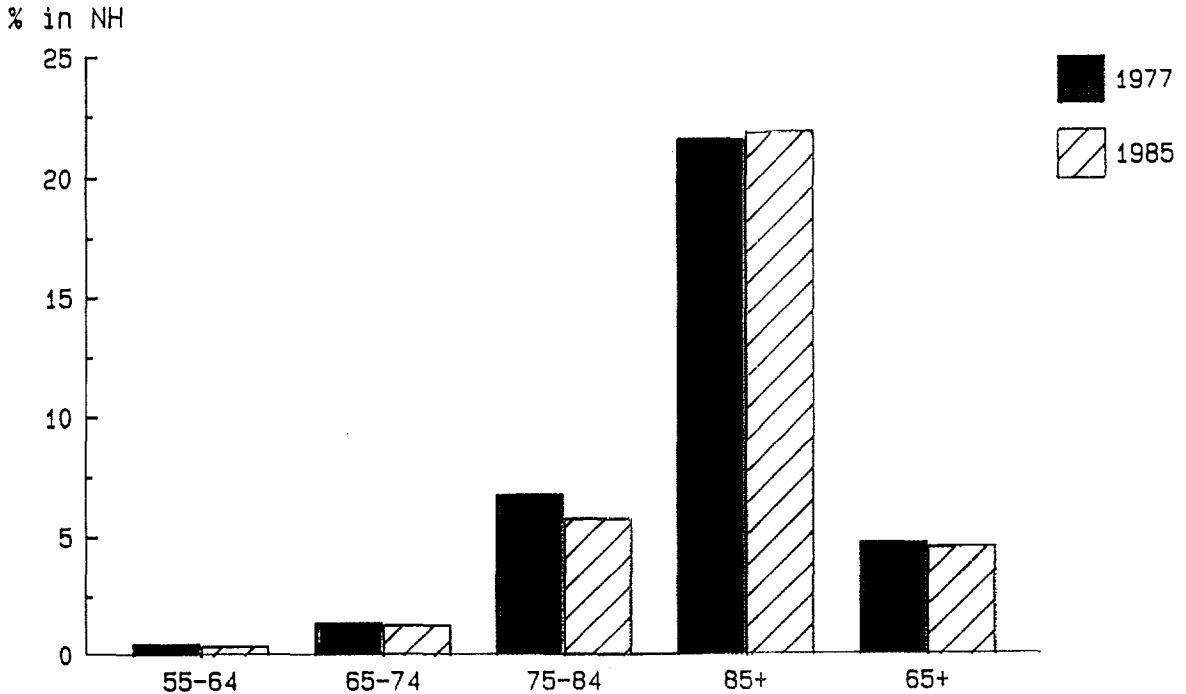
FIGURE 6

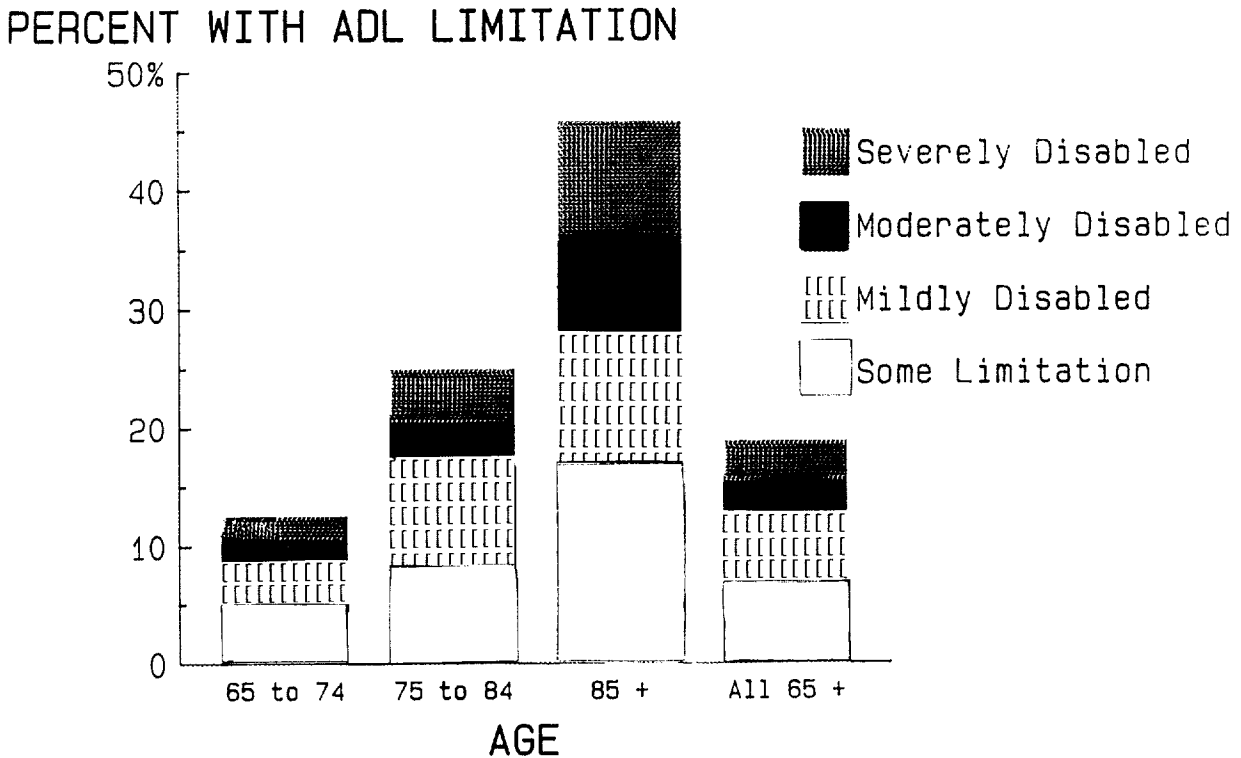
NURSING HOME RESIDENTS BY AGE
1977 AND 1985



National Center for Health Statistics, National Nursing Home Surveys of 1977 and 1985.

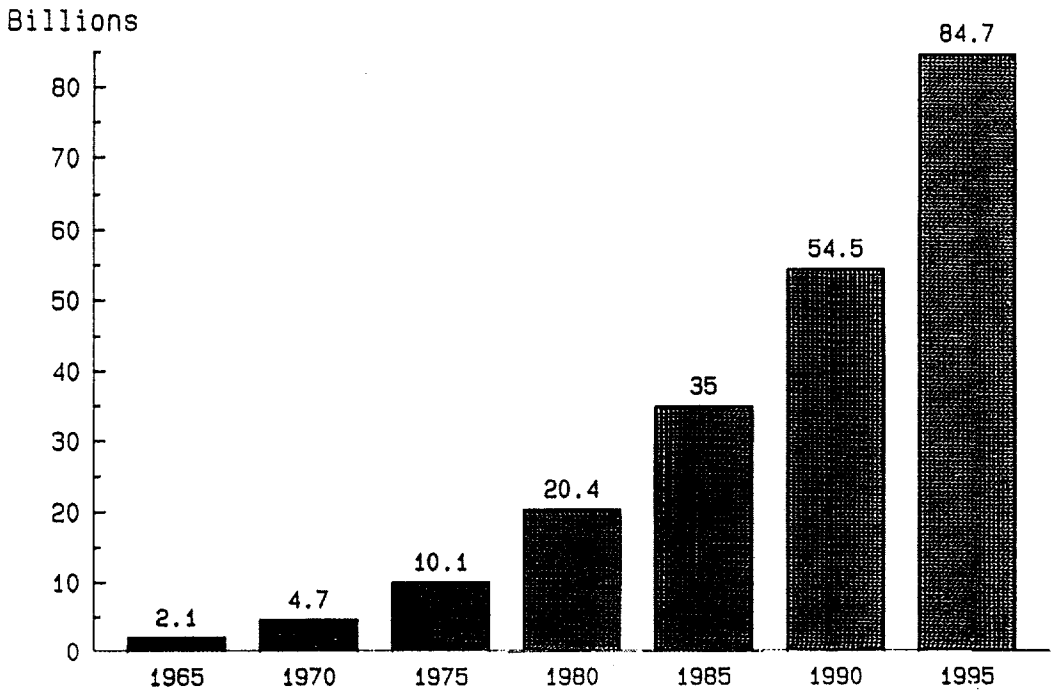
FIGURE 7

ACTIVITY LIMITATIONS AMONG NON-INSTITUTIONALIZED ELDERLY



National Long-Term Care Survey, 1982, Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation

FIGURE 8



Health Care Financing Review, "National Health Expenditures, 1986-2000," Vol. 8 No. 4, Summer 1987.

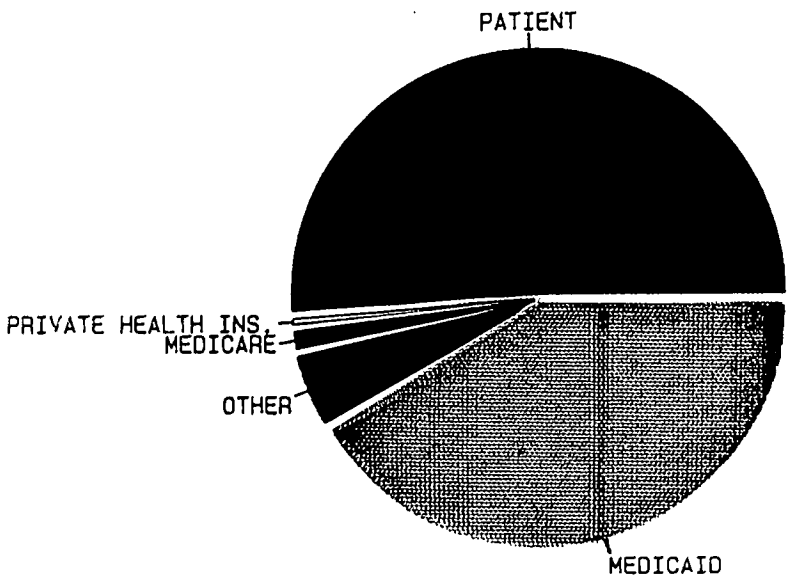
is being borne by either the frail elderly themselves (in terms of unmet needs or out-of-pocket payments) or by unpaid family and friends, the growing "care-giver" segment of society.

Figure 9 shows how the nursing home expenditures are presently funded. Note that the largest portion other than individuals is paid out of state Medicaid funds. Medicare pays very little. If we can assume that individuals are not likely to band together to solve the problem, then the next most logical source, from an economic standpoint, is the states, whose Medicaid budgets are rapidly being consumed by increasing nursing home costs for the indigent. To use Dennis DeWitt's golden rule, "He who has the gold makes the rules," we can see that it is Medicaid with the most gold involved as a single entity. One can anticipate then that the rules will be made at the state level. Through certificates of need and strict restrictions on capacity of nursing homes, Medicaid is attempting to control, not the need for services, but the availability of services for which Medicaid provides the financing. From 1980 to 1986 Medicaid's share of the tab has dropped from 48% to 41%. Will this trend continue? Given the demographics we discussed, the needs are inevitable. Restrictions on capacity to provide services will only force alternative means to meet those needs. There is no value judgement intended here; in fact, alternative mechanisms such as the Social Health Maintenance Organizations, the continuing care retirement community concepts, life care at home, private insurance, and family and community support all may be "better" solutions than state-controlled Medicaid funded nursing homes. Medicaid restrictions imply that by 2010, these alternatives will be forced to develop so that Medicaid's role will be smaller, albeit still significant.

What role will private insurance play? First let's discuss whether this long-term care business is an insurable risk at all. The lifetime probability of nursing home entry is 40%-50%. If so large a segment of the population will at some point require nursing home stays, should one merely save for it or is it insurable? The high probability in and of itself is not a basis for making this risk uninsurable. In fact, if that were the case, life insurance would not exist today. After all, the probability of death at some point (for most of us) is 100%. What we insure is untimely death. In nursing home insurance (one piece of the long-term care need) what can be insured is not only the early or

FIGURE 9

WHO PAYS THE TAB?



Health Care Financing Review, "National Health Expenditures, 1986-2000," Vol. 8 No. 4, Summer 1987.

untimely need, but also the unknown duration. Figure 10 shows the duration of lengths of stay for a cohort of entrants at ages 65 to 75, 75 to 84, and 85 and up.

Note that, while many people may enter a nursing home, very few will stay for the long duration. Because of the long tail, only 17% of the people who enter a nursing home will account for over 77% of the total days spent by the entire cohort. It is this duration curve which makes insuring against possible nursing home confinement clearly an insurable risk.

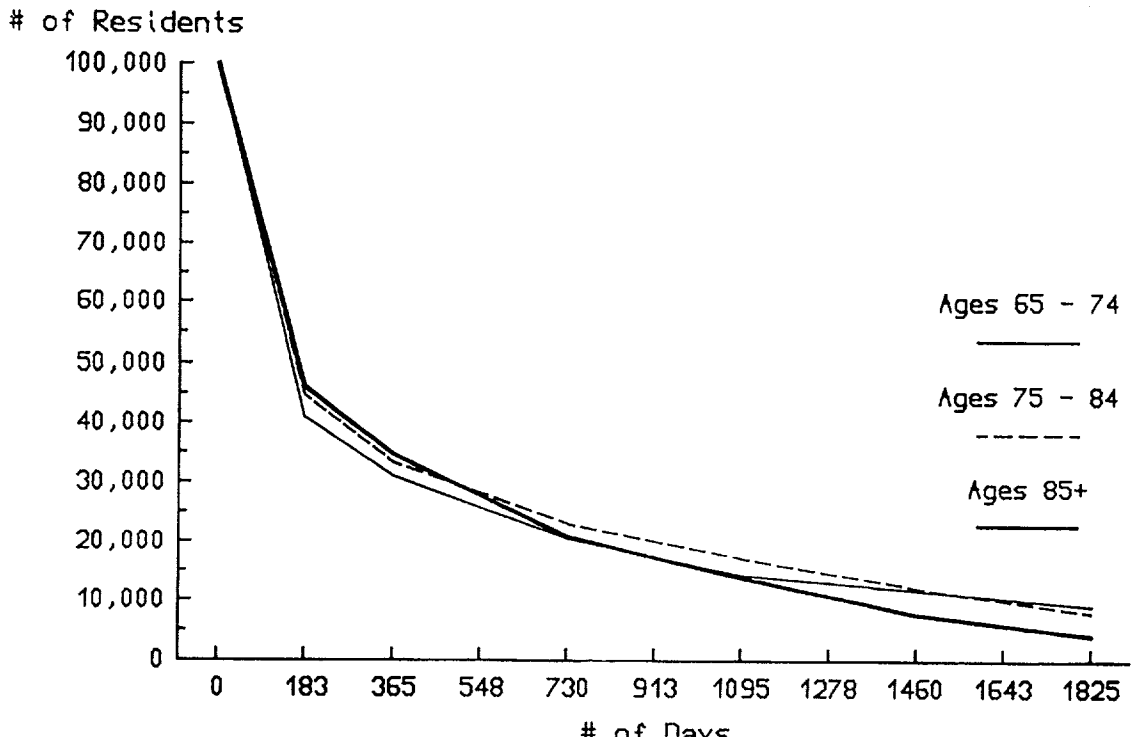
While one can never know how much to save in order to protect themselves against the catastrophic long-term stay, that durational piece can be pooled effectively among all people who enter a nursing home, or better yet, among all people who face the risk of ever entering a nursing home. Thus, the insurable piece is the duration. Yet today almost all insurance policies limit the duration or limit the maximum amount of benefits available under the policy. While this makes the risk more predictable for the insurance carriers, it defeats the real purpose of insurance. This is a feature that will change between now and the year 2010. Lifetime benefits much like unlimited major medical will become much more widely available as insurers expand the base of policyholders, thereby making the carrier's risk less volatile. By 2010, the roles of both individual and group insurance programs will be substantially greater.

Given that we have an insurable risk, then awareness of the need for such coverage becomes today's major obstacle to insuring the long-term care service need. Knowing that there is a need for pooling the risk of long-term care by those who provide the pool, does not make a product viable unless the public wants to swim. At Johnson & Higgins we have conducted surveys in retirement communities and discussions held with administrators of nursing homes show that the perceived value of insurance is low even among people closest to the costly care.

To sell LTC policies, one must overcome the lack of perceived value, the lack of interest in thinking about a nursing home stay, and many myths associated with how nursing home care is provided today, leaving the product attractive only to those with imminent need. There is evidence that awareness levels are changing brought on by discussions in Washington, coverage in newspapers, and the

FIGURE 10

NURSING HOME RESIDENTS REMAINING BY DURATION SINCE ENTRY



Medical Care. 22 (10); 901-911, 1984. By permission of the publisher, J. B. Lippincott Co. Philadelphia, PA.

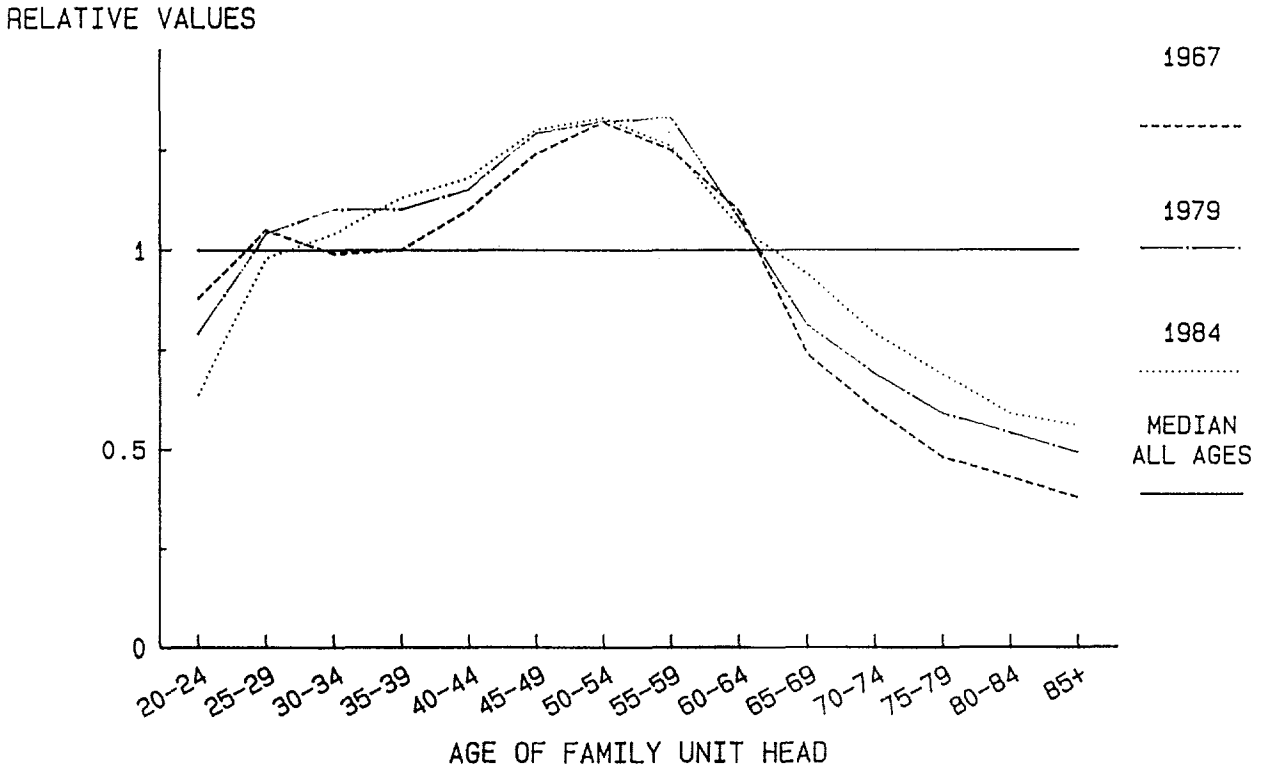
growing number of companies publicizing and marketing policies to cover this risk. In one survey conducted at a retirement community, 95% of the residents were aware that Medicare did not cover them for a long stay in a nursing home. This is quite different from the 1984 AARP survey where 79% of their members thought that if they needed a nursing home, Medicare would pay for it.

Another underlying trend which will have an impact on the situation in 2010 is the affluence of the emerging retirees between now and then compared to those who are presently retired. Barring too many more 108-point negative drops in the stock market or other financial catastrophes, people reaching retirement age in the coming years will be better off than the present group of retirees. In the August 1987 *Social Security Bulletin*, Daniel Radnor examined the changes in income of the aged and other groups from 1967 to 1984. His study shows that the increases in real income for the elderly have been substantially higher than for the under 65 group when measured in real dollars and adjusted for size of unit. Increases in Social Security benefits, higher interest rates, and improved private retirement plans were the major factors increasing the income of the aged, resulting in a dramatic drop in the poverty rate for the aged between 1967 and 1984 from 28.1% being below the poverty line, to 12.4%. This is less than the poverty rate for all ages of 14.2%. Figure 11 shows relative median income values by age of family unit head and illustrates this point.

Note particularly the dramatic improvement in relative incomes at 85 plus, between 1967, 1979 and 1984. Those who are 85 today had their prime working years during the depression. Those who will be 85 in 2010 may have benefited from the rapid increases in home equity, investment results substantially better than were available in the first half of the century, and the positive effects of Social Security, private pensions, Individual Retirement Accounts (IRAs) and other asset accumulation vehicles. If this trend continues, by the year 2010 the elderly will have substantially greater assets to protect and better means by which to purchase insurance or alternative pooling mechanisms to face the potential risks of long-term care.

Who's playing today? Over 100 insurance companies are offering some form of long-term care insurance today. Most are offering indemnity policies. However, recognition is growing that service-based programs, life care at home, and Social Health Maintenance Organizations offer alternatives that will be explored. These

RELATIVE MEDIAN INCOME VALUES



Dennis Radnor, "Money Incomes of Aged and Non-Aged Family Units 1967-1984," *Social Security Bulletin*, August 1987.

companies are taking some risks while other companies are taking advantage of the situation. As awareness of the need for this insurance increases, so will the ability of certain companies to scare the elderly into buying poor policies which are later pulled from the market or have the premiums increased beyond their capacity to pay. There will be companies, and there have already been companies, entering the market and then pulling out, leaving the policyholders out of coverage and out the premiums. As actuaries we have a role to play in developing, designing and signing off on the actuarial adequacy of the premiums for these products. Failure to do so will only add ammunition to the arsenal of those who would, as a minimum, regulate severely the industry, and, as a maximum, advocate a government-based social insurance program. If today's trend toward sales results and bottom line profitability drives the insurance industry, then by 2010, social insurance will dominate the long-term care field much as Medicare today dominates acute care for the elderly.

The effects of a pure social insurance program can be illustrated by Medicare's past. A recent Senate study reported that in 1965, prior to enactment of Medicare, the elderly paid 15% of their income for healthcare[1]. Now, 20 years later, the elderly pay 17% of their income out-of-pocket for healthcare. Moreover, the existence of the Medicare program is one of the factors which has led to spiraling medical care costs rising at almost 4% per year faster than the overall Consumer Price Index (CPI).

On the other hand, the combined retirement programs of social security, private pensions and savings have provided more comfortable retirements with a universal floor of protection. It is this type of three-legged stool that offers, in this author's opinion, the best scenario for the year 2010. There will always be a place for the federal programs to fund for those who are unable to do so. Medicaid fills this role presently; however, inadequately. With the growing elderly population and a declining workforce relative to that population, transferring income from one generation to another will add to the intergenerational friction that we can expect in the 21st century. A mechanism by which risks are pooled and assets are built up today from this generation to fund our own benefits allows a more equitable and individually responsible approach.

[1]A Report by the Chairman of the Subcommittee on Health and Long-Term Care of the Select Committee on Aging, House of Representatives, August 1986.

Key to this development will be the role of employers. Just as with pension plans and the under-65 health benefits, employers will have to take a major role in the future of long-term care. However, with all the other problems faced by America's corporations today, including the existing postretirement healthcare liabilities, it will be some time before nursing home and long-term care needs will be financed with employer funds. However, there are other options available which lend themselves to corporate involvement. These options available to employers range from educational efforts to sponsorship of insurance programs.

Impetus for action today will come from a recognition of current benefits to an employer in terms of employee productivity. Recently, a survey of 70 companies found less than 20% of employees had no problems related to elder care while 47% had some problems and over 1/3 had a "notable problem" related to care today.[2] Time spent on personal phone calls, loss due to stress, early leaving and late arrival, absenteeism and unscheduled time-off all related to elder caregiving resulting in productivity decreases. The long-term care tab is already being paid to a degree by Corporate America.

In response, one major U.S. drug company has instituted several programs for relatively little expense. They offer a lunch program in three parts to let employees know there are others with similar problems, and to provide information on where help is available, what agencies are doing what, where case managers are available and which financial resources presently can be obtained. Second, they utilize an internal communications program on healthcare with emphasis on elderly issues. Through this communication mechanism, they help employees with dependent parents to know where to go for help, and make them aware of how the system works to deliver services today, thereby enhancing the possibility that today's educated employee and community base will help find tomorrow's solutions. Third, they hold focus groups to discuss the problems common to various employees.

Another approach is through employee assistance plans. Going a step further, some employers have begun looking at sponsoring employee pay-all insurance plans for long-term care. The cost to fund for long-term care is minimal if

[2]Henry M. Wallfesh, Retirement Advisors, New York, New York, Comments at May 5, 1987 Conference, Spotlight on Eldercare.

funding begins at younger ages. Eventually, we will see an option at retirement where the present value of a pension, which may run tens of thousands of dollars, could be reduced by $10,000 which could prefund at age 65 a benefit of $50 a day for three years with some home healthcare benefits as well. We will also see plans where the employer provides basic benefits and allows the employee, through his own contributions, to supplement that benefit.

It is these small but initial steps that are taking place throughout the country today that present a positive view for the year 2010. As any good manager knows, identification of a problem is 50% of the solution, and Corporate America as well as Washington much more aware of the problem today than they were even as recently as 1980.

Barring widespread acceptance of euthanasia, a black plague or holocaust, there's a big bill coming due. That bill will be paid either by universal (government) insurance, private sector risk-pooling mechanisms, individual savings, or increased caregiver burdens. My preference, much like Bob Myers' three-legged stool for Social Security, is for some combination of the above.

Our decisions and actions today will influence not so much the size of the bill, but how the bill will be allocated among us and our children, and whether it will fall on individuals, groups of people, or society as a whole. Whether or not we liked the dinner, the bill will be paid. What we can influence is how we like what we get for what we pay.

MR. GRIFFIN: Stanley Wallack is with Life Plans, Inc., and also with Brandeis University. He is an economist by education and started working on healthcare matters quite early in his career. He was the developer of the social HMO demonstration projects which are going on now, and is currently working on the development of various risk management and insuring techniques for long-term care. He has some ideas on ways of handling the problem that are new and not widely accepted yet, but a good bet to be much more widely accepted in the future.

DR. STANLEY S. WALLACK: I'd like to tell a story about an actuary driving a car in West Virginia. He was going home very late at night and unfortunately he missed the curb and went over a cliff. He was fortunate. As the car was

tumbling down, he got out and held onto a branch. He looked down at the bottom of the gorge and he could barely make out the water running and the rocks, and he said "wow." He looked up and he could barely make out the top of the hill. Then he closed his eyes and said, "Have you got any ideas?" and he heard a voice saying "Jump, jump." Well then he said, "Does anybody else have any ideas?" I suspect the actuaries out there are going to have to look for some new ideas, because I don't think the current ideas out there are really going to be winners. I think as you get into a more educated market and as the employers start to discuss this, they're going to want different products.

I also think the elderly are going to get educated. Hal and I have been out there doing the same surveys and a year or two ago if you surveyed the elderly people with regards to long-term care, they really thought Medicare covered them or their supplements covered them. The most dramatic thing in the last year has been the education of the elderly. They now are learning very fast that in fact they are not covered. And I think that's one of the first good outcomes of the private sector getting involved in this whole industry. It's starting to educate people to their needs and that is the first step in selling products.

I've done some of the analysis on the idea of distribution of costs by individual and my numbers are a little different from Hal's, but they come out in exactly the same place. If you look of the role of insurance, it makes a lot of sense because the distribution of expenditures is very, very skewed. In fact, I do a lot of work for the federal government for HCFA and I've looked at the distribution of acute care expenditures, and let me just tell you that the distribution of long-term care expenditures is more skewed over one's lifetime than acute care expenditures. A smaller percentage of the population is going to use a larger percentage of the dollars in long-term care. So it's a service, it's a good that in fact demands, almost begs itself for some kind of risk pooling.

As Hal said, it could be done on a social insurance basis, or it could in fact be done through some private markets. I, for one, think there's a good deal of time for private markets to develop. At the Congressional Budget Office, I wrote a paper called "What About Part C of Medicare?" as a way of financing long-term care. That was the last paper I did in Washington. Nobody received

it very well. It wasn't something that Medicare as an acute care program was in fact going to take on. And in fact in 1976 there were very few people in Washington that even knew about the long-term care problem. Well they've gotten educated. Denny's going to tell you about the education he's put on in Washington in the last couple of years. But just because you're educated in Washington today, it doesn't mean you're going to favor a Federal solution. I don't think anybody wants to relive Medicare and thinks that we're back in 1965. Those of us who still deal a lot in Washington think there are higher priorities for the federal government. Some people worry about deficits. Other people are worrying about trade gap and there are even some social do-gooders like myself who are worried about education in this country as being a major problem.

I do believe the government is going to worry about the problem. It isn't that the government can say there is no problem. The government has to recognize the problem. It's going to start to do some things in regulation, but it's going to start to observe the responsiveness of the private sector. And much like Hal said, I think the challenge is really for the private sector to develop solutions that distribute the burden of long-term care fairly and equitably. Second, I think the real challenge is to develop innovative products -- products that the market wants. Third, I think we have to develop products that are profitable. And I think there can be some profitable products in this field.

My task is to tell you what I think the world is going to look like in terms of the new long-term care products that are going to make sense. Let me talk about the four issues that make up any kind of long-term care financing program. The first one is, who's the population that's going to be covered? The second one is, what are going to be the services or benefits that are going to be provided? The third is, how are you going to pay the providers of services? And the fourth is, what are those systems that appear going to in fact look like?

Hal said something which I can't disagree with but at the same time I have problems with, and that's that the employers represent the key to this marketplace. No doubt if we follow most social insurance programs, it would be the employer that will start to say that's a problem. But all I see so far, with one

very minor exception, and that's Harvard University which has more money than Prudential is that, very few employers are in fact willing to bear that cost. In fact the system is going to have to be voluntary and maybe it will be done through a flex plan but I for one, having worked with a few unions and a few others, see that it is very unlikely. I do believe the first strategy and the one that's being followed should be to try to develop markets and products for the elderly, because they are going to be able to buy these products in increasing numbers. Hal gave you a few facts and figures and I think he did bring out the statistics on how many more elderly we are going to have and how many more very old elderly are going to put a demand up for services. But I think just as remarkable is the income of the elderly. If you look at 1950 and today, in real terms the elderly have twice as much income, on average. It's been doubled in real income terms and Hal mentioned some of that. The median income of the elderly family is $18,000. Twenty percent of them have incomes of more than $30,000.

Those facts about the income of the elderly, their income floor, their wealth, is going to become more and more known, not only among the private sector but also in Washington. As we start to look for solutions, we're going to say the elderly can start to buy more of the products for themselves. We're going to be hearing about reverse mortgages, and conversions of life and pension policies. I think it's clear that the income of the elderly, those over 55, those over 65, and those over 75, is going to go up. Once educated, they are going to be a population that is so risk-averse that they're going to be the likely candidates to buy many of these first generation and second generation products.

But the fertile question is, will the private solutions that are going to be developed by people like you and your marketers and people like myself, really going to be attractive? One of the nice things about having worked in Washington for a lot of years is that once we develop a solution, you don't have much choice. It doesn't really have to appeal to a heck of a lot of people. You have Medicare, that's it, you take it. Well you don't have that luxury. You've got to develop a product that's going to sell in the private market, and one of the issues is that what you have done in long-term care isn't very innovative today. In fact, I call it privatization of Medicaid. Let me ask you, would you buy the following policy for your mom or dad, aunt or uncle? The typical policy out there for a 75-year-old person costs about $800 a year, provides about three

years of nursing home coverage, and maybe one year of home health if you go to the nursing home for a year previously, so you'll probably never use the benefit, and it provides a per diem benefit of around $60 a day. Would you buy that policy? Would you recommend $800 a year for a policy that provides those kinds of benefits -- basically a nursing home policy? Would you tell your parents to buy it? One, two, there are three. Well I wouldn't and I think in fact if you go through the calculus, it's not a very good buy. Because in most places in the United States you don't stay at a nursing home very long to go on Medicaid and you're in the same institution as where you started. I don't think the policy is very attractive and, therefore, I am amazed, when I see 400,000 to 500,000 policies being sold right now among the elderly. The numbers Denny has are just boggling to me.

Now I think that tells us something about the potential of this market, though, and if we start to offer good products they may be very attractive. Let me start to tell you about some of the things I think will make up the good products and ones that I believe the elderly will have an interest in. One of the things I've got to tell you from working in the government for a lot of years and working in a lot of states, is how little we know about the elderly, and the little we know about their real preferences. State agencies don't know what the elderly want; they never asked them. They just say you have the nursing home benefit. And neither has the federal government really taken care of the population it serves.

One of the things I've been doing over the years as I get a project or a grant or a contract, is trying by bits and pieces to learn more about the elderly. The first thing that comes across over and over again, and it makes a heck of a lot of sense, is what the elderly want more than anything is to stay home. They want to find a way to remain in their home for as long as possible. And they like it at home. If they didn't like it they would have moved. And if you know the data on mobility among the elderly, they don't move when they're above 65 or 70 years of age. They want to maintain that stability. They want to maintain as much security as they possibly can and they want to keep things whole. They want to stay home. They are worried about their financial protection and they are worried about access. They know what nursing homes look like out there. As Hal said, we have a nursing home industry which is driven by a welfare program. The elderly want access to one of those good nursing homes.

They also want access to other kinds of services. With regard to long-term care, these numbers are combined from various studies. There is some other data on the worry about getting into a good nursing home. Forty-six percent of the people we surveyed are worried about that; they're also very much worried about in-home assistance. That is one of the major concerns of individuals because they want to stay at home. If you start to look at the elderly and survey them over and over, the following three things start to arise. First is that they do want some financial protection. They understand, once you explain that they have no insurance, the problems that long-term care can create. Second, they really want some home healthcare. They want the ability to stay home. Third, they want to have access to a system.

Now we haven't had enough data yet to really describe how this varies among the elderly. But my hypothesis is the following: As you get older, it becomes more difficult to comprehend the system, to find your way to the appropriate services. So access becomes a more and more important issue as you look at the elderly. And you are going to see very different markets by the age of the elderly. You've first got to break yourself apart from thinking all of the elderly are the same. You start off with a 65-year-old. Then have to look at him at 75 and you have to look at him again at 85. What I think is the following, as we start to learn about them: The 65-year-old person is most worried about the financial issues. They're worried about maintaining their estate, maintaining their retirement income. As you move on and one gets a little frailer, one gets more and more worried about the ability to stay at home and home health service support becomes more important. Then as you get a little older, as you get into your 75 and 80 years of age, access becomes overwhelming. One interesting fact in support of this is that if you look at what are called life care communities, or continuing care retirement communities where individuals actually buy into a residence that provides nursing home care as well, the average age of persons who buy into these systems is around 78 to 80, and in fact it's going up. The reason isn't financial protection. The reason turns out to be an awful lot of wanting the social support and wanting the access to the care.

Many people want long-term care insurance for estate protection. Most of the nursing home policies are for two-year protection and they don't provide for that tail and therefore they don't do that. Some provide adequate income, particularly for one's spouse, if one's worried about that. Very few of them help one

to stay out of a nursing home because the real benefit is the nursing home care. None of them now provide access to a quality nursing home. They don't help you with the access issues. They're indemnity products. You get into a nursing home yourself and you get the benefit there.

The policies therefore of the future will need to be significantly different. They are first of all going to have to have substantial and meaningful home health care. They're going to have deep coverage protection against catastrophic costs, because that is really the risk that most of the people get worried about. They're going to pay $200,000 in expenditures and they're also going to have to do something with access to quality care. Those are very different products than we have now. It's very, very different than an indemnity product. It seems to me you're looking at a series of products and the market's going to demand that they be comprehensive policies in terms of coverage and be linked more and more into a service delivery system. I think those are the ones that are likely to prevail. That's likely to be the system in the future. It's likely to have local personality. You know you all talk about healthcare being local, well long-term care is even that much more local. It's really lifestyle. It's really very much more local than acute care. They're going to have local personalities and they're going to be relatively small systems or providers that are going to be providing the care.

Well if that's true, how does insurance come into all this? I think that's the key issue. If you start off with a localized delivery system that is comprehensive, and yet you're going to have to bear risk, how does insurance merge with these local delivery systems? There, I think, is the real challenge to actuaries. The real challenge to those people that are thinking about the issue is what I call how to pay. Think about it in the terms of a localized delivery system that's combining services and financing. The closest thing that comes to mind is an HMO. Now one of the biggest mistakes that I think we've made in health care is to make HMOs little insurance companies. We started out with HMOs and we all liked HMOs because we thought an organized delivery system providing a comprehensive array of services would be efficient. We really thought that a managed care system would more appropriately control for utilization. But those of you who are running HMOs or those of you helping employers manage HMOs, know that HMOs don't win or lose based on their efficiency today; they win or lose based on their underwriting. They win or lose on who joins. We've really

created a terrible mistake in healthcare by combining in the managed care systems the incentives, call it the incidence of somebody getting sick or the incidence risk, as well as the utilization risk.

Now I think those are the two major risks that we face in healthcare and our real problem has been we haven't been able to separate the two. The incidence risk, I think, is what the actuary should deal with. It's history. It's trying to get a good handle on what the potential is of an event occurring. The utilization risk is, as I see it, is once somebody is disabled, or once somebody goes into a delivery system to get care, what the variation of services is. What's the utilization risk? That's behavioral. You all are looking for ways to pay providers. Once you start to do things that get into behavior, you lose control. What you have to try to do is understand the incidence risk, understand how to pay for that, and then give a provider a payment that lets him manage the utilization or the utilization risk. Now that's a long discussion and I'm not sure I can walk all the way through all the elements. But in the HMO world that means you find an appropriate way to adjust the health status and pay HMOs based in fact on what the likelihood is of becoming disabled. On an indemnity program or a service program, there really are two steps. The first is getting a better handle on the health status of the population you are insuring and the second is getting some objective measures of an illness, like a Diagnostic Related Group (DRG) payment.

Now how does all that make any sense to what I'm getting at with regards to payment in the long-term care area? I do believe there are models that are starting to play this one out. We've been working with Metropolitan, for example, and with Group Health of Puget Sound. This is one of the innovative policies that has been developed which brings together a local provider, a large HMO on the west coast, with an insurance company. What they've done is said that the insurance company should really be insuring for the incidence of becoming disabled. Metropolitan pays out benefits when somebody becomes disabled. That then becomes a disability payment to the organization who then has to manage the care underneath that. That's one model of merging an insurance company with a local delivery system. I think those kinds of models where the insurance company has the ability to measure incidence risk, takes care of large populations, and starts to deal with local delivery systems, is one of the ways that the system is going to start to move.

Let me tell you about, just briefly, the four models that are out there now that have this potential. They're local managed care delivery systems that offer a comprehensive array of services and yet can have some potential for insurance. The first model which is relevant in this discussion is the social HMO. That's a model we developed for the federal government. Basically, it is an improved Medicare system. It's an HMO with a chronic care benefit package attached. In this model, the federal government is really the insurance company. In fact it's the Medicare program which could potentially get some large savings because we've reduced utilization rates tremendously because we're capitating these various plans. It's one provider who's actually at risk for an array of services -- long-term care, chronic care services, and acute care services. It gets a fixed payment from the federal government and it's supposed to manage the care efficiently. The trick in that model was to reduce hospital days. In some of our sites, we've reduced hospital days by 40% or 50%. What happens then is there is a lot of money to free up for the chronic care benefit package. It's an organized delivery system. There are now four social HMOs and the concept seems to be gaining a little bit.

The second model is the one I mentioned to you. It's an HMO with a very comprehensive long-term care insurance policy. That's the Metropolitan and the Puget Sound model. Again, it's adding on a long-term care benefit for a group that's in an HMO.

The third concept is one that we developed and it's now being tested in Philadelphia. It is the notion called Life Care at Home. In this model we've tried to use all those surveys we did of the elderly, using the fact that they wanted to stay at home and the fact that they wanted a comprehensive benefit package. We've developed a concept where they can stay at home but be in a delivery system and participate with the delivery system. Think of it as a PPO in long-term care. It is now being tested. We've done market surveys in a variety of cities and it's one concept which I think meets a lot of the needs of the elderly.

The last concept, and it's the one that's happening throughout the country and growing fastest right now, is continuing care retirement communities. There are probably 700 or 800 continuing care retirement communities now in the United States. Today it is the only comprehensive catastrophic long-term care policy

that's around. These are small communities, on average 300 to 500 people, and in fact they become, although they didn't want to, mini-insurance companies. They're actually risk pooling on that basis and they're charging, a lot of them, one premium to everybody. These communities are now the fastest growing thing in long-term care. There are probably 2,000 or so that are being built or are on the drawing boards. What they reflect is the elderly, that the wealthy elderly are looking for a system that gives them a comprehensive array of services and income protection.

Well those are a set of delivery systems that are starting to evolve. What we are likely to see in long-term care is not something that is very different from what you've been seeing in acute care. On one side you're going to start seeing providers. The analogy is the HMO offering a series of options, the triple option, offering managed care and PPOs. On the other side, the insurance companies are going to be have to be able to provide a comprehensive long-term care insurance policy that's going to let people move with that policy to delivery systems and then eventually into a life care community. So I see the need from both an insurance company and from a delivery system to offer a policy that allows individuals to move along as their needs change over time. The challenge, I think, is in the insurance companies' hands. I think you've got about 10 years to try to think of some solutions and I think the real key is doing something different than Medicare and Medicaid.

MR. GRIFFIN: Finally, we have very fortunate timing in having Dennis DeWitt here, because he's the Executive Director of the Health and Human Services Task Force on Long-Term Care Policies. He has been working on that project for a little over a year, and it was just completed. The report was released September 21, 1987 and he's going to be changing roles very soon now. Before that, he was in the private sector at the Alaska Health Association and before that at the California Hospital Association. We expect to hear a lot of the ideas developed in Dennis' Task Force repeated in the next few years, so I think it will be a useful set of ideas to hear now.

MR. DENNIS L. DEWITT: The Task Force focused on five general areas: public awareness, consumer protection, market development, employer and pension-based products and tax incentives, and came up with recommendations in those areas. There was very little surprise in terms of what we did but I think there

is a need for some backdrop on where we are, why I think the recommendations are very important, and where the federal government's going to be on some of these.

When we get into long-term care and what the federal government is going to do, I think we need to have a little "Government 101." Those of you who have a feeling that what happened in November, 1980, was an aberration in our political history are going to be sadly disappointed on January 20, 1989, when the administration changes. I think many people would agree that what Reagan brought in, in terms of understanding that there is not only a bottom to the barrel, but that we have reached the bottom of the barrel, is going to continue. The Senate did change this last election from a Republican-controlled Senate to a Democratic-controlled Senate, but I would challenge you to find the Democrat that won on a tax and spend basis. Most of the Democrats that won out-conservatived the Republicans. They did not run on traditional tax and spend issues. If you look at what's happened around Gramm-Rudman-Howllings, I think you'll find that there's not a real great amount of excitement to get out front and spend more and spend more. Now we back into it. There are a whole lot of other things that happen, but biting off a major long-term care insurance program is certainly not one of those marginal things that we can hide.

However, there are some things that Congress noted and one of those things is who can afford long-term care insurance, whatever it may be. Some figures that I took from the Brooking's Institute long term care study with principal investigator Joshua Wiener show that they were suggesting that a range from 26% to 45% of those over 65 could afford long-term care insurance, a typical policy that we have out today. If you use that on the 1987 numbers for those over 65, a low estimate of about 7.9 million people can afford it. A high number would be about 14.2 million can afford it. You get out to 2010 and you're talking about somewhere between 10.9 and 19.5 million people who, given the Brooking's approach, which I think is fairly conservative, can afford their own long-term care insurance policy. What that means to some of you that are in the business, taking the lowest number and estimating a policy of about $500 is a potential of almost $4 billion of premium. If you go to the high number, you're talking about almost $10 billion. Those are 1987 dollars, by the way. There ought to be some interest in someone going after that $10 billion that's out there.

Now we're not the only ones who know that. Congress knows that as well. So I think that what you're going to see is Congress and this administration and the next administration much more anxious to find out how to get as much solved outside the public sector as is possible. Now this isn't to say that there's not going to be the need for the Medicaid program. Certainly there are those who are not able to, and never will be able to afford any sort of long-term care coverage. The Medicaid program will continue. But I don't expect that you're going to see a strong step forward in the public sector. There simply is not the money there to address the issue.

The other thing that we hear a lot about is a public/private sector approach. The one that most actively has been kicked around would have the federal government cover long-term care services beyond two years. The individual then would be responsible for funding the first two years. It seems to me there are some severe problems with that. I don't think that's a very efficient or effective way for us to develop a private sector. I think that if we moved in that direction we would certainly squelch the private sector. With what's left there simply is not enough private sector moving forward on this.

The other issue is the one called budget neutrality, which means that we want to put this program out there and not have it cost the federal government more than what we're already spending. So, you play around with it so that you offer services to people who, me for example, would be very unlikely to ever access the Medicaid program or other public programs, and try and get folks who will use the program, the marginal folks, to purchase long-term care insurance. Well if you stop and think about that, that's a real nice thought, but what we don't know about are the characteristics of what's called a spend down population. If you believe that they just barely have any money to contribute, and spend that down real quickly, then there's no money for them to buy insurance. What you're really into is kind of a reverse Robin Hood approach. That is that those folks who would ordinarily access the Medicaid program on an indigency basis are going to be asked to put up the money that would fund long-term care insurance for me. I learned that I'm in the top 2% of incomes, and so, I suspect, are you. That seems to me to be pretty poor public policy and is pretty unlikely to move forth in our society. The idea took off about a year ago and it was the rage, and everyone I know who has looked at it has backed off or has said that budget neutrality is not as important now as it

used to be. And I suspect that in spite of those protestations, budget neutrality is going to be a major issue for the next 10 years.

Another area that we looked at was consumer protection and this is a critical issue. The National Association of Insurance Commissioners has a model statute out which the task force endorsed. However, we suggested that policies ought to be guaranteed renewable. We thought that it was really unconscionable for a company to be selling a long-term care insurance policy for 15, 20, 30, 40, or 50 years and unilaterally decide they were not going to renew. We thought that if we were going to have that long-term coverage, folks have got to have the guarantee that something is going to be there for them. Interestingly enough the NAIC is now moving to make that part of their model regulations and they are encouraging states to make that part of their regulatory apparatus. I would suggest to those of you that are in the development mode, would suggest that it's in your best interest to work with your state legislators and your state folks throughout the various states to get that thing implemented. It will keep the federal government out. And I think that's probably a very good place for the federal government to be in this arena.

In the tax areas and market development, there really needs to be some help. Mostly what has to happen in the tax area is for the federal government to get out of the way. For example, we need to have a provision, if we're going to be honest about this, to allow long-term care coverage to be funded through cafeteria plans in spite of the fact that the level premium approach indeed is a prefunding approach. We need to make that exception. We need to change some of the rules around life insurance and disability insurance so that we can put a long-term care insurance policy on top of a disability or a life product. What we're suggesting is not so much that we have massive tax assistance, but that the federal government could help a lot by just getting out of the way.

The other things I wanted to look at are those areas where we made recommendations. Inform consumers, for example. Stan talked about what used to be and what is now. There are still an awful lot of folks who believe that Medicare and Medigap does cover long-term care insurance. That needs to be changed. Well what would happen if we really got into that? Let me show you some quick projections. The AARP study of a couple of years ago said that only 20% of the people over 65 were aware that they had a need. That's about 6.3 million

people. Of those people, there are about 1/2 million policies out there so that means about 8% of the folks are aware of a policy. If we just keep things about the same, in the year 2000 with no change at all, there would be maybe 1 1/2 million policies out there. If we're able to increase just the understanding of the need to half the people and the same ratio buy, that's a million and a half people covered. In 2010 what I think will happen if we really got involved, and the awareness goes up to 80% of the people with still only 8% purchasing, is 2.8 million get covered. Just simply getting the message out. That's why it's so critical and why our report focused so much on the public relations aspect of the whole issue of long-term care insurance.

Now, with this education, Stan has already hit on the issues of the different kinds of products that are going to be demanded, and the pressure for new and innovative products. And I think that that's going to be something that we're going to see a lot of. It's important, however, that the first and second generation policies continue to sell and we do need to get them out there actively in the marketplace because without the movement through the first and second generation, we're not going to get to those policies that some of us would like to see out on the street. We are also a group that believes strongly in the need to move in the employer base. And it is interesting that one of the speeches I starting giving early on is that if this is such a darn important social issue, why haven't the states and the federal government and insurance companies moved forward and offered it as a benefit to their own employees? Well I am happy to tell you today that Senator Wilson from California has introduced legislation so that federal employees might have the option of long-term care insurance coverage through the employment place. And it's going to be based on the Federal Life Insurance program. Fortunately, the federal government doesn't have to abide by federal laws, so it makes it much easier for us to do those things. And the other thing that's been encouraging is that the Aetna last month announced the availability of a long-term care insurance product for its employees. So we've started to get the folks who ought to be stepping forth stepping forth. And I think this is a very important thing to have happen.

The next area we talked about was permitting the voluntary use of vested pension funds to purchase long-term care insurance. What we suggested is that you ought to be able to take your IRA or some other vested pension program and earmark a portion of it for long-term care. One of the things we need to

do when we develop policies to fit in is to have coverage for long-term care begin in preretirements. Projections are that 40% of the disabled population by the year 2000 will be under the age of 65, so this is not just an elderly issue. I really enjoy looking around and seeing a lot of us who are under 40 talking about the elderly, which is ironic given the fact that while we think of it sort of esoterically, in our hearts we really don't believe in mortality or morbidity yet. And I would suggest that as you design your products you keep that little comment in mind. You ought to be designing products for folks that are going to be using the products, as opposed to what you think ought to be a nice thing for someone whose shoes you've really not walked in much. And I think that's one of the problems that Stan was alluding to in terms of the kinds of products that we see out there and the kinds of real needs we ought to be servicing.

In any event, what we were suggesting is that you ought to be able to use your pension funds -- do designate some of that for long-term care coverage. Now it does a lot of things. In terms of a defined contribution plan, it's a piece of cake. In terms of a defined benefit plan, you all get paid to solve that problem. I mean that's what you're here for. I'm just here to throw the ideas up; you guys have to solve them. But if it were allowed to happen, again using some estimates we got from the Brooking's and some other studies that were done internally in Health and Human Services (HHS), there are about 43.5 million elderly. And stealing a little bit from the Employee Benefit Research Institute and some other reports, about 63% of those folks ought to be covered by pensions. It would be about 27.4 million people who could participate. What's the cost of it to the federal government if you allow that money to be moved over and then paid out without having taxes paid on it? It would be about $1.64 billion a year. But here's the interesting part. Even on conservative projections on what it might do for the Medicaid program, the Medicaid total savings would be about $5.7 billion. The federal share, remember Medicaid is a state federal program, is about $3.2 billion. This program offers conservatively an actual savings to the federal government of about $1.5 billion. So Congress knows these kinds of things and Congress is going to be looking to get the private sector out in front, out doing the things that it ought to do so that Congress doesn't have to solve these problems.

The other thing that I want to hit very quickly is data sharing. One thing that I think that we have to remember is that the data that we have is not what

makes each company unique, it's how that data is managed. And I would strongly urge you to participate with the Society of Actuaries and its attempt to develop a database. It's one of the strong recommendations that came out of the task force. It's one of the things that's going to make long-term care a reasonable thing to do and an understandable thing for you over the long haul.

MR. KERRY A. KRANTZ: I just want to share a resource that I discovered in our law library. It's called, "What Legislators Need To Know About Long-Term Care Insurance." Much of what was discussed today is covered in there and there's an extensive bibliography in the back. You can get it from the Marketing Department, National Conference of State Legislators, 1050 17th Street, Suite 2100, Denver, CO 80265.

MR. DEWITT: It's an excellent document and it's one I would recommend to all of you.

MR. GRIFFIN: I know there's a lot of concern about induced demand if we do set up these products and I wonder if any of you want to comment on how you see that problem being controlled.

MR. DEWITT: From the regulatory perspective one of the things that the Task Force said is that it's incredibly important that insurers be allowed to design products that accommodate that and take that into account. The concern is that if you don't, you've got some real problems, so in terms of support, you'll find that in our document. How you're going to do it, I think I'll ask the others.

DR. WALLACK: With regards to nursing homes, I think a lot of us worry about it somewhat less. But a lot of people really fear the increased demand for home health services. I think the movement is afoot to use objective measures of need or disability for people for different levels of care, and that's really the best predictor. In long-term care, we use the functional status of someone, and we can look at the criteria of the ability of someone to perform without assistance. Those are objective criteria that can be measured. You can train people to assess individuals in an effective way, and I think that's one way of really saying that person has that need; therefore, that person is eligible for a given level of care.

MR. BARNEY: With two out of three people who would be assessed as needing a nursing home, or not being in a nursing home, obviously the impact of induced demand can be substantial if one tries to price a product today on the actual utilization of nursing homes presently in an uninsured environment. Bob Myers and I had a conversation on this just the other day. There is some thought that perhaps 1/3 or 25% of the elderly people today are living in conditions under which, if you had a program that would give them access to a nursing home, would improve their living conditions. If that were the case, a federal social program in my opinion becomes a much more expensive proposition than anything that Washington is likely to undertake in the near future.

MR. KIRAN DESAI: Stan, you just briefly touched on reverse mortgages and that being a very creative way of providing long-term care. That plus foster grandparenting could be a very creative way of meeting the needs of the elderly. I was wondering if you would care to comment on that.

DR. WALLACK: I mentioned reverse mortgages because of the recognition of how much the elderly have in assets in their homes. To date, there has been very little use of reverse mortgages. That is understandable. I mean people don't want to give up their home, and they're going to have to find a really good reason to do it. I see some of these long-term care options as an attractive thing because if you offer a policy like the life care at home policy, which says this is going to allow you to stay at home, you reduce some of those fears. You've got to have something that people want to purchase and it's got to be significant and it's also got to compound their interest in staying at home.