Chapter 8

Private Long-term Care Insurance: A Niche or a "Big Tent"?

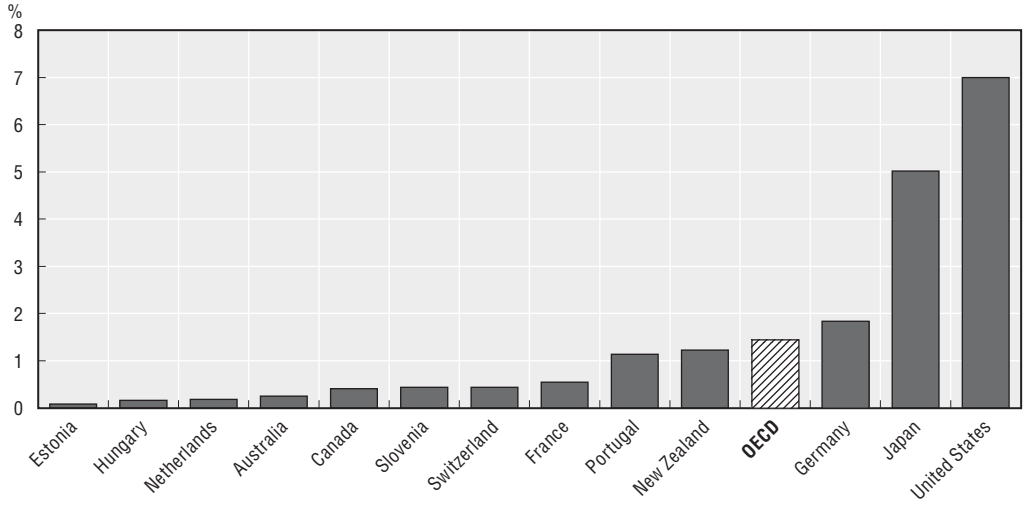
Given the expected increase in total long-term care (LTC) expenditure, there is interest in some OECD countries in the potential role of private LTC insurance. Indeed, financial planning for retirement may include the subscription to a private LTC coverage product to protect one's income and assets against the risk of needing long-term care, in order to reduce the burden it would create on the family and provide more choices regarding the care received. But, there are very different views regarding the merit of private LTC coverage. For some, this could leverage new financial resources towards long-term care, thereby alleviating future potential pressures for governments to increase their support. For others, it could represent a less efficient and more costly way to ensure universal and comprehensive coverage, relative to public pooling. However, private long-term care coverage arrangements represent small markets in OECD countries. This chapter describes and analyses the role and size of private LTC coverage arrangements across OECD countries. It examines the potential factors affecting the size of LTC insurance markets and countries' initiatives to encourage its development. It then discusses the role that private insurance arrangements could play in LTC systems in the future.

8.1. A small number of OECD countries account for the largest markets

In OECD countries where private LTC insurance is sold, the market is generally small. As shown in Figure 8.1, private insurance arrangements play the largest role in the United States and Japan financing about 5 to 7% of total LTC expenditures; but they generally account for less than 2% of total LTC spending. Typically, private LTC insurance arrangements develop around a country's public LTC system, either to complement available public coverage, or provide benefits where there is no public LTC coverage. For instance, in Germany, private LTC insurance offers substitute cover to the population who opts out of the public LTC insurance. In the United States, most of the buyers of private LTC insurance are not eligible for Medicaid, which is targeted to the poor. Private LTC insurance can also offer complementary coverage for the portion of the LTC cost not covered under universal public plans, such as in France, Belgium, Japan and Germany.

Figure 8.1. **The private LTC insurance market is small**

Share of total LTC spending



Note: Data refer to 2008 for Canada, Estonia, France, Hungary, Germany, New Zealand and Slovenia; 2007 for Australia, and Switzerland; 2006 for Japan and Portugal; 2005 for the Netherlands. Except in the case of the Netherlands, New Zealand, Slovenia and Spain, data refer to long-term nursing care only.

Source: OECD System of Health Accounts, 2010; and US Department of Health and Human Services, 2010.

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Information on the proportion of the population covered by private coverage arrangements is limited; the literature points to the United States and France as two of the leading markets in terms of the population coverage. In the United States, about 5% of the population aged 40 and over holds a LTC insurance policy. In France, in 2010 about 15%[1] of the population aged 40 and over, held a LTC insurance policy.

A wide range of private LTC coverage arrangements with varying eligibility rules, benefit triggers and benefits paid can be found in OECD countries. Two main products have emerged over time, the reimbursement model, designed in line with private health insurance arrangements, and the indemnity model designed in line with annuity contracts.

Reimbursement policies are the dominant model of private insurance arrangements in the United States. Typically, they provide the eligible recipient with an indemnity up to a designated limit to cover for nursing home, home or outpatient care expenses. There is a wide selection of reimbursement policies in the United States in terms of, for instance, the maximum amount of benefits payable (per day, per week, per month or for a maximum number of years), waiting periods before one can receive benefits (duration of deductible) as well as benefits protection against inflation. Recently, indemnity policies have started being offered in the market.

In France, indemnity policies are the dominant model. Typically, they provide eligible recipients with a fixed level of monthly benefits for life, once the insuree meets criteria set in the policy regarding the level of dependency and waiting period. About 20% of indemnity policies solely cover the risk associated with severe or very severe levels of dependency, while about 80% also cover the risk associated with moderate levels of dependency (FFSA, 2009). Again, there is a wide array of indemnity policies available in France.

In Germany, two types of private long-term care insurance products have developed. First, as part of the implementation of the compulsory LTC insurance system established in 1995 and consistent with the structure of the health insurance system, a compulsory private LTC insurance pays for individuals who have opted out of social health insurance. This market provides coverage for about 9% of Germany's population and is highly regulated (Arntz *et al.*, 2007). Second, voluntary LTC insurance insures eligible LTC expenses not covered by the social LTC insurance programme. In 2009, close to 1.6 million people held such supplementary private insurance, equivalent to about 3.5% of the German population aged 40 and over. In this market, the majority of policies sold are indemnity policies.

In Belgium – in line with the structure of its public LTC system, which is mainly provided as part of public health insurance – private coverage for the portion of health services not reimbursed by public health insurance can be obtained through complementary mutual health insurance, which are of a reimbursement type. As a stand-alone policy, private LTC insurance is not available in Belgium.

In Japan, private LTC policies are available either as principal coverage or as a rider to main life/medical insurance policies. Generally, they allow the insured to receive cash benefits once reaching a certain level of dependency.[2] Cash payments can take the form of a lump sum, an annuity or mix of the two. Some estimates suggest that since the introduction of the public LTC insurance, in 2000, the size of the private market has stagnated and remained low (Tachibanaki *et al.*, 2006, Yasukawa and Inoue, 2007). In 2000, about 2 million individuals, equivalent to about 3% of the population aged 40 and over, had taken out LTC insurance (Taleyson, 2003).

In the United Kingdom, the market for long-term care financial plans is very small. Information from the Association of British Insurers (ABI) suggests that at the end of 2008, the total number of long-term care policies in force was of about 40 000, which is equivalent to less than 0.05% of the population aged 40 and over. Other private LTC insurance markets are emerging, such as Canada and Italy, predominantly based on indemnity policies.

Box 8.1. **Who buys and what products? The case of the United States and France**

In the United States, in exchange for an annual payment of about USD 2 100 to USD 2 500 per year (2008), a single 60-years-old could typically obtain an individual LTC insurance policy that would pay up to USD 150 a day for covered services including nursing home services, assisted living facilities, home-care services and adult day care for a maximum length of three years. Benefits would typically start to be paid 90 days after an insured individual qualifies for LTC. In addition, the policy would typically provide for inflation protection, such that the maximum daily amount would be increased by 5% compounded annually (Tumlinson *et al*., 2009).

A study prepared for the America's Health Insurance Plans provides information on some socio-demographic characteristics of individuals who purchased LTC insurance in 2005. More than 60% of buyers were between 55 and 70 years of age, more than 55% were female and about 60% were college graduates. More than 70% were married, with reported income above USD 50 000 a year and total liquid assets of USD 100 000 and over. In 2005, 90% of individual LTC insurance bought provided coverage for institutional and home services. The average daily benefit amount was slightly higher for nursing-home care (USD 142) than home care (USD 135) and the average policy duration was about five years. Average waiting periods before receiving benefits was 80 days and about 75% of policies bought had inflation protection. The average annual premium of individual LTC insurance policies was just above USD 1 900 per year representing about 7% of the average income of the elderly population age 65 and over (McDonnell, 2010). Close to 30% of the LTC insurance market in the United States consists of group insurance policies.

In France, in exchange of an annual payment of about EUR 400 and EUR 500 per year (2008), an individual of about 60 years of age could obtain an individual LTC insurance policy that would pay about EUR 600 a month in the event of severe or very severe dependency (*dépendance lourde*) and between about EUR 200 and EUR 400 a month in the event of moderate dependency (*dépendance partielle*). Generally, benefits would start to be paid three months after an insured individual qualifies for LTC. LTC insurance coverage can provide for inflation protection, but both the monthly benefit amount and the premium levels will typically be subject to annual increases (FFSA, 2009; Dufour-Kippelen, 2008).

In France, in 2008, the majority of subscribers to an individual LTC insurance policy were aged between 56 and 66 years (FFSA, 2009). An empirical study using the SHARE database has examined a number of factors affecting the probability of holding an individual LTC insurance policy in France. According to this study, among the population 50 years and over, those that are relatively younger, that are married or have children, that have attained a higher level of education or that expect to leave a relatively large estate/bequest are more likely to subscribe to an individual LTC insurance (Courbage and Roudault, 2007). In 2008, buyers of individual long-term care insurance policies, paid an average premium of about EUR 360 a year, while the average level of monthly benefits was about EUR 540 per insuree. In 2008, among individuals covered by insurance contracts still in force, about 45% solely had coverage for severe or very severe levels of dependency. Generally, individual insurance contracts include waiting periods before receiving benefits of about three months and about 75% of them offer inflation protection. The group LTC insurance market is large in France and represented about 45% of the LTC insurance contracts in 2009 (FFSA, 2009; 2010).

Recent market developments in some OECD countries suggest that insurance providers are moving towards private LTC indemnity policies providing a fixed cash benefit to qualifying insurees, which can be used according to the insurees' preferences. The main

advantages of the indemnity model are the simplicity and flexibility it offers to subscribers and its conduciveness to facilitate the management of the financial risk associated with dependency for providers. More specifically, under the indemnity model insurance providers need to gauge the prevalence of dependency among a group of insurees over time, which can be defined in a more robust manner especially for severe and very severe level of dependencies. This contrasts with reimbursement policies under which an insurance provider typically needs to gauge both the prevalence of dependency among a group of insurees as well as the level of care that will be required at a given level of dependency over time, which is more uncertain and difficult to foresee (Cremer and Pestieau, 2009).

8.2. Market failures and "consumers myopia" explain why the private LTC insurance is small

In theory, the significant financial uncertainties in terms of potential need, intensity and duration of long-term care provide a powerful rationale for sharing this risk across individuals (see Box 8.2 for a conceptual assessment of private pooling arrangements). Yet, in countries where private LTC insurance is sold, population coverage remains low. The literature, mainly from the United States, points to a number of factors explaining the difficulty of developing comprehensive markets for private LTC coverage.

Box 8.2. **Assessment of private LTC pooling arrangements**

The role that private LTC insurance coverage can play is subject to debate among policy makers and experts alike. This section assesses the potential benefits and shortcomings of private LTC pooling arrangements with respect to access, comprehensiveness, financial sustainability, equity in financing and quality of LTC services.

While private LTC can increase the ability of most individuals to pay for potential future LTC expenses (Doty *et al.*, 2010), it is generally not accessible to the whole population. For instance, private pooling arrangements typically exclude the most vulnerable segment of the population such as those who are currently using LTC services or those with a high risk of using them in the short term (*e.g.*, individuals over 70 years of age).

Private LTC insurance plans, like many public coverage programmes, do not cover all expenses associated with LTC. Private LTC insurance typically provides for a pre-defined benefit package under which maximum benefit amounts are set. While individuals generally have the choice among more or less comprehensive policies at corresponding prices, modest and middle-income individuals may opt for less coverage at affordable premium levels, still leaving them at risk of facing significant LTC expenses.

Private LTC pooling arrangements could have the potential to leverage new financial resources and to alleviate future financial pressures on governments. But, thus far, their impact has been limited. Private pooling arrangements may also provide a framework to guide the financing of future LTC expenditures. Private pooling arrangements are, in principle, fully funded and include a pre-funding element thereby accumulating reserves to face the expected growing need for benefits pay-out in the future. Nevertheless, as the number of insurance providers increase, an increasing share of premium payment may be used for administrative purposes instead of financing future expected LTC expenditures and premium levels may still rise.

Risk-related pricing, which is predominately used for the management of private pooling arrangements, can alleviate some inter-generational equity concerns with respect

Box 8.2. **Assessment of private LTC pooling arrangements** *(cont.)*

to the financing of long-term care. In principle, under risk-related pricing, older eligible cohorts should contribute more to the pool given their higher likelihood to draw benefits from it in the short and medium term. However, risk-related premia typically do not relate to income, so that low and modest-income individuals are required to spend a relatively larger portion of their disposable income on private insurance. This may disproportionally affect women who typically have lower average income. This makes them more likely to not access private pooling arrangements on affordability grounds.

It can be argued that by increasing enrolees' ability to pay, private LTC insurance can help some individuals access more quality care. In addition, private LTC benefits, predominately in the form of cash benefits, may foster personal choice by providing dependent individuals with more flexibility in their LTC decisions, which may lead to higher well-being. However, cash benefits alone are not sufficient and dependent individuals, especially those with cognitive diseases, would generally benefit from formal advice to guide them in the choice of services and to support them in navigating LTC systems. Furthermore, an increase in one's ability to pay will not guarantee an adequate supply of quality service.

On a conceptual basis, while private pooling arrangements can bring about a number of benefits, they involve inherent drawbacks on accessibility and equity grounds. Public interventions can aim to mitigate these drawbacks but, in practice, the development of comprehensive markets for private LTC coverage remains a challenge due to the combination of supply and demand factors listed above.

First, well-known market failures due to asymmetric information in the private LTC insurance market, such as adverse selection and moral hazard, lead insurers to protect themselves by limiting access to coverage. Adverse selection would translate in only those with high-perceived LTC risk buying in or keeping the insurance policy, while moral hazard would translate in insures using more LTC services that they would have required because they are covered. With a view to mitigating adverse selection, insurers typically limit eligibility to a private LTC insurance to those with no pre-existing health conditions associated with dependency. This is often referred to as underwriting.[3]

Second, insurers face significant uncertainty regarding future costs, or the evolution of supply and organisation arrangements for long-term care. For instance, future trends in the onset of dependency are unknown, and there is uncertainty with respect to the costs of providing a unit of care as well as with the projected return from the invested accumulated reserves (Tumlinson *et al.*, 2009). This may result in insurers setting relatively higher premia or paying lower benefits. For instance, research in the United-States found that the typical LTC policy purchased marked premia substantially above expected benefits (Brown and Finkelstein, 2007), thereby reducing value for money for the subscriber. Premium mark-up may lead to lower demand for private LTC coverage as a result of its higher prices. In addition, the complexity of certain LTC insurance contracts makes it difficult for potential insurees to assess value for money.

Third, challenges associated with the ability of insurers to control the covered LTC risk might also lead to premium volatility. To ensure the financial viability of an insurance plan, insurance contracts include clauses that allow for the level of premia to increase if the overall level of risk shared within a pool of insurees increases. For instance, in the wake of the economic crisis, a number of existing LTC insurance policy holders in the United States

have been subject to an increase in premium (Tergesen and Scism, 2010). Premium volatility makes the cost of private LTC coverage less predictable and may reduce the confidence in these types of insurance plans. Alternatively, low consumer confidence can also arise with respect to one's likelihood to benefit from such a plan.

Fourth, low demand for private LTC insurance may also reflect individuals' myopia in planning for the financial risk associated with long-term care. For instance, the risk associated with dependency is often deemed as too remote to warrant coverage starting at a relatively young age. Individuals' perceptions on the level of public support also affect the perceived need to hold private coverage. These may translate in individuals delaying until an older age decisions regarding the purchase of a private LTC coverage, when they are more likely to face high premia and less likely to pass underwriting tests.

Fifth, low demand may also reflect competing financial obligations and priorities faced by individuals and families, such as paying for children' education, schooling, and buying a house. It can be argued that for working-age households, the purchase of a LTC insurance should take place once a sufficient level of retirement savings have been accumulated and life insurance policies have been acquired. For households with low income, the cost of subscribing to a private LTC coverage can represent a high share of their disposable income. Some studies note the relatively small proportion (around 20%) of the United States population that can afford private LTC coverage (Melis, 2003).

Last, the availability of potential substitutes such as public coverage programmes can play a role in mitigating the demand for private LTC insurance. Given individuals' expected income and asset situation, and the comprehensiveness of public LTC coverage, willingness to buy private LTC insurance may be low. It could also be argued that the availability of family or friends providing care assistance may mitigate incentives to purchase insurance, although in France households with children have a higher probability to subscribe to private LTC coverage (Courbage and Roudault, 2007).

8.3. Policy and private-sector initiatives to increase take up

Regulations and fiscal policy

Regulatory intervention and tax incentives can be used to reach a number of policy goals such as fostering broader access to private LTC coverage, promoting the development of certain types of insurance schemes through, for example, standardisation of insurance contracts or the establishment of minimum requirements as well as promoting competition among insurance providers.

Tax incentives effectively aim at reducing the purchase price of a private LTC insurance, in order to stimulate demand.[4] Providing preferential tax treatment to private LTC schemes is often cited has a mean for governments to increase awareness of LTC risks as well as to signal the importance of advance planning. Preferential tax treatment for private LTC insurance exists in the United States, Spain, Mexico or Austria. Typical tax advantages include deductions or tax credits based on the level of private LTC insurance premium paid. In Mexico and in Australia, subject to limits, an individual may be eligible for a tax allowance equivalent to the amount of premium paid. In the United States, premia paid towards qualifying private LTC policies are considered as eligible health expenses which can be deducted when exceeding a given share of an individual's income. In the United States as well as in Spain, preferential tax treatment is also provided by

excluding from an employee's taxable income the value of premia paid by employers as part of a group LTC insurance plan.

Generally, regulations aim at protecting individuals who purchase insurance as well as enhancing the quality of insurance products sold, for example by limiting the ability of insurance providers to cancel contracts or to alter premium levels following a change in an insuree's condition. Regulations also typically provide for risk-management frameworks to ensure the solvency of insurance plans.

For first-time purchasers, in many OECD countries, there are few limitations on an insurer's ability to impose exclusions on coverage based on pre-existing conditions as well as considering health-related factors as part of premium setting. For member countries of the European Union, EU law does not permit governments to regulate private insurance contracts and impose access-related standards, except in cases where private coverage plays a primary or alternative role to a compulsory social cover scheme. For instance, specific LTC regulations have been implemented in Germany as part of its compulsory private long-term care insurance market, which specify that premia and benefits be established in line with those of the social compulsory LTC insurance. Compulsory long-term care premia are also limited to maximum premium paid under the public social long-term care insurance system and providers generally cannot exclude or charge extra premia for those with pre-existing conditions.[5]

In the United States, as a complement to existing state regulations, the federal Health Insurance Portability and Accountability Act (HIPAA), outlines the requirements private LTC plans must meet in order to qualify for preferential federal tax treatment. Under HIPAA, coverage must begin when a person is certified as needing substantial assistance with at least two of the six ADLs due to a loss of functional capacity, or requiring substantial supervision because of a severe cognitive impairment. Functional limitations need to last for more than 90 consecutive days. Insurance providers must offer inflation protection and non-forfeiture benefits. Currently, most policies sold in the United States meet those requirements and are therefore eligible to the tax reduction.

Building public/private partnerships

In some OECD countries, the interaction between private LTC insurance coverage and public systems is regulated or specific programmes are designed to encourage complementarity between private and public coverage mechanisms.

In 1987, specific private-public partnership initiatives were established in four states (*i.e.* California, Connecticut, Indiana and New York) in the United States. The public-private partnership programmes have been designed to encourage individuals, especially moderate and middle-income individuals, to purchase LTC insurance. They were aimed at promoting higher quality insurance products. This was achieved by a better co-ordination between Medicaid assets eligibility rules and the level of benefits received under a private LTC insurance, such that if a policy holder received USD 100 000 in benefits from her Partnership-qualified LTC insurance policy, she could retain USD 100 000 worth of assets over and above the State's Medicaid asset threshold. Since the passing of the Deficit Reduction Act of 2005, which allowed for the expansion of the LTC Partnership Programme to all states, most states currently have active Long-term Care Insurance Partnership Programmes. On balance, the partnership has had mixed results. For instance, while the partnership did promote higher quality insurance products, it still only represents a small

share of the overall LTC insurance market in the four initially participating states. In addition, the partnership has had mitigated success in attracting moderate and middle-income individuals to obtain LTC coverage (Alliance for Health Reform, 2007).

Singapore, which is not an OECD member, launched the Eldershield programme in 2002. Eldershield represents a different type of public-private partnership under which the programme is designed by the Government, but priced, sold and managed by private insurers (Hoffman, 2009). In 2009, three private insurance providers delivered and managed Eldershield. One feature of the Eldershield programme is that it provides for automatic enrolment, with an opting-out option (similar to the proposed Class Act in the United States). Enrolment is automatic for most aged 40 years, except for those already unable to perform three of the six defined activities of daily living. Individuals are provided with an initial window of three months to opt out of the plan. After opting out of the plan the option of opting-in remains but the individual will be subject to higher premia and underwriting. At the end of 2006, about 750 000 or about 50% of the population older than 40 years of age were covered under Eldershield. In addition, the opt-out rate has declined since the inception of the programme. In 2006, from those eligible and automatically enrolled in the programme, 14% opted out of the programme relative to 38% when the programme was first launched (Wong, 2007) (see also Box 8.3).

Box 8.3. **Public/private partnership, experience in the United States and Singapore**

As part of the Partnership programme, in the United States, a qualified policy is certified by the state. It typically provides for comprehensive benefits (at home and in institutions) and includes state specific provisions for inflation protection. Evaluation of the Partnership programme suggests that it had reached about 200 000 individuals by 2006, and that about 80% of those who purchased a partnership insurance policy would have purchased a "traditional" policy in the absence of the programme. In addition, the level of household income and assets of Partnership policy holders is comparable, on average, to the one of "traditional" LTC insurance policy holders (United States Government Accountability Office, 2007).

Under the Eldershield program, in Singapore, premia are typically age and gender-related and do not relate to income. Premia are fixed at the age of entry and payable annually starting from age 40 (*i.e.,* for those who do not opt out) until age 65, unless they become eligible to benefit payout. After the premium paying period (typically up to 65 years of age), an individual is covered for life. In addition, Eldershield also includes a non-forfeiture feature that allows a policy member who fails to make a given premium payment to retain some benefit coverage as long as a minimum amount of the premium are paid.

Eldershield targets benefits to those with severe disability (unable to perform three of the six defined activities of daily living) and has been designed according to the fixed indemnity model. When first introduced, eligible individuals would receive a benefit of SGD 300 per month up to five years. In 2007, the plan was enhanced to SGD 400 per month up to 6 years. For comparison purposes, depending on one's functional status as well as the quality of accommodation *(e.g.,* number of beds in one room) average nursing home charges can range from about SGD 1 000 to SGD 3 500 per month (Tan Ling, 2007).

Reaching the working-age population: The role of group LTC insurance

Group insurance coverage typically takes place in the context of employment and has the advantage of encouraging early subscription into a private LTC insurance plan. Group coverage can provide a number of benefits to enrolees, including the potential ability to negotiate better coverage solutions, as well as lower premia. Group plans may also result in fewer exclusions, based on the spread risks within a large group. For the insurance providers, group insurance mitigates the risk of adverse selection with the potential benefit of reducing the overhead costs associated with underwriting tests.

In France, the group LTC insurance market is large. In 2009, it represented about 45% of the LTC insurance contracts (FFSA, 2009). Employees covered under a group insurance plan are generally required to participate in the plan and employers may pay for a portion of the premia on behalf of the employees. Nevertheless, a portion of the group plans provides temporary annual coverage for the risk of dependency and does not provide coverage for future risks once an individual is no longer working (Gisserot, 2007).

Close to 30% of the LTC insurance market in the United States consists of group insurance policies (America's Health Insurance Plans, 2007). Some private employers offer group long-term care insurance coverage as a voluntary benefit. Contrary to group health insurance coverage, employers do not typically contribute to the premium cost. In March 2007, 12% of private industry workers were offered long-term care insurance coverage as part of a group plan (US Bureau of Labor Statistics, 2007).

In addition, in the United States, the federal government, as well as a growing number of state governments, also offer group long-term care programmes for their employees as a voluntary benefit. For instance, in 2002, the federal government began offering group long-term care insurance benefits for federal employees, retirees, and certain family members. As part of the federal plan, eligible individuals are provided with an enrolment period, during which they can voluntarily enrol into a group plan. Enrolees pay the entire premium associated with the plan. In 2005, the average age of federal enrolees was 56 years at the time of enrolment, compared with an average age of 60 for enrolees in individual products. Preliminary evaluation of the programme found that for a comparable level of benefits, premia paid as part of the federal programme were generally lower for both single individuals and married couples compared to similar products available in the individual market (United States Government Accountability Office, 2006). The evaluation also found that group insurance products, including the federal programme, expected to pay a higher percentage in claim payments and lower percentage in administrative costs compared with individual insurance products. Despite these benefits, participation rates in group insurance products are relatively low, with about 5 to 8% of the eligible population enrolling into such plans (United States Government Accountability Office, 2006).

Private sector innovations and mixed insurance products

A number of initiatives, mainly from the private sector, may have the potential to direct additional private resources towards long-term care. In most cases, initiatives aim at combining LTC insurance products with other types of financial products (Mayhew *et al.*, 2010). These innovations generally seek to widen the range of products available and thereby can help meet the diverse needs of the population, but take-up has generally remained low across countries.

Some insurance providers offer LTC insurance policies as part of life insurance policies, which tend to have a much larger diffusion. Typically, these provide cash advances in the event that the policy holder requires long-term care for an extended period of time, paid out of the death benefit or the accumulated savings build into the policy. For elderly individuals, both life and LTC insurance policies can be seen as pursuing similar ends in terms of ensuring that there will be some assets left for transfer to survivors. This type of life insurance policy is available in a number of OECD countries such as the United States, France, Canada and Australia. In 2008, close to 150 000 individuals (about 5% of the market) was covered for LTC risk under such an insurance contract in France (FFSA, 2009).

Other financial products provide the possibility to convert home equity, which can represent a significant portion of the net-worth of elderly individuals, into cash. Reverse mortgage can provide a means to continue living in one's home while paying for required LTC services or to free up some cash in order to subscribe to a LTC insurance. These financial products have been available for some time in the United States and the United Kingdom and they are also available in Australia, Denmark, Ireland, Spain and Sweden. In the United States, two of the three main reverse mortgage products are government insured. In Ireland, a sort of public "reverse mortgage" programme, called the Nursing Home Loan, has recently been introduced for those who need long-term nursing-home care. The programme provides individuals with the flexibility of not selling assets such as their home during their lifetime in order to pay for their care. The loan can be repaid at any time but will ultimately fall due for repayment from one's estate upon death. The loan is provided according to the personal contribution towards the cost of receiving care in a nursing home. It also has relatively low upfront charges and applies preferential interest charges over the duration of the loan equivalent to the consumer price index.

Akin to reverse mortgage-type of financial products, closer ties could be established between private medical/general retirement savings accounts and the purchased of a private LTC insurance. This option is available only in a few countries such as the United States and Singapore. In Singapore, savings accumulated in a Medisave[6] account can be used to pay for Eldershield premia. In the United States a limited portion, depending on the enrolee's age, of the accumulated savings in a health account can be used to pay for a tax-qualified long-term care insurance. That said, as for private LTC insurance, evidence shows that individuals with relatively higher level of incomes are generally more likely to participate to private medical/general retirement savings account. In addition, it could be argued that increasing private savings to meet the private costs associated with LTC does not represent the most efficient means to pay for these costs, as it does not allow for the sharing of the risks associated with activity limitations across the population (Productivity Commission, 2011).

Long-term care insurance has also been combined with life annuities (Box 8.4). A life annuity provides for a series of regular payments over a specified and defined period of time in exchange for a single premium payment made at the outset. Relative to a traditional life annuity, a life/LTC annuity will typically provide for a reduced life annuity in exchange of an augmented one once the need for long-term care arises. The market for such annuities is fairly narrow as the purchase of an annuity requires a significant up-front single premium payment. Such life/LTC annuities are available for example in the United States and the United Kingdom.

Box 8.4. **Additional information on reverse-mortgage and life/LTC annuities**

The "*reverse mortgage*" or "*home equity conversion mortgage*" does not have specific income requirement, so that home owners with low and moderate income can borrow. In addition, a loan does not need to be repaid by the home owner unless they wish to sell and/or move. For example, individuals who move from their home to an assisted living home or a nursing home for more than a given period of time (*e.g.* 12 months) can be required to pay the loan back. Cash received from a reverse mortgage can be used for any purpose. Ultimately, the loan is payable from one's estate upon death. Lastly, reverse mortgage is not the only alternative available to elderly home owners to convert home equity into cash. Other alternatives can include selling one's home, downsizing to a smaller home or taking a home loan. Depending on individual circumstances and preferences, those alternatives may be preferable to subscribing to a reverse mortgage contract, which can be complicated and costly.

There are two main types of *life annuity products* which include a LTC component. These can be referred to as "immediate LTC annuity" and "deferred LTC annuity". Under a deferred LTC annuity, a share of the single premium payment is allocated to LTC insurance funds, which can be accessed in the event that long-term care expenses are incurred. Generally, the rules of the annuity define how much can be accessed on a monthly basis from the long-term care fund. Depending on the annuity, underwriting test can be less stringent compared to those used in the private LTC insurance market. Immediate long-term care annuity plans are typically designed to cover the actual expenses associated with long-term care. Under such arrangement, an individual already in need of care can pay a single premium to buy a policy which will begin to pay for some or all of care expenses incurred for life. Under such arrangements, the "pool" of fund is shared among individuals who already are dependent so that risk sharing takes place over the period of time over which an individual will require long-term care.

Up to now, these innovations have had a limited impact in improving access to LTC coverage. Nevertheless, some are more promising than others. For instance, the combination of life and LTC insurance policies as well as "reverse mortgages" provide seniors with different avenues for mobilising additional liquidity out of their accumulated assets to pay for LTC-related expenses (see Chapter 9 for a more detailed discussion on this issue). Nevertheless, while these products widen the range of possibilities to direct resources towards LTC, the subscription to a private LTC insurance is likely to pay for a more significant share of LTC expenses.

8.4. Conclusions: Private long-term care insurance has some potentials but is likely to remain a niche product

As a pooling mechanism, private LTC insurance has the potential to help individuals and families manage more effectively the risk of facing significant out-of-pocket LTC expenses. In fact, as seen in Chapter 7, public LTC coverage systems across OECD countries require users to share a portion of the cost for their care, albeit at a different levels. Yet, even in countries where public LTC coverage is less comprehensive, people continue to rely predominantly upon out-of-pocket payments (and therefore upon their savings), or on family-based arrangements. This outcome reflects, in part, people's lack of awareness of the financial risk associated with LTC and understanding of what private LTC insurance can do in mitigating this risk. Given that the efficiency of LTC pooling mechanisms

generally tend to improve through broad and early subscription, some OECD countries have intervened through regulation or fiscal policies to encourage broader coverage.

Public initiatives have ranged from enhancing the quality of LTC insurance products, to lowering the purchase price of a private LTC insurance, enhancing the complementarity between public and private LTC coverage, or making the subscription to a private LTC insurance automatic with an opting-out option. Thus far, in the context of voluntary pooling arrangements, public initiatives have generally had limited success in broadening access to private LTC coverage. But, some public initiatives seem to be less cost-effective than others. For instance, preferential tax treatment needs to be considered carefully in terms of its effectiveness to affect demand. More specifically, most of the fiscal cost of a tax measure can take the form of a "windfall" to those relatively better-off individuals, who would have purchased the insurance even in the absence of the tax reduction. Alternatively, support towards the purchase of a private LTC insurance could be targeted to lower-income individuals thereby compensating for the regressiveness of risk-related premiums.

Group LTC insurance can also represent an avenue for reaching working-age individuals so as to promote early subscription into a private LTC plan. While employers may see little benefit in contributing to an insurance covering the risk associated with dependency beyond an employee's working life, group insurance can still benefit employees through lower premia and higher-quality benefit packages. Still, not all workers are involved in paid employment. In addition, with increasing labour mobility and the onset of dependency typically arising well after retirement age, group LTC insurance can raise issues of portability and continued access to coverage. Portability features, either from one group-plan to another or from a group-plan to an individual plan, can play a role in ensuring continued access to LTC coverage as well as non-forfeiture benefit features, which allow policy subscribers to retain some LTC coverage even if they were to stop paying into the plan after retirement.

To date, evidence suggests that left on their own device, voluntary private LTC pooling mechanisms will remain niche products, which principally serve the segment of the population with relatively higher income and accumulated assets (Ergas and Paolucci, 2010). The market could potentially expand as younger generations become better aware of the financial risk associated with LTC based on the experience of their elders, and become more comfortable with LTC insurance products and their underlying features (Zhou-Richter *et al.*, 2010). Nevertheless, unless mandatory, any expansion of the voluntary market will be subject to perennial supply and demand issues inherent to private coverage.

Notes

1. In 2009, about 1 million individuals had subscribed to an individual LTC insurance. In addition, close to 850 000 individuals had subscribed to a group LTC insurance coverage while about 150 000 had complementary coverage through a life insurance policy (Fédération Française des Sociétés d'Assurance, 2010). Furthermore in 2010, about 3 million individuals had coverage against the risk of dependency through mutual insurance contracts (Caisse Nationale de Solidarité pour l'Autonomie, 2010).
2. Private LTC insurance eligibility criteria can differ from the eligibility criteria of the public LTC insurance system.
3. Through underwriting an insurance provider determines the risk associated with an applicant, which can result in the provider declining to offer a policy.

4. Evidence on the elasticity of demand of LTC private insurance is limited and suggests that elasticity may be around 1.25 (Gopi Shah, 2010; Cohen and Weinrobe, 2000). Assuming that all policies sold are eligible to the tax incentive, more than 75% of the incentive would be targeted to individuals who would have subscribed to a policy in the absence of the tax reduction.
5. Insurance providers must also participate in a system of risk equalisation for premia.
6. Medisave is a mandatory saving scheme meant to help individuals pay for medical expenses after retirement.

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