RECORD, Volume 27, No. 3*

New Orleans Annual Meeting
October 21–24, 2001

Session 77PD
Baby Boomers in Nursing Homes: Societal and Medical Trends that Affect Long-Term Care Policies

Track: Long-Term Care

Moderator: DAWN E. HELWIG
Panelists: DR. PATRICK IRVINE†
DR. JANEMARIE MULVEY‡
DR. PAUL YAKOBOSKI

Summary: In this session, panelists speculate how the health care delivery system will change over the next 30 years and the effect these changes will have on the long-term-care (LTC) policies issued to baby boomers today. The panelists contrast this with the current environment, including problems with the availability of trained care, infrastructure and geographical differences in care.

MS. DAWN E. HELWIG: We are going to expand beyond the title of this session since we will not limit this discussion to the topic of baby boomers and nursing homes. It's a discussion of baby boomers with future LTC needs, in both nursing homes and home health care.

We are honored this morning to have three non-Society members presenting to us, which will make for a very interesting and exciting panel. Patrick Irvine is a doctor—a physician consultant—with more than 20 years experience in LTC, geriatric medicine and managed care. Patrick has a national consulting practice that focuses on providing product care services for seniors, in concert with providers, payers and patients.

DR. IRVINE: Thank you, Dawn. I'm a physician and have spent many years as a clinician. My role today is to set the stage for you about what is going to happen

†Mr. Patrick Irvine, not a member of the sponsoring organizations, is an independent physician consultant in Minneapolis, MN.
‡Ms. Janemarie Mulvey, not a member of the sponsoring organizations, is senior retirement research associate with Watson Wyatt Worldwide in Washington, D.C.
§Mr. Paul Yakoboski, not a member of the sponsoring organizations, is director of research for the American Council of Life Insurers (ACLI) in Washington, D.C.

Note: The chart(s) referred to in the text can be found at the end of the manuscript.

over the next 30 years to those of us who are younger, and will be in nursing homes or in need of LTC services. I hope you'll understand a lot of this is conjecture, but there are trends in the system right now that I think will make a big difference in what really happens to us and some of our parents.

It is likely that you are aware of the new demographics occurring in the world, specifically, in the United States. The composition is increasing in terms of old people. The group of people who are very old, in particular, is growing the fastest. They are the ones who need services the most; mortality has declined and life expectancy is increasing.

One of the most important things is that the proportion of the functional years of our lives are increasing as well. So, to live more years probably means to live more functional years. The other problem is that more people will need LTC services as we live out those longer years.

I will focus on three trends. They are hard to predict from this point, but I think we're going to see some improvement. All of these are very major improvements in the LTC system and the health system in general.

The first one is that we're going to have better navigation of how people get into the LTC system. This refers to the nursing homes, home care and some of the assisted living and other variations on where people live. Right now the system is chaotic for those individuals who are trying to work their way through it, though I think there's hope on the horizon for better navigation.

Secondly, I think there will be major improvement in the way care is delivered to elderly people, and chronic illnesses are going to be addressed better. Improved clinical treatments and organized approaches to care will yield advantageous outcomes.

And, thirdly, I will discuss enhanced technology. There are many more trends, but these are closest to the things I do, therefore I am more confident explaining them.

Before we get there, I will go to chronic illness, and what that experience is like. It generally happens to people starting in their 50s or 60s, and it occurs in more than one chronic condition, so it's not usually a simple experience. The health care system that these people go through has always been designed for acute disease. Most insurance systems are designed around acute disease. When you look at a chronic illness that extends over years and years, it's a different experience that these systems have just started to adapt to. It is, interestingly enough, a process, not an event. So people who have this happen to them live it day-by-day. It's not something like having a fractured arm, then getting it fixed and going on with the rest of your life.

The other unique part of it is that patients have part of the experience. More than any other part of the health care system, with LTC, the patients contribute to their own health care decisions. They have more choices, and their participation makes the experience very special—very different than for others who go through it. Lastly, as chronic disease goes on and on, one gradually develops functional impairments, disabilities and death. And that is why we're talking about LTC insurance for the future.

Aging people live with their chronic conditions and expect to experience lifestyle changes. They often think they're ill when they are not, or they think they're well while they're actually ill. Since they develop pain and disabilities, control becomes the issue. The fear of losing autonomy and the need to retain dignity become paramount as they go through the experience, and they also don't want to be a burden to their family members and to society. A very intense drive underlies the experiences of these families and individuals.

As the person gets older, and as the chronic disease progresses, he or she starts talking more from a cure model to one of caring. In other words, the person needs to have people who are supportive and give comfort. Having a reasonable quality of life becomes more important in curing the disease or turning it around.

Now people who are younger don't always appreciate that disabilities are actually caused by these chronic illness and that they occur over time. And as the disease progresses, one first has mild losses that cause inconveniences. It takes the person longer to do things. He or she may forego certain things. He or she may need some assistance, but still gets along okay.

Then, as this experience progresses, the instrumental activities of daily living (ADLs) will drop out. The higher order daily functions—things like shopping, taking care of one's own money, and driving a car—the person is not able to do as well, and starts to lose these functions. These activities may stop, but the person may go on living his or her life. That's one of the unique things about long-term as opposed to other parts of health care.

Lastly, as a person progresses down this path, he or she starts to develop problems with the activities of daily living. When first challenged, it takes longer, then after awhile, it may take four hours to get dressed in the morning. This is just too long.

So it becomes one of those things, again, where it's not a binary experience. It's not digital. It's analog. So there's always variation and there's always movement. It goes up and down and is hard to monitor. It's also hard to know what's important and what to act on. Bathing and dressing are the first challenges of the ADLs—a hierarchy you may be familiar with. Then, mobility undermines the ADLs and the rest of our lives. And so mobility problems are fundamental in terms of a person's ability to live a reasonable quality of life.

Now the other part of this is that even though there may be a disease or a chronic illness, these things boil down to basic functions, like weakness on the left, and problems walking or thinking. Those things lead to a loss of our ability to function in all those domains.

One or three conditions, or even psychological issues, can lead to weakness. So this becomes extremely complex in terms of the left side of the equation regarding what symptoms drive the right side of this loss of quality of life.

Physicians think from a clinical standpoint regarding the common things leading to LTC needs, such as dementia, immobility, falls and fractures, urinary incontinence and fecal incontinence; the latter of which is not tolerated very well and is very hard for families and individuals.

People can become very isolated or need nursing home services. Concerns may be frailty and weakness, difficulty just making it through the day and getting things done, malnutrition because someone is not eating as well, losing weight, isolation and nocturnal activities.

Night activities are often the hardest ones for family members to cope with. If a person is caring for an Alzheimer's patient who's up all night walking around the house, the caretaker has a terrific challenge in terms of keeping his or her own quality of life. This is a major reason for LTC services or for institutionalization.

Looking at the problems I have mentioned, which are the most common and which are the most devastating? The most difficult to handle are dementia, fecal incontinence and nocturnal activity, then the rest fall into place.

Traditional Function Paradigm

Function = Individual Capacity and Environment

Individual capacity = physiology, psych, and path

Environmental support = devices, people, settings

Needs, resources, & choices determine outcomes

We've always used this kind of paradigm for function, in which functional ability is related to individual capacity and environment. Some people put one under another and equate these, which I've never understood. Look at the individual's capacity in the middle that's related to the physiology of his or her system, the pathology of the conditions, the diseases and the psychology. Is the person motivated? Is he or she depressed? What's happening to that person?

The environment is really the individual's support system, which may be the devices people set. Then these things can be put together, with needs representing individual capacity, the impression of what the person needs, and the resources representing the environment. It's really the choices amongst those and the decisions for optimists that are so broad-based; and expand this realm of opportunity in terms of what people could do, what they want to do, and where they end up going. It's a very unique part of health care.

In every other part of health care, in terms of the kind of acute care system and the medical care system, there are many fewer choices available to people. There are lots of choices, but in the LTC system, people have much more control and the choices for approaching a problem are much broader.

Now if one asks, "What kinds of decisions would a person make about long-term-care needs?" there are inputs on the left, (Chart 1) which include: clinical conditions, resource needs, and how long the illness lasts. If it lasts a long period of time and the needs are major, those people are not going to do well without a lot of help. Those people with pain and/or isolation are more likely to need a lot of help, depending upon the family.

I don't know how many of you are going through this with your parents, but it is a very difficult up-and-down experience with a broad base of variables. The individual can decide to be independent and tolerate the disabilities, add devices where possible, then build a matrix of health. This can be an informal matrix—family, friends and neighbors, a formal matrix built from home care agencies, or a move later to assisted living, with more formal assistance in a nursing home.

These decisions are very difficult, because the inputs are always going up and down. The process involves working toward a decision on the right side with a lot of variable input on the left side—moving, changing and always wondering. Then, with this decision-making box, it is difficult to know what's happening, and what decisions are out there.

The reality is that this doesn't happen in a decision. It's not an event. It's a process. It took me years to learn that. And it's very much a process in terms of when the family is ready and when the patient is ready. If you’re trying to decide whether or not a nursing home is the best choice for the patient, you have a new thing happening—either to the caregiver or to the individual, which changes the equation. So it will always go like this for a family, as the members work their way through it. The other problem, of course, is that they often don't know a lot about the other side, because they don't know what services and settings are available.

The good news is that there's tremendous growth in investment in this kind of thing. There are new ways to navigate that will make a big difference. Hospitals and other sources provide people to help with this. The health insurance industry has recognized this is a major issue and it has a major bearing on acute care costs. The

LTC insurance industry has help available for those who will benefit from it. More professional care managers are also being developed. And every day there's a new Web site or some new consumer service available to help people, so they can get through this process and with as much ease as possible.

Another problem facing families and individuals is to the challenge of getting the best answers, because, again, the process continues onward over time. Now if one insures a product that provides this service and realizes how unstable and disorganized it is, this would be good news in terms of the future.

The second major point in my discussion is that the clinical areas are improving outcomes. I'll talk about cardiovascular disease, Alzheimer's, arthritis, and falls, fractures and osteoporosis.

I will start with arthritis. I'll bet almost everyone in this room or a family member has been touched with a hip replacement operation for a father, mother or other family member. I've got neighbors who've each had two new hips. It changed their lives. It gave them back a real quality of life and will help them over the next 20 or 30 years. That, I think, is a major improvement in the way we deal with disabilities, so there's a major advantage in terms of what's happening with surgeries.

The same thing is happening with medications. With osteoarthritis and the other problems that people have with mobility, there are new medications that don't have the side effects, and offer—if not better—the same kinds of advantages in terms of the outcome. With rheumatoid arthritis, for example, there are new attempts to work with immunotherapy, the goal of which is for the disease to not advance, since the character of the disease changes. It gives a person many more years of quality of life and activity. That, combined with new surgical techniques, can make a major improvement in the lives of people with rheumatoid arthritis.

The same is true with the people who have osteoporosis. The risk of falls and fractures is increasingly high, the older you get. And we have new measurement techniques that tell us who is at risk for osteoporosis. We also have new approaches to prevent the falls that break the hips. This includes hip protectors or pads that people wear in case they fall, which makes it much less likely to fracture a hip.

Cardiac treatment is really phenomenal. Much improved prevention is available. Hypertension is being dealt with much better than it was in the past. Lipid therapy is available and more and more people are taking these medications. There are randomized clinical trials that show positive outcomes in terms of preventing heart disease and prolonging life.

The other thing that's happening for those who get coronary artery disease is that they are subject to the new treatments like lytic therapy. If someone comes into the hospital for a coronary problem, which in the past would have indicated a clear myocardial infarction in progress, we give him or her lytic therapy and the disease

reverses before our eyes. And every time that happens, a patient is preserving myocardial function.

In other words, the pump is preserved as opposed to having an infarction and dying, so there's myocardium left to pump as years go on. The same thing is happening with flow restoration—reperfusion kind of experiences—whether it's coronary artery, bypass grafting, stents, or angioplasties. If you look at this, in its aggregate progress over time, there's now a tremendous advantage for people like Dick Cheney, who now live a very active and functional life. People like him would have been dead if they had their current conditions ten years ago. You can see a difference in people all over the country.

The other thing happening is that disease management is making a difference, but the outcome is that we will have a lower incidence of congestive heart failure in the future, because there will be less coronary artery disease, which is a major cause of congestive heart failure. Also, fewer strokes will occur. That's less disability in the long run. And for those who've had these experiences, you've got a better quality of life, better life expectancy and function than you've had before, because the impact of the conditions has lessened and moderated over time.

Heart failure disease management, for me, is a very exciting thing. It's the ability to organize care for people in a population, measure the outcomes, then adjust the process as you go to make sure you're getting the best outcomes. It's a very common practice in HMOs, for example, but it's also common among other types of health insurance carriers.

You identify the people who are at risk. We look for the people who are at risk, who also need intervention, where we can make a difference. We're assured that they had a proper diagnosis and that the treatment is appropriate. We educate them and involve them.

Remember, we talked about chronic illness, the unique place in which people are involved in the care of a loved one. This is the place where people are given scales, or calling numbers, or a telephone call to become engaged. They are actively involved. For example, if the patient's weight goes up, the loved ones get a call. . They also make sure that they're compliant with medications. So the end results are generally much greater adherence, much better compliance and involvement, and better outcomes in terms of the disease. People are living longer and have better quality of life.

This is true across the system, in disease management—organized approaches to treatment. But they're now out there for congestive heart failure (CHF), diabetes, asthma, and cancer. The list is getting longer every day, and I think it's making a difference. We don't have to look very far right now. If you look at the multiples in the stock market, of some of these companies doing disease management, how

high they are is quite astounding; where a couple years ago there wasn't nearly this kind of optimism.

Case management. We're getting much better at that. It's more systematized, longitudinal, and much better in terms of outcomes. Patient safety is finally recognized. As a geriatrician for 20 years, I've been trying to tell people that the hospital is dangerous for an older person. Finally, people realize this and we're making a difference in terms of what happens in hospitals.

On the consumer engagement side, there's finally much more for consumers in terms of education, tools to get engaged, and help for them. That is probably going to be the most exciting part.

I'm going to move to Alzheimer's disease (Chart 2). As you can see, the number of cases is increasing over time. These are people who have trouble with higher order functions. It's an opportunity for devices because of the things they can't do.

ADLs are problematic for a large proportion of these people, and are a major reason that people have LTC insurance. It's a major disability among the elderly and one of the hardest things to watch or experience within your own family.

There are new things happening for this disorder that may make a big difference over the next 20 to 30 years. One is that we have better ways of diagnosing Alzheimer's, which in the past has been a diagnosis of exclusion. I think that will change. We know more about it and how it happens, and have shown families how to recognize early parts of it.

Lastly, we have the ability, with new medications, to finally treat it in some way. Much more needs to be done on the medication side, but there are three medications out there today that many people believe make a difference for Alzheimer's patients. I also think the pharmaceutical companies are in the first stage of creating several medications over the next 20 to 30 years that will help.

Other types of treatment are now available for the families. Caregiver support, which was lacking so much, is getting better and better. The issues of intimacy and family caregiving, are more of those hidden causes of institutionalization. For many of us, this includes giving our mother, father, or spouse a bath, or helping him or her on the toilet. These are very difficult things for many families to undertake or do for very long. People can get help in terms of how they approach it; and using other mechanisms that can be mitigated makes a difference.

Chart 3 is the trajectory that one might see. And without going into each disease, whatever the condition is, there's a downward trend that goes with it. And what I hope will happen over the next 20 years is that we go from a line that goes down to a line that stays up higher where people live in one place longer and have more functionality.

The trajectories will rise and we will delay or mitigate needs for LTC service. They're going to be pushed out further, and we're going to probably use some things longer, but as far as using the ones that are more and more extensive and difficult, they'll probably be pushed out further in the process. And in that process I think there will be more options for care as they decide how to live their lives, given their disease trajectory.

Now I will finish with the opportunities of technology, and by this I mean simple technology. In the past, we had little use of devices. People were embarrassed to use canes or walkers. The devices that were available didn't work very well. They cost a lot of money and it was an uphill battle to try to get somebody to use one of them.

It's like trying to get somebody to use a hearing aid. If you went to a nursing home fairly recently, the drawers next to the beds were full of hearing aids that weren't being used, and it's been hard to get people to adopt them. Part of the reason has been that the devices haven't worked very well, and that there have not been a lot of choices in terms of what they bought. They weren't very adaptable. You couldn't get the equipment into a small bathroom, for example, or there wasn't enough room in the bedroom to move something in.

So for a lot of reasons that are hidden from the average person, there's a slow adopter kind of pathway here amongst people who need devices, and the new devices provide great opportunity. They fit. They're exciting. They're colorful. And there's more peer pressure out there now to use them, so you'll see them comparing nursing or walkers or canes. And you'll see people walking around at Christmas time with canes that look like candy canes.

A lot of ingenuity is happening and there's much more energy in marketing. The kind of thing that will make a big difference the number of assist devices there are now to get somebody or to help a person get out bed. They may be kept on the wall, on the bed, on the end of the bed, on the ceiling, or on the bedside; there are all kinds of things related to ADLs that didn't exist ten years ago.

Now the dynamics here are that the facility of these devices increases when labor costs are high. It's going up tremendously in nursing homes and in home care, where the demand to stay at home is increasing, and when people have more disposable income to spend. So I think this is a good time in terms of devices.

The other thing that I think people don't often recognize is that the device is the perfect thing. If the patient wants privacy and real independence, if he or she really wants to use the bathroom alone, the best way to do that is with a device. It's not like that when a person gets somebody to help.

And the same is true with reliability, that no matter how hard home care agencies or families try to schedule and be there when they're needed, it's very difficult. The

device is there. It's always there. It's always ready (as long as it's working, which is another issue), but they are working better now than in the past. And the devices, also, are there to help monitor conditions, improve safety, and provide communications. ADLs and IADLs are there as they've always been, but these new kinds of applications are going to make a big difference in how they use them and the outcome of their use.

In summary, there are more organized approaches that will help people get better LTC, and have their needs met in LTC. They'll be more efficient, and have more productive lives. I think that will make a big difference for families who are working through this.

Secondly, we need clear improvement in our outcomes, preservation of function, and minimized dependency in terms of clinical care.

Lastly, when we come to those tipping points, the decisions are very difficult. If there's going to be an adjustment, we need to figure out if we're going to act earlier with better options for people long-term, or if we're going to be able to stay where we are and institutionalize a lot later than before. So there are a lot of forces here that are very optimistic for this industry, and for people who have chronic illnesses.

MS. HELWIG: Our next speaker is Janemarie Mulvey. Janemarie is a senior retirement research associate with Watson Wyatt Worldwide. She has more than 16 years of experience in employee benefits, most notably working with LTC insurance. She recently received a 1999 Author Award from the *Journal of Financial Service Professionals*, for an article titled, "Retirement Planning for Baby Boomers: The Role of LTC Insurance."

DR. JANEMARIE MULVEY: Let's switch gears from the physiological aspects of LTC to the economic aspects. I'd like to talk to you today about the basics of LTC financing. Some of you who have worked in the field have seen these statistics before, but for those who haven't, it will be additional information for you.

In Dr. Foot's keynote address yesterday, (Session 1GS) he talked about the baby boomers and what an impact they've had on society. You know, they've crowded the school systems, they're crowding the stock market, and in 30 to 40 years they'll be crowding nursing homes, or other assisted living or LTC facilities.

Then, the 65-year-old population is going to more than double by 2030 when all the baby boomers have reached 65. Life expectancies are increasing and demand for LTC services is expected to increase as well. This is going to put a big strain on both private and public resources, including Social Security, Medicare and Medicaid, and we have to figure out how we're going to pay for these costs.

Estimates that we did when I was with the ACLI, show that long-term expenditures will increase four-fold over the next 30 years. And these are real dollars. These

aren't nominal dollars. To put this into perspective, by 2030, $528 billion will be paid for LTC services. This is greater than what's being spent on Social Security today, so it's a lot of money. And as a share of gross domestic product (GDP), it will go up dramatically.

So who's going to pay for these costs? Look at current trends and payment. The largest public payer for nursing home care is Medicaid, paying about 41%. For home care, Medicaid and Medicare barely pay 30%. So today the individual is still paying a great deal of these costs. Out-of-pocket costs for nursing homes are about 46% and out-of-pocket costs for home care are about 61%. And notice that nursing home care dominates the expenditure picture. A lot of that is because it's an experience form of care.

So there are a number of problems with this current system. It's a patchwork system, with a little bit here, a little bit there. Medicaid is derived from both federal and state revenues, and has very limited coverage. I'm going to talk more about both of those in detail.

Then there's a very small LTC insurance market. The other key problem is that public programs have strong institutional biases, and if you want the government to pay for your care after you impoverish yourself, you're going to be in a nursing home. Nearly two-thirds of spending is for nursing home use. And most of the public funds available, again, are for tested programs and really only apply to people after they impoverish themselves.

So what is the answer? Well, LTC insurance is a viable option. The problem is most people purchase or are thinking about LTC when they're getting close to needing the care themselves. They're 65, 70, 75 and decide to start thinking about it. But just like life insurance, where premiums get much higher when you get closer to the event, LTC insurance premiums are much higher as you get older. This doesn't mean you can't buy it when you're older, but in terms of affordability, it makes more sense to buy it when you're younger.

We did some simulations to look at who could afford it. In 40- to 44-year-olds, 71% could afford it if they purchased it at that age; and the same goes for 81% of 45- to 49-year-olds and 72% of 50- to 54-year-olds. At age 65-plus, about a third can afford it.

So the key, really, is to get the baby boomers to purchase LTC insurance, but they're too busy saving for the kids' college education and for their own retirement. They're not really interested in this or in taking care of their own elderly parent. So how do we get them motivated?

I think they're in denial. They really underestimate the future risks and costs of LTC services. They associate nursing homes with LTC and refuse to go. There was a *Wall Street Journal* article yesterday that said the two most frightening words in the U.S.

language are *nursing homes*. People just don't want to go to a nursing home. But since they don't want to go, they're not going to worry about how they will pay for it in the future. They think if they don't look at it, they won't have to do it.

And the other thing is there are a lot of misperceptions about who will pay those costs. Some people think the government will pay them, while others think their retirement savings will pay. I'll take you through some of these things in terms of the key facts.

The risks are very real. More than half of women and only a third of men will need to pay LTC costs at some point in their lives. People aged 85 and older are six times as likely to need LTC as people in their 60s. And the numbers are severely impaired if these trends continue and disability rates don't change, or if technology doesn't improve to help them; in that case we'll more than double the costs from $3 million to $6 million by 2030.

Table 1

Long-Term-Care Costs: Now and in the Future

	Year		
Annual Cost Per Use	2000	Nominal 2030	Constant 2030
Home Care			
Adult day care	$12,981	$56,100	$31,500
Homemaker	15,110	65,300	36,700
Home Health Aide	15,743	68,000	38,200
Assisted Living	25,300	109,300	61,400
Nursing Home	44,100	190,600	107,000

Source: ACLI, 2000

The costs are very expensive. Table 1 shows a current trend, as nursing home costs will go from $44,000 to $107,000 per year by 2030. That's in real terms. And this is conservative. $44,000 is the average for the whole United States, but in New York City or another urban area, it's more like $75,000. Family home care costs, if you assume three visits from a home health aide per week, will go from $15,700 to nearly $38,000, in real terms, in 2030.

Now baby boomers associate nursing homes with high costs and refuse to go. Nursing homes are still a dominant form of care, but services at places for the aging

are costly. The cost of services exceeds income, especially among those over age 85. Their costs continue to rise and will get more expensive in the future.

Also, at older ages there's a higher probability of going to a nursing home, because a family may have exhausted financial resources by paying for health care. A person may have outlived a spouse or caregiver. And rates and severity of disability increase. And the more severe the disability, the more likely one will need to go into a nursing home, because they provide round-the-clock care.

The real bottom line is that the government funding available will largely be for nursing home care. So if one can't afford to go, it is necessary to rely on the government. There are a number of illusions about who will pay. If you talk about LTC, people say things like, "I can rely on my retirement savings," or, "The government will pay for me."

A corollary to that is if the government's not paying now, they're going to pay something in the future, because the elderly are going to be so politically powerful that they'll have to take care of us. Myth three is, "My family will take care of me." I'd like to take you through each of these.

The first myth is this: "I can rely on my retirement savings." Well, it is true that 50% of LTC policies are paid out-of-pocket and 50% of Americans believe that their savings will be sufficient to pay for LTC in the future. But, if you believe the numbers I showed you earlier, that LTC costs are going to go up, you have to save a lot of money now to pay for those costs, versus buying a LTC policy.

Here are some examples: An average 45-year-old has to save ten percent of his or her income. An average 55-year-old has to save 12%. This is just for LTC services. This is not for retirement. And if you look at a savings rate today, people are not even saving this for retirement, let alone for their future LTC needs.

Since everybody is an actuary here, I will give you some numbers. The cost of a nursing home, say, for a 55-year-old when he or she gets to age 85, will be about $300,000. A 45-year-old will pay nearly $500,000. The 55-year-old would have to save $4,400, and the 45-year-old would have to save $3,500.

The average income today, if you look at population statistics, shows that the 55-year-old will pay 12% of his or her $36,000, and the 45-year-old will pay ten percent. So this is quite unaffordable for those in the middle-income bracket to save for their LTC services in the future. Now if you're a CEO and you make millions of dollars, you may have this money, but middle America does not have it.

Another myth is this: "The government will pay my LTC bill." One-third of Americans believes the government will fund their LTC needs. The reality is this is limited. Medicare only covers short stays in the nursing home. The home care

benefit is limited to medically oriented care, and it does not cover custodial care, which includes many of the activities of daily living.

Also, it is necessary to exhaust one's assets before Medicaid will pay. One really has to be impoverished. Also, the government provides strong incentive toward nursing home care, as I said earlier. And, the government itself is going to face increased financial pressure in the future. They're going to have trouble paying their own bills.

An example of this is the Medicaid nursing home costs. We did some simulations to look at what Medicaid would have to pay in the future, given financing trends. They didn't change much and there wasn't a large LTC insurance market. Also, Medicaid nursing home costs would more than triple in the future to $134 billion in 2030. Again, these are constant dollars over and above general inflation costs.

The problem is that Medicaid revenues include the seventies fund and general tax revenues. There's no cost fund like Medicare, so really it depends on how much tax revenue growth they've got. Well, tax revenue growth is usually tied to wage growth. But, if LTC expenditures rise faster than wage growth, which has certainly happened in the last ten years, then expenditure growth will go up 143% and revenue growth will go up 56%. Something has to give in terms of the government's coverage of a future liability. They probably would have to raise taxes or try to push the costs off to the individual.

A corollary to this myth that the government will pay is the government will add a LTC benefit in the future. Currently, it's eye doctor fees and prescription drugs for the elderly. In following the debate on Medicare and Social Security, commission after commission is trying to come up with solutions for the future baby boomers, and there's really no magic bullet. They can't make the hard decisions for Social Security and Medicare. It's doubtful that they're going to add another long-term entitlement benefit for the elderly, and of course the budget surplus is almost gone, so that will not happen in the future.

Also, the government has put out a number of initiatives and legislation that really indicate that they want people to take personal responsibility. The Federal Employee Program is in the field now. The proposal is back. They're offering LTC insurance to federal employees next year. I think that's going to prompt a lot people in Washington, who see their friends in the federal government or other places receiving this benefit, to think, "My employer should do this for me."

Also, there are a number of legislative proposals on Capitol Hill for taxes used for LTC insurance. They want to have an above-the-line tax deduction, similar to the IRA, where one deducts LTC insurance premiums right off the top. People in Washington are thinking that will help prompt the baby boomers and others to purchase LTC insurance. So I think the government's sending a number of signals that they don't really want to pay for it in the future.

The third myth is this: "My family will take care of me." In fact, nearly 20% of caregivers have quit work or reduced their hours in order to take care of somebody, but this is very costly. There are a lot of hidden costs here. Besides being time consuming, there are lost wages to the economy, and lost tax revenues, so it's not a free good. It does cost something.

In fact, a recent study said that if caregivers were paid, the costs would run from $45 to $94 billion a year. Long-term expenditures were at a cost of $110 to $120 billion for 2000. So if all those caregivers were paid, those expenditures would almost double. There is a real cost there, and it's not a free good.
Just to show how costly it is in terms of caregiving hours per week—taking care of a severely impaired person is more than a full-time job, at 56 hours a week. This is definitely not the best alternative for people giving the care (Chart 4).

Another reason that caregiving is not something to rely on is that there are going to be fewer family caregivers in the future. Doctor Foot talked about this yesterday. He said the fertility rate is going down, and boomers are having fewer children. Divorce rates among boomers have nearly doubled that of their parents. And studies show divorced parents are less likely to receive LTC services from their children. Finally, the rate of never-married women is about to double, compared to the generation of the parents of baby boomers, so there are not going to be as many caregivers as we may hope.

So what are the options? Private LTC insurance is an option. As I showed you before, it's affordable for two-thirds of the boomers. A wide variety of products out there support at-home skilled care. They cover alternate care facilities and allow boomers to age in place successfully and retain their independence, which is what everybody's supposed to do. I think one of the keys to getting at the boomers is the employer market. You'll hear more from Paul about that.

Studies have found that for employers to be successful in offering LTC insurance, they have to effectively communicate many of the things I showed you earlier. You can't have new employees come in, hand them a piece of paper, and say, "We've got this LTC benefit. Do you want to sign up for it?" and that's it. That way, they won't think about it. They really need an educational campaign to get them interested, and they have to understand the future risks and costs.

Table 2

LTC Insurance Should Be Part of the Retirement Planning Process

	Age Today	
	45 year old	**60 year old**
Option 1: Rely on Retirement Savings		
Annual Savings Needed	$3,557	$4,481
Lifetime Assets Needed at Age 85 to Pay for 2 Years of Nursing Home Care	$489,446	$235,432
Option 2: Purchase Private LTC Insurance		
Annual Premium Contribution	$417	$883
Lifetime Value of Premiums	$57,907	$47,277
Potential Savings from LTC Insurance		
Annual Savings from LTC Insurance	**$3,140**	**$3,598**
Lifetime Savings from LTC Insurance	$431,539	$188,155

Source: Mulvey and Stucki, 1999

Note: Calculations are based on a 2-year long-term care policy with inflation protection of 5 percent. All numbers are represented in future dollars and assume a 7 percent return.

23

Table 2 reiterates the key to expansion—encouraging persons to invest at younger ages when it's more affordable. Working baby boomers are a key target, and employers need to help educate them about the risks and costs, and include LTC insurance in the retirement planning process. That's really the key about the retirement planning process. When people sit down and do their retirement plans, they should think of the future LTC policy and how to pay for it, whether it's insurance premiums, savings, or something else.

One final point is that when you hear people talk about LTC insurance, they say they don't want to pay for something they will not use. Well, people buy personal property insurance and don't use it, and don't wish for their house to burn down so they can use it. I think LTC insurance for many is really peace of mind. If people do not use it, fine, but at least they had it.

MS. HELWIG: Now we will wrap up with Paul Yakoboski, who is going to talk to us about where we are today in our LTC sales efforts, and who's buying LTC policies. Paul is director of research for the ACLI. He's responsible for their research in areas such as retirement income security, annuities, LTC insurance, disability income, and reinsurance.

Prior to joining ACLI in 2000, Paul was a senior research associate with the Employee Benefits Research Institute (EBRI), specializing in retirement income security issues. Before that, he worked in the Human Resources division of the U.S. General Accounting Office.

DR. PAUL YAKOBOSKI: When we think about retirement, when we think about retirement planning, either at our own personal level or from a public policy perspective, we think about whether or not we are saving enough money. Are we saving the money in the right way?

Maybe we think about managing that money once we reach retirement. Issues of annuitization can draw down better. Typically there are exceptions at the individual levels, but in the aggregate on policy perspective and among individuals themselves, we typically don't think about LTC and paying for LTC expenses. And as Janemarie's numbers just showed, we should be thinking about this because it's expensive.

From our perspective at ACLI these issues really go together. The most important reason, from our perspective, to own LTC insurance is to protect the assets that you've worked so hard to accumulate through the course of your working career. And that's been our message while Janemarie was there and continues to be the message now that I'm there. It raises the basic questions of, "What are individuals thinking? In particular, what are individual owners of LTC insurance thinking? Why do they have the policy?"

So in the past year we released two reports on the long-term insurance market, examining this very question. The first report dealt with the individual market—people who bought a policy on their own. And we surveyed about 1600 individual policy owners. Then the follow-up report looked at the group market. And in there we looked at two groups of individuals—those who actually own a policy through the workplace and those who we've labeled potential enrollees, i.e., they've been proactive in seeking out information from their employer, and from the provider through their employer. They don't own a policy yet.

In each survey, we looked at the owner. We looked at his or her motivation and thought process for buying LTC insurance for owning it. In addition, we have very specific information about the policies that they do own and it's not self-reported. We get that information matched up from their actual insurance carrier. In essence, what we seek to understand is why they own what they own.

So this morning I would like to run through what I consider to be five of the key findings from this research. (1) Among policy owners, LTC insurance is an integral part of retirement planning. (2) Interested private coverage is increasing, even among younger individuals. (3) Market expansion means increasing diversity among owners. (4) Workplace education encourages LTC planning. (5) We're completing the circle, linking long-term education to retirement planning in order to promote coverage.

A fundamental message from merging insurable data is that consumers view LTC insurance as a valuable retirement planning tool. This is a retirement income security issue, by and large, for many owners. And 98% of individual policy owners

say that preparing for LTC expenses is a very important part of their retirement planning, with 70% saying it's very important.

On the group side, there are similar types of results. The same message emerges. LTC planning is an important part of retirement planning. And, in fact, the younger the enrollee, the more important the retirement link. Two-thirds of enrollees who are under age 50 say it is very important, compared with 60% of those who are aged 50 to 59. This retirement link of ownership, because it's important for retirement preparation, is beginning to manifest itself with increased interests among younger individuals.

When we look at individuals who have bought their policies relatively recently in a three-year period, '97–'99, and compare them with the '92–'96 period, we see that 39% of the people who bought their policies in the latter years were younger, under age 65. They're buying it before they hit retirement, and it is ten percentage points higher than in just the four previous years before that. So we really see the focus move down through the age sector.

We also see this in the group market, where the younger the potential enrollee, the more likely he or she is to ultimately own a LTC insurance policy—or at least that's what they tell us. Seventy-six percent of people under age 40 say they are likely to buy this type of policy, compared with 63% of those aged 50 to 59.

Now of course the true differential is overstated there, because some of those older individuals likely have already bought a policy; but still, the difference is notable. In addition, younger owners are more likely than their older peers to be motivated by a desire to protect their own retirement assets. In an individual market, 40% of owners under 65 cite this as the most important benefit of coverage, compared with less than 30% for those who are 65-plus.

So in terms of what's underlying the motivations and what the thought process is, there's a growing difference—a real difference between young owners and older owners. Not only are younger owners more likely to say that this is a retirement planning issue for them or that a major benefit is asset protection, but we also see it in the policy features that they select.

For example, policies with substantial benefit levels, such as long benefit duration, which are depicted in Chart 5. If you look at either a home care benefit duration or nursing home care benefit duration, individuals who are younger owners are much more likely to have the substantial, lengthy benefit duration levels. And here, for example, in home care, 36% of the young owners have benefit durations of greater than six years, compared to 16% of those who are 65 and older.

In the nursing home area, we now have figures of 53% versus 29%. So it's not only an issue of retirement income, it's an asset protection issue. Actually, look at what these people own and you see evidence that that indeed is the case. I think it's fair

to say, with this growing interest among younger individuals in this underlying motivation, that the retirement link is only going to grow in importance over time.

The individual survey further highlights that as the LTC insurance market expands. As Janemarie said, it's expanding, but it is expanding slowly. There will be an increasing demand on notice, not surprisingly; and along with that, increasing opportunities posed by emerging market segments from nontraditional sectors.

What this implies, then, is that increasing coverage rates will depend upon developing messages that reach different groups of potential individuals. So this is important both for public policy makers who want to promote LTC coverage and insurers and practitioners who want to do the same thing.

Let me consider two areas. One is financial status and another is gender. The fact is, when you look at policy owners, many have limited financial resources. It's not just a rich person's product. And, interestingly, the fewer financial resources an owner has, the more important they view LTC planning as part of their retirement planning. The reason I own it is to protect what I do have. Richer individuals are probably more comfortable—even if they own a policy—with their ability to cover themselves anyway.

When we look at gender issues, the emerging market segment is men. Historically, this has been a woman's product. The more likely one is to need the coverage, the more likely one is to have been exposed to the need as the caregiver. We see it's not just among men, or particularly, those who are buying policies for reaching retirement. Thirty-two percent of recent male owners in the individual market have bought their policies pre-retirement.

And when you look at the motivations of men and women, again, it differs. For men, what's the primary motivation? Protecting the assets they have accumulated. For women, life's a bit different. There is more of an issue of avoiding dependency and ensuring adequate care. So all issues remain important, but it's the degree of magnitude and understanding of the market segment. You want to target different groups of people or emerging markets, such as younger males.

I will move on to impacting and motivating individuals to own a policy. Not surprisingly, some in the group reported that communication and education have an impact, and the more intensive the communication, the greater the impact. One-half of current group owners who received LTC information through work say that it motivated their decision to own a policy. Seventy percent of those who received information and attended some type of seminar or presentation and counseling say that it motivated their enrollment.

Basically, it now gets to the slidings that we've already uncovered when we look at retirement savings programs through work or worker education programs in 401(k) plans. That is a long-term process, but the evidence is there that you can affect

knowledge levels, attitudes, and ultimately, behavior, in the forms of savings behavior or purchase decisions.

And coming full circle then, what's the most effective message we can convey to people? Our survey results indicated that communication and education material that incorporate a retirement planning angle are our best bets to motivate today's workers to buy a policy.

We look at potential enrollees in the group market, i.e., individuals who are, in some sense, on the cuff of buying a policy. Those who learned about retirement planning along with LTC planning—a whole package together said that it had given, in essence, a great deal more thought to these issues, and it has made more of an impact upon them and their knowledge levels and their likelihood of buying.

So to conclude, a secure retirement obviously depends on the accumulation of sufficient assets. But it also depends on protecting those assets, particularly from the potentially devastating expenses of LTC. If you believe the figures that Janemarie just showed us, and I do, you're going to need nursing home care, you're going to impoverish yourself, you're going to have to save an unsavable amount of money to fund your retirement. So what's the best option? To buy LTC insurance.

And the research that I just discussed makes it clear that a growing number of individuals are very much the minority, but more of them are coming to this realization. The research further indicates that communication and education by both the public policy makers and practitioners who incorporate this retirement link may be the key to boosting the ownership of private coverage. Now it's something that would benefit individuals as well as the public by relieving pressure on public programs.

MR. JOHN MIGLIACCIO: I have a question for Dr. Yakoboski. You talked about enrollees and potential enrollees. Can you define who you were looking at here? I know one of the issues, particularly, related to the presentation about baby boomers, is that currently, only about half of them are covered by pension plans. So if it's a relationship between getting employer education, if only half of them are covered by pension plans, then only half of them have received that kind of education.

DR. YAKOBOSKI: Enrollees and potential enrollees. "Enrollees" is what the name says. It's people who are actually enrolled in a workplace-based LTC plan. So it may be at their current job or it may be a policy that they signed up for at their previous job that they have kept up.

"Potential enrollee" is a more subjective designation, but based on the information that we were able to collect through the participating carriers and employers, it identified individuals who have been, in some sense, proactive in seeking out

information. So they, themselves, went to their employer or to the insurer behind the plan and asked for information, and showed up for a counseling session, but they actually do not own a policy as of the time of the survey.

So it is a little bit more narrow of a group than just anybody who works for an employer who doesn't choose to participate. There are individuals who are seemingly oblivious to the fact that their employer even has a LTC plan. They are not in the group that we designated as potential enrollees.

MR. JIM GLICKMAN: I have a question for Dr. Irvine. I sense from your discussion that the advances in medical care, devices, and marketing have led to longer, healthier, and less dependent lifestyles.

What concerns me from an actuarial standpoint is that most of the claim costs are highly oriented toward the older ages—85-plus and 95-plus. To the degree that a lot more people are living to these older ages, and that there are a lot better medications and medical facilities to take care of them, are we also looking at people when they get to the very frail years?

Are they staying in facilities or in care scenarios for a much longer time because medicine's able to keep them alive, though it is at lesser and lesser levels of functionality—especially when there are two spouses and one's 90 and the other's 95, and one spouse takes care of the other spouse a large percentage of the time. Now they're too frail to do that. Is there going to be a shifting and bunching of it to the 80, even 85, 90, and 95-year-old categories? Could you give us a sense of these things from your practical experience?

DR. IRVINE: Much of it speaks for itself, actually. I do think that wherever people are, whether it's in their own home, in assisted living, or a nursing home, that their length of stay in that setting is going to be longer now. Also, it will be a transition away from nursing homes heading toward other settings—hopefully, more home-based or home-centered care.

What happens when it gets toward the end, the circumstance is often very complicated, and the patient is frail. Some of the things that happen are difficult. I'm not sure I have the answer, but in medical care, one of the things observed is that near the end of life there is almost an informal decision made with respect to aggressive therapy. And if you look at the recent publications regarding the last year of life for Medicare, the cost of the six months prior to death go down rather than up.

I wonder whether some of those factors related to choice will have a big bearing on how utilization happens at that point. With people who are very frail and weak and are not very engaged with society or in interacting with people, there's more of a tendency today to appreciate that it stands in their life and not be aggressive about how they're treated.

I think as time goes on, two things will happen to force it. One is improvement in the quality of life and functionality as people are getting older. My opinion is that people reach the stage where our quality of life is very poor. We will also see people more willing to be less aggressive and let them go. People are going to feel better about that for themselves.

MR. BARRY EAGLE: Following up on that, Dr. Irvine, do you see North America moving to the way some of the European countries are going, with respect to a more proactive recognition of those later years not being positive and people actually making direct choices?

DR. IRVINE: I'm probably not the person to speak about that, but it does happen today in our country. The informal advanced directive is what I've called it for years. It's that if someone is very frail and disabled and needs medical care, that person is less likely to get the highest technology and most expensive services. I think that's a humane way to deal with it.

I personally haven't seen anything where how it happens becomes deliberate. Right now it's a more humane way to approach prolonging life and questions as to whether that life is meaningful. I think that's happening today, and it should be.

MR. GREGORY A. GURLICK: Dr. Mulvey, I was encouraged by Chart 6 that showed LTC insurance covering five percent of cost. You know penetration rates are relatively low. You know these people are relatively young. They're in the early policy years and we're still covering five percent. Have you ever projected out if we didn't sell another policy, how would that percentage increase over time? And then if we did sell more policies, what kind of penetration rate would we need to get it up to 25% of the total cost being paid for by insurance? 33%? 40%?

DR. MULVEY: I haven't done current trends in terms of what the future would be, but I did look at expanded coverage of LTC insurance when I was at the ACLI. And if I recall, it would cover about a third of the cost of LTC by 2030, assuming some lapse rates, and that everybody who could afford it purchased it. So it won't cover all of the costs, but it would cover about 30% compared to five percent today.

MR. RICHARD A. DIAMOND: Dr. Irvine talked a little about different types of care we may see in the future—more reliance on devices, for instance. And my question is for anybody who wants to respond to it. What is the risk that a baby boomer buying a policy today will find that when they need the care, the policy doesn't cover the types of care that are being provided in the future?

DR. MULVEY: That's a good question. We get that a lot. People ask what happened to flexibility. Some of the policies now are flexible. They have per diem policies that give money to the insured, who can use it for different types of care. I'm not an insurer, so I'm not quite sure how it's handled at insurance companies. As things

change over time they can amend policies to cover certain things, so I know the policies are becoming more flexible in what they cover.

DR. YAKOBOSKI: I'll chime in to say that the growing flexibility of policies indicates the importance of when people out there are buying a policy to educate themselves well and rely on some degree of professional advice from their insurance agent, who should be able to guide them through.

You know, for some people, it may be a bit of a complicated decision, but it's a very important decision. So if a person takes the time to think things through, considers what's covered, what's not covered, looks at what he or she is actually buying, and then makes a good choice, a buyer should be okay.

DR. IRVINE: My own perspective is that it's pretty incredible to see the variation and opportunities that are available to people now who need LTC. And without going into that in great detail, it would be hard to predict what kind of settings would be available. But if the policies are focused more on things like two ADL deficits or something in that mechanism or that description of need, that should handle most of those circumstances.

The place, though, where I think we're really lacking is in the public's understanding of LTC. Most people—and some of this has been spoken about already—still think LTC is nursing home care, and the myths are so rampant, even among people who are not younger. One of the issues out there could be that the younger you are, the less likely you are to understand LTC insurance or the LTC industry, so in some respects, it would be harder to sell a policy or for them to appreciate what they're buying.

Whereas, as people get older, into their 40s and 50s, and maybe their parents have experienced it, they still aren't going to understand it very well, because of how complicated it is. So if there were a way in which all of us could come to understand more about it, it would help the industry sell more policies and balance out some of these costs that are out there, because the myths are rampant even among physicians and nurses.

DR. VICTOR FRIED: What we've seen here today signifies the importance of individuals having LTC and purchasing LTC insurance. Given that, for most individuals in the country, and given the relative importance with respect to pension plans or other heath care needs; has an organization such as ACLI, the Academy or any of the professional organizations done anything to educate the government?

For example, educate Congress, to motivate individuals and employers to say, "This is a benefit that needs to be addressed, and if we as a government can't provide these benefits, at least we can provide some incentive and motivation for individuals who provide this benefit." Is this something that's being addressed currently?

DR. IRVINE: I'll lead off with that. From our perspective, from ACLI's perspective, we are the trade association for the life insurance industry, so we're out there quite actively with the staffers of policy makers, both in Washington and at the state levels, discussing LTC and the importance of the issue to interested staffers. It's self-evident what the demographics are, what the situation is, and what the needs are, and people are working on public policy proposals to promote individual coverage.

Just last week I was working with the staff person internally who's responsible for the District of Columbia and putting together some information that we're using to push for a tax credit within the district. That's the type of thing that goes on at various state levels. And, as Janemarie mentioned, the policy proposal was also circling around Washington of and above the line credit, similar to what one would get for saving money in an IRA. So it is an issue for public policy makers. Obviously, there are higher issues right now for public policy makers, but from a retirement income security perspective, it's moving up the ladder in terms of priority level.

As far as educating the public, that's a job for myriad organizations. We have consumer brochures about LTC, which we send out. They're also available on our Web site. We're not alone in that sense. Some of the best education simply occurs out in the real world through the insurance companies themselves and through their agents. And when you sit down with the class looking at their situation, it may be time for you to think about LTC, given everything else that you're doing a pretty job of taking care of.

DR. MULVEY: I would like to add to that. The whole federal employee LTC plan is evidence that the government has been looking at this. I think over the past five years this has become a more popular subject and they're realizing voters are interested in it. You know, and you can see from the attendance in some of these LTC things, that it's becoming more popular. I think there were close to six sessions on LTC, while there used to be very few, so I think it's becoming more prominent.

MS. CORI E. UCCELLO: I'm the Senior Health Fellow at the Academy of Actuaries, and we put out an issue brief very recently, to the Hill, looking at options for increasing LTC insurance coverage. We looked, specifically, at tax subsidies and at offering tax deductions versus tax credits. And we are also going to be pursuing other issue briefs in this area. We also have visits with Hill staffers and talk to them and offer our expertise as actuaries to help them design their proposals.

DR. IRVINE: A different perspective is meeting with the staffers. At some point, policies and such are best translated into a congressperson. I think the complexity of this process is overwhelming to all of them, and so anything that can be done, education-wise, is important.

I recently had an experience with a former senator who was very pivotal in much legislation related to health care, and is now very active in LTC. There are still

things he doesn't understand about it. I see it all the time working with a LTC organization that tries to work with an acute care organization.

This is a complex industry, a complex process that is hard for anybody to translate into public policy, and it's hard to make a difference. And when you do it, you worry, because you're not sure it's based on the right information. Anyway, I wish we could simplify it.

MR. GENE SHYHCHERNG: I think the panel has already gotten the broader issue, but the one thing missing is cost. LTC is very expensive. We recently discussed the federal program with the Office of Management and Budget (OMB). They tried to cut the cost all ways, but their assumption is only a very low percentage of participants: ten percent.

Okay, 50% of the employees realize that affordability is important now. The cost issue nobody addressed—that's recent. Even though most people realize that this is very important coverage, how many really purchase it because of the cost issue? If we cannot solve the cost issue we'll never address the increase of purchase.

DR. MULVEY: And I think a lot of the cost issue exists because people look at those of older ages purchasing LTC. If you get to the younger ages, it's much more affordable. And, in fact, as Paul showed, a lot of the benefits purchased are much more comprehensive, because they can afford it. So I think that's the point.

The federal government's assumption of ten percent was also very conservative. They're hoping for a lot larger take-up. And they also include retirees in that estimate. There are a lot of retirees in the federal government, so it's hard to say. I think it is more affordable at younger ages.

DR. YAKOBOSKI: I'd go back Janemarie's presentation and the figures she had about affordability. The fact is, it's probably more affordable than most people realize. Significant fractions of the population could afford it. It goes back to information and education.

Now, in some sense, what misinformation is out there about how expensive this product is? It's analogous, too. You know, the misinformation about the gigantic amount of savings that you have every year if you fund your retirement, as opposed to small amounts of money started early will probably get you where you need to be. This, again, is Janemarie's point.

You know, relatively modest premium amounts, especially at early ages, give you the protection that you're going to need, but people don't know that. So, granted, for many people, cost is an issue; but we'll pay now or pay later. Which way is going to be more affordable?

Chart 1

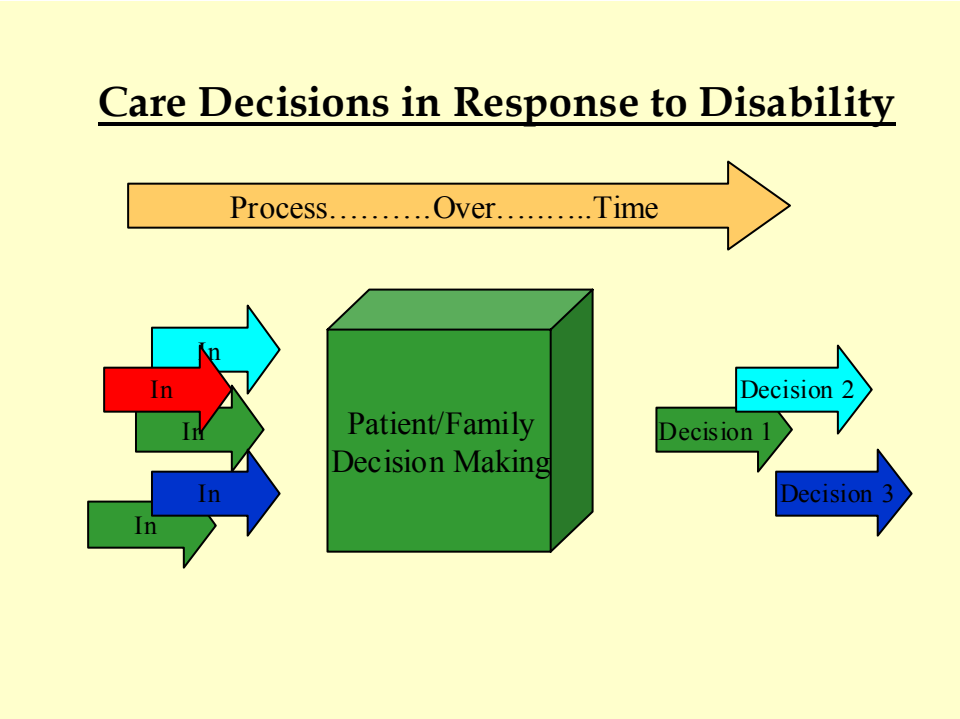


Chart 2

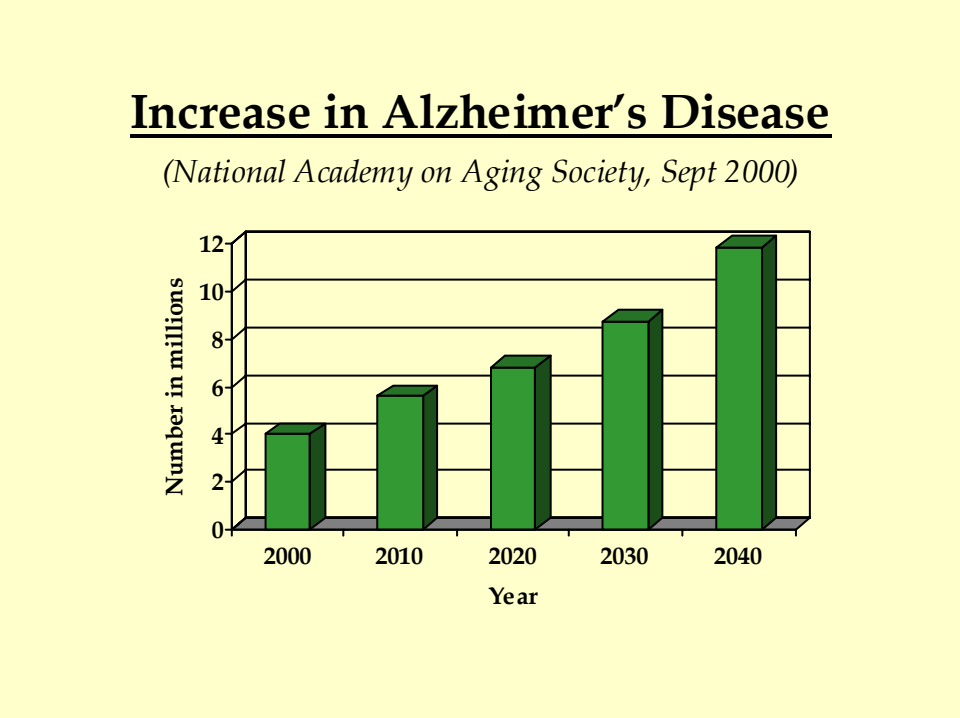


Chart 3

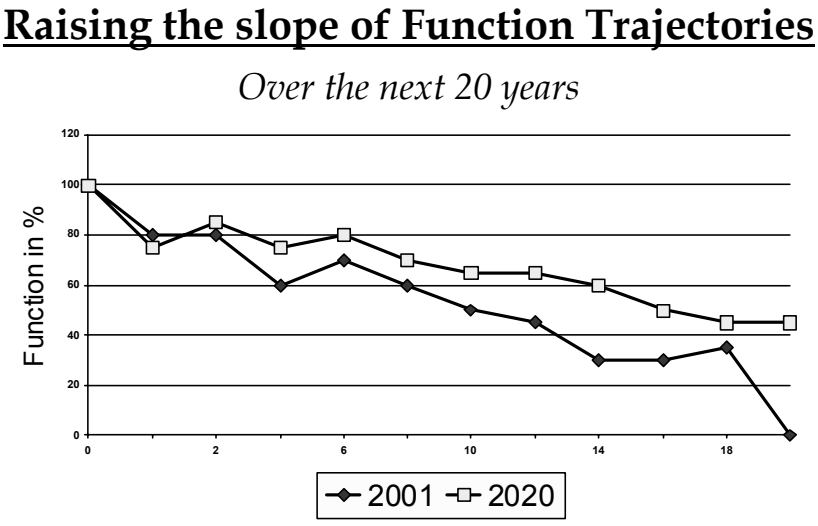
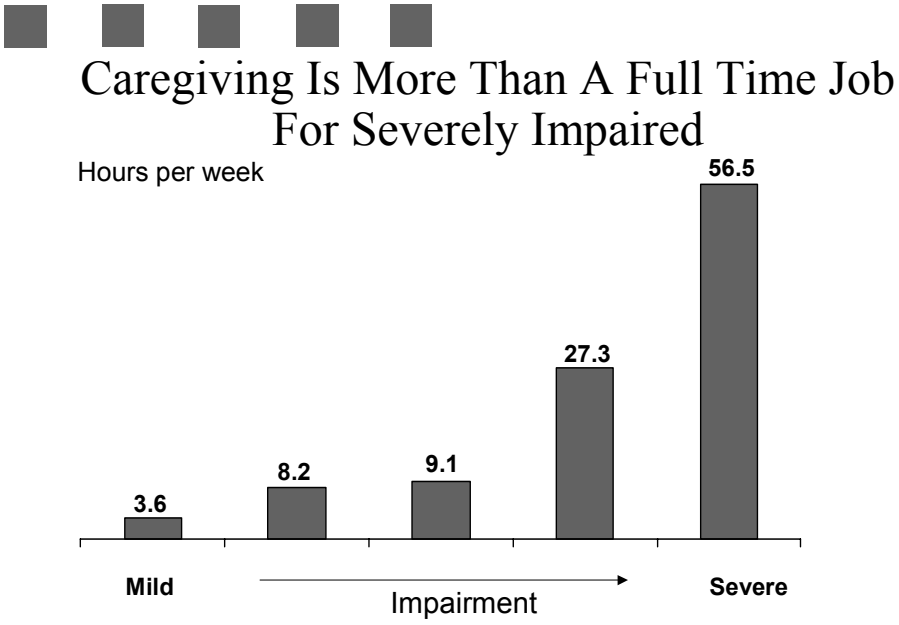
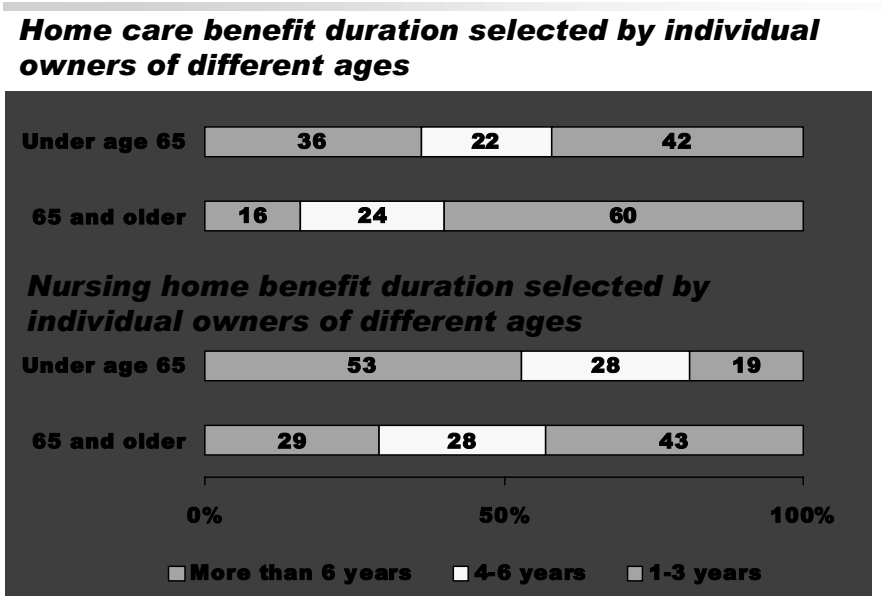


Chart 4



Source: National Alliance for Caregiving and AARP, *Family Caregiving in the U.S.* (1996)

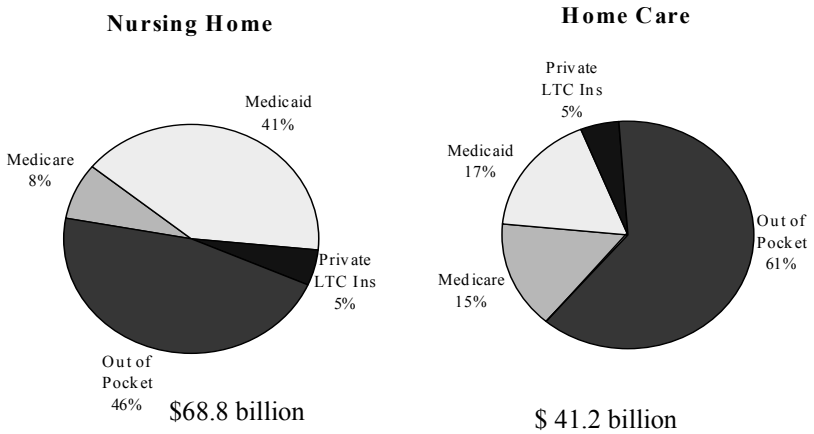
Chart 5



FINANCIAL SECURITY. FOR LIFE.

Chart 6

Current Sources of Payment for Long-Term Care Expenditures- By Type of Care



Source: Mulvey and Stucki 1999