SQUIRE SANDERS

IN SICKNESS AND IN HEALTH: REFORMING PENSIONS AND SOCIAL CARE

Pensions White Paper 2013

1 FOREWORD

In Squire Sanders' White Paper *"Pensions in the Age of Austerity"*, October 2012, we discussed the way that the balance of responsibility for pensions between the State, employers and the individual was coloured by the financial crisis. We made ten recommendations about how to introduce greater flexibility and improvements into the pensions system within the current economic constraints. One of those recommendations was that the relationship between pension savings and the funding of long term care urgently needed to be reassessed, given the projected increase in demand for care services caused by an ageing population. The debate about social care provision is not a new one but making the connection with pensions is.

The Report of the Commission on the Funding of Care and Support in England and Wales, chaired by Andrew Dilnot, was published in July 2011[1]. The Government responded with its own White Paper, *"Caring for our Future"*[2], which endorsed Dilnot's central principles for reform and formed the base for the Care Bill[3] now in Parliament. The Care Bill incorporates a cap on lifetime contributions to adult social care costs and an increased asset threshold beyond which no means tested support would be given. There has been widespread criticism that the medical care and "hotel" cost caps have been set at an unrealistically high level for most individuals and that the new regime is therefore fundamentally flawed[4]. Nonetheless, there is Parliamentary consensus and progress has been made in starting to reform the system of care provision which, as Dilnot pointed out, was originally designed in 1948 and is not fit for the 21st Century.

In presenting its final proposals, the Government asked the pensions and insurance industries to come up with new ways of funding social care. This paper contains Squire Sanders' response to that challenge, and our recommendations for change.

In this paper, we consider attitudes towards the integration of pensions and social care and discuss how pensions may be a viable source of funding as part of a wider solution. We also assess the changes needed to legislation and benefit design to ensure greater flexibility to meet social care costs.

To inform our response, we conducted a pensions industry survey with *Pensions Insight* magazine to ask about attitudes towards how social care funding could be integrated into pension provision. We also used our survey to gauge the level of knowledge of the projected costs of social care within the pensions context. We are grateful to all those who responded to our survey and also thank the wide range of industry experts with whom we have had discussions.

Squire Sanders
October 2013

1 The Report of the Commission on Funding of Care and Support (July 2011)

2 HM Government's Caring for our future: reforming care and support (July 2012)

3 Care Bill

4 For instance The Strategic Society Centre's A Cap that Fits (September 2013)

2 EXECUTIVE SUMMARY AND OUR RECOMMENDATIONS

The Government's challenge to the pensions and insurance industries to find funding solutions to our future social care costs raises several issues which go to the heart of pension policy and design.

- What are pensions for? Everyone agrees that they are designed to produce an income in retirement until death but, to date, no Government has attempted to prescribe *how* we should spend our money when we retire. So flexibility in design, especially in a defined contribution world, has become the norm. Recent changes such as the introduction of income drawdown, the abolition of compulsory annuitisation at 75 and the preservation of the tax free lump sum are all important parts of that flexibility. All of these factors conspire to put the onus back onto the individual so that when there is a need for care, the decision about how to fund the cost is taken at the time and there is no incentive to plan for care costs in advance.
- Pension plans offer their members little by way of flexibility in the shape of the benefits taken. Many defined benefit plans allow members to provide additional benefits for their dependants by surrendering part of their entitlement (even if few take up this facility) and defined contribution plan members can choose to pay for inflation protection and can also provide for dependants if they wish. However, any attempt to assign pension benefits to another person is illegal under pensions law (for good reason, to protect the member from duress or his own recklessness) but this militates against providing for the future cost of care with a third party.
- Pension tax treatment is not designed with future social care in mind: it would be an unauthorised payment to pre-fund the costs of care out of future pension income or divert a lump sum to a third party.
- The pension *commencement* lump sum is just that: it is only available in one go when an initial pension is taken from the plan. Deferring part of an individual's lump sum entitlement (for instance to pay for later care needs) is not an option without complicated re-engineering of the plan benefits into other arrangements which in turn brings an associated transfer cost.

Given this background, plus all of the psychological barriers to pre-funding for a risk which may never materialise, it is not surprising that pensions vehicles have not been used to pre-fund for care costs. If the Government is serious about giving the pensions industry the tools to access pensions capital wealth for care, then it has three main options:

- Extra tax incentives to save for care;
- Compulsion to save for care;
- Reshaping pensions and tax legislation to allow pension savers to make choices about whether they save for care, and how they do so.

We believe that only the latter course of action is viable. Overcoming these barriers will require not only a change of attitude towards pensions but a change in legislation. This would be an arduous task and there will naturally be reluctance to make further legislative change in pensions, inevitably leading to greater administrative burdens.

Our Recommendations

- **Savers should be permitted to earmark part of their pension rights in advance of retirement to provide for care. There should be no compulsion to do so.**

- **Earmarked pension savings should be capable of being charged in favour of a local authority or other suitably approved care provider** (who would provide the care facility) and invested in safe asset classes to prevent against depreciation or be managed by an authorised insurer to provide a deferred annuity within or outside the pension plan.

- **Pension savers should be able to split and defer their tax free lump sum entitlements** within the same plan (either in addition to or instead of pre-funding by earmarking funds in advance) so that care needs can be provided for by a capital sum at the time of need.

- **Any capital within a pension plan which is earmarked to provide for care (or any premium paid) should be protected if the member dies before the care need arises and the funds for care are not used.** Unused capital would therefore be available, or a refund of premium paid on death, subject to inheritance tax, just as is now allowed through income drawdown products.

- **Unused reliefs and allowances should be portable between savings vehicles and between couples.** If we are to reduce the burden of care costs on the State by integrating pensions into funding solutions, there must be an incentive in the more flexible use of tax reliefs made available to encourage savers.

- **Pension payments to appropriate care providers should be included within the authorised payment regime.**

- **Flexible benefit structures within the workplace should be designed to allow for these new care saving options**.

- **Simple standardised health checks, relievable for benefit in kind purposes, should be delivered via the workplace, supported by health education alongside financial education.**

- **Government should ensure greater awareness of the true cost of care by delivering simple and effective communications**. As recent experience showed with the introduction of automatic enrolment (*"I'm in, are you in?"*), media campaigns can nudge savers to a desired political solution to a seemingly intractable problem. Care is no exception.

We do not believe that pensions savings can provide all of the answers to the problems of funding care and there will continue to be a need for other assets, whether property or other investments, to play a part in an integrated solution. Our report discusses these issues and the wider barriers to funding solutions in greater detail; we look forward to engaging with you in the debate.

Catherine McKenna
Global Head of Pensions, Leeds
T +44 113 284 7045
E catherine.mckenna@squiresanders.com

Clifford Sims
Partner, London
T +44 20 7655 1193
E clifford.sims@squiresanders.com

3 INTRODUCTION: FUTURE DEMAND FOR SOCIAL CARE

The Report of the Commission on the Funding of Care and Support in England and Wales, chaired by Andrew Dilnot[5], contained two key recommendations: a cap on lifetime contributions to adult social care costs of £35,000, and an increased asset threshold to help the less well-off of £100,000, beyond which no means tested support would be given. The Government responded to Dilnot with its own White Paper, "Caring for our Future", which endorsed Dilnot's central principles for reform and formed the base for the Care Bill now in Parliament. However, financial constraints led to a much higher Government figure of £75,000 for medical care costs, tempered by a higher asset threshold for means testing (or Upper Capital Limit) of £123,000[6]. Individuals who need care will still be responsible for meeting accommodation or "hotel" costs, although these will be capped by local authorities at around £12,000 per annum. The new cap and asset threshold will come into force in April 2016, but from April 2015 there will be a right to defer selling an individual's home in order to pay for residential care and local authorities will be under new duties to assess care needs.

The case for reforming the financing of adult social care was well made by the Dilnot Commission and does not need repeating here, especially for a pensions audience which is familiar with the demands of increasing longevity and the consequent change in the dependency ratio.[7]

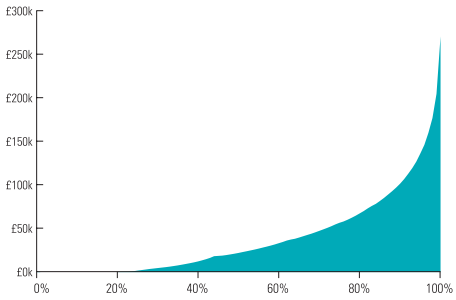
What is less well appreciated is the expected cost of care for the generation over age 65. According to the Government's figures, more than 80% of the population will require care and support after age 65 and half of those in this age bracket can expect care costs of up to £20,000. One in ten can expect costs of over £100,000.

As longevity continues to increase, the demand for long term care is also likely to increase. Dementia, one of the main causes of disability in later life, is currently estimated to affect around 820,000 people. However, by 2051, late onset dementia is projected to more than double and exceed 1.7 million. Age UK also points towards research which suggests that the risk of being in a care home increases with age: to almost 16% for those aged 85 and over[8]. With the number of people over 85 in the UK projected to double in the next 20 years and nearly treble in the next 30 years, the need to tackle the future funding of long term care is critical.

The Cost of Care

"We estimate that a quarter of people aged 65 will need to spend very little on care over the rest of their lives. Half can expect care costs of up to £20,000, but one in 10 can expect costs of over £100,000. Some could spend hundreds of thousands of pounds. There is no way of predicting in advance what the costs might be for any one person.

Expected future lifetime cost of care for people aged 65 in 2009/10, by percentile (2009/10 prices)



Source: ESHCRU/PSSRU microsimulation model

We know that for those who are born with a disability, or who develop a care and support need during their working life, lifetime costs will be considerably higher."

Dilnot Commission

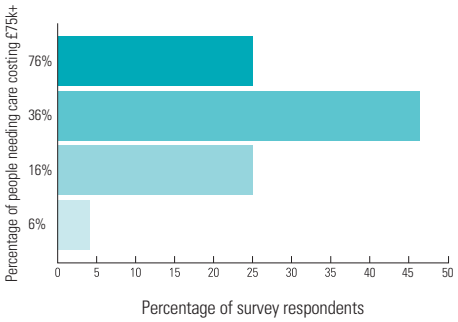
5 See footnote 1

6 The cap was originally expressed in 2010/11 prices at £61,000. The Upper Capital Limit was similarly set at £100,000 in 2010/11 prices, equivalent to £123,000 in 2017/18 prices. Because the Government decided to bring forward the reforms by a year, the adjusted figures for 2016 will be a cap of £72,000 and an Upper Capital Limit of £118,000

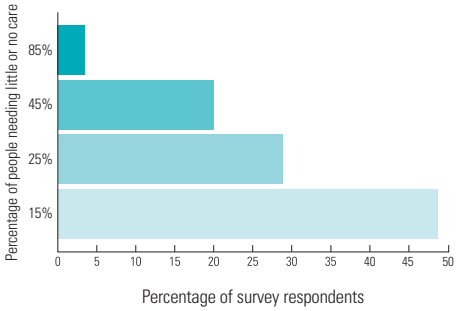
7 This ratio measures how much the population of the elderly is dependent on the working age population. See Actuarial Profession's Long Term Care – a review of global funding models: A background paper for discussion, draft (22 October 2012). See also the ILC's UK Study Ageing, Longevity and Demographic Change (2013)

8 Age UK's Later Life in the United Kingdom (July 2013)

What percentage of people do you think will need care in retirement costing in excess of £75k?



What percentage of people do you think will need little or no care in retirement?



Our survey found a surprising variation in awareness of these projected needs. When asked what percentage of people would need care in retirement costing in excess of the cap of £75,000, only 25% chose the answer matching the Government's findings (16% of people over age 65 will incur medical care costs at such a level)[9]. Indeed, there was a significant over-estimation of the number of people who would require such care: just over 70% of our respondents thought that at least 36% of the population would need care in excess of £75,000.

This finding was corroborated by the second question we asked in our survey: what percentage of people respondents thought would need little or no care in retirement? 27% of respondents chose the answer matching the Government's findings (25%[10] of over 65s will have little or no need for care) with 50% of our respondents under-estimating the number of people in this bracket).

These questions were intended to draw attention to the fundamental problem of demand for the pre-funding of social care: no one knows in advance how much (if any) care one will need and for how long. Comparably, this is no different a dilemma than any other insurable risk that we all face every day of our lives, but consumers do not take the same attitude to the risk of their house burning down or having a car accident as they do to needing care support. The law and commercial reality ensures demand for other insurable risks, such as buildings and car insurance, and those risks are serviced by highly competitive markets. The reasons for this are complex and include confusion over the universal free health services provided by the NHS and those which are not free, such as social care and its associated accommodation costs. No similar imperatives or incentives to save for post-retirement care costs exist and the market is, relatively, far less well developed.

There are other deep-seated reasons including confusion and fundamental misunderstandings of what the NHS will provide in relation to universal health care and how part of our National Insurance Contributions (NICs) help to pay for those NHS services.

One respondent to our survey voiced a commonly held view: *"employers are currently obliged to pre-fund social care costs - it's called National Insurance"*. But NICs for health care (unlike, ironically, for supplementary State pensions) are not hypothecated in this way and NICs do not pre-fund the system at all: they are a pay as you go tax.

9 Paragraph 23 of the Department of Health's Policy statement on care and support funding reform (11 February 2013)

10 See footnote 9, paragraph 5

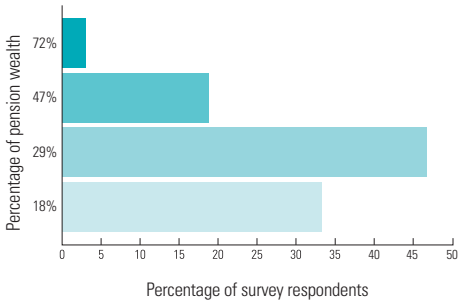
4 AFFORDABILITY ISSUES

There is of course no point in discussing the funding of social care without looking at the macro-economic background: if pension savings are inadequate to provide sufficient income in retirement then they cannot provide any part of the answer to the financing gap for long term care costs. In our survey we asked two questions which dealt in turn with the resources of the current generation of over 65 year olds and a broader question about all sources of asset wealth and how much pensions savings contributed to the overall picture.

Interestingly, just under a third of our survey respondents knew that of the current generation of over 65 year olds 31% have total household wealth equal to or greater than £500,000; 63% of our survey respondents estimated the figure as being much lower at 13%.[11] In the cohort of 45 to 64 year olds, 43% of households have total household wealth in excess of £500,000.

For this purpose, the ONS defines total household wealth as a net wealth measure by adding together property, financial assets, physical wealth and private pension wealth. Given the different degrees of liquidity of these asset classes which, on one level at least, dictates how available they would be to fund social care, we also asked our respondents what percentage of British people's wealth overall they thought was held in pensions. Only 18% of our respondents chose the right answer (47% of total wealth, compared to property wealth of 33%, financial wealth of 11% and physical wealth of 9%).[12]

The Office for National Statistics classes individual wealth as financial, pensions, physical or property. What percentage of British people's wealth do you think is held in pensions?



Demographic Trends

Current demographic trends may affect people's ability to fund care in the future. Between 1980 and 2008, statistics show that marriage rates in the UK continued to fall. During the same period, however, divorce rates continued to rise at a steady level. What is not clear is whether this will result in more elderly people living on their own and having to rely on professional care, whereas historically they could have relied on the care from a spouse, or whether it is simply a case of people living together but not marrying, in which case the issues may be more around rights and responsibilities both in relation to the provision of care and inheritance.

Over recent years we have also seen a growing pressure on public spending, causing inevitable squeezes on the public purse[13], including for local authorities who are primarily responsible for the provision of long term care facilities. As public spending fails to keep pace with demographic changes, responsibility for funding for long term care will shift towards the employee (and maybe even the employer).

11 Office of National Statistics' Total Household Wealth by Region and Age Group (June 2013)

12 ONS defines financial wealth as comprising formal financial assets such as bank accounts, stocks and shares and informal financial assets such as family borrowing. Physical wealth consists of contents of main residences and any other property as well as collectables, valuables, vehicles etc.

13 PWC's Gaming the Cuts (April 2013)

5 THE CURRENT MARKET FOR FUNDING OF CARE PROVISION

Lack of Suitable Products

Even where there is interest in saving towards long term care costs, the products currently available are not well suited to meeting these needs. The current tax-efficient savings vehicles are limited in number and each have limitations placed on their operation. The Government has laid down the challenge for the design of other products. But what type of product does the market need?

In publishing its White Paper in July 2012, the Government drew upon research commissioned from Ipsos MORI[14] which discussed the barriers to the development of financial products. These included general unwillingness to plan for the future, a "state-will-provide" mentality, a lack of understanding both of potential care needs and of the products available, and a concern about cost.

Many of these factors will sound familiar to a pensions audience. Providers of products (notably insurance companies), have raised their own concerns about the viability of product development against an uncertain background, including concerns about profitability, poor potential take-up, uncertainties about funding/funding frameworks, unpredictability of risk, complexity and bureaucracy.

As part of that research, Ipsos MORI asked about the range of possible products (noting that few commented in detail). The following were mentioned:

- Annuities e.g. Immediate Needs, Disability Linked Annuity
- Convertible critical illness policy
- Insurance products
- Equity release
- Insurance products linked to pensions
- 'Care' savings accounts
- Long term care bonds
- Flexible life policies
- Interest only loans on property

Any savings or insurance-based vehicle offered to help manage long-term care costs must be able to address the twin challenges of certainty and flexibility, and there are no current products which sufficiently meet both of these goals.

14 Ipsos MORI's Caring For Our Future Engagement: Analysis of Responses (February 2012)

Property or Pensions?

What of other asset classes? Equity release products designed to provide an income from property assets have made a much more direct contribution to capital funding of the care market for a variety of reasons. These include the greater incidence of property ownership and the fact that when a person needs residential care, the soon to be empty house becomes a means of funding the new accommodation cost. Just Retirement have estimated that total UK housing equity for over 65 year olds is around £750 billion which suggests that a significant proportion of the current generation of over 65s could at least afford to fund the majority of their own care via property assets without recourse to pensions savings[15].

Generational Attitudes

Although the statistics referred to in section 4 above for the amount of wealth held in pension arrangements may appear surprisingly rosy at first glance, different generations have a different attitude towards and ability to accumulate sufficient wealth to meet retirement needs.

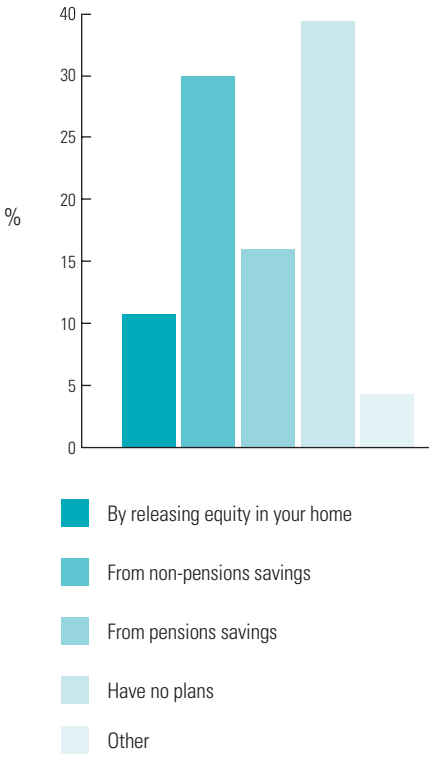
Various surveys have shown that the post-war generation of current pensioners have markedly different (and more generous) attitudes to ensuring that they have sufficient wealth to pass on to their children. This is of course also the generation which has benefited from historic defined benefit pension provision. But attitudes to passing wealth to future generations are changing: "spend it whilst you can" is not an uncommon philosophy.

Separately, there is often an emotional and financial attachment towards property ownership – "an Englishman's home is his castle" – and this reluctance to give up property ownership will always act as a restraint on funding of care. The dilemma of having to sell the residence in order to fund care costs has of course been recognised by the Government in the Care Bill, by the introduction of the deferred payment system on a nationwide basis[16].

15 Comparable statistics show that total net financial assets (excluding property) across all age groups stood at £4,140bn in 2012 (source Lloyds Bank; ONS, DCLG and Halifax), of which £2,195bn were held in life and pension funds. Towers Watson's Global Pension Assets Study 2013 measured total pension assets of US$2,736bn, of which 26% are DC (or $711bn); 74% DB (or $2025bn)

16 Care Bill, clause 34

If you, or a dependant, need care in old age how are you planning to finance it?



There is a skewing of pensions wealth towards older generations. Younger generations increasingly will live in a defined contribution world without the security of their defined benefit parents' pensions wealth. The same younger generations will have different debt patterns: student debt is a new phenomenon and property ownership itself is happening at a later age.

Younger generations will find it harder to accumulate the same level of property wealth to support the equity release market of the future. A significant number of those individuals sitting in between older and younger generations, often referred to as *"tomorrow's pensioners"*, are *"fearful of the future … [with] one in five… finding it difficult to manage financially"*[17] . However, without reform, future generations will need to save significant amounts to accumulate sufficient capital assets to meet all of their retirement needs, if indeed that is possible.

Against this background, when our survey asked about how respondents were planning to finance care in old age for themselves or dependants, slightly more (16%) were planning to use pensions savings than equity release (11%). Non-pensions savings were more popular than either pensions or property (30%), but 39% had no plans in place at all.

Not surprisingly, many of our survey respondents commented on this underlying question of the ability to save more for social care. One commented that "*when we already have a DC time bomb in terms of general low levels of saving for retirement, adding in a specific expectation for social care is unrealistic*" and another noted that there was "*fundamentally not enough money around - certainly not in pensions yet*". But others were more sanguine: *"the pension lifetime allowance should be increased by a supplementary "care LTA" to allow additional tax efficient saving to meet care costs"* and "*if a cap is put on the amount an individual would have to contribute, then he can plan for that cost himself*".

17 Age UK's Economic Tracker (Summer 2013)

6 STRUCTURAL BARRIERS

Leaving aside the issues of savings adequacy and alternative funding via property, the regulatory and taxation conditions placed on pension plans limit not only the amount of savings that can be accumulated but also restrict the time at which benefits can be accessed, the shape of those benefits, to whom they must be paid, and variations to the pensions and benefits that can be drawn. All of these factors have combined so that pension vehicles have not to date been considered as a direct source of pre-funding for long term care, even when in practice they are used to meet care costs when pension income comes into payment.

Income Stream Design

Although there is considerable wealth tied up in pensions, pensions wealth cannot easily be accessed in a case of need. There is an obvious need to avoid the "moral hazard" of frittering away pension savings designed to provide for post-retirement income. Pension plans are designed to encourage long term saving and restrict access to saved funds until later in life at a time when long term care is most likely to be needed. They are designed to deliver an income stream with the option of a tax free cash lump sum on retirement. The current legislative regime requires that a regulated arrangement must provide benefits only to the pension plan member or his spouse, civil partner or dependants (with limited exceptions). There is no flexibility to pay benefits to a third party within the authorised payment regime. Statute voids any attempt to grant a charge over pension entitlements[18].

Lack of Integration with Other Welfare Benefits

Alongside their characteristics in providing a relatively inflexible income stream, pension arrangements are not integrated with any other State welfare benefits: the only link to benefits provided by the State has been by reference to the basic State pension or the State second pension, where contracting out of the latter has been an option to determine the basis of accrual and contributions. This option is now in the process of being withdrawn for DB plans from 2016 as it has already been for DC plans. There is no automatic correlation with other benefits, whether State-subsidised or means tested. The Department for Work and Pensions is separately run and budgeted for from the Department of Health. Some pension plans do deal with issues of health and illness by allowing for the acceleration of pension payments. Serious ill-health lump sums are available where a person has a terminal condition with less than 12 months to live and, more generally, in DB plans early retirement on actuarially enhanced terms may also be permitted. As a consequence, the unwritten assumption for those who retire in good health, whether from DB or DC plans, is that any care provision is a purely private affair to be dealt with at the appropriate time.

18 Section 91 of Pensions Act 1995 (with some exceptions to this general principle contained in s91(5))

Tax Treatment

Readers will be aware of the tax advantages to pension savings, which are not enjoyed in the same way by funding for care via other savings or insurance products. If the Government wishes to encourage individuals to fund for retirement and also meet care costs, it is difficult to see how this can be achieved without providing some kind of incentive or compulsion. Incentives to save for pensions have been eroded with the reductions in the annual and lifetime allowances since first introduced in 2006, but still provide a meaningful savings incentive. Unused pension tax relief could potentially be used to provide incentives for social care funding, without a wholescale change of approach, particularly if coupled with greater flexibility on the purposes for which pension savings could be used.

In addition to pension tax reliefs, other tax reliefs are available, some more relevant in practice to higher earners than others[19], not all of which are used in full by each tax payer. We doubt that *additional* tax incentives are a realistic possibility in the current age of austerity, where tax incentives are being reduced (for example the tax reliefs on private pensions savings) rather than extended. Accordingly we assume a system of tax reliefs for funding the cost of long term social care will be unachievable politically. However, we do consider that current tax incentives to support pension saving could be adapted to encompass social care provision within the same taxation regime.

One possibility in any long term care solution is to enable a "total tax relief budget" for each individual, to allow transferrable tax reliefs to support care provision whilst reducing other tax reliefs less relevant to individual needs, as part of a more holistic approach to care funding and as part of a more joined-up total welfare approach. A "welfare pot" combining state and private care and pension provision to meet the needs of an ageing population could be a way forward to bridge the current gap between different types of provision, dealing with all welfare issues together, with a properly integrated approach to state funded and privately funded provision. The expenses of caring also need to be recognised, within the same tax relief budget. We would also suggest that unused reliefs and allowances should be portable between couples (however "couples" is defined) recognising that in a long term and/or permanent partnership, caring for each other is usually a joint responsibility.

19 Examples include: enterprise investment scheme relief; dividends from venture capital trusts; interest and other income from certain gilt edged securities; certain health and employment insurance payments; and income from individual savings accounts and personal equity plans

Lump Sum Inflexibility

The typical pattern of drawing benefits from a pension plan includes drawing a significant amount as a tax-free lump sum, but only at the start of retirement – it is a pension *commencement* lump sum - in exchange for a lower annual pension. The lump sum is attractive, not just for its tax advantage but as a means by which many can satisfy their dreams of retirement at an age when they are more likely to be fit and healthy. However, there is neither an incentive nor flexibility to use any part of the lump sum to prepare financially for future care needs *within* the pensions vehicle in a tax efficient environment, and the focus of an individual at the point of retirement may not lie in ensuring that the remaining pension after taking any lump sum will suffice for the individual's maintenance. The current rules around the timing as to when a pension commencement lump sum can be paid are also overly complex[20]. Outside the drawdown regime for DC pensions, neither is there flexibility to earmark or defer pension in favour of a further sum when the need for it may be greater later in retirement.

Accordingly, we suggest that an individual should be able to defer taking all or some of the pension commencement lump sum at the start of retirement, and earmark it for care needs, so that it can continue to accumulate in a tax privileged environment, until care is actually needed, coupled with protection of the capital sum should death occur before the fund is called upon to provide care.

Inflexibility of Drawdown

Government has played a part in a gradual reshaping of the pensions landscape by introducing income drawdown for DC, abolishing both compulsory annuitisation at 75 and the default retirement age, all of which are leading to a cultural shift in what "retirement" really means. As an alternative to a traditional pension payment, drawdown is available for those with the required levels of DC pension savings and subject to the terms of the pension arrangement in question. We welcome the 2011 changes to pension income drawdown[21] and consider that they should be further built upon to introduce greater flexibility as to how an individual may alter the shape of his drawdown pattern to better address certainty of income at a time of life where greater care costs are likely to be incurred.

20 Finance Act 2004, Schedule 29, paragraph 1 and HMRC's Guidance Manual RPSM09104130

21 Including where those with a minimum income of £20k have greater flexibility and can drawdown an unlimited amount

Pension Vehicles

The overall degree of flexibility in the form of and timing of pension benefits will depend on the type of pension vehicle in which they are housed. These are generally:

- Traditional DB plans which typically offer some ill health protection in the payment of incapacity pensions, and some options around surrender of pensions for dependants, but little flexibility around the timing and shape of pension payments.
- DC vehicles (whether contract or trust based) where investment flexibility and risk is with the member, and which only provide early access to pensions savings on ill health, and, particularly if they are occupational trust-based, may not enable flexibility around the timing of payments unless the member transfers on retirement.
- Self-invested personal pensions, which offer much more flexibility around the timing of retirement and options for drawdown, where that inherent flexibility could support the earmarking of funds for social care, but which are outside the reach of many pension savers who don't practically have access to the SIPP market.

We suggest that in any wider review of social care provision and in considering legislative change, the merits of different pension vehicles should be assessed in relation to social care provision, recognising that not all are the same.

7 OTHER FACTORS

In addition to the structural barriers noted, there are a number of other barriers to a coordinated approach to social care provision which currently disincentivise social care provision. The social attitude towards budgeting for care has been noted by the ABI as "*a major challenge in a society as rooted in consumer spending as we are and where many people carry an exaggerated sense of what the State will provide for them in old age*"[22]. In any long term solution, addressing how people are motivated to plan for their personal care and the behavioural economic factors involved becomes critical.

The UK's current savings regime is highly complex. That complexity is a disincentive for the saver to save[23] and a meaningful comparison between differing products is almost impossible for any consumer to make.

Going back to basics, the care burden is shared between the State and the individual. Ultimately, an individual's circumstances will determine how the individual's part of that burden should be met but clarity about the right approach to long term care planning should be via an integrated approach. Although it is not intuitive, bringing care into the mainstream financial planning arena (alongside other risks) would heighten public perception of both the costs of care and the likelihood of needing it. In addressing consumer motivation, lifestyle triggers (e.g. marriage, birth of children, point of retirement) ought to stimulate a buying decision for care requirements.

Approach of Other Countries

We suggest that, despite different methods of State funded care and health arrangements, certain aspects of other countries' approaches could help to inform the UK debate, particularly in relation to the use of privately funded policies to top-up state care provision.

As an example, Germany operates an insurance arrangement, paid for by a combination of employer and employee input, although not State-backed. In the US approximately 59% of long term care payments were made by the government funded Medicaid and Medicare programmes[24]. Medicaid is a means tested welfare system which is designed to fund medical and health related services, whilst Medicare is an insurance programme for people with disabilities. Both of these programmes are funded by taxation. Medicaid is, therefore, only available to low earners. For those who are eligible for Medicare, only around half of the healthcare costs are paid for out of the policy.[25]

22 The ABI's Identifying the Challenges of a Changing World: The trends facing insurers towards the 2020s (2013)

23 Put the saver first: catalysing the savings culture, Michael Johnson, Centre for Policy Studies (September 2012). See also its sister paper Simplification is the Key, stimulating and unlocking long-term saving, Michael Johnson, Centre for Policy Studies (June 2010)

24 The SCAN Foundation (2011)

25 The Actuarial Profession's Long Term Care – a review of global funding models: A background paper for discussion, draft (22 October 2012)

"If platforms can fulfil their potential to attract a wide base of customers to online consolidated saving practices, they could stimulate greater saving and help bridge the uncertainties surrounding moving from accumulation to decumulation which can deter people from pension saving in the first place"

Source: *ABI*

This differs from the UK Government's plans in the Care Bill (where the proposal is to cap the value of assets taken into account before State care funding is provided and where there is universal health care), but is relevant to the consideration of how the US public has taken more personal responsibility for their own care (akin to the current UK theme of encouraging pension saving via automatic enrolment).

The US also uses partnership arrangements whereby the amount of insurance coverage purchased equals the amount of the assets that are protected from consideration if an individual needs to apply for Medicaid[26].

Consistent Standards

Currently, State funded social care is provided by Government via local authorities. The complexity and arbitrariness of some features of the current care system need to be addressed, for example in relation to local variations in the level of care and qualification requirements. If any future system is to involve pension arrangements, there needs to be a consistency of approach in addressing the difficult issues of release of funds from insurers and other pension arrangements to care providers. We suggest that a pension arrangement should be able to treat as an "authorised payment" a payment to a registered care provider (i.e. the body which provides the care for which the funds are released and which meets the regulatory criteria established), where the local authority has confirmed that the needs assessment of the individual has been met. In the event that the care provider becomes insolvent, the statutory obligation to provide care reverts to the local authority.

The Role of Technology

There is also a role for technology in provision for care. A holistic approach to retirement and care planning could be achieved by employers and individuals making increased use of technological platforms. The ABI argues that *"if platforms can fulfil their potential to attract a wide base of customers to online consolidated saving practices, they could stimulate greater saving and help bridge the uncertainties surrounding moving from accumulation to decumulation which can deter people from pension saving in the first place"*[27]. A number of insurers have already invested in platform-based technology to enable individuals to manage their financial planning, but an industry-wide investment in such technology for both public and private sector employees is required. This will not be easy, especially as *"future customer attitudes to data will be one of the most challenging areas for insurers to gauge in the decades ahead."*[28]

26 This would mean that $50,000 worth of long term care insurance would pay for $50,000 worth of care. If further care was required, an individual could still apply for Medicaid, and would still retain $50,000 worth of assets. See footnote 25

27 See footnote 22

28 See footnote 22

8 ENGAGING EMPLOYERS

Irrespective of any state funded solution to funding for long term care, the workplace may be the best location for developing and communicating the necessary privately funded long term care solutions.

In our survey, 22% of respondents thought that employers should have no role at all, with 59% of respondents considering that the employer's role should be to encourage or educate employees in the provision of social care costs, with the remainder considering that the employer should have some role in the funding of social care costs.

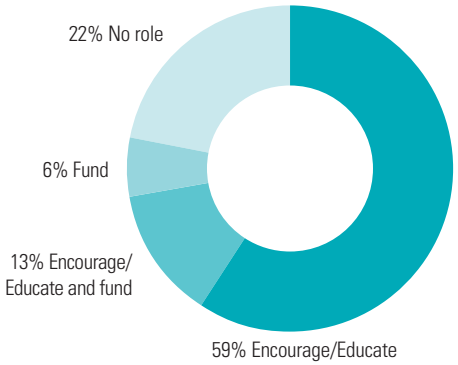
In the workplace, employers have the attention of their employees for longer each day than any Government department. Academic research has shown that employees have more trust in their employer than in Government or financial services providers. Engaged employers therefore have the ability to design flexible benefit arrangements to include pre-funded care options, including within a pension vehicle (assuming our recommendations are adopted!).

Many employers already choose to provide permanent health insurance up to normal retirement age to replace both salary and pension contributions, although they have no regulatory obligation to do so. Financing insured arrangements for medical care and PHI arrangements is designed for pre-retirement age support, either to encourage an early return to work or to replace income from employment. PHI is a start, and many enlightened employers will supplement PHI with return to work engagement or absence management programmes. This practice should be supported.

The CBI has carried out extensive work in this area, most recently in its "Fit for purpose" survey in July 2013[29]. This paper estimated the direct cost to the UK economy in 2012 of absence from work at £14 billion a year or £975 per employee. Nearly a third (30%) of all working time lost is attributable to long term conditions. The report also notes that *"caring for family members or other dependants is another potentially growing factor behind absence (cited by 11% of employers for manual workers and 17% for non-manual). Moreover, breakdown in support arrangements can act as an added factor on occasion (with 9% of employers seeing this as a major driver of absence among their non-manual employees)".*

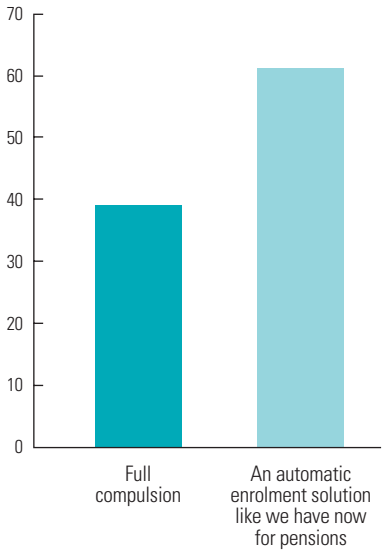
With the abolition of the default retirement age, and the consequential likelihood of employees remaining in employment past age 65, employers will need to approach the challenges of an older workforce where older employees may not have the funds to retire and meet their own needs for retirement income and the costs of their own care, but where deteriorating health could impact on their ability to meet the requirements of their job.

Do you think employers should be obliged to encourage or fund employees to meet social care costs?



29 CBI's Fit for purpose - Absence and workplace health survey 2013 (July 2013)

If employers were obliged to pre-fund social care costs in the workplace, would you favour:



Were pension and social care costs to be better provided for from an earlier age, this could support an employer to meet the growing challenges of an ageing workforce. Accordingly, an enlightened employer should not be discouraged from the idea of a healthier and therefore more productive and motivated workforce, which will also be capable of working longer and saving more towards its retirement/social care needs.

Compulsion?

There are few voices calling for compulsion in saving for long term care. This is unlikely to be attempted in the UK while we have a State funded health service for core care costs and, unlike a pension, long term care may not be a universal need.

In our survey, when asked whether, if employers *were* obliged to pre-fund social care costs, respondents would favour an automatic enrolment type solution, or full compulsion, only 38% favoured compulsion. In the non-compulsory group, one respondent commented: *"I have no confidence that greater compulsion will bring about better or more affordable care for the elderly"*. From the minority favouring compulsion, the comment from one of our respondents was typical: *"Like pension auto enrolment, without some compulsion (sooner rather than later) not enough change will be made and the funding 'gap' will continue to widen"*.

We consider that the priorities must be to encourage greater saving generally (by whatever means) and to incorporate more flexibility as to what those savings can be used for.

The Employer's Role in the Communication Challenge

If the Government is to raise awareness of the need for individuals to provide for their social care, provision of clear and consistent information about the level of State provision and the remaining responsibility of the individual to provide for any care needs not provided by the State becomes key in incentivising an individual to plan and save adequately.

We therefore advocate a workplace communication structure to deliver communication material designed by the Government that addresses universal, consistent, clear and simple provision of information on what is and isn't covered by the State, how likely employees are to need funds for care, and what solutions there are for care funding, but disseminated via employers. This could be akin to information provided on automatic enrolment but should highlight the key messages in a clear and simple way, in contrast to the more complicated approach used for automatic enrolment.

We summarise our conclusions and recommendations in section 2 of this paper. We would welcome your views and please contact us if you would like to participate in the social care and pensions debate or have any questions or comments.

CONTACTS

Catherine McKenna
Global Head of Pensions, Leeds
T +44 113 284 7045
E catherine.mckenna@squiresanders.com

Clifford Sims
Partner, London
T +44 20 7655 1193
E clifford.sims@squiresanders.com

Helen Miles
Partner, Birmingham
T +44 121 222 3138
E helen.miles@squiresanders.com

David Griffiths
Partner, Manchester
T +44 161 830 5359
E david.griffiths@squiresanders.com

Anthea Whitton
Partner, Leeds
T +44 113 284 7364
E anthea.whitton@squiresanders.com

Kirsty Bartlett
Partner, London
T +44 20 7655 0298
E kirsty.bartlett@squiresanders.com

Daniel C. Fowler
Associate, Leeds
T +44 113 284 7336
E daniel.fowler@squiresanders.com

Donna McEnery
Business Development Manager, Leeds
T +44 113 284 7515
E donna.mcenery@squiresanders.com

Andrew Gregory
Media & Communications Manager, Europe/Asia
T +44 20 7655 1257
E andrew.gregory@squiresanders.com

SQUIRE SANDERS

squiresanders.com