Barriers and Opportunities for private Long-Term Care Insurance: What can we learn from other countries?

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More resources needed to pay for LTC in the future: Public spending on LTC as % of GDP, 2010-2060
Base case scenario


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Facing up to the increase in resources needed to fund LTC in the future:

• moderating the need for care
  – Best way to moderate the need for care is to improve the prevention and management of chronic illnesses and their disabling consequences.

• increasing the share of resources to fund it
  – It will be difficult to increase the amount of funding through public financing (taxation/social insurance).
  – Public finance is also mostly Pay-As-You-Go, with potential intergenerational inequity and serious sustainability issues.
  – Public financing guarantees risk-sharing, coverage and equity. Can public/private partnerships deliver the increased levels of resources needed to finance care, while guaranteeing risk-sharing, coverage and redistribution?

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How do we pay for care?

• Unpaid care: biggest source of care
• private savings and assets: maybe with special savings accounts or use of housing equity
• private insurance: takes very different forms depending on underlying public system and product design
• private insurance with public sector support: e.g. subsidy, tax concessions, partnership...
• public-sector tax-based support: funded from general taxation; usually allocated according to need and, in most countries, ability to pay
• social insurance: hypothecated payments; allocated according to needs and contributions.
Different country experiences with LTCI

- **US**: 8.1 million policy holders (2011) market is reducing in size as providers need to raise the premiums to cover larger than anticipated care costs.
- **UK** market offers only INAs at present, about 22,000 people hold insurance.
- **France** (5.5m) and **Germany** (1.7m): private insurance sold relatively successfully as top-up to public system.
- Italy: big rise in people insured due to collective sector agreements (group purchases). About 355,000 in 2009.
- **Israel**: large market, LTCI bought mostly with health insurance.
- Singapore: Eldershiel plan, private/public partnership, all population over 40 is automatically enrolled but can opt out. Some public subsidies.
Why is insurance a good idea?

- The potential cost to the individual of LTC, when not insured, is highly uncertain and can be catastrophic.
- Insurance pools the risks of catastrophic costs, so those are shared between everyone in the scheme.
- Insurance redistributes resources from those with lesser to those with higher care needs.
- Insurance is more efficient than private savings because removes the need for each individual to save up to the maximum possible lifetime cost of their care.
**Different types of private LTCI, very dependent on the existing public system LTC coverage**

- Full LTC Insurance (usually safety-net public system), private insurance acts as substitute for the public system.
- Top-up or supplementary LTCI (usually partial public coverage of the costs of care).
- Immediate Needs Annuities: at the point of needing care, insure against very long duration of care needs.
- Disability-linked annuities: payments increase if the beneficiary becomes disabled.
- Combined LTC and Life insurance: benefit paid at death if it has not been needed for LTC.
Barriers to the development of a private LTCI market

• Supply-side:
  – Uncertainty about the future numbers of people needing care and unit costs of care.
  – Adverse selection
  – Insurance-induced demand
  – Unclear regulatory framework.

• Demand:
  – High costs and poor affordability
  – Risk perception, misconceptions and uncertainty about public coverage.
  – Low preference for insurance
  – Mistrust of private insurance.
Tools for public LTC policy to encourage wider take-up of LTCI

- Tax incentives
- Taking on part of the risk (partnerships)
- Promoting awareness
- Encouraging cheaper products (e.g. group purchase)
- Compulsion, or automatic opt-in (redistribution mechanisms needed)
- Facilitating regulatory framework
The role of private insurance and the public system: international evidence

• Private insurance seems to work best when:
  – not expected to cover the entire risk of LTC (complement/top-up),
  – the public system entitlement is clear
  – linked to annuities
  – sold to groups rather than individuals

• Potential for new forms of public/private financing partnerships?

Looking at England: interviews with insurers

• Long period of expectation of change in public financing of LTC. Individuals and insurers cannot plan.
• Individuals above means-test continue to be exposed to full financial risk of care.
• Potentially disability-linked annuities could play a bigger role, but not tax-benefitted in the same way as pensions, so not very attractive.
• Most people are not paying enough into their pensions, difficult persuade them to buy disability-linked annuities as well.
• Unions could play a stronger role, in other countries this has led to more offer of employer-led group insurance.
• Expectation that a Dilnot-style cap is unlikely to make much difference.
• Potential for more take-up of INAs if financial advice is more generally available on entering care homes.
• Potential for products that combine equity release with longevity-risk protection.
Conclusions

• Private voluntary LTCI on its own is unlikely to contribute significantly to the financing of LTC.
• In countries with predictable universal partial coverage private LTCI has an increasingly important role complementing the state and the family in funding care.
• Potential for new forms of partnership between the state and the insurance market.
• Relying on private long-term care insurance as the main source of long-term care financing would require very substantial subsidies or compulsion.