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

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How Can Private Long-term Care Insurance Supplement State Systems? The UK as a Case Study

Funded by the AXA Research Fund.

This project aims to:

- How to address challenges facing wider take-up of long-term care insurance in the UK, including interaction with state funding;
- Estimate expected life-time costs of care for older people in the UK, by gender and other characteristics under different patterns of care;
- Estimate possible premiums for different potential types of private or private/public insurance policies;
- consider the affordability and attractiveness for different individuals of policies with varying levels of premiums and pay-outs, for a range of assumptions on how insurance would interact with state funding; and
- prepare projections to 2032 of public and private social care expenditure under different potential insurance schemes.

Commenced in April 2010 and will end in December 2012.

Based at the London School of Economics with partners at Nuffield Trust, University of East Anglia and Universitat de Barcelona.

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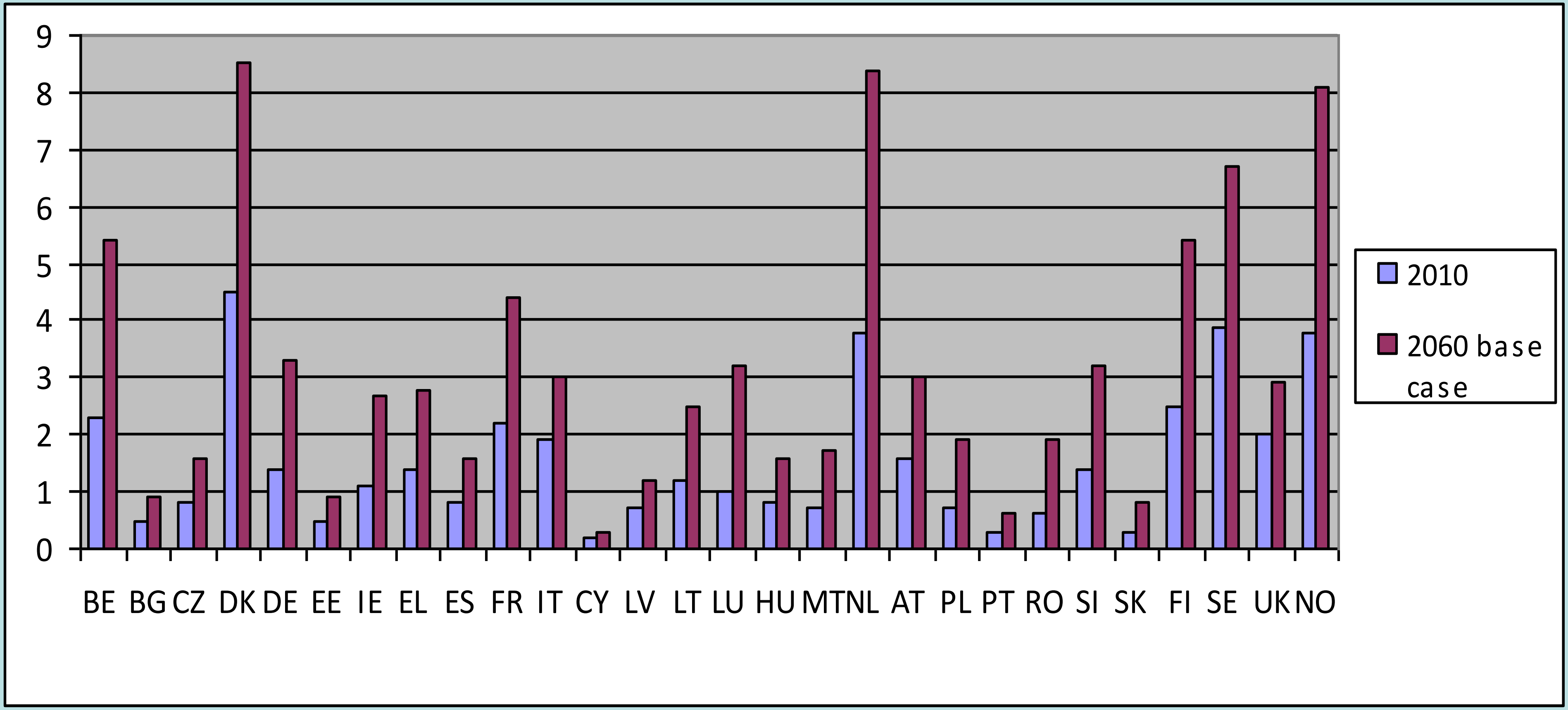
More resources needed to pay for LTC in the future: Public spending on LTC as % of GDP, 2010-2060 Base case scenario



Source: The 2012 Ageing Report: Economic and budgetary projections for the EU27 Member States (2010-2060). European Commission.

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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 a complete rethink of the way we deal with chronic illnesses and their disabling consequences.

- **increasing the share of resources to fund it**
  - It will be very 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 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?

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: 7 to 8 million policy holders (2008) 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 (3m) and Germany: (1m) 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: Eldershield 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 high higher care needs.
- Insurance is more efficient that 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 and misconceptions and uncertainty about public coverage.
  - Low preference for insurance
  - Mistrust of private insurance.

How can public LTC policy 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.

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Conclusions

- Private voluntary LTCI on its own is unlikely to contribute significantly to the financing of LTC.
- In countries with universal partial coverage private LTCI has an increasingly important role complementing the state and the family in funding care.
- Potential for many 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