Institute and Faculty of Actuaries

Caring for our future

Consultation on reforming what and how people pay for their care and support

Department of Health

25 October 2013

About the Institute and Faculty of Actuaries

The Institute and Faculty of Actuaries is the chartered professional body for actuaries in the United Kingdom. A rigorous examination system is supported by a programme of continuous professional development and a professional code of conduct supports high standards, reflecting the significant role of the Profession in society.

Actuaries' training is founded on mathematical and statistical techniques used in insurance, pension fund management and investment and then builds the management skills associated with the application of these techniques. The training includes the derivation and application of 'mortality tables' used to assess probabilities of death or survival. It also includes the financial mathematics of interest and risk associated with different investment vehicles – from simple deposits through to complex stock market derivatives.

Actuaries provide commercial, financial and prudential advice on the management of a business' assets and liabilities, especially where long term management and planning are critical to the success of any business venture. A majority of actuaries work for insurance companies or pension funds – either as their direct employees or in firms which undertake work on a consultancy basis – but they also advise individuals and offer comment on social and public interest issues. Members of the profession have a statutory role in the supervision of pension funds and life insurance companies as well as a statutory role to provide actuarial opinions for managing agents at Lloyd's.

Institute and Faculty of Actuaries

Funding Reform
Department of Health
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25 October 2013

Dear Sirs

IFoA response to 'Caring for our future – Consultation on reforming what and how people pay for their care and support'

The Institute & Faculty of Actuaries (IFoA) welcomes the opportunity to comment on the Department of Health's consultation on reforming what and how people pay for their care and support. The IFoA's response focuses on those areas where we feel actuaries can add a unique contribution. This response has been prepared by members of the IFoA's Health and Care Board and Pensions and Long Term Care Working Party who have expertise in the financial impact of long term health and social care needs on individuals and the State. These groups are currently conducting research in the role that the private sector could play in financially supporting the potential impacts of 'The Report of the Commission on Funding of Care and Support: Fairer Care Funding' (the Dilnot Report).

RESPONSES TO CONSULTATION QUESTIONS

Question 1: Do you agree that the future charging framework should be based on the following principles? The principles are:

- ***Comprehensive***
- ***To reduce variation in the way people are financially assessed; be transparent, so people know what they will be charged***
- ***Promote wellbeing and support the vision of personalisation, independence, choice and control and enables delivery of funding reform***
- ***Be user-focused reflecting the variety of care journeys and the richness of options available to meet their needs***
- ***Encourage and enable those who wish to take up employment, or plan for the future costs of meeting their needs to do so; support carers and not place additional burdens on them, in recognition of the invaluable contribution they make to society***
- ***Minimise anomalies and perverse incentives in choices between care settings***
- ***And be sustainable in the long term.***

The IFoA agrees that the future charging framework should be based on the principles as set out above, and would emphasise that in order to encourage people to plan for the future it is crucial that the reforms are sustainable in the long term, transparent and that there is limited variation in the method of financial assessment to simplify future projections.

The IFoA would also like to note the valuable contribution of informal care provision which, based on the national minimum wage, is currently estimated to be c£30 billion per annum.[1] There are significant potential social and financial implications if the informal care sector were to decline in the future.

RESPONSES TO CALL FOR EVIDENCE

Evidence Question 4: What flexibility should be given to local authorities in how they provide assessments of a person's needs to accommodate the introduction of the cap and meet demands on local authority resources? How can we ensure assessments still support wider aims to signpost people to types of care and support, reflect each person's preferences, and ensure safeguarding concerns are dealt with appropriately?

Assessments by local authorities need to be carried out on a consistent basis in order to create a fair and manageable system. The resources to carry out these assessments may be stretched and may not necessarily be balanced across local authorities, particularly as the local authority will have many and sometimes conflicting demands on their resources. The development of common assessment forms and tools could aid in creating greater consistency.

Health and care actuaries typically work in multi-disciplinary teams, working closely with claims managers. Claims managers are responsible for assessing the validity of a claim based on the claims triggers set out in the policy conditions. This could include a disability assessment for an income protection policy; or a care assessment for a long-term care insurance policy, which historically have been based on activities of daily living (ADL) or a significant cognitive impairment. One role of actuaries is to ensure that what is assumed in the pricing is consistent with how the claims are assessed in practice. These insurance based claims triggers are designed for the same purpose, i.e. to determine eligibility to receipt of the insured benefit, as a national minimum eligibility threshold (for assessing whether an individual is eligible to start contributing towards their cap). These claims triggers could be looked to in the development of a national approach.

Evidence Question 25: What financial solutions will be important in helping different groups pay for their care? What are the priorities in terms of supporting the market to develop?

The Institute and Faculty of Actuaries has two key working parties focused on Long Term Care (LTC):

- LTC Working Party – this working party is researching approaches used in other countries and those used in the UK historically; and
- Pensions & LTC Working Party – this working party is focusing on the future link between pensions and LTC; and the potential for product development in response to the Dilnot Report and how this will impact individuals financially.

Consumer needs under the proposed regime

Prior to needing care an individual will have additional income needs dependent upon their lifestyle and cost of living; these will affect their expectations in later life and their level of resources for meeting care needs. For example, some individuals will opt to receive care at home instead of or before going into residential care. Should an individual's care needs mean that they are required to move into a care home they will need to be able to pay for their daily living costs and their care fees. On average these would be around £28,000 per annum for residential care and £38,000 per annum for nursing care based on average care homes fees across the UK for the financial year 2012/13[1]. Once the cap is reached (estimated to be around 4.5 years)[2], the need for income within the care

[1] Laing & Buisson (2013) 'Care of Elderly People UK Market Survey 2013/2013', Laing & Buisson: London.
[2] IFoA Pensions and Long-Term Care Working Party: Products Research Group

funding regime will drop to around £12,000 per annum which we understand represents the expected contribution to daily living costs in 2016.

A key need for individuals in retirement will be access to a range of products that can give them a flexible income, meaning they are able to meet the uncertain demands of a range of potential care needs. The IFoA Pensions & LTC Working Party is currently considering the potential product range and notes that while some of these products already exist, others will require further development. There will likely be a range of potential financial solutions available and the relevance of each will be dependent on where an individual is on their care journey and their personal wealth situation.

Details of the potential products are outlined below.

1 Insurance

1.1 Long-term care protection insurance

This type of insurance would require individuals to pay regular premiums in return for a predetermined contribution towards LTC costs if needed. These premiums could be individual payments from post-tax income, as part of pension contributions or as deductions from the accrued pension. This could be paid over the period of an individual's lifetime or until a fixed age i.e. retirement age. It is likely that the benefit paid would be based on some Activities of Daily Living (ADL) measurement for a predetermined period; for example, on failing 3 ADLs the insured receives a weekly amount covering the care fee in excess of living costs, currently £300 per week on average[1], for 5 years. The framework for receipt of these benefits could usefully link to the expected time taken to hit the cap.

The product could be provided as part of a group or workplace arrangement (which is more appropriate for a pension funding route) or through individual private insurance. Provision in the form of a rider benefit to a main policy may be successful, for example, as an add-on benefit to a life, critical illness or income protection insurance policy; or as an add-on insurance benefit to a defined contribution pension.

2 Pension Drawdown

2.1 Income drawdown

Under income drawdown, a member has the flexibility to withdraw a variable income from their pension pot throughout retirement up to pre-defined maximum annual limits calculated by the Government Actuary's Department (GAD limits) on behalf of HMRC, which are based on average life expectancy. Any remaining benefits not yet taken from the pension pot on death can be passed on through the member's estate (tax charges apply). A potential change to provide more support for care provision would be to increase the GAD limits (to be based on reduced life expectancy) for members with eligible needs, to allow them to draw down their pension assets more quickly to fund their increased care costs.

Members with a secure pension income of at least £20,000 per annum can currently drawdown from their pension pot without any maximum limit applying. This is known as Flexible Drawdown. A refinement to support care provision might be to decrease the £20,000 per annum limit for members with eligible needs to the level of the required contribution to daily living costs. This would enable more people to drawdown income more rapidly to meet existing care costs.

2.2 Variable annuity

Variable annuities are similar to income drawdown, but provide a guaranteed minimum level of income within an income drawdown framework. Typically, funds would remain invested and therefore,

their value would fluctuate. The minimum income level may be increased periodically should the funds have risen in value but would not fall below the guaranteed minimum level should the funds have fallen in value.

The insured can vary the level of income subject to GAD limits (and ideally these would be adapted to vary according to health) and therefore, it is possible that the guaranteed minimum income could increase on going into care. Variable annuities also provide a guaranteed death benefit based on initial fund size and a surrender value is available equal to the value of the underlying investments.

2.3 Ring-fenced pension fund

A ring-fenced pension savings fund that can only be used to finance LTC costs for the member or dependant as the need arises. This could be done either through drawdown or by utilising the fund to purchase another type of product such as an immediate needs annuity. This arrangement could be funded by transfers from defined contribution (DC) pension pots and potentially by partial defined benefit (DB) transfers. Any unused LTC balances within the fund could then be passed on, exempt from tax, if used for the same purpose. If there are no dependants the balance would then form part of the estate and would be subject to tax.

3 Annuities

3.1 Immediate needs and deferred needs annuity

Immediate needs and deferred needs annuities are available outside of the funded DB/ DC pension framework, and are currently the only products for care sold with any scale in the UK due to them being purchased at the point of the individual needing LTC. An immediate needs annuity provides an income for the rest of the insured's life based on their life expectancy (assessed through individual underwriting at the point of taking out the contract).

A deferred option is also available where no annuity is paid for the deferred period. This enables an element of self-insurance for the duration of deferral and hence reduces the cost for the individual yet still provides the certainty of protection in the long term. Deferred periods available are generally between 1 to 5 years.

These products currently require a considerable lump sum investment at the time of purchase and are often funded through individual savings or by releasing equity in the individual's home.

3.2 Disability linked annuity

A disability linked annuity would be funded by a typically significant single premium, payable at retirement either from pension savings and/ or other savings, such as ISAs. Similar to a traditional annuity, a disability linked annuity pays an income for as long as the life insured is alive and the income can be level, RPI-linked or increasing on a fixed basis, e.g. 5% per annum. The key difference is that the annuity income currently starts around 10% per annum lower than a traditional normal health annuity and steps up to a much higher level (or levels) should the insured life require long term care.

4 Housing related

An individual's home (along with their pension) is most likely to be their biggest source of wealth. There is potential to release equity from the home using an equity release type product to fund an individual's care needs whether that be in their own home or in a care home.

Current equity release products tend to be for a lump sum or for an income stream. Changes would be needed to accommodate care funding needs which would require regular payments (e.g. monthly) at a likely smaller level than is typically offered in the market place (for example, if care were provided in the insured's own home). A reduced life expectancy would also need to be factored in to the pricing approach.

How these products can meet consumer needs

The products referred to above can be made more flexible in their design structure (subject to the legislative framework). However, they cannot, of themselves breach consumer reticence to engage with the need to fund LTC needs or their financial inability to generate the funds at the required level. We discuss these issues further below.

Income drawdown and variable annuities provide a flexible level of income. Therefore, as long as the individual has sufficient pension savings, they would be able to fund their care needs through a drawdown arrangement. The improvements suggested in the potential products section above could facilitate better product interaction with LTC needs.

The long-term care protection insurance and disability linked annuity are less flexible as products, but they could be designed to more closely match consumer needs under the capped cost of care regime. However, both would require individuals to provide some level of pre-payment for a future event they are not certain will occur.

The ring-fenced pension fund would meet care needs to the extent funds were made available and prefunded.

Immediate and deferred needs annuities are purchased at the point of need and would meet the care needs to the extent the individual could afford it.

Issues and priorities in terms of supporting the market to develop

Most of the pension solutions identified above require individuals to set aside money or give up income to make a provision for potential long term care needs. Currently, there is a lack of awareness of the cost of care, a lack of saving for old age more generally as illustrated by the growing pensions under saving and a general belief that the State will cover the costs of care through the NHS. There is also a general denial from individuals on the likelihood of needing care. Consumers will also be wary about making long terms savings if they are not confident that the level of state provision will remain unchanged. To generate an increased demand for saving for long term care there needs to be a combination of consumer education and the potential for financial incentives to be available (and as a minimum for disincentives to be removed).

Lessons could be learned from overseas on ways to increase this awareness. For example, in France there has been a considerable growth in uptake in private provision with a 15% per annum growth rate observed, leading to France becoming the second largest market globally for LTC[3]. The OECD report 'Providing and Paying for Long-Term Care' stated that 15% of the population aged over 40 had a Long-Term Care policy in 2010.[4] This growth has been mostly attributed to the wide discussions that took place in the French media on how to fund LTC, making the public more aware of the risks and costs involved in funding LTC and the gaps in public provision. The national solidarity

[3] Kessler, D (2008). 'The long-term care insurance market', *Geneva Papers on Risk and Insurance – Issues and Practice* **33**: 33-40

day introduced in 2005, where a public holiday was given up and workers' pay was donated to charities helping the aged, is also cited as facilitating an increase in awareness.

There are some changes in regulations that might be made which could support the product solutions discussed, for example:

- The ring-fenced pension fund is a new concept and would require changes to pension / tax rules to enable implementation;
- Varying GAD limits according to health (e.g. number of ADLs failed) would facilitate an effective drawdown solution;
- Granting tax relief on the protection insurance premiums could help increase demand for the product; and
- A solution that could help increase pension and LTC saving generally could be to change the auto enrolment minimum contribution rules so there is an additional element of specific LTC contribution made (either as part of or in addition to the current post-staging 8% minimum).

Under a variable annuity and a disability linked annuity, initial income is around 10% lower than it would be for an equivalent annuity without the step up of income on needing long term care. This means these products are unlikely to appeal to the majority of people who elect to maximise their current income in retirement. This is reflected in the current retirement annuity market where a low proportion (less than 10%) take up an inflation-linked annuity, which offers a lower initial income in return for protection against increases in the cost of living. Activity is needed to convey the risks individuals face from these potentially short-term decisions to maximise cash (both in normal health retirement and for LTC).

Issues around funding the products

There are currently a large number of competing pressures for household income and there is already believed to be a large protection insurance gap in the UK. It is also widely documented that there is not expected to be sufficient individual savings being made for regular retirement income at the requisite level[5].

The average cost of residential care in 2012/13 is £28,000 per annum[1]. For a disability linked annuity to provide this level of income, after accounting for the State pension, at the point of needing long term care (determined as the failure of 3 ADLs) an individual would need a significant pension fund of over £100,000[6]. In 2012, the average individual DC pension fund at the point of annuity purchase was £30,000[7]. Therefore, for many people a disability linked annuity would not provide a complete solution to their potential future LTC needs. However, this product could form part of the solution where an individual has other assets such as property to help meet their financial care needs. A similar argument applies to the other pension solutions proposed that, based on current pension saving levels, for the majority of people their pension will not be enough to support their LTC needs in isolation.

Clearly, the extent to which the above pension solutions can be used to support long term care needs will depend on the level of pension savings. Greater saving into pensions could be encouraged by increasing the flexibility of pensions.

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[4] OECD (2011) 'Help Wanted? Providing and Paying for Long-Term Care', OECD: France.
[5] Swiss Re (2012) 'Term & Health Watch 2012', Swiss Re Europe S.A., UK branch: London.
[6] Rickayzen, B. (2007) 'An analysis of disability-linked annuities', *Actuarial Research Centre (180) pp 1-43.* Cass Business School: London.
[7] Crawford, R. & Tetlow, G. (2012) 'Fund holdings in defined contribution pensions', Institute of Fiscal Studies: London.

Issues for the financial services industry in creating products

The main issue insurers have in product creation is being able to correctly price and hold future reserves for the obligation they have to pay the consumer. This will in part depend on the claim definition (or trigger) and the level and duration of claim payment. Lessons need to be learned from the pre-funded products that were developed in the 1990's. In retrospect, these were under-priced by insurers due to the lack of relevant insured data available to price the products initially and the large improvements in longevity observed since their inception.

Another potential challenge for both insurers and local authorities is that the claims triggers under the insurance products are unlikely to dovetail exactly with the local authority assessment triggers. This has the potential to create confusion for future policyholders and may make accurate planning more difficult, particularly where the scope and entitlement to State benefit in the future appears uncertain. The IFoA believes that it will be important to get a clear understanding of the two "claims" assessment systems and how they might differ, in order to better understand these differences and the potential for future convergence. Currently insurers are only selling immediate needs annuities or deferred needs annuities in any real volume, as they are bought after the insured has developed the LTC need so do not require a claim definition trigger.

Evidence Question 29: How can we ensure a proportionate approach to reviews so personal budgets and independent personal budgets record the costs of meeting a person's needs as circumstances change?

Different tools could be developed for annual reviews depending on the degree of change in an individual's care needs or circumstances. For example, the level of local authority involvement could range from an online update where there have been no or only low level changes in circumstances, to a phone call or a personal visit as the magnitude of the change in the individual's circumstances increases. It would be helpful for a standard form to be applied and for the information to be captured electronically for future use and for sharing across government departments as appropriate.

Evidence Question 30: We welcome views on whether the annual care account statement should include projections of when a person may reach the cap or qualify for financial support. How can this be provided without putting the local authority at risk of challenge?

Including some form of simple projection in an individual's annual care account statement would be useful to assist their future planning of care needs and the funding thereof. It will be important to illustrate the potential variability in personal outcomes.

Actuaries have skills and experience in the setting up, development and management of projection models. It is, however, important to note that a model is only as accurate as the data that is fed into it. Therefore, the gathering and analysing of data to develop assumptions on which to base the projections are equally as important as the baseline individual data.

Projections of when an individual may reach a cap, or qualify for financial support should include assumptions/ input on:

- Interaction with State Benefits, including Department for Work and Pensions and Department of Health;
- Assets including any housing wealth;
- Pension income;
- Any other income; and
- Current care needs and future "wants".

In addition to a base run (as per above) it would be prudent to include some additional scenarios to illustrate how the results could potentially change if one or more of the financial, demographic or

desired outcome assumptions were to change, for example a change in pension income, a change in care needs, a desire for a more expensive care home. By providing a range of potential outcomes this could reduce the risk of challenge to a local authority arising from individual expectations not being met through a change in circumstances and the wider environment.

If you wish to contact the IFoA about this response please contact Helena Dumycz, Policy Manager (helena.dumycz@actuaries.org.uk / 020 7632 2118) in the first instance.

Yours faithfully

Jules Constantinou
Chair, Health and Care Board