Focus

October 2012

Long-Term Care
Insurance

SCOR Global Life

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Preface

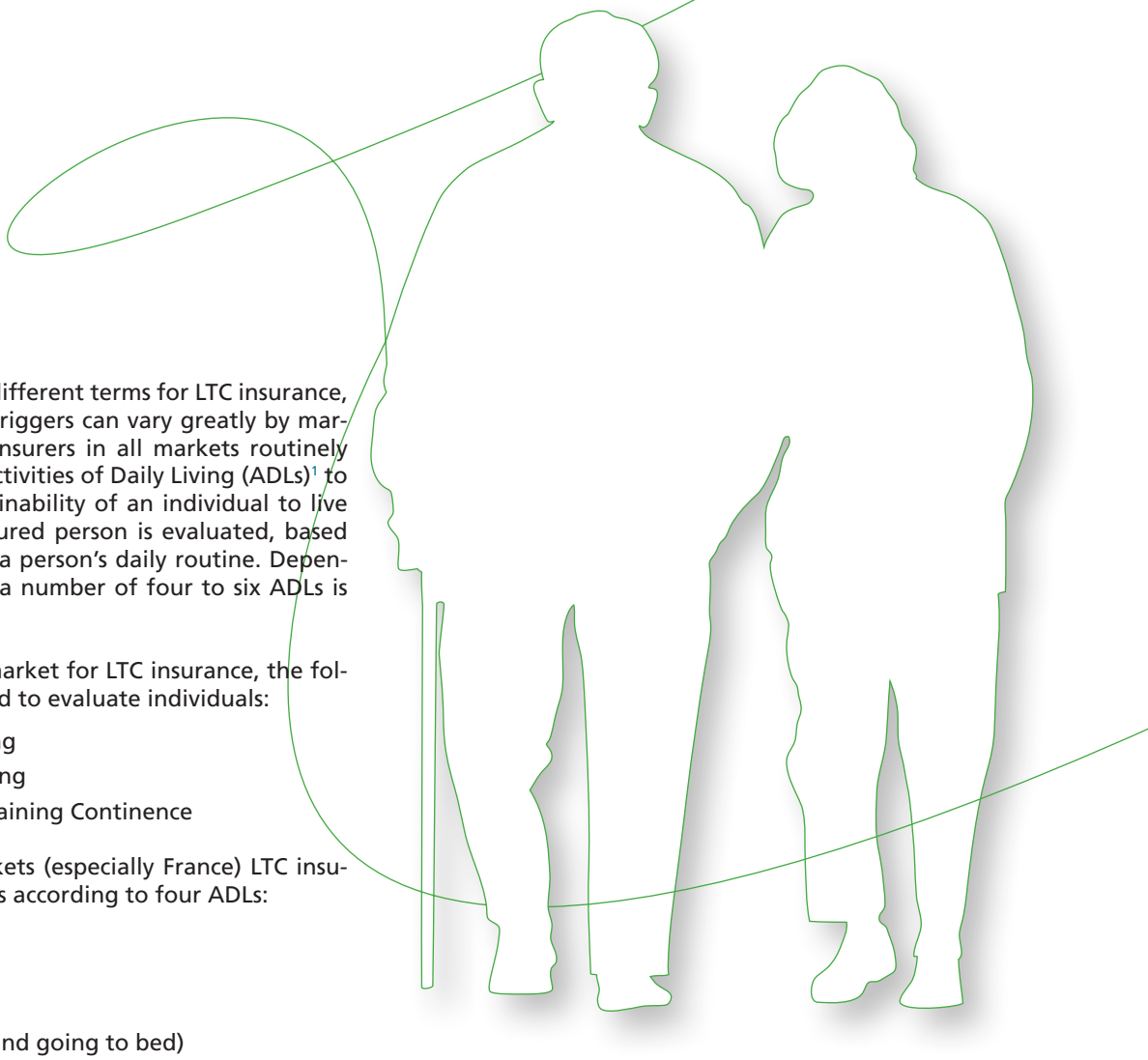
The growing number of elderly in the populations of Western industrialised nations highlights the awareness of the risks and needs for Long-Term Care (or LTC) which are directly related to the increasing life expectancy in these countries. Persons who are unable to live independently are reliant on the help of others in their everyday lives. Their needs for assistance can range from facilitating mobility, shopping, preparing meals and other household tasks to washing and feeding in the most extreme cases. The cost of LTC often exceeds the current income of the person in need and may rapidly consume their wealth and savings.

LTC insurance pays for those services that allow individuals to live independently or in a community setting if they become unable to perform the basic activities of living. LTC benefits are triggered by the need of an insured person for total and/or partial LTC. In this respect, it is comparable to disability insurance (occupational disability insurance). However, the benefit triggers as well as the period of payments differ quite considerably depending on the market and the product.

LTC insurance is relatively new compared to classic products such as life insurance and annuities. While the first private policies were introduced in some markets in the 1970s, the breakthrough in nearly all markets was only achieved after years (sometimes decades) of marketing LTC insurance. On the public side, national governments have responded differently to growing LTC needs with a variety of funding systems. In general, health care regimes tend to be mixed systems that combine public financing with some element of private financing. Most but not all systems include (mandatory) sickness insurance; almost all such programs are in some part financed directly by general taxation.

This Focus intends to provide readers with an overview of the current status of public and private LTC insurance in selected countries. It will also clarify the basic aspects of product design.

1
Defining the benefits of private LTC insurance



Just by comparing the different terms for LTC insurance, it is clear that benefit triggers can vary greatly by market and product. LTC insurers in all markets routinely refer to the so-called Activities of Daily Living (ADLs)[1] to measure the ability or inability of an individual to live independently. The insured person is evaluated, based on specific activities in a person's daily routine. Depending upon the market a number of four to six ADLs is taken into account.

In the US, the largest market for LTC insurance, the following six ADLs are used to evaluate individuals:

- Eating
- Bathing
- Dressing
- Toileting
- Mobility
- Maintaining Continence

In most European markets (especially France) LTC insurers evaluate individuals according to four ADLs:

- Washing
- Dressing
- Feeding oneself
- Mobility (getting up and going to bed)

In addition to the definitions used by insurance companies for loss of independence, further evaluation methods have been established – in many instances by government-run social welfare programs. The so-called "Instrumental Activities of Daily Living" (IADLs)[2] are used here, which are mainly directed towards domestic activities or social skills.

Examples for IADLs include:

- Use of telephone
- Use of public transport
- Handling money
- Taking medicines
- Shopping

1 • ADL grading by Sidney Katz.
2 • IADL Definition by Lawton.

1 - 1

Severe and moderate loss of independence

Most LTC insurance providers distinguish between two grades of loss of independence:

- Severe (total) loss of independence
- Moderate (partial) loss of independence

The payment of benefits depends on the type of claim. In the case of moderate loss of independence many of the products provide only a defined percentage of the benefit, whereas in cases of severe loss of independence the benefits are paid in full.

According to most policy conditions a moderate loss of independence can be said to take place when the insured person cannot perform half of the listed ADLs (two out of four ADLs or three out of six ADLs, respectively). Severe loss of independence is assumed to apply if the insured person cannot exercise at least three out of four ADLs or five out of six ADLs, respectively.

Dementia occupies an exceptional position in the claims definition as the person concerned definitely needs permanent care but does not necessarily suffer from the loss of one or more ADLs. Therefore, most LTC products include a special clause for the commencement of dementia (e.g. Alzheimer's disease), which is then evaluated as severe loss of independence.

1 - 2
Annuity payments versus reimbursement of costs

A key feature of basic life insurance is that a fixed benefit is paid out when the insured individual dies. Hence the benefit is not exposed to the risk of cost increases.

In contrast, there is no way to know in advance what LTC costs may be. Since both mortality and morbidity are involved (i.e. how sick is the insured, how long they live in such a condition), LTC insurance is relatively difficult to price. One solution used by life insurance companies offering LTC products is to focus on the so-called long-term benefit as if it were an annuity. In cases where the insured needs LTC (according to policy conditions), the insurer pays a fixed level of benefits for either a fixed period of time or for the remaining lifetime of the insured regardless of the actual costs of care necessary for the insured person.

For the LTC insurer, this approach reduces cost inflation on the claims side and allows predictability for both costs and revenue stream. For the policyholder the advantage lies in guaranteed benefits and guaranteed premiums, as cost increases on the claims side do not affect the amount of the benefit payments.

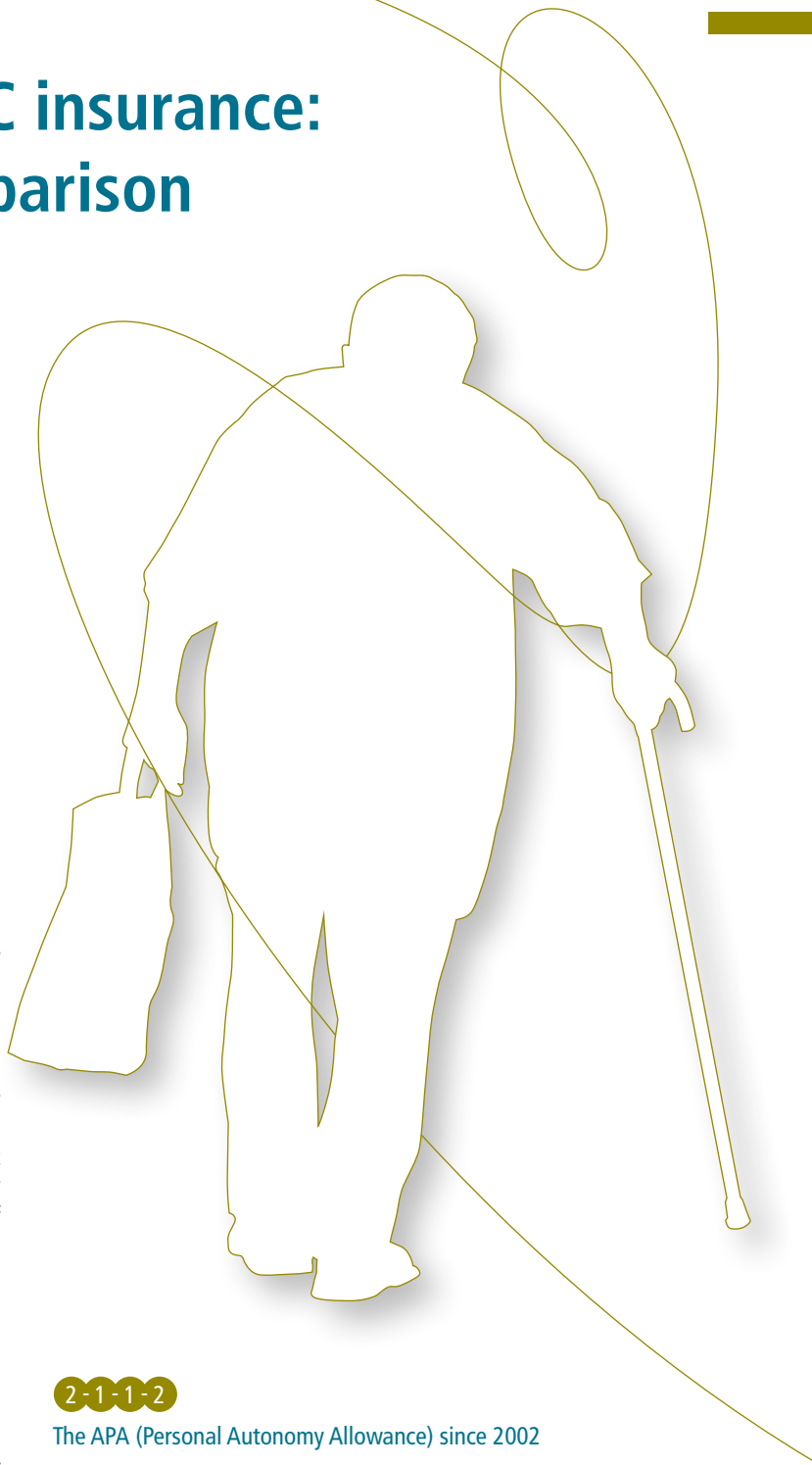
1 - 3
Elimination period / Deferred period

The claim elimination period generally corresponds to the period of time set for the covered risk to materialise.

For example, with French LTC insurance the conditional elimination period is a significant product feature. In case of illness the elimination period is one year from the beginning of the insurance period, i.e. if illness-related need for LTC occurs within the first year, the insurers are exempted from paying benefits. However in the case of accident-related need for care there is no elimination period and benefits are paid immediately. For dementia-related need for care there is a much longer elimination period; in most cases a period of three years applies in order to counteract anti-selection.

The claim deferred period corresponds to a period of time from the beginning of a claim. During this period, even if the claim is accepted, the insurer does not pay any benefit, it will be paid after this period if the insured is always claimant. It is usually 3 months long but may reach 6 or 12 months.

2
Private and public LTC insurance: an international comparison



2-1 France

2-1-1 The social protection system

2-1-1-1 The PSD (Specific Long-Term Care Benefit) 1997-2002

In the 1990s, issues concerning the funding of LTC for the elderly led the French government to set up a specific scheme to cover such provisions. The scheme introduced in the 1970s, the ACTP (Third Party Assistance Compensation), was a cash benefit aimed at people with a disability rate over 80% who required third party assistance. This benefit was not subject to an age limit. The ACTP was originally intended for the disabled but as the population aged it wound up being paid mainly to the elderly, leading to an explosion in the number of beneficiaries and therefore of the cost.

As a result, in 1997 the government introduced the PSD (Specific LTC Benefit). This consisted of a benefit:

- Dedicated to persons over age 60 years (who were no longer eligible for the ACTP)
- Dependent on the beneficiary's level of independence assessed using a single scale, the AGGIR scale (Autonomy Gerontology Iso-Resource Group)
- Intended for only the most severe cases of loss of independence (GIR 1 to 3)
- The introduction of a system of recovery from the beneficiary's estate had the advantage of limiting expenditure on the scheme but had a dissuasive effect on take-up as many potential beneficiaries were attached to the idea of leaving an inheritance, however modest, to their children
- The level of benefit was set at the local (departmental) level, leading to regional disparities.

2-1-1-2 The APA (Personal Autonomy Allowance) since 2002

In order to limit the drawbacks of the PSD scheme, the APA (Personal Autonomy Allowance) was introduced in 2002.

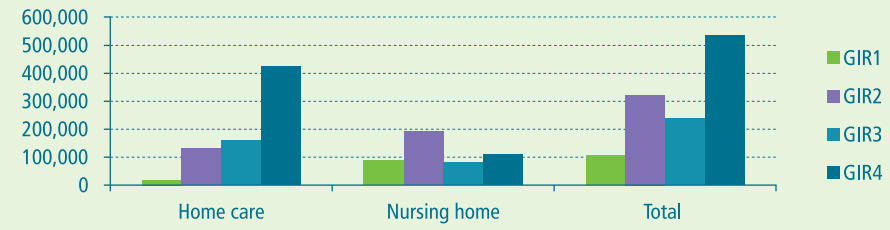
Amongst other things, this new version of the scheme allows:

- Provision for certain states of partial loss of independence (GIR4), which has led to an expansion of the number of people eligible
- Abandoning the system of recovery from inheritance
- Introduction of a national scale for the benefits.

In December 2010[3], the scheme had 1.2 million beneficiaries, breaking down as follows:

Fig. 1

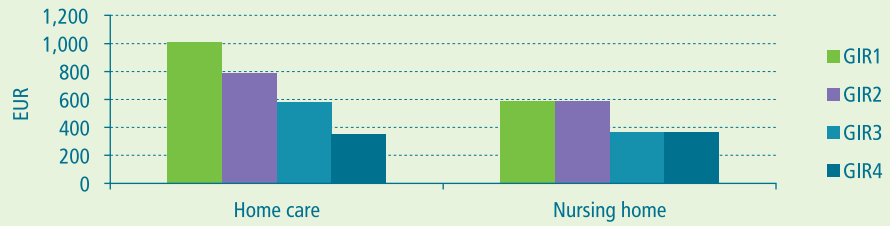
Beneficiaries of the APA at 31/12/2010



The average monthly allowance allocated was €495 on 31/12/2010. The effective monthly allowance paid fell to €372 after deduction of possible means-tested financial contributions by the elderly person (co-payment scheme). Unsurprisingly, the higher the level of loss of independence, the higher the benefit paid.

Fig. 2

Monthly amount of the APA at 31/12/2010



2-1-1-3

And now…

The growing cost of this scheme and the explosion in the number of eligible people quickly led the government to rethink the overall structure of social provision for the dependent elderly. Now the aim is to provide sufficient aid to cover cost of care for those at the end of their lives, whilst securing the funding of that provision and without abandoning the principle of solidarity.

It is also worth remembering that in spite of the progress that the PSD and the APA undoubtedly represent, people suffering a loss of independence may still have to contribute substantially to the cost of their own care. If we consider that the average monthly pension is about €1,200 and that the cost of caring for a dependent person can easily exceed €2,000 a month (even €3,000 in extreme cases), it is clear that there is still a problem covering the needs.

At the time of writing, this long-delayed reform has not been carried through yet. It should be noted that a considerable amount of work has gone into the consultation process and drawing up a synthesis of the situation. Four reports were submitted to the Ministry of Solidarity and Social Cohesion in June 2011.

3 • Source: DREES - APA - Results of the quarterly survey – statistics for Q4 2010 (No. 1-2011).

2-1-2

Private insurance cover

2-1-2-1

The LTC insurance market summary - key figures

The LTC insurance market represents €500 million of premiums annually for a population of more than 5.5 million policyholders. Premiums collected are split almost equally between private insurance companies[4] (55% of the total) and Social Economy insurance players[5] (45% of the total), but 75% of the insureds have policies with a social economy player. At the same time, there is also a predominance of premiums relating to individual products (75%), whereas the majority of the insureds are covered by group policies (75%).

2-1-2-2

Private insurers mainly distribute individual LTC cover…

Most individual cover is offered by insurance companies. With the rise in bank insurance, banks have become the main channel of distribution, particularly for the most recent generation of products. The annual volume of premiums amounts to €300 million, and 22 companies currently offer 40 policies. The market is highly concentrated; 70% of policyholders and premiums collected are in the hands of just five companies.

With the exception of the 10% insureds under compulsory group policies (representing €14 million of premiums or 5% of the total), virtually all insureds have taken out an individual LTC insurance policy. The average annual premium per head is €345 (for total LTC) for individual policies and €70 for cover through a group insurance policy. Benefits paid amounted to €113 million in 2009.

2-1-2-3

Different development models in the Social Economy

With about 3.6 million policyholders, the mutual sector covers the largest number of people. It is worth noting that this sector concerns to a large extent group policies covering public service workers (75% of premiums) although a smaller but significant part of the €123 million collected by organisations subject to the Mutual Code concerns individual contracts (€31m).

For their part, premiums collected by "Institutions de Prévoyance" (benefit institutions) represent €117 million and 600,000 policyholders. The policies offered are mainly individual policies; only 10% of the premiums (€12m) come from group policies taken out by companies for their employees. Finally, it should be noted that this sector is extremely concentrated with the biggest player collecting over 50% of premiums.

Fig. 3

Portfolio at end 2010 (Premiums)[6]

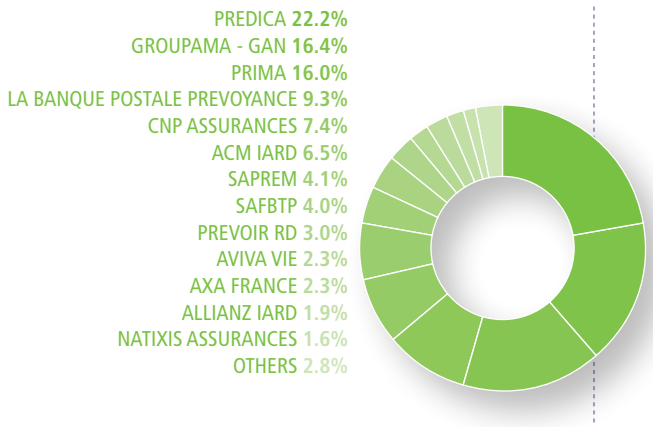
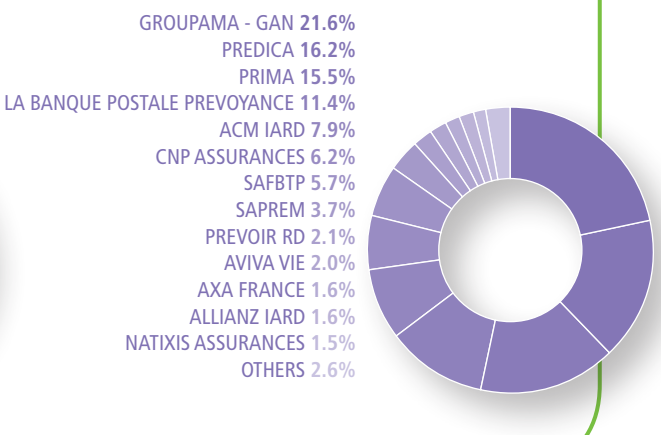


Fig. 4

Portfolio at end 2010 (Number of insureds)[7]



4 • The frontier between Insurance companies subject to the French Insurance Code and Social Economy insurers can be blurred, insofar as companies who are members of the FFSA (French Federation of Insurance Companies) may be controlled by mutualist or jointly controlled groups, for example.

5 • Mutual Societies and Provident Societies.

6 • Source: FFSA-GEMA - LTC insurance 2010 – Quantitative and qualitative aspects – April 2010.

7 • Source: FFSA-GEMA - LTC insurance 2010 – Quantitative and qualitative aspects – April 2010.

2-1-3 A constantly evolving market

LTC insurance offerings have become highly diversified since the first products were launched. There have been several generations of products:

- 1980s – First generation

Contracts were mainly individual level premium policies (often contractually guaranteed). Only total LTC was covered in the form of a life annuity based on ADLs. The maximum entry age was 70 years.

- 1990s – Second generation

Appearance of equipment benefits and partial LTC cover; the maximum entry age was now often 75 years. AGGIR scale introduced to define loss of independence (often combined with ADLs). Launch of the first group contracts and assistance services.

- 2000s – Third generation

Multiplication in the number of complementary benefits (provision of care or coverage of caregivers' respite, fracture benefits, caregivers' death benefit…). Development of group products.

2-1-3-1 Definitions and products

A wide variety of products and offerings

As we have seen, the products now available have become much more comprehensive, even complicated. Paradoxically this sophistication has often been a response to marketing difficulties that have been encountered. Indeed, the decision to purchase cover remains a difficult step for many people to take, for reasons both psychological (fear of diminished health at the end of life, random nature of the benefits) and financial (the sometimes-high cost involved). Rather than catalogue the available guarantees, we will set out below some of the main principles of the type of cover offered.

Structure of the premium and the insurance promise

Now there are two major families of products co-existing on the French market: what are known as "lifetime level premium" products and "risk premium" products.

Lifetime level premium products

The insured is covered for life in return for the payment of a premium that will remain constant over time and may still enjoy partial cover if payment of the premiums ceases after a minimum insurance period of eight years (type of cover offered since the 2000). Although the premium paid by the insured is fixed on the entry date, it is nevertheless reviewable on an annual basis depending on the technical results of the contract weighted by the evolution of the LTC risk.

The first year's premium is usually higher than that for a risk premium product as part of the premium paid at the beginning of the contract will serve to cover the risk in future years, when the annual level premium will be lower than that real cost of the year.

Risk premium products

These are often statutory mutual contracts where members are generally covered as long as they benefit from the health cover provided by their complementary health insurance. If their membership is terminated, the cover ceases regardless of many years of premiums have been paid. The premium paid by the insured is reviewable annually according to group demographics and the technical results of the contract. If the contract is terminated, only annuities already being paid will continue to be paid. It is sometimes possible to opt to maintain the cover without medical underwriting or a waiting period applying.

The premium is generally lower than for a lifetime level premium product, as the premium paid covers only the risk of occurrence for the current year. The contract is governed by the principle of intergenerational mutualisation.

2-1-3-2 Different approaches to defining LTC

There are two main methods for assessing loss of independence, the Activities of Daily Living (ADL) and the Iso-Resource Groups (GIR). In some cases, the two methods may be combined.

Activities of Daily Living (ADL)

Loss of independence is recognised after assessment of the number of Activities of Daily Living which permanently and irreversibly require the assistance of a third person.

The definitions commonly used are based on four, five or six ADLs:

- Bathing
- Walking
- Dressing
- Eating
- Continence
- Bed-chair transfers

This approach is often completed by a test to determine how far the loss of independence is due to neuropsychiatric causes (the Folstein Mini Mental State Examination, for example).

An example of a definition of total loss of independence may be "three activities of daily living not accomplished out of five" (scored 3AVQ5). Depending on the number of activities applied, other definitions may include: 3AVQ4,

4AVQ6, 4AVQ5 or 5AVQ6. For partial loss of independence, definitions may be 2AVQ6, 2AVQ5, 2AVQ4 or 3AVQ6.

Iso-Resource Groups

Introduced when the PSD was created, this system allows people to be classified according to their need for assistance due to their loss of independence. Each person may be classified in GIR (Iso-Resource Group) according to the degree of loss of independence. There are 6 GIRs:

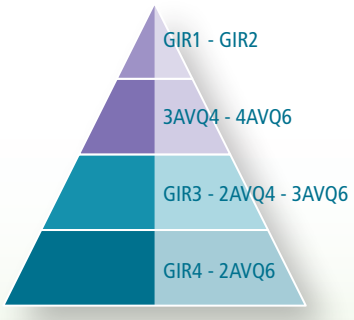
- GIR1 Bedridden or wheelchair-bound people who have lost their mental, physical, locomotive and social independence, and require constant attendance and care.
- GIR2 Bedridden or wheelchair-bound people whose cognitive functions are not totally impaired but require assistance with most activities of daily living, or those with cognitive impairment but who are still able to move around.
- GIR3 People who retain their cognitive abilities and some of their ability to move around, but who need daily help, sometimes several times a day, with bodily functions.
- GIR4 People who need help with transferring, but who once they are out of bed, can move around their home. They need help with bathing and dressing.
- GIR5 People who can still move around their home unaided, but need occasional help with bathing, meal preparation and housework.
- GIR6 Corresponds to people who can still accomplish the activities of daily living independently.

Correspondence GIR/AVQ

The GIR and ADL methods are quite commonly combined, although some cover refers only to the AGGIR scale, and in some cases other assessment methods.

It is not always possible to establish a perfect correspondence between the two approaches to assessing loss of independence. However, we may consider the classification below as a guide to loss of independence, with the least severe forms shown at the bottom of the pyramid and the most severe at the top.

Fig. 6



Total loss of independence, partial loss of independence and complementary cover

Initially, only total LTC cover was offered. Gradually, to give more content to the cover and put across a less anxiety-inducing message at the time of sale, partial cover began to emerge.

Today most of the latest generation products on the market consist of main cover (a life annuity paid monthly for total LTC) as well as complementary cover for partial loss of independence also paid as an annuity (30% to 66% of the total LTC annuity).

Fig. 5

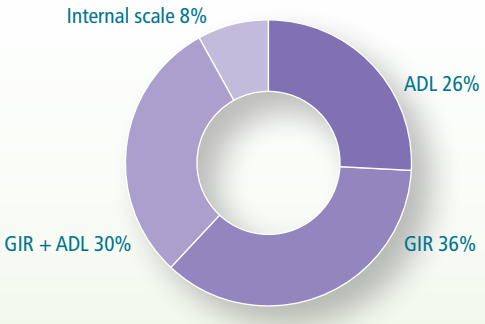
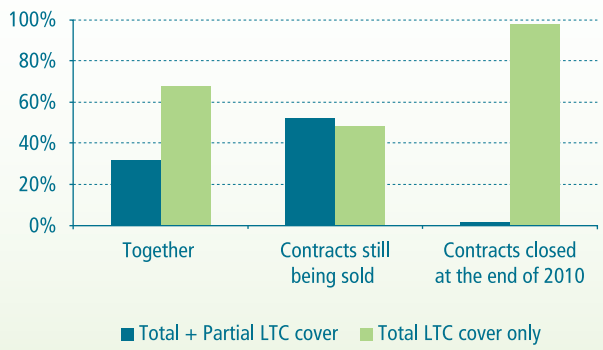


Fig. 7

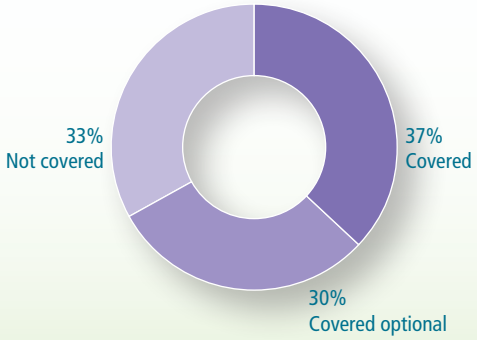
Types of LTC insured



These annuity-type benefits are sometimes complemented by a lump sum for "equipment", various services provided by assistance companies and a range of optional benefits.

Fig. 8

Contracts including an equipment benefit



The options on offer include amongst other things lump-sum benefits for: "caregivers", "caregivers' respite", "fracture" and "caregiver's death".

2 - 1 - 4

Risk assessment and control

The length of the commitment and the nature of the risk mean that it is necessary to set up a system of risk assessment and control, which will most often include:

- Elimination periods (with return of premium insurance): frequent in individual policies, absent from most group policies. The elimination periods usually seen are one year for sickness, three years for dementia and other neurodegenerative diseases. These elimination periods mean that adverse selection and the limits of medical underwriting can be reduced.
- Deferred periods: usually for individual policies but sometimes for group contracts. The aim is to avoid paying benefits for cases of short-term loss of independence as these contribute substantially to the cost of the cover. Deferred periods are usually 90 days, except for accidents (absolute or relative elimination periods).
- Entry age limits: these rarely exceed 75 years. Beyond that, the risk becomes very real and the premiums become discouragingly high. Moreover, medical underwriting becomes more delicate with increasing age and the risk of declining the cover becomes much greater.
- Medical underwriting: applied to all individual policies, sometimes also group contracts when the number of insureds is small.

The price is directly linked to the level of medical underwriting applied and the existence of an elimination or deferred period. Recent trends seem to show that the approach to medical underwriting is changing, with it being relaxed in some cases.

2 - 2

USA

Public services such as Medicare and Medicaid remain the primary providers of LTC insurance, funding about 63 cents of every dollar disbursed in 2010[8]. In comparison, commercial providers (with about seven million policyholders) chip in 8 cents of every dollar.

For the past 30 years, private insurers have offered products to help future retirees prepare for the care that two-thirds of them will need in their lifetimes. However, LTC products have proven difficult to price sustainably and administer effectively. Many consumers are turned off by what they see as high prices, unaware or simply not facing the high likelihood that they will become disabled in older age. Others may count on public provisions, not knowing or not facing the limited coverage provided by Medicare or the economic conditions that must be met before they qualify for Medicaid.

There is some good news; carriers now have access to the data and tools to understand the risks much better than before, and recent product innovations combining LTC insurance with life insurance products may signal a much looked-for turnaround in a critical insurance market. However, if sales of the new LTC/Life combo designs end up attracting only the affluent market segment, market opportunities may be limited.

We will touch on several themes that affect the LTC insurance market in the United States:

- The Demographic Shift

Over the next two decades, a generational wave of tens of millions of Americans will move into a period of life with elevated high risk of disability. Two-thirds of these seniors will become chronically disabled before they die.

- Public Provision of LTC Insurance Strained

Medicaid was never meant to be the primary provider of LTC that it has become. The program is under pressure to cut costs whilst at the same time retirement-driven enrolments are spiking. Benefit gaps will continue to be filled by other sources, including private LTC insurance.

- Public-Private Accord

Insurers and governments have looked to partnering together to stimulate more consumer participation in the private LTC insurance market but to date these attempts have not been productive.

8 • http://www.cms.gov/NationalHealthExpendData

Fig. 9

U.S. Consumer Need for LTCI – Much Larger Than Public and Private Capacity Combined
(in millions of persons)

Age	Total Population	Likely to need LTC(1)	LTC needs, Medicaid Eligible (Low)(2)	LTC needs, Medicaid Eligible (High)(2)	Estimated Size, Private LTCI Market (Low)(3)	Estimated Size, Private LTCI Market (High)(3)	Estimated Private LTCI Policyholders(4)
0 to 64 Years	267.8	16.0	5.1	6.4	5.3	6.7	2.6
65+ Years	40.1	27.3	8.7	10.9	9.0	11.4	4.4
Total	307.9	43.3	13.9	17.3	14.3	18.2	7.0

Even on a conservative basis, the private LTCI market in the United States could increase by another seven to 11 million policyholders – at least doubling from current inforce levels.

Sources: http://www.census.gov/population/www/projections/files/nation/summary/NP2009-T2-C.xls, The Henry J. Kaiser Foundation.
Long-Term Care: Medicaid's role and challenges [Publication #2172]. Washington, DC: Author, 1999, LIMRA 2010 Group Versus Individual Products Survey.

Assumptions

(1) 63 percent of persons of LTCI policyholders are age 65+; 68 percent of persons age 65+ years will need LTCI; this is treated as conservative estimate for level of needs in overall population (reflects LTCI underwriting selection effect) • (2) between 32 and 40 percent of all persons age 65+ will qualify for Medicaid LTC (range of metrics available) • (3) between 50 and 55 percent of non-Medicaid eligible persons comprise the potential private LTCI market (provides target range around the estimate 52 percent of employers that provide group LTCI) • (4) 63 percent of LTCI policyholders are age 65+ years.

- Legacy Pricing Challenges

Thirty years ago, carriers recognised an opportunity to sell private LTC cover as a stand-alone product. Sales were originally brisk, peaking in the 1990s. However, about that time insurers started to recognise that they were underestimating risks. Since then we have seen companies begin to curtail sales, limit the benefits, raise prices and, more recently, exit the market.

- Promising Innovations in Recent Years

Products combining LTC insurance and life cover have been introduced in recent years. These offerings are experiencing strong sales growth, eclipsing sales of older stand-alone LTC designs.

2-2-1

The Demographic Shift in the US

Over the course of the next two decades, the generation born in the aftermath of World War II (from 1945-1964) will enter its retirement years. According to the 2009 US Census Bureau projections, the population age 65 years and over will increase from 40.1 million in 2010 to 54.3 million in 2020 and then reach 70.8 million by 2030.

"This year, about nine million men and women over the age of 65 years will need Long-Term Care," says the Medicare website. However, this only measures the benefit payouts of this year; the number of persons who will need LTC insurance in the near future is much larger. According to the American Association of Retired Persons "the lifetime probability of becoming disabled in at least two activities of daily living or of being cognitively impaired is 68%" for persons age 65 years and over[9]. Using this proportion, about 23 million seniors between the ages of 65 and 85 years are likely to need LTC assistance in the future. About eight million seniors are eligible for both Medicare and Medicaid – potentially leaving an estimated 15 million for the private market.

Seniors, though, are not the entirety of the LTC insurance market, only comprising 63% of the total[10]. Another eight million persons age 64 years and under are at risk of disability, though these younger individuals are usually covered by LTC group policies.

Using data from the American Association of Long-Term Care Insurance, one analyst[11] estimated that the potential LTC insurance commercial market numbers are between 15 and 18 million persons. This number will only grow as the retirement population expands.

9 • Beyond 50.2003: A Report to the Nation on Independent Living and Disability, 2003, 11 Jan. 2005.
10 • Rogers, S., & H. Komisar. Who needs Long-Term Care? Fact Sheet, Long-Term Care Financing Project. Washington, DC: Georgetown University Press, 2003.
11 • Alan Schmitz.

Fig. 10

Annualized Cost of Nursing Home Long-Term Care by Disability Group
(costs in year 2000 USD)

Age	Mild/ Moderate Disability	Impaired ADL only	CI Only	Both Impaired ADL and CI	Average Cost
Male					
65+	20,562	41,795	13,502	39,801	37,287
75+	20,809	43,483	16,985	39,180	37,916
85+	25,756	44,819	13,667	38,884	38,841
95+	21,471	45,571	NA	39,431	40,023
Female					
65+	25,641	41,047	24,890	49,819	43,842
75+	24,610	41,900	26,955	50,352	44,705
85+	25,084	43,729	28,681	52,276	47,042
95+	21,894	48,218	33,108	56,824	52,148

Based on 1984-2007 experience data, average nursing care costs grow more expensive at older ages due mostly to greater likelihood of severe disability – and there is a significant gender difference in costs.

Source: Society of Actuaries National Long-Term Care Survey data 1984-1994 • http://www.soa.org/files/pdf/news-healthcare-stallard.pdf

2-2-2

Leading Cause of Bankruptcy among Seniors

According to Genworth's 2011[12] Cost of Care Survey, the average LTC event lasts three years, with much longer stays (five to eight years for most Alzheimer's cases) being possible. Depending on the kind of care received, the cost can run from a median $39,135 for assisted living to $77,745 per year for a private room in a nursing facility.

Given that the median worker age 55 years and over had about $50,000 in personal savings (Employee Benefit Research Institute, 2011 Retirement Confidence Survey), an uninsured LTC event spells financial disaster. "Covering the cost of becoming chronically ill is the leading cause of bankruptcy among older Americans", according to Dr. Robert Pokorski, chief medical strategist for The Hartford[13]. The disabled senior is likely to exhaust their savings quickly, be forced to dispose of assets and look to relatives, some of whom will dip into their own retirement savings, cut back on work hours (or even quit their jobs) to care for a disabled loved one, resulting in potential hundreds of thousands of dollars in lost earnings.

12 • http://www.genworth.com/content/products/long_term_care/long_term_care/cost_of_care.html
13 • LOMA Resource, Sep. 2011.

The economic cost of this voluntary out-of-pocket care, both in expenditures and in lost earnings, is in the tens of billions of dollars per year.

2-2-3

Public Provision of LTC Insurance in the United States

2-2-3-1

Medicare

Medicare was originally set up as a funding mechanism to cover health care experiences for recipients of Social Security. It was never intended to be an LTC insurance program; the qualifications for assistance can be very particular and in most cases Medicare will not cover all LCTI expenses. Regardless, a range of relatively short-term, medically necessary care situations is supported.

Nursing home care, up to 100 days of care in limited situations, is Medicare's most visible LTC function. Beneficiaries must need daily skilled care (seven days a week of nursing care or five days a week of rehabilitative care). In addition, the beneficiary must have been hospitalised for at least three days within the 30 days preceding admission to a Medicare-certified skilled nursing facility and pay a daily co-payment ($133 in 2009) for the 21st through the 100th day of care. After that, Medicare no

longer pays any nursing home benefits[14]. The median daily cost for semi-private nursing facility care is $192, (Genworth) so not only are there high co-payments, but if the person requires care beyond 100 days, he or she becomes responsible for the total cost.

Medicare also covers health benefits for homebound recipients with proven need for intermittent or part-time skilled nursing care or therapy services. In these situations, as long as the criteria are met, no co-payment is required and there is no limit to the number of covered visits. There are also provisions to pay for select medical equipment items for use at home, including walkers, canes, wheelchairs and commodes that could assist with LTC needs. The program also covers hospice care including care from doctors, nurses, therapists, and home health aides, for persons expected to die within six months.

2-2-3-2

Medicaid

Medicaid, originally intended as funding for people with low or no income, has become the leading provider of LTC services in the United States. According to 2010 Department of Health and Human Services data, Medicaid pays for about 33% of overall LTC expenditures while Medicare pays for 30%, with a smaller amount covered by other public sources; 8% is from commercial LTC insurance providers, both group and individual cover. "Medicaid currently finances nearly 34% of all home health care and 43% of the nation's nursing home spending", as well as a wide range of other LTC-related services, with a combined outlay of $106.4 billion[15].

Income eligibility levels for Medicaid vary from state to state. Supplemental Security Income (SSI) recipients often qualify for Medicaid automatically; others with limited income and assets may qualify as well. Medicaid looks at assets such as savings accounts when determining eligibility, but homes, cars and household furnishings are usually out of the calculation. In some states it is possible to qualify for Medicaid after spending their income and assets on nursing home and other health care expenses; this is called Medicaid "spend down." Generally, states allow nursing home residents covered by Medicaid to keep $2,000 in assets and an income of about $30 per month[16].

Medicaid expenditures are expected to grow very quickly over the coming decades. Retirements are forecast to drive 7.5% per year increases in Medicaid enrolments through to the end of the decade, more than doubling the beneficiary population over estimated 2010 levels[17]. By 2030, the typical state will spend 35% of its operational budget on Medicaid – half of this outlay on LTC services alone. States are already scrambling to find opportunities to cut costs. A few have begun cutting community and home-based care funding, despite its significantly lower cost relative to institutional care[18].

2-2-4

Public-Private Partnerships – Good Intentions But Limited Results (So Far)

Policymakers, care providers and academic researchers have collaborated from time to time, conducting research and sharing knowledge around LTC issues. Private insurers and governments have looked to partnering together as well, to stimulate more lower and middle-income consumer participation in the private LTC insurance market. States are motivated to reduce pressure on their Medicaid budgets and companies want to boost sales, and both states and carriers wish to promote inclusion of LTC insurance in consumers' long-range financial planning.

To address these goals, state-based insurance partnership programs were introduced in 2005, using "partnership LTC" programs, which offered tax benefits and asset protection features, to reduce the incentive to burn through assets in order to qualify for Medicaid later. The program attracted a surprising number of high-income applicants and failed to reverse the long-term decline in new LTC insurance sales in the private market.

2-2-5

Private LTC Cover – A Legacy of Pricing Challenges

When private LTC products were first introduced to the US market in the 1980s, there was no prior experience with the product so carriers looked to what they thought to be similar products, such as life and health policies. The first designs were stand-alone policies that covered only LTC expenses. Consumers quickly recognised that LTC insurance pricing was very attractive compared to the benefits being offered; sales growth was robust in the early years.

By the 1990s, however, many of the risk assumptions priced into LTC insurance were proven overly optimistic by actual experience; the first sign was when policy lapse rates came in much lower than expected. For 1984-1999 LTC insurance business, the voluntary lapse rate for

14 • Kaiser Family Foundation, http://www.kff.org/medicare/7067/med_longterm.cfm
15 • 2010 Deloitte issue brief.
16 • Kaiser Family Foundation.
17 • Truffer CJ, Keehen S, et al, Health Affairs, 29(3): 522-5292008.
18 • Deloitte.

individual LTC insurance was half that for individual life (5% versus 10% in the 2nd policy year) with both product lines converging toward 4% lapse by the 10th year. By that model, carriers that assumed "life like" lapse rates in the pricing wound up with roughly 30% more claims exposure than expected (in policy count).

Interest rates were another set of assumptions that gave LTC writers headaches. By the late 1980s, interest rates descended to roughly half the levels from earlier in the same decade. For LTC writers of that era, 7% rates on United States 10-year Treasury bonds were historical lows. As the subsequent decades have demonstrated, yields could – and did – go much lower to the point that by September 2011 new issues of 10-year Treasury were earning less than 2%. If average portfolio returns were 5% instead of 7% on 20-year old legacy business, that would mean roughly 30% lower than expected investment returns over the block of business's lifetime.

More than lapse and interest rate risk, LTC insurance pricing is about gauging accurately the chance that a higher than expected number of policyholders will sicken, qualify for care, and how long they will need that care. As with other product writers, LTC insurers underestimated longevity improvement – and for the past 30 years there has been sustained and rapid longevity improvement at older ages.

As actual product experience was recognised, carriers began to adjust their product offerings and raise prices. Consumers began to back away. Some insurers left the market. In some instances where regulators have allowed it, carriers raised prices on in-force. The steady downward trend in stand-alone LTC insurance sales has continued to this day. Moreover, while there are still over 100 companies selling LTC insurance, the market has become concentrated; two thirds of sales by new premium are dominated by five companies.

2-2-6

Private LTC Insurance – No Two Policies Alike

Cost reimbursement on private LTC policies match benefits with the payout structures of Medicare, Medicaid and other public programs. The need to track Federal and state program benefits adds significantly to the policy administration workload but otherwise carriers risk reimbursing the consumer for portions of care costs already covered by Medicare and Medicaid.

LTC insurance coverage can vary widely. Some policies may cover only nursing home care. Others may include coverage for a whole range of services like care in an adult day care center, assisted living, medical equipment, and formal and informal home care. Most purchasers of individual LTC insurance buy their cover in their 40s and 50s when their health is still good and premiums are lower; however, LTC insurance can be bought at advanced ages. Policies purchased at age 65 years average $1,800 a year for four years of comprehensive coverage; at 79 years, they average $5,900 a year. However, individuals with pre-existing Alzheimer's or other serious health conditions may not be able to buy a policy at any price.

High prices are the leading consumer objection to purchasing LTC insurance. However, there are many ways to structure the policy contract to make rates more attractive. For example, LTC policies can have deferred periods – during this time, policyholders must pay for their own care: the longer the deferred period, the lower the premium. Consumers can also select the length of years of LTC benefits; lifetime coverage is very expensive but a four-year benefit term will outlast the length of 90% of LTC events and be much more affordable.

The level of coverage in x number of dollars per day can be specified, as well. Since it can be difficult to determine the actual cost of cover years in advance, many carriers offer inflation protection riders to keep up with the rising cost of LTC, but this option can be very expensive. A 2009 Bankers World survey found that when adding inflation protection to a single 60-year old individual's three-year benefit period, a 90-day elimination period plan took the average premium from $714 to $1,707.

In most LTC plans, policyholders qualify for some coverage when they cannot perform two out of six activities of daily living and more if more activities are impaired. Daily benefits (LTC costs) range from $40 to $350 for the term of LTC coverage specified in the policy (i.e. two years, five years or lifetime). In the event of eligibility for benefits, the policy will be continued premium-free. For joint lives, a discount is granted.

Finally, most LTC insurance policies offer certain tax benefits. These policies are called Tax-Qualified, or TQ, policies. Depending on age, the policyholder can include some or all of the premiums for a TQ policy as a medical deduction on their Federal income tax form. In addition, payments received from a TQ policy generally do not incur Federal tax[19].

19 • http://www.medicare.gov/LongTermCare/Static/LTCInsurance.asp?dest=NAV%7CPaying%7CPrivateInsurance#TabTop

2-2-7

Recent Developments – Combination Products

The stand-alone product, as outlined above, is not a simple offering. It is difficult to negotiate, price and administer. The risks are complex, difficult to track and credible experience data to understand mortality and morbidity at very advanced ages simply was not available until the 2000s. Now that LTC insurers understand the underlying risks much better, some have had enough and as part of their post-2008 de-risking efforts, have exited the market or raised prices to discouraging levels. Others, seeing opportunity, have opened not one but two new attempts to provide LTC benefits – by attaching them to individual life products.

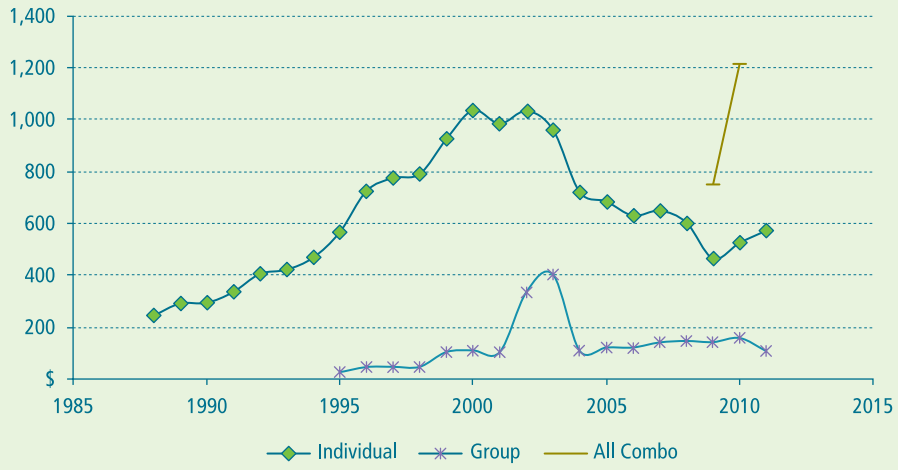
Linked-benefit products have been around for years but never took off before 2009. The first reason was simplicity of the new design; the LTC benefit was often sold as a paid-up multiple of the death benefit, with the mortality underwriting taking precedence, and since the dollar exposure was capped for the carrier, much of the uncertainty around claims experience for standalone LTC insurance was taken out of the picture. This made the LTC/Life combo an easier risk to estimate and therefore price more attractively to consumers.

Acceleration of benefits riders have always been available in cases of terminal illness but the success of the LTC/Life design encouraged some carriers to visit ways to expand this traditional option for individual life cover as a means to provide for LTC expenses. Unlike the linked-benefit, the LTC acceleration rider is an additional premium, paid as part of the base policy. The amount eligible to pay for terminal illness, critical illness or chronic illness care is limited to the size of the death benefit, which is drawn down to either zero or a fixed residual amount to ensure that some death benefit is available to beneficiaries. These types of policies tend to be sold at larger face amounts than LTC/Life combos – buyers tend to be older and more affluent, though younger consumers are showing more interest in acceleration products.

How did these new designs compare to their stand-alone forerunners? In 2010, new premium on stand-alone policies was $524 million, up 13% from the year before. In contrast, sales of all combination products (linked-benefit products and acceleration products together) were $813 million in 2009 – and grew 57% to $1,280 million in 2010. In terms of policy count, 45% of sales are linked-benefit designs; 55% are acceleration products (LIMRA).

Fig. 11

LTCI New Premium, Individual, Group and Combo
(in millions of USD)



In 2010, 235,000 individual LTCI policies were sold for $525 million in new premium. That same year, 26,000 combination products with LTCI cover were sold for $1.2 billion in new premium, about 20 times more per policy.

2-2-8 A Word on Group LTC Insurance

Group LTC insurance in the United States only represents 19% of all in-force premiums; so far, it has never come close to overtaking individual LTC insurance sales. However, in terms of lives served, group LTC insurance has become a very important segment of the market; 34% of all insured lives get their LTC insurance through group plans, either employer sponsored (ES) or association plans. In terms of new business, group plans are even more significant, with 44% of all new buyers purchasing group cover in 2010.

Business growth for group LTC insurance is driven foremost by sales of new ES plans, and second by expansion of existing ES plans. Expanding benefits and adding new association groups are minor contributors. The year 2009 was understandably a bad year, as few companies were setting up shop or adding staff in the wake of the financial crisis. Group sales staged a comeback over the last two years: despite sluggish sales through mid-2011, LTC insurance sales finished the year up 16 percent. Gains were driven by a doubling of sales (up 109%) of group LTC insurance to new participants of existing ES groups. Similar to the individual LTC insurance segment, group LTC insurance is highly concentrated; five carriers command 93% of market share by new premium; a downturn by any one of these companies can have a marked impact on industry metrics.

Despite the downturn, the sales trend for group LTC insurance over the past decade has been one of modest, steady growth. Companies are interested in buying ES plans; over half (52%) of 2011 LIMRA survey respondents indicated that they value LTC insurance as an option to their workers[20]. Similarly, consumers like the convenience of purchasing through their place of work and the low premiums relative to individual coverage and, for some workers, the opportunity to purchase a LTC cover that might be otherwise unavailable.

2-2-9 Outlook

As we have just discussed, group LTC insurance is currently experiencing some challenges but prospects look good – but what about individual cover? Combination product sales already dwarf new premium issues of stand-alone LTC insurance, but will this last? In addition, combo sales have a long way to go before overtaking stand-alone LTC insurance's $8.9 billion annual inforce premium. An ongoing anchor on many insurers' returns is mispriced legacy business; some companies have chosen to cap their losses in the segment and move on. Others have chosen to continue.

The new combo designs are proving to be simpler ways to provide much-needed LTC cover that depends first and foremost on the mortality expertise of the life insurer. The days of unlimited lifetime LTC guarantees may be over for most carriers – but some consumers are finding plenty of value in the recent innovations.

The question remains – can these combo designs, which are mostly sold to affluent consumers, be scaled to serve mass affluent and middle-income markets as well? If so, then the individual LTC insurance market in the US could be on a revival trend.

2-3 Germany

The German LTC insurance market is determined by the compulsory LTC insurance scheme (5th pillar of the social security system), which was introduced in 1995. Due to its extensive presence – it is obligatory for anyone in a public or private health insurance program to have LTC insurance – the demand for additional private coverage was rather low for many years. Since the recent debate on financial viability about public care insurance began, the public's awareness has significantly changed.

The fear of becoming sick and in need of care in old age was the third biggest fear (55%) for most Germans, according to the annual survey of the R+V Insurance Company in 2011. It has since become the biggest concern of most German citizens on issues directly affecting their personal well-being.

2-3-1 The compulsory LTC Insurance

2-3-1-1 Definition of loss of independence in compulsory LTC insurance

The definition of loss of independence and its classification into three levels are legally established. While the degree of loss of independence is ascertained as meeting the definition (see below), the classification into LTC level I to III then follows based on the daily care requirement in basic care[21] and domestic care.

"A person in need of care is any person who, due to a physical, psychological, or mental illness or disablement,

20 • LIMRA Group Versus Individual Products Report 2011.

21 • Basic care includes assistance in feeding, mobility, and body care.

needs assistance (to a greater or higher degree) for the normal and regular activities of daily life for at least six months."

Illnesses or disabilities in the spirit of the paragraph above are:

- loss, paralysis or other functional disturbances of the supporting and movement systems,
- functional disturbances of the internal organs or sensory organs,
- disorders of the central nervous system such as apathy, memory problems or orientation disorders, as well as endogenous psychosis, neuroses or mental disabilities.

The compulsory LTC insurance provides for the classification into three main severity levels:

- 1. Substantial need for care (LTC level I)

There is a need for assistance at least once a day for at least two activities in basic care. The extent of care needed is at least 1.5 hour a day.

- 2. Strong need for care (LTC level II)

There is a need for assistance in the basic care at least three times a day at different times of the day. The extent of care needed is at least three hours a day.

- 3. Severe need for care (LTC level III)

There is a need for assistance in basic care throughout the day and night. The extent of care needed is at least five hours a day.

- 4. Hardship Case

If the care requirements exceed LTC level III, it is classified as a so-called hardship case.

- 5. Limited everyday competence (LTC level 0)

Persons for whom LTC level I is too strong, but nevertheless need care due to a "limited everyday competence", are classified into LTC level 0[22].

2-3-1-2

Insured of public and private compulsory LTC insurance

In accordance with the principle that LTC insurance is part of a general health insurance, those persons who are insured publicly also need to be covered for LTC (compulsory LTC insurance) by public health insurance policy with an Ersatzkasse (substitute health insurance society). Accordingly, privately insured persons[23] have to be covered against the risk of LTC by a private health insurance.

By December 31st, 2009, there were about 70 million people insured or co-insured by compulsory public health insurance. At the same time, more than nine million people were covered by private compulsory health insurance.

2-3-1-3

Statutory benefits of the compulsory LTC insurance

The following table gives an overview of the most important benefits provided by the compulsory LTC insurance – benefits are listed separately, according to type of care and LTC level, effective January 1st, 2010. The overview does not include measures for improving the home environment, which, regardless of the LTC level, can amount to €2,557 per measure[24].

The costs for technical and other nursing articles will be refunded 100%. However, under certain conditions, a co-payment of 10% is paid by the policyholders up to a maximum sum of €25 per nursing article. Expenditures on nursing articles for consumption will be refunded up to €31 per month.

According to the nursing care reform of 2008, the bene-fits listed in the table on page 21 will be further increased from January 1st, 2012. From 2012 onwards, the figures are as follows:

22 • The so-called LTC level 0 was established with the reform of the public LTC insurance of July 1st 2008, primarily, in order to provide benefits to dementia patients, who did not comply with the previous definitions of LTC level I to III.

23 • Under certain conditions, publicly insured persons can change to a private health insurance. However, the insured has to prove an income for example that is above the contribution ceiling of the health insurance. While the premiums for public health insurance are measured in percent of the income, the private health insurance premiums are calculated according to age and gender.

24 • Considering an appropriate personal contribution.

Fig. 12

Table of Benefits of the German Compulsory LTC Insurance 2010

Type of Care	Payment frequency	LTC Level I	LTC Level II	LTC Level III (Hardship Case)
		(in €)	(in €)	(in €)
Home Care **Allowance in kind** **Care Allowance**	 Monthly Monthly	 440 225	 1,040 430	 1,510 (1,918) 685
Nursing substitution **by relatives** **by others**	 Up to 4 weeks per year	 225 1,510	 430 1,510	 685 1,510
Short-term nursing **Care expenses**	Annually	1,510	1,510	1,510
Partial-stationary day and night care	Monthly	440	1,040	1,510
Additional benefits for persons in need of assistance with considerable need for general care	Annually	2,400	2,400	2,400
Full-stationary care	Monthly	1,023	1,279	1,510 (1,825)

Fig. 13

Table of benefits of the German compulsory LTC insurance, from 2012 onwards

Type of Care	Payment frequency	LTC Level I	LTC Level II	LTC Level III (Hardship Case)
		(in €)	(in €)	(in €)
Home Care **Allowance in kind** **Care Allowance**	 Monthly Monthly	 450 235	 1,100 440	 1,550 (1,918) 700
Nursing substitution **by relatives** **by others**	 Up to 4 weeks per year	 225 1,550	 440 1,550	 700 1,510
Short-term nursing **Care expenses**	Annually	1,550	1,550	1,550
Partial-stationary day and night care	Monthly	450	1,100	1,550
Additional benefits for persons in need of assistance with considerable need for general care	Annually	2,400	2,400	2,400
Full-stationary care	Monthly	1,023	1,279	1,550 (1,918)

2-3-1-4

Beneficiaries from the compulsory public and private LTC insurance

As of the end of the year 2009[25] around 1.6 million people received home care benefits from the compulsory LTC insurance. With around 1.5 million people, the public compulsory insurance accounts for the lion's share thereof.

For the same period, the benefit payments for stationary care were clearly lower. At the end of 2009, about 741,000 people received insurance benefits, 39,000 of them were from private compulsory LTC insurance.

2-3-1-5

Premiums for compulsory LTC insurance

While the premiums of public and private compulsory LTC insurance do not differ from each other, they are defined differently in the two systems.

Since July 1st, 2008, premiums for public care insurance have been set to 1.95% of the gross income earned (until then, the premium rate was 1.75%). The gross income assumed is based on the annual income of the insured, which is capped at the so-called contributions ceiling[26]. Childless people over the age of 23 years must pay an extra premium[27] of 0.25% of the gross income assumed, so that the premium rate for these persons amounts to 2.2%. The employers' contribution towards compulsory LTC insurance premiums is 50% of this amount. However, this does not apply to the extra premium for childless people. As with the basic health insurance, spouses and children can be co-insured in the public compulsory insurance scheme without additional premium charge.

The premiums calculation by the private compulsory insurance companies is based on actuarial methods. However, the law limits the premium level so that the privately insured are not at a disadvantage. Employers also contribute 50% towards the premiums of the private compulsory LTC insurance.

2-3-1-6

Financial development of the public and private compulsory LTC insurance

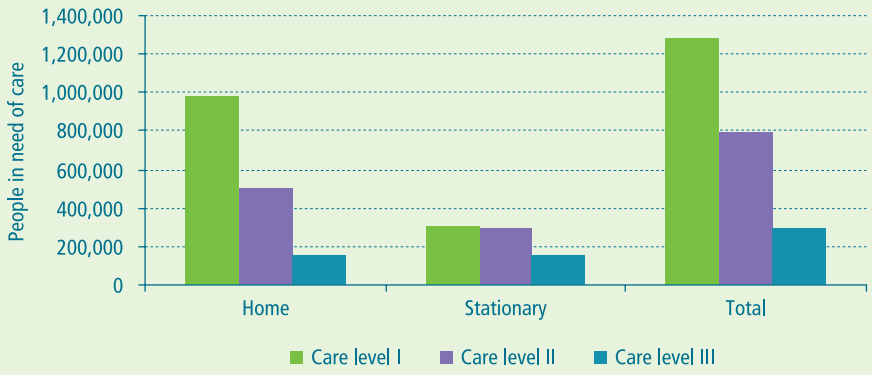
The significantly higher burden of the public compulsory LTC insurance in comparison to its private counterpart is clearly reflected in the annual results.

The significant increase in public LTC insurance happened because, after the introduction of the general compulsory LTC insurance, premiums initially were only collected; the first claim cases were processed and paid out, but not until one year later. This enabled the creation of a reserve for financing existing and future claims.

There is a slight anomaly in 2006 results. This is due to the changes in the method of collecting in 2006, which entailed withdrawing 13 monthly premiums for the year.

Fig. 14

Number of beneficiaries from home care in Germany
(at the end of 2009)



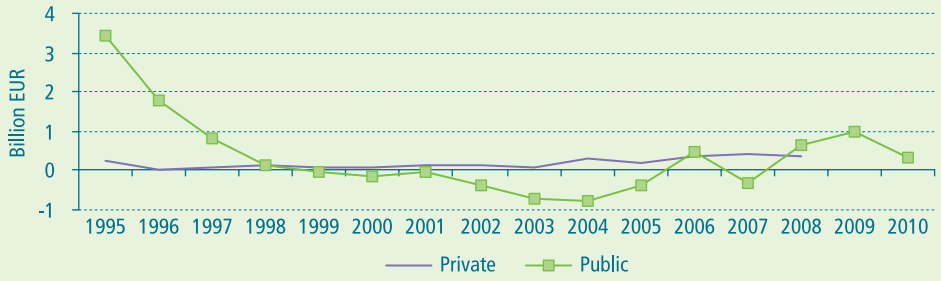
25 • The benefit figures of the private compulsory LTC insurance relate to the period ending 31.12.2008.

26 • In January 2010 the contributions ceiling of the public health and compulsory LTC insurance is set to €45,000 per year, or €3,750 per month, respectively.

27 • Since January 1st 2005, childless members of the health insurance must pay an extra premium of 0.25%. Exceptions to this are people, who were born before January 1st 1940, or have not yet reached the age of 23, respectively. This extra premium is paid exclusively by the insured. Employers will not be considered thereto.

Fig. 15

Comparison of the annual results of the private and public LTC insurance (1995 – 2010)



2-3-2 Private (additional) LTC Insurance

2-3-2-1 The product range of life insurers

In addition to the compulsory LTC insurance and supplementary LTC insurance offered by the private health insurance, the life insurance sector has also established LTC insurance products. The model of LTC annuities has become established in Germany exactly as it has in other European life insurance markets. The dominance of the public care insurance, and the trust established by the financial security offered in the case of LTC, has since the early 2000s affected sales of additional coverage policies in quite a negative way. The public debate on the future financing of the compulsory LTC insurance and the increased awareness of risks for LTC, have then increased the sale of LTC annuities in Germany again.

The statistics of the GDV[28] concerning new business policies and in-force business of the German life insurers are as follows:

Fig. 16

Increase of portfolio in the private LTC insurances of life insurance companies (2002 – 2011)

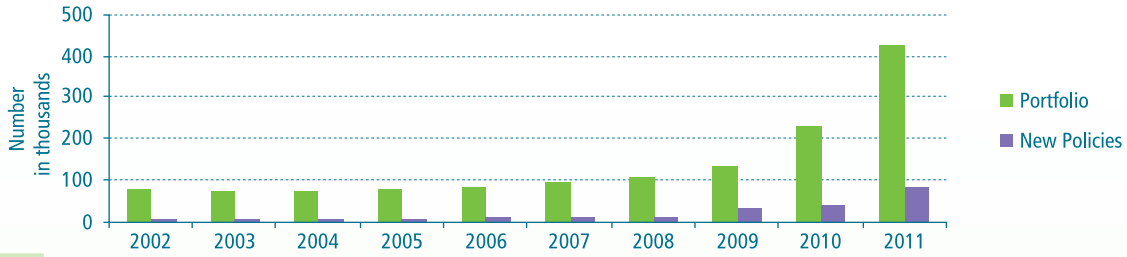
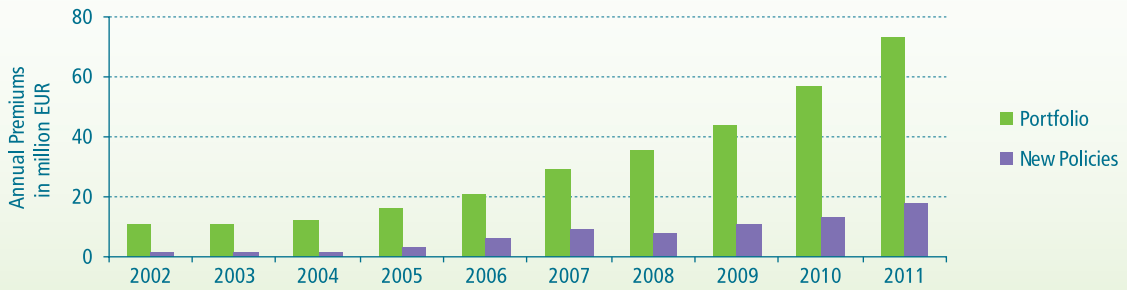


Fig. 17

Annual premiums of life insurance companies' private LTC insurances (2002 – 2011)



28 • Association of German Insurers.

At the end of 2010, the average insured annuity in the LTC pension portfolio (including additional insurance for LTC annuities) amounted to €10,856 per annum. In the new business, in the same year, the average annuity reached about €13,004.

2-3-2-2

The product range of health insurers

In addition to compulsory LTC insurance, private health insurers in Germany offer further LTC riders. With around 1.1 million policies, the daily nursing allowance (i.e. the comparable product to the LTC annuity of the private health insurers) plays an important role.

These figures reflect the public perception that LTC insurance is a health insurance product. They also explain the clearly distinctive portfolio growth of LTC annuity and daily nursing allowance insurance.

Apart from the daily care allowance, private health insurers also offer LTC costs riders which in the case of a claim will replace part or all of the conditional LTC costs.

The main difference between the offerings by life and health insurers does not necessarily lie in the insured benefit. A fundamental critical point of health insurers' daily nursing allowance cover is the annual opportunity to adjust premiums, which does not exist in the field of LTC annuities. In addition, premiums have to be continuously paid in the case of claim for daily nursing allowance or LTC costs riders, whereas the LTC annuity covers the loss of independence without the further payment of premiums.

2-3-3

The distribution of LTC insurance in Germany

From the perspective of the German health insurance companies the LTC rider (in particular the daily nursing allowance rider) has proven itself as successful additional coverage. Apart from the offer to holders of comprehensive insurance (i.e. those people who due to their income level or status moved over to private health insurance), the private insurers also offer their additional coverage to those insured with the public health insurance. For some time, cooperation with the public

Fig. 18

Number of private LTC riders of the private health insurers (2002 – 2010)

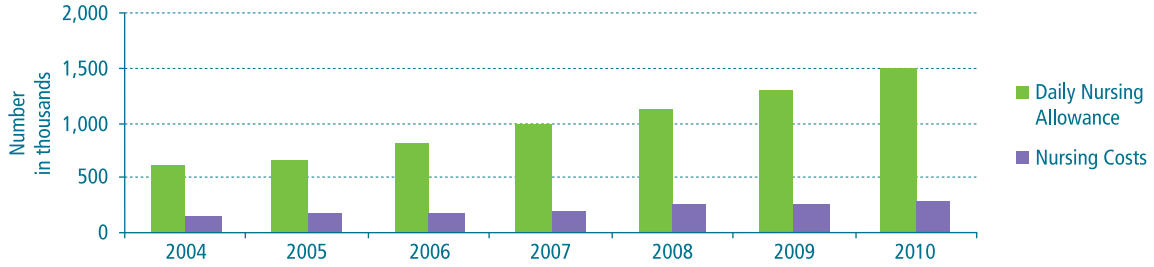
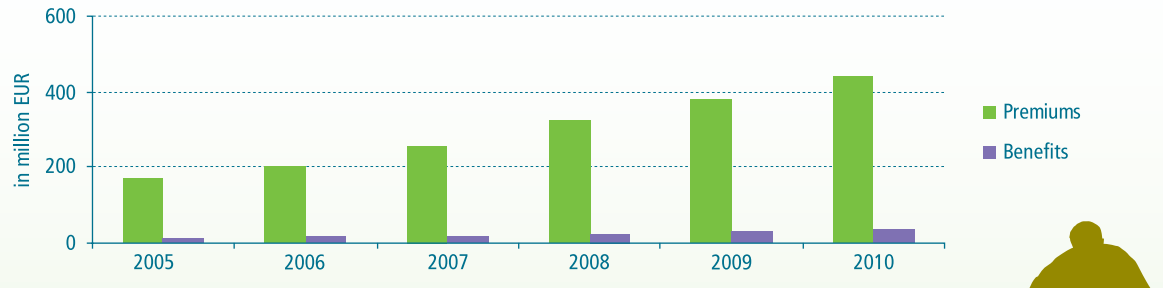


Fig. 19

Premiums and benefits of the LTC riders of the private health insurances (2005 – 2010)



insurers and the Ersatzkassen (substitute health insurance societies) has been used for this purpose. Many times in the past, the additional coverage was sold as a package, which made distribution of the product easier. As the switch from public to private health insurance has become more difficult, the number of new applicants of comprehensive insurance has declined significantly. All the more, offers of additional health insurance coverage serve as a door opener for the distribution and are offered in mailings as well.

The situation is different when it comes to life insurers, who for years have been on the lookout for a suitable product for seniors, in order to open up this customer segment to the distribution. For decades, German life insurers did not offer any other insurance products to the age group of 60 years onwards except for pure annuities. As a result, there was a drain of customer money from life insurers' portfolios to customers' bank accounts. In search of reinvestment products, German life insurers discovered LTC annuities as a possible solution. What first started with the adaptation of accident insurance[29] for seniors led to widespread commercial exploitation of LTC annuities. Because of sales structure considerations, the first LTC annuities were exclusively based on the claims definition of compulsory LTC insurance. Meanwhile, this definition is used in addition to the generally acknowledged ADL definition.

2 - 4 Spain

In Spain, the Law 39/2006 on LTC, as approved by the Spanish Chamber of Deputies, provides the foundations for configuring the System for Self-Sufficiency and Attention to Loss of Autonomy (SAAD – Sistema de Autonomía y Atención a la Dependencia) as the fourth column upholding the social benefit coverage system (this is along with the national health system, the educational system, and the pension system as they have developed in recent years).

Following the approval of Law 39/2006 of December 14th, Decree 504/2007 was approved on April 20th, 2007, setting the standards for evaluating degrees of loss of independence.

Based on existing definitions of ADL used by other European and American programs, the Standard that complements the Spanish law provides for three degrees of loss of independence (Moderate, Severe and Major) with two levels for each degree:

- Moderate: the person needs assistance to perform ABVD (Basic Functions of Daily Life – Actividades Básicas de la Vida Diaria) at least once a day, or requires limited assistance for his personal self-sufficiency.
- Severe: the person needs assistance two or three times a day to perform several of the ABVD, but does not need assistance from third parties on a continuing basis, or extensive assistance for his personal self-sufficiency.
- Major: the person needs assistance to perform several ABVD several times a day, and given his loss of physical, mental, intellectual or sensory self-sufficiency, the ongoing assistance of a third party is indispensable; or he requires general assistance for his personal self-sufficiency.

The Law provides for gradual implementation until 2015, privileging the care of the ones who need it most.

The principles underlying the Law are as follows:

- Public nature of the benefits
- Universal access to coverage under conditions of equality throughout the entire Spanish state
- Complete and comprehensive care of needy persons
- Cross-coverage of policy measures for care for persons with loss of independence
- Evaluation of the needs of persons, with consideration of criteria of equity
- Personalisation of care
- Establishment of prevention and rehabilitation measures
- Help persons in situations of loss of independence to be able to enjoy as much self-sufficiency as possible
- Help persons to remain in their own environment whenever possible
- Quality, sustainability and accessibility of services
- Involvement of cared persons and, as applicable, their families and entities that represent them as provided for in the Law
- Collaboration of health and social services in providing services to beneficiaries of the Spanish System
- Participation of the private sector and the "third sector" (private non-profit organisations with a social objective that are engaged in social solidarity work) in providing services and benefits
- Interagency cooperation
- Incorporation of benefits provided for by the Law in the network of social services of the Autonomous Communities

29 • In the early 2000s, numerous accident insurance products for seniors came onto the market, which apart from the extended definition of accident (e.g. inclusion of the break of the neck or of the femur), also included comprehensive assistance services.

- Inclusion of gender perspectives, considering the different needs of men and women
- Persons with major dependent status shall be cared for preferentially

As provided for in the system, the benefits for LTC as set forth in the Law may take the form of a service or financial benefit; the latter shall be an exceptional circumstance. In any event, said financial benefit shall always be associated with a service.

2-4-1

Review of the Spanish definition

The Spanish definition is based on an evaluation of the assistance required by a person in order to perform 10 activities, which are in turn broken down further into different tasks.

Each activity is assigned a set of points, which add up to 100.

Activity	Points
Eating and drinking	17.8
Control over urination/defecation	14.8
Bathing	8.8
Other personal care	2.9
Dressing	11.9
Health maintenance	2.9
Physical (body) movement	7.4
Movement within the home	12.3
Movement outside the home	13.2
Household chores	8

The number of points per activity is distributed among the tasks into which the activity is broken down.

The chart below provides detail on the first activity defined by the standard "Eating and Drinking".

Eating and drinking	100%
Open bottles and cans	10%
Cut or slice food into pieces	25%
Use cutlery to lift food up to the mouth	25%
Hold a beverage container	15%
Lift the beverage container to the mouth	15%
Sip beverages	10%

The level of assistance required in order to perform each activity is evaluated and a coefficient is assigned.

Does not need help	0%
Supervision / Preparation	90%
Partial physical assistance	90%
Maximum physical assistance	95%
Special assistance	100%

The final score is obtained by adding up the weighting of the sub-activities which the person being evaluated cannot perform, weighted by the coefficient of the degree of support required for each task, and the weighting of the corresponding activity.

The degree of loss of independence is a function of the number of points obtained.

Degree	Level	Points
I (Moderate)	1	25 - 39
I (Moderate)	2	40 - 49
II (Severe)	1	50 - 64
II (Severe)	2	65 - 74
III (Major)	1	75 - 89
III (Major)	2	90 - 100

In the case of persons affected by mental illness or disability (or whose perceptive/cognitive capacity is affected), a specific weighting table will also be used for the tasks; the final score selected shall be the one that is of greatest benefit to the person being evaluated.

2-4-2 Comparison of the Spanish and French definitions

The French LTC model's definition is clearly exportable to this market. An itemised analysis of the definition of coverage in both countries has been conducted. The objective of this study, accordingly, was to identify similarities in the two concepts of LTC.

If one itemises the activities included in each definition, it can be seen that the Spanish definition includes activities of daily life that are not included in the French definition.

Our theoretical evaluation started with a comparison of activities covered by both systems. Next, we conducted a second analysis based on a real population, extracted from the Survey on Disabilities, Deficiencies and Health Status (INE 1999).

This survey provides a very thorough database:

- Age, sex, region of residence
- Activities where the difficulties are found (out of 36)
- For each activity:
  - Type of assistance received and necessary
  - Severity of loss of capacity to perform the activity
  - Anticipated course of development of the loss
  - Deficiency causing the loss
  - Age when loss occurred
  - Temporary or permanent character of the loss

For each person encompassed by the definition, the Spanish definition and the name of the activity lost (French definition: ADL) is reviewed.

The findings obtained are consistent with the first comparison; accordingly, we can state that it is possible to quantify precisely each level of loss of independence under the Spanish definition as a function of the loss of ADL under the French definition.

The French model clearly dovetails with the content of Spanish law. Technical parameters derived from experience in France (given the lack of statistical information on prevalence and longevity of the population in Spain) could provide a consistent and more appropriate starting point.

Activities / Spanish definition	Activities / French definition
Eating and drinking	
Control over urination / Defecation	
Bathing	
Dressing	
Moving physical objects	
Movement within the home	Movement
Movement outside the home	
Other personal care	-
Health maintenance	-
Household chores	-

2-4-3

Insurance products in Spain

Several products and coverage modalities have been launched in Spain at this time that include benefits in the form of principal or income that can be of a temporary or lifetime nature.

Nevertheless and despite of all efforts, the penetration of this insurance is low, as can be seen in the following table:

Fig. 20

	No. OF INSUREDS	NET PREMIUMS WRITTEN (NET OF CANCELL)		TECHNICAL PROVISIONS		
	As of 31/12	JAN – DEC 2009	Δ Year to Year	As of 31/12/2009	Δ Year to Year	Δ from January
2009	15,477	2,164,294.05	5,100.39%	3,300,966.93	21,511.64%	21,511.64%
2010	17,453	2,420,809.90	9.47%	4,358,006.84	31.26%	31.26%

	REDEMPTIONS AVAILABLE / ANTICIPATED	MATURATIONS	DAMAGES / LOSSES	RENTS PAID	TRANSFERS
2009	0.00	0.00	0.00	33,828.10	0.00
2010	0.00	0.00	0.00	20,830.37	0.00

Source: ICEA

The difficulties currently faced by the Spanish public sector (with regard to financing as well as providing services to needy persons) make it even more important for the private sector to be the one to step up and complement the State in assuming a basic role in responding to the needs of persons in dependant status.

2-4-4

Distribution in Spain

LTC products can be marketed either from the bank sector or through traditional channels.

As in all processes for launching an insurance product on the market, just as the product structure, coverage, selection conditions, gaps in coverage, rates, etc. are carefully studied, it is necessary for the message that is transmitted to be carefully crafted in order to highlight the points which will resonate best with the customer:

- The Spanish market is primarily oriented toward an especially sensitive segment of the population, the market for elderly persons: they refuse to be pigeonholed as such. The consumers are experienced and prudent, they have time to review, compare and decide.
- The advertising message must focus on solutions and not problems, implying a certain age but without proclaiming it because for many people LTC is a taboo subject. The values to be communicated should be more consistent with comfort, security and peace of mind, since these persons want to preserve their self-sufficiency and dignity, along with their functional and financial independence.
- It is impossible to create a product geared toward covering 100% of the costs of LTC, which, as we have mentioned previously, can be as much as €3,000 a month. Accordingly, it may be necessary to adapt the amount of the lifetime monthly income to supplement other resources, such as informal assistance, retirement pensions, public LTC benefits, and the savings potentially generated. Accordingly, the product is supplementary and not intended to compete with or replace other offerings on the market, such as reverse mortgages. It is difficult to see how the return a person could obtain from such an offering could be sufficient to compensate for the expenses of loss of independence.
- Furthermore, it is important to stress becoming aware of necessity, and not potential tax incentives. Obviously, a tax benefit is desirable and necessary, but not enough to ensure the success of the product. To rely exclusively on a fiscal assumption could warp the spirit of the coverage.
- Of course, the product will also have to be properly adapted to the distribution channel. Regardless of what the changes might be, it will be necessary to focus sales on creating the need and take extraordinary care to ensure that the client understands just what he is really purchasing in order to avoid high cancellation rates.

2 - 5 Other European countries

2 - 5 - 1 Switzerland

Private LTC insurance is not a success in Switzerland. In order to understand why, one has to look at the social security system in Switzerland, which is very developed and offers a substantial financial aid in case of care need.

In addition to the compulsory health insurance, the disability insurance (Invalidenversicherung or IV) and / or the Alters- und Hinterlassenenversicherung (AHV), i.e.: old-age and survivors' insurance, are also responsible for nursing cases in Switzerland.

Health insurance pays a defined nursing fee per day for stays in nursing homes, and IV and AHV provide an attendance allowance. Health insurance benefits, as well as the attendance allowance of the IV and AHV respectively, are paid independently of the financial situation of the insured. If financially necessary, a supplementary benefit is granted in addition to the attendance allowance of IV or AHV respectively. This award is based on analysis of the assets of the person in need.

The classification of dependency in IV and AHV is based on three LTC levels and is identical in both cases. It is very comparable with the usual six ADLs of the international private sector according to Katz[30]. However, the health insurance uses a different classification, the so-called BESA[31] levels.

The health insurance classification is defined by law[32]; it also depends on the necessary regular assistance for daily tasks or supplementary supervision respectively.

2 - 5 - 1 - 1 Disability Insurance

During active working life – i.e. until general retirement age – 64 years for women and 65 years for men – the IV is responsible for the attendance allowance in case of claim.

The conditions for benefit payments are:

- The insured has a permanent residency in Switzerland
- There is a loss of independence, according to level 1 – 3
- There is no claim for accident insurance or military insurance
- The elimination period is one year

The insured event is given in the need for constant assistance due to health reasons related to the ADLs, or in the need for supervision. In addition, assistance for activities of daily living is insured (i.e. the inability to live alone, the need for support with contacts outside the house, or the risk of isolation). In this case, a disability percentage of at least 25% is assumed.

Allowances differ according to the LTC level; they were doubled for home care with the fourth IV revision in order to support home care.

Level	Nursing Home	Home Care
1	228 CHF / month	456 CHF / month
2	570 CHF / month	1,140 CHF / month
3	912 CHF / month	1,824 CHF / month

The attendance allowance is independent of the insured's income or assets.

The main reasons for dependency are illnesses and birth defects, with less than 5% resulting from accidents.

Fig. 21

Beneficiaries of attendance allowances and IV-annuities, according to the causes of disability, December 2009[33]

Causes of Disability	Attendance Allowance Beneficiaries	Disabled Pensioners	Probability of Dependence
Birth Defects	14,400	28,500	50.3%
Illnesses	15,100	193,400	7.8%
Accidents	1,400	22,200	6.5%
Total	30,900	244,100	12.7%

30 • According to Katz (see paragraph 2.2).
31 • BESA means Residents' Classification and Accounting Systems.
32 • 831_201; article 37 Dependency: Assessment.
33 • BfS; IV-statistic December 2009.

Approximately 13% of all annuitants also receive an attendance allowance from the IV. For beneficiaries who became dependent by illness or accident, the combined percentage is roughly the same (14.3%, or 7.8% and 6.5% respectively) while half of the persons with birth defects and disability annuities also get attendance allowance.

The analysis of the causes of disability in the cases of illness and accident show that diseases and injuries of the nervous system are by far the most frequent causes of severe cases.

In cases of illness, psychoses are the most frequent cause with 35% of all attendance allowances, followed by diseases of the nervous system with 30%. In the case of severe dependency, the diseases of the nervous system are the most frequent cause with 65% of all cases[34].

In cases of accident, the nervous system is affected in 49% of all cases, followed by bone injuries with 40%. In the severe cases, the affected nervous system (with 62%) is the most frequent cause, as it is for illnesses[35].

2-5-1-2

Old-age and Survivors' Insurance (AHV)

The Old-age and Survivors' Insurance, AHV (Alters- und Hinterlassenenversicherung), is responsible for the attendance allowance in case of loss of independence at retirement age, i.e. the age of 64 years for women and 65 years for men.

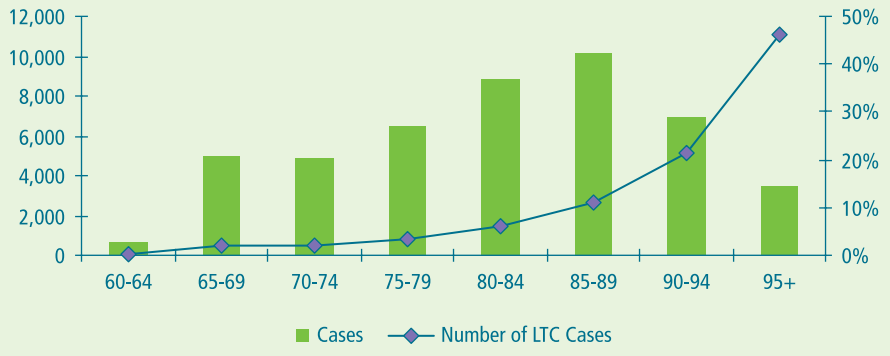
The conditions for payments are the same as for the disability insurance, but additionally the insured needs to receive an annuity by the AHV. The benefit levels are the same as in the disability insurance for grade 2 and 3 but with no distinction between nursing home and home care.

If the insured already receives an attendance allowance of the IV, he/she will be paid the same amount by the AHV in the form of a subsequent old-age annuity.

While 0.5% – 1% of IV insureds receive attendance allowance this percentage continues to increase in the AHV. In the 80-84 year age group, this percentage is already 5%. For 85-89 year olds it accounts for over 10%, and for those aged 90-95 years it accounts for 20%. Above the age of 95 years nearly one in two old-age annuitants is in need for LTC.

Fig. 22

Number of beneficiaries of attendance allowance by the AHV 2009, displayed by age groups and in percent of the annuitants, according to Swiss Social Insurance Statistic 2009



34 • BfS, IV-statistic December 2009.
35 • BfS, IV-statistic December 2009.

2-5-1-3

Supplementary Benefits

In addition to attendance allowance, there are supplementary benefits for the insured in need of care after an evaluation of the financial need. These supplementary benefits depend on the regular income and assets of the person in need of care.

In 2009, the average supplementary benefits for those insured persons who were receiving old-age annuities and living in nursing homes amounted to 2,879 CHF per month. For persons living at home and receiving supplementary benefits, the average monthly payment by the AHV amounted to 898 CHF. Due to the low financial cushion of persons who already become dependent in working age, the average supplementary benefits by the IV are significantly higher: 3,275 CHF per month for nursing homes and 1,027 CHF per month for home care[36].

One-quarter of single persons living at home and receiving supplementary benefits receive amounts of less than 500 CHF per month. However, for more than 40% of the persons living in nursing homes and receiving supplementary benefits, the amount is more than 3,000 CHF per month[37].

The funding gap for people living in nursing homes is caused by high nursing home costs, while beneficiaries of supplementary benefits living at home can claim supplementary benefits due to low revenues[38].

2-5-1-4

Health Insurance

Since 1998, the costs for nursing homes taken over by health insurance have been growing by an average of 4.5% per year. For LTC benefits alone, the costs amounted to approximately 1.8 billion CHF in 2008, which corresponds to 7.9% of the OKP's[39] total costs.

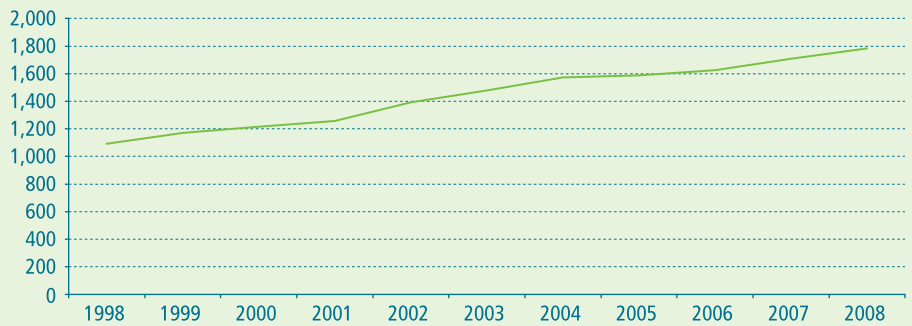
In comparison to the IV and AHV, health insurance uses a different classification for the evaluation of the dependency: the so-called BESA levels. For the care in nursing homes, both LTC costs and caretaking costs are calculated according to the BESA levels. These levels depend on the daily need for care in minutes.

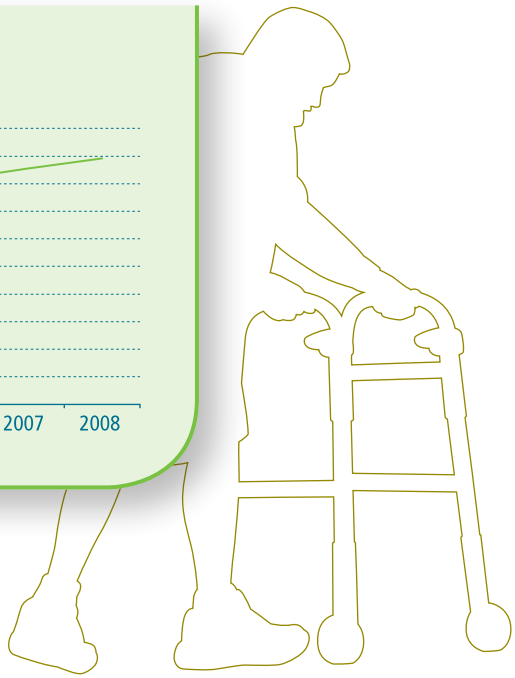
BESA consists of five levels:

Level 0: no care requirements
Level 1: occasional / low care and treatment requirements
Level 2: light care and treatment requirements
Level 3: moderate care and treatment requirements
Level 4: extensive / severe care and treatment requirements

Fig. 23

LTC cost of the health insurance in millions CHF[40]





36 • BfS statistic of supplementary benefits by the AHV and IV 2009.
37 • BfS statistic of supplementary benefits by the AHV and IV 2009.
38 • BfS statistic of supplementary benefits by the AHV and IV 2009.
39 • OKP: Obligatorische Krankenpflegeversicherung: Compulsory Health insurance.
40 • Statistics of the compulsory health insurance, 2008.

2-5-1-5

Personal Contributions for Nursing Homes

The personal contributions to be paid by the insured (or absorption of costs by the communities as supplementary benefits) whilst staying in a nursing home consist of an accommodation fee and a nursing fee, as well as a personal contribution fee.

While the difference in IV annuities between women and men is not that large, it is enormous when regarding old-age annuities of the occupational pension system. This leads to a discrepancy almost twice as high for women in all care levels who receive an old-age annuity.

Based on average assumptions for the benefits received in old age pensions and disability pensions (both first and second pillar) the following discrepancies can be determined by care level, gender and type of annuity.

Payments by social security agencies are customised according to care levels so that the absolute discrepancies, unlike the percentages, do not change considerably. This makes it easier to identify the needs, independent of a potential care level.

Persons with no or merely low assets (according to the asset-related allowances) are supported in case of discrepancy by supplementary benefits which are not welfare payments. For persons with assets above the asset-related allowances, asset drawdown begins in the event of nursing case.

Now we will start with a close look at private coverage in the area of health and life insurance.

2-5-1-6

Private LTC Insurance Coverage in Switzerland

In Switzerland there is private LTC insurance in the form of both life and health coverage.

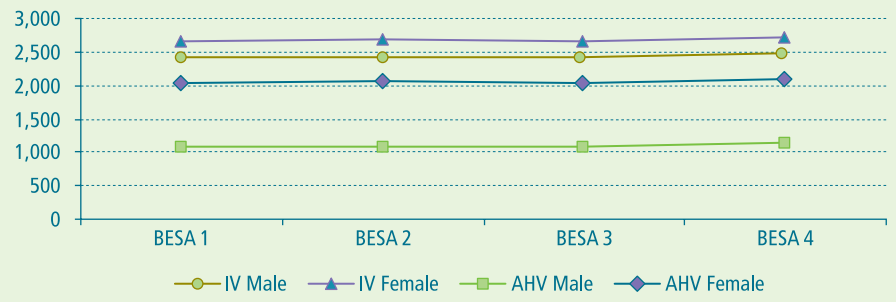
The existing product in life insurance pays a lifelong annuity for people in need of at least 60 minutes care per day, having reached the age of 65 years, after an elimination period of two years, and a deferred period of three months. In recognised nursing homes, the annuity is paid out 100%. In other nursing homes, or in home care, 25% is paid. Pre-existing illnesses from the list of certain serious diseases (such as diabetes with leg disability or dementia suffered before the age of 65 years, or before the taking out of the policy respectively) lead to an exclusion of benefits, as does the entitlement to disability benefits.

For health insurance, there are various providers offering models of cost reimbursement. The insured chooses a limit of up to 300 CHF per day, from which home assistance for home care or food and accommodation in nursing homes, will be reimbursed. The elimination period either is established for two years, or can be determined by the insured to be between a half and three years. The duration of benefit payments is lifelong or restricted to 10 years, depending on the provider. Required for the payout is the regular need for basic and treatment care by the OKP. In some cases, the benefits can be reduced – i.e. if other insurance policies have been taken out.

There is also a health insurer offering lump-sum insurance with a 100-point system. This system is similar to those in France and Spain. Points are assigned for 10 daily life activities: zero (no need for care), five (partial need for care) or ten points (complete need for care). Starting with 25 points, the chosen lump-sum, to a maximum of 180 CHF per day, is then paid out in four

Fig. 24

Average discrepancy, according to gender, type of annuity, and care level



steps: 25%, 50%, 75% or 100%. The benefit duration is life-long and the elimination period amounts to three years for diseases, although it does not apply in the case of an accident.

The advantages of LTC insurance within the framework of life insurance lie in the guaranteed premiums and the premium exemption in case of claim. The cost reimbursement, which is the common model in health insurance, does not entail the taxing of benefits. Annuities must be taxed.

None of the private insurance companies' solutions has proven to be successful until today. The reason is two-fold. On one hand, premiums are expensive. On the other hand, gap analysis is complicated; the personal situation of the insured can change over such a long time of insurance cover that the best advice at the time of application might not be the best advice at claims stage and might cause the non-receipt of a supplemental state benefits.

2-5-2 Italy

Comparable to the situation in Spain, the LTC insurance business in Italy has also led a reclusive existence. Although around 20 Italian insurers have been offering private LTC insurances for several years, the demand for it remains fairly limited. One of the reasons for this may be the enduring importance of the family bond in Italy, but here too the effects of social changes have long been recognisable.

The product design of the Italian LTC insurance products is strongly based on the French ADL model.

2-5-3 England and Wales

Although all European countries expect an increasing percentage of people in need of care in the years or decades to come, the development of public and private LTC insurances has been long in coming to certain countries of the European Union.

State benefits in England and Wales[41] are not sufficient to provide the benefits that individuals expect following a loss of independence. However, despite this shortfall the private LTC insurance market has not yet benefited and is currently in a moribund state.

In the early 1990s, a few providers sprung up to provide a pre-funded LTC benefit, which combined pure risk coverage with a savings element. Over a period of about 15 years, the small number of providers in this market had sold less than 50,000 LTC policies and the last provider exited the market in July 2010, citing a lack of demand.

Reasons for the failure of this market are manifold. It is in part due to the British mind set and the mistaken belief that the state will look after them as part of the cradle-to-grave welfare state provision. Even for those who do realise that state provision will be poor, LTC is still considered too expensive especially for most individuals who have failed to save sufficiently for their retirement and have limited retirement income. There is also clearly a lack of realization that, at the time of retirement when pre-funded LTC provision could be relatively affordable, the state will only provide for people with limited assets (less than £23,250) and limited income. Given the high level of home ownership in the UK, most people will fail to meet at least the asset criteria as their homes are worth many times this minimal amount. For those individuals who do not meet the requirement for state provision they would need to sell their home[42] to fund their own care if they do not have other assets. This policy has proved incredibly unpopular as individuals often wish to pass their main asset on to their children and resent this being lost to their family and taken by the state. People who do meet the minimum criteria and are in need of care can rely on benefits from the social services and the National Health Service, which is supported by the government. The social services pay benefits for home care and care in nursing homes. However, there is significant inconsistency in the system and depending on where the beneficiary lives, funding levels in a particular area and what they suffer from, they may or may not have their care paid for. For example, in England, cancer patients get full care while Alzheimer patients get no financial help.

One product that has established itself in the UK is an Immediate Needs Annuity. This product is bought when a person's condition deteriorates such that they need immediate continuous social care and their life expectancy is severely reduced. However, the costs of this product are of course expensive for most individuals, given that it is purchased at the point of need. The insurance provides certainty against the individual living too long in the care home and the families' inheritance being extinguished as a result. It is really a form of longevity insurance but for those that are in need of care.

LTC has risen up the political agenda many times in recent years but has struggled to gain sufficient prominence in the political debate. In 1997, a Royal Commission for LTC insurance was established and in 1999 recommended the provision of free LTC benefits for all people in need

41 • The rules for Scotland are more generous and care is more readily funded at the present time.

42 • This requirement is disregarded while a spouse resides in the main residence.

of care. In 2000, this recommendation resulted in the NHS plan, which provides government-financed LTC benefits for stationary and home care. More recently, the now departed Labour Government again put this on the agenda with a Green Paper suggesting a Partnership Approach between the State and the Individual whereby the costs for LTC are funded more equitably across income groups by a structured system where individuals are required to pay for a certain percentage of their care depending on their income. The new government is again looking at this and the independent commission (Commission on Funding of Care and Support – the Dilnot Commission) set up to recommend a fair and sustainable funding system for adult social care in England presented its proposals in July 2011.

The key recommendations were[43]:

- To protect people from extreme care costs by recommending a lifetime contribution cap that any adult needs to pay at £35,000, after which they would be eligible to full support from the state.
- To increase the level at which no means-tested help is given from £23,250 to £100,000.

The impact of these recommendations on the maximum proportion of asset depletion is shown in the graph below.

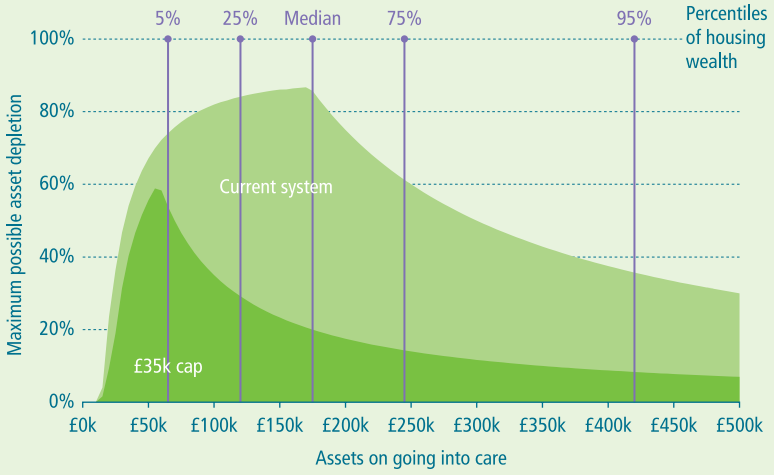
These proposals followed the sentiments of the previous government's Green Paper in that they have been designed to make the system much fairer and to reduce the uncertainty and worry associated with the possibility of very high care costs.

The additional cost of the proposal (in excess of those of the current system) if it had been brought in 2010 would have been £1.7 billion or 0.14% of GDP. The independent commission felt that this was a very small additional cost given the very low level of current public spending being spent on LTC for older people compared with that being spent on healthcare or social security for that same group of people.

The recommendations, if accepted, should stimulate both supply and demand for private insurance products as the capped risk will be more tangible to the individual and insurers will find it easier to design suitable and affordable products. These products would likely be linked to tax-efficient vehicles such as disability-linked annuities (linked to pensions), equity release (linked to housing) or pre-funded insurance products (linked to tax-efficient savings or conversions from life insurance or critical illness products).

It is now down to the government to decide whether to approve the recommendations. This is an incredibly difficult issue for the government to resolve given that the UK is battling with the largest public deficit in the last 50 years. However, public and cross-party political opinion is that reform in this area is needed. The current timetable is for implementation in 2013 at the earliest.

Fig. 25



43 • The full report can be found on www.dilnotcommission.dh.gov.uk/2011/07/04/commission-report/

2 - 6 Israel

In Israel there are three different providers of LTC, namely the public sector, the sick funds and private insurance.

There are several bodies responsible for LTC in the public sector:

- Ministry of Labour – for working population
- National Insurance – for retirees with low income, home care up to 18 hours per week
- Ministry of Health – for retirees with low income, nursing home care paid; this is called LTC codes

The Ministry of Health is regulating the sick funds and the finance ministry the insurance companies:

- Sick funds – group LTC cover with insurance companies as risk carrier and the sick fund as policyholder; around 4 million insureds, representing 75% of number of insureds
- Private insurance – individual covers and in the past also group cover mainly with employers. As from the end of 2011 group LTC covers in private insurance are no longer allowed as short term covers

2 - 6 - 1 Sick funds

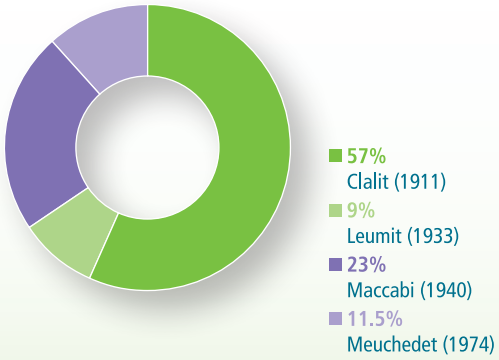
Four sick funds provide basic health insurance:

- Clalit was founded in 1911 and is the biggest sick fund. More than half the Israeli population are member in the Clalit sick fund
- Leumit, meaning "national", was founded in 1933 and is the smallest sick fund
- Maccabi was founded in 1940 and covers around a quarter of the population
- Meuchedet is the most recent one; it was only founded in 1974

Since 1995 all residents of Israel have to be insured with one of the four sick funds for basic health insurance. The cover is determined by the Ministry of Health and the contribution of the member is based on his salary up to a ceiling. The choice of residents for the sick fund is free and there is an obligatory acceptance from the sick fund. They are competing on the services, own hospitals and own doctor network.

Next to the basic health cover the sick funds also offer a supplementary cover to their members including free choice of doctor in hospital, extended services, medication out of the basic basket. Initially, this supplementary cover also included LTC cover. The members did not buy LTC but it was included in the supplementary cover and this might explain the high penetration rate of LTC insurance in Israel. More than 4 Million people are insured through the sick funds and more than 320,000 individual policies exist. It has to be seen what will happen with the individuals covered in the past by group policies. The number of insureds in group covers amounts to 580,000 at the end of 2009.

Fig. 26
Sick funds in Israel



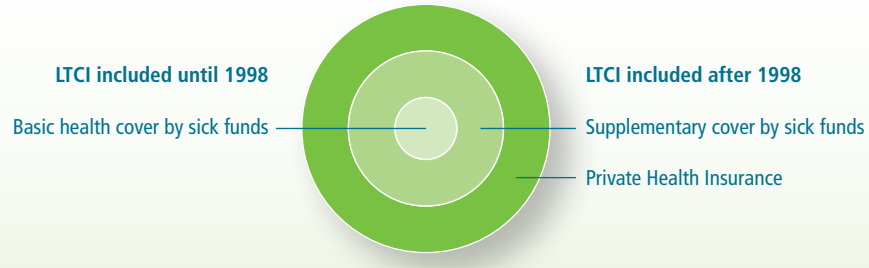
The budget reconciliation law of 1998 introduced that LTCI could be offered by the sick funds only via a group policy with a private insurance company. Therefore, the supplementary cover and LTC were separated. LTC has been insured with insurance companies, while the sick fund has been with the policy holder. Whoever had a LTC cover in the sick funds in 1998 was automatically covered in the new group policy with a private insurance company. Although the price went up there were no significant cancellations.

The LTC covers with the sick funds are group covers which still will be allowed under the new regulation. Benefit payments are based on 3/6 ADLs and dementia. The benefits are reimbursements in nursing homes up to the assured monthly payment, sometimes with a franchise of 20% and some weekly hours of care (in some policies) or monthly payments for care at home independent from actual costs. The duration of claims payments are 5-6 years in three groups and lifetime in the fourth one. The cover is decreasing after 3 years in one group and for the lifetime cover twice decreasing after 3 years and after 5 years. In some groups the benefit depends on the entry age of the insured. There is a deferred period for new members in only one group and

the elimination period after a claim occur is 1-3 months. All new members undergo underwriting in these group policies.

Fig. 27

LTC cover provided by sick funds in Israel



2-6-2

National Insurance Institute

In 1980, the parliament passed a framework for the National Insurance Institute (NII) to collect fees for Long-Term Care Insurance and in April 1988 benefits to complement the already existing service provision were introduced. Since April 2011 the funding is 0.14% of the salary for employees and 0.09% for employers while the government contribution amounts to 0.02%.

Depending on the level of the loss of autonomy, the social security grants a total LTC support of 9.75 to 18 hours per week. However, this support is limited to older people who are already retired. This could be one of the reasons why a very high proportion of young people have taken out a private LTC insurance in Israel.

In 2009, more than 135,000 people, with a 70% share of women, received benefits from the LTCI programme. Around one third of them are older than 85 and around 16% less than 75 years old. Half of the beneficiaries live alone.

2-6-3

Insurance Regulation

The LTC market in Israel is highly regulated.

The cover is based on 6 ADLs; their definition is determined by the commissioner of insurance. For individual insurance the minimum cover is 50% payment for 3/6 ADLs and 100% for 4 or more for dementia. The market standard is 100% for 3/6 and if one is incontinence 100% for 2/6.

For group covers, continuity (insurance of insurability) was granted to the insured. The benefits for group policies might have been lower than for individual covers. In the group policies of the sick funds 100% of the benefit is now granted for 3/6 ADLs and for dementia. In other group policies, mainly offered as a cheap cover from employers to their employees, the benefit structure might differ.

For all LTC covers the premiums can be level or yearly renewable term, but as of age 65 premiums have to be level and from 2012 with an increase limited to 4%. This is to avoid extreme premium increases from age 64 to age 65 and therefore a higher lapse probability which does not reflect the sence of cover need.

Premium adjustments always need to be approved by the regulatory authorities, e.g. to avoid price dumping. Furthermore, it is obligatory for people up to the entry age of 85 to be accepted for individual insurance after underwriting.

In 2012 the commissioner published a new regulation to allow only lifetime policies in the private LTC market.

2-6-3-1

Home care versus nursing homes

In the public sector around 70% of LTC cases are taken care at home, while in the private insurance this percentage is closer to 80%. In the public sector there is no payment for care at home, while in the private sector there is. The public sector offers services in such cases.

2-6-4

Private insurance

In 1978 the first LTC insurance product was offered on the market. However, it still took several years before one could speak of a real breakthrough of the product. Compared to populations that total around 7.4 million inhabitants, the private LTC insurance reaches a high market penetration with over 4 million insureds. All four major (compulsory) public health funds now offer their customers extensive LTC insurance coverage in the form of group policies. Contrarily to the health insurance funds, these LTC insurances are not compulsory. In addition to the group insurances, the Israeli insurers also offer LTC insurances as individual policies, albeit at a significantly higher level of premium.

The first Israeli LTC insurance products were based on the principle of cost reimbursement. The definition in the case of a claim had already been determined according to the ADL model, in which principally 6 ADLs were to be used. On average, 100% of the benefit was covered at the loss of at least 5 ADLs (complete loss of autonomy). With a loss of 4 ADLs the insured person could still expect 75% of the insured benefit; however, the period of benefit payments for the first LTC insurances was restricted to 3 – 5 years.

In 2003, an extensive re-regulation of the LTC insurance took place by regulatory authorities, due to the complexity of the LTC insurance product. In different circular letters, the framework conditions for the LTC insurance product have been tightened up. Apart from the guideline of a precise definition for the case of claim, the verification obligations in the case of claim have also been clearly defined. In order to also provide benefits for people with a partial loss of autonomy, the lower limit for the case of claim has been leveled down to the loss of 3 ADLs. In this case, 50% of the insured benefit has to be provided.

For individual policies on the market, it is taken for granted that at the loss of 3 or 2 ADLs, one of which is incontinence, 100% of the insured benefit will be paid.

As well as the restricted period of benefit payments of the usual 3 to 5 years, Israeli insurers also offer lifelong benefit payments. The reorientation of the LTC insurance in 2003, led to the adjustment of the initially quite low premium rates all over the market. On average, the premiums increased by 40 – 50%, whilst hardly affecting the success of the product.

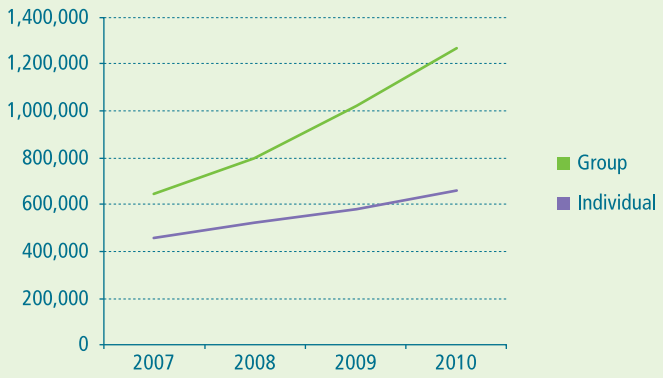
In Israel exclusions exist for pre-existing conditions of one year until age 65 and half a year thereafter. This applies to dementia as well, which is very different from the French approach of having a 3-year elimination period. However, in Israel strict underwriting is performed.

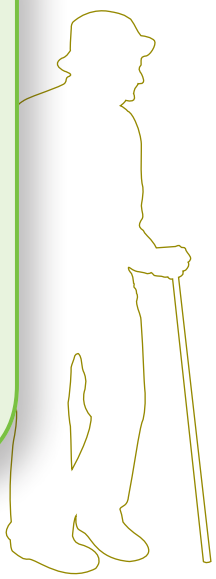
The private insurance market has seen an annual increase of about 20% from 2003 until 2009[44]. Around 1/3 of premiums come from individual insurance.

The premium development in private LTCI, without taking into consideration the sick fund cover as of 2007 until 2010, is as follows:

Fig. 28

Premium development in private LTCI





44 • Source: Israel ministry of Finance.

2-6-5

Reform in private insurance

The Ministry of Finance sent out a consultation paper to the insurance companies on various issues. The main ones are:

- Yearly renewal term premium until age 65 and afterwards the request of level premium, which leads to a jump in age 65 of up to 5 times the premium as in age 64 for individual insurance.
- Continuity option in group policies because it is very expansive. Insureds are not aware that leaving a group leaves them either without LTC insurance or with a high premium increase. The benefit of the group policies at young ages are very limited and can be covered by either Critical Illness or Personal Accident policies.

As a result, in 2012, the commissioner published some regulation on the issues. For yearly renewable term rates an increase of maximum 4% is allowed. This might lead to more level premium policies.

For group policies like for individual policies the request is that the insurance period will be for the whole life of the policyholder (and cannot be cancelled by the insurance company).

For pricing, cross subsidization between policyholder, age groups and genders is no longer allowed. Only a maximum of 5 years by group of age is allowed for pricing purpose.

2-7 Singapore

2-7-1

Background

Launched in 2002 under the auspices of the Singapore Ministry of Health (MoH), the ElderShield Scheme is a national severe disability insurance scheme to help Singapore citizens and permanent residents pay for their long-term step-down care if they become severely disabled.

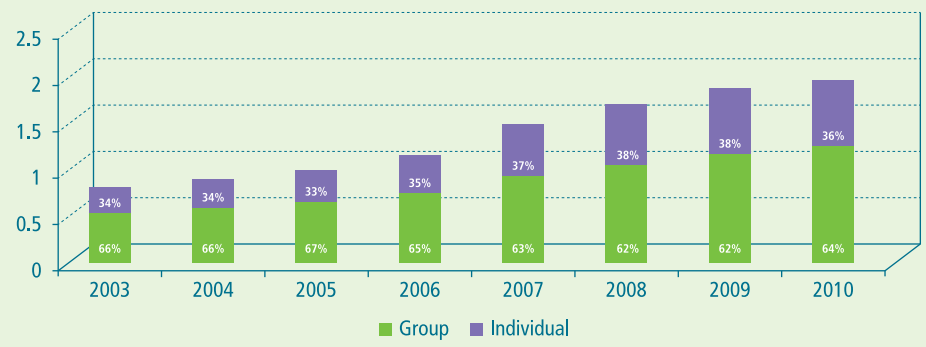
Following the insurance industry practice for severe disability insurance products, policyholders who cannot perform three or more of the six Activities of Daily Living (ADLs – washing, dressing, feeding, toileting, mobility and transferring) are given a monthly cash pay-out of S$300 (approx. €150), up to a maximum of 60 months. There is however no separate assessment criteria for cognitive impairments.

In order to ensure consistency in claims assessment, a panel of doctors from both the private and public sector (currently 68 in total as at February 2011) was formed. These doctors were given specialised training to acquire the skills to assess claims based on ADLs.

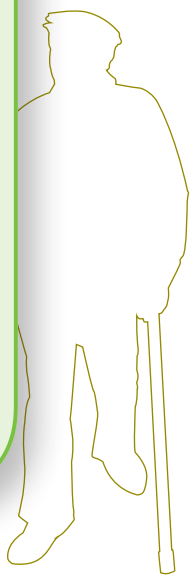
The Scheme was never intended to meet the full costs of care; it is meant to provide a basic level coverage while keeping the premiums affordable to all, especially those from the lower income groups. The choice of S$300

Fig. 29

Total gross insurance premiums in the long-term nursing care sub-sector in the years 2003-2010 (in NIS Billions, Percentages)



Source: analysis of the Capital Market, Insurance and Savings Division, of data of annual reports of the insurance companies based on the non-consolidated reports of the companies.



payout per month was deemed as sufficient then to cover a substantial portion of a patient's share of subsidised nursing home charges and defray the expenses of those who choose home care. At the time the scheme was launched, data was said to show that most people would need financial assistance for severe disabilities for about five years.

In Singapore, it is not uncommon for the elderly to live with their grown children. In fact, for those aged 80 years and older, less than 10% live alone. With this in mind, and in line with the government's philosophy of promoting family support and community-based services for the care of the elderly, the insurance payouts are in the form of a cash benefit and not tied to the reimbursement of institutional care.

In order to encourage a wide participation, an opt-out scheme was introduced where all members of Singapore's mandatory pension fund (Central Provident Fund, or CPF) aged 40 to 69 years were automatically enrolled without any underwriting. The opt-out feature also helps reduce anti-selection. After plan launch, all CPF members that turn 40 years old or are new CPF members aged 40-69 years are automatically enrolled. Premiums are deducted from a member's CPF account and this helped make the cost even more bearable as there is no immediate cash outgo and moreover contributions to CPF is tax deductible. Furthermore, while coverage is lifetime, members need only pay premiums for a limited period (up to age 65 years for most). Premiums are determined at age of entry and are level throughout the premium payment period. Premium rates are however not guaranteed although the revision in rates must not happen more than once in five years and each revision should not be more than 20% of the previous rates.

To encourage private sector participation and promote competition, the operation of ElderShield was initially awarded for a period of five years to two private insurers – namely Great Eastern Life and NTUC Income – via a competitive bidding process. To-date the ElderShield has been held as one of the examples of the uniquely Singapore experiment in involving the private insurance sector in a National Insurance Scheme. While the Government moots the idea of National Insurance scheme, the pricing and operation of the scheme is run by the private sector in consultation with the Government.

2-7-2

Reformation of ElderShield and public tender

In April 2007, the MoH conducted an open tender to appoint insurers for ElderShield for a new five-year period (October 2007 – September 2012). The intention was to reform the ElderShield structure with effect from October 2007 with the following objectives:

- Retain a "basic ElderShield" for all Singaporeans that will help pay for basic no-frills long-term step-down care.
- Allow private insurers to offer "ElderShield Supplements" with additional benefits and premiums on top of the basic ElderShield plan.

The insurers were invited to bid for:

- The right to offer the basic ElderShield as an opt-out scheme for eligible CPF members from October 2007; and
- The right to offer ElderShield Supplement plans. The ElderShield Supplements will be marketed as opt-in benefits and the premiums may be payable from policyholders' MediSave accounts up to specified withdrawal limits which currently stands at S$600 per year.

Insurers were invited to submit quotations of their proposed premiums for the scheme. The selection of insurers would take into account several factors such as the proposed premiums, the effectiveness of proposed business plans for ElderShield, expertise and experience in relation to severe disability or LTC plans, and level of investment in resources for managing ElderShield policies and claims.

2-7-2-1

Results of public tender

On 19th June 2007, the MoH announced the results of the tender. Aviva was selected as the third insurer to compete with the two incumbents, Great Eastern Life and NTUC Income. Aviva proposed the most competitive premium bid, and Great Eastern Life and NTUC Income agreed to match these rates.

Several changes to the ElderShield scheme were announced as well:

- The monthly pay-out for ElderShield was enhanced from S$300 to S$400 and the maximum payout period was extended from 60 to 72 months in the event that the policyholder is severely disabled.
- The monthly premiums were increased by only S$2.
- The new scheme remained an opt-out scheme. CPF members reaching age 40 years will be automatically covered under this new scheme unless they opt out.

However, there will be no auto-upgrading of benefits for the existing policyholders. Existing policyholders need to be medically underwritten before they can upgrade to the new scheme or purchase the ElderShield

Supplement. For the upgrade, existing policyholders also have to pay a one-off premium adjustment. MoH has worked with the ElderShield insurers to spread the adjustment premium over a period of five years to facilitate ease of payment by policyholders.

2-7-2-2

Premium rebates

The ElderShield contract contained a premium rebate provision, whereby if the actual claims experience turned out to be less than projected, the insurers must give rebates back to their policyholders. According to a press release by MoH on 22nd June 2007, the rebate is estimated to be S$60 million, which is approximately 7% of premiums paid.

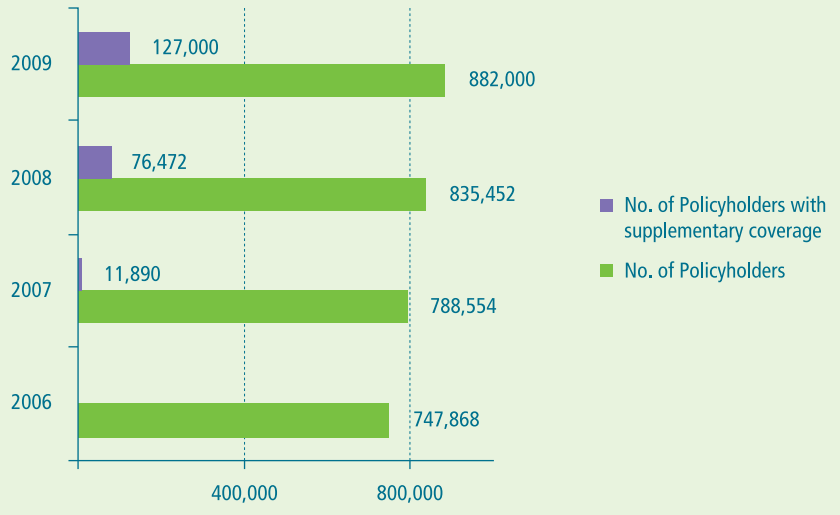
2-7-3

ElderShield – Current status

Based on published figures as at end 2009, number of ElderShield policyholders reached 882,000 (55% of those eligible for coverage) of which 127,000 (14%) have purchased Supplemental ElderShield plans. Opt-out rate has dropped from 38% (launch of scheme in 2002) to around 14% in 2006 and is said to be under 10% in recent years.

Fig. 30

Number of Policyholders

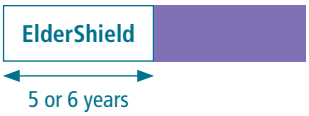


Source: MoH

2-7-3-1

Benefit Description of supplementary riders currently offered

I – Supplements which are extensions of basic ElderShield

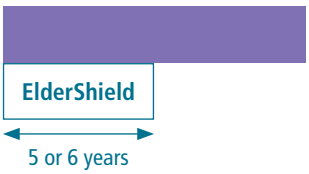


When do the payouts start?
They will commence in the following month after your basic ElderShield Policy has paid out the 60th or 72nd payout (depending on whether you are on ElderShield300 or ElderShield400).

How long is the maximum payout period?
Depending on the type of Supplement bought, the maximum payout period will be either a fixed period (4 or 5 years) or lifetime. All monthly payouts will be discontinued upon death.

Applicable Supplements:
ElderShield ValuePlus 300 and 400, ElderShield Lifetime Care 300 and 400

II – Supplements which overlap with basic ElderShield



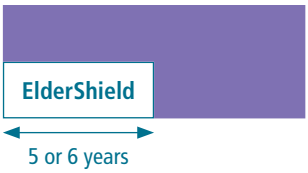
When do the payouts start?
They will commence in the same month as your basic ElderShield Policy.

For the first 60 or 72 months (depending on whether you are on ElderShield300 or ElderShield 400), you will receive payouts from both policies. After which, only the Supplement will continue its payouts until the maximum payout period has been reached.

How long is the maximum payout period?
Depending on the type of Supplement bought, the maximum payout period will be 6 or 10 years. All monthly payouts will be discontinued upon death.

Applicable Supplements:
ElderShield Comprehensive and ElderShield Care

III – Supplements which integrate with basic ElderShield



When do the payouts start?
They will commence in the same month as your basic ElderShield policy. For the first 60 or 72 months (depending on whether you are on ElderShield300 or 400), the Supplement will provide a payout on top of your basic ElderShield payout.

E.g. An ElderShield400 policyholder who buys a Supplement with S$1,000 monthly benefit, will receive benefits as shown in the table:

	First 72 months	73rd month onwards
From ElderShield400	S$400	S$0
From the ElderShield Supplement	S$600	S$1,000
Total	S$1,000	S$1,000

How long is the maximum payout period?
Depending on the type of Supplement bought, the maximum payout period will be 12 years or lifetime. All monthly payouts will be discontinued upon death.

Applicable Supplements: MyCare and PrimeShield

Since launch, the MoH has made it clear that the ElderShield scheme was meant to evolve with time. At the beginning, MoH set up the scheme to offer a minimum level of coverage; the MoH was also encouraging the private industry to follow up with supplementary plans. However when it was evident that the push from the private industry was not forthcoming, MoH provided further impetus during the last reform in 2007.

In a recent interview with the press, the Minister of Health has announced that the ElderShield scheme will be enhanced to offer better coverage and he wished for more policyholders to supplement their existing cover. Originally scheduled for 2012, the MoH has announced that the new five-year tender exercise will be delayed till 2013 to allow the Ministry time to review the scheme and suggest necessary enhancements to make it relevant in current times. It is clear that the benefits under the scheme will be increased and hopefully the Ministry will also consider the introduction of a separate and more appropriate criteria for assessing claims from cognitive impairment such as dementia.

2 - 8

Japan

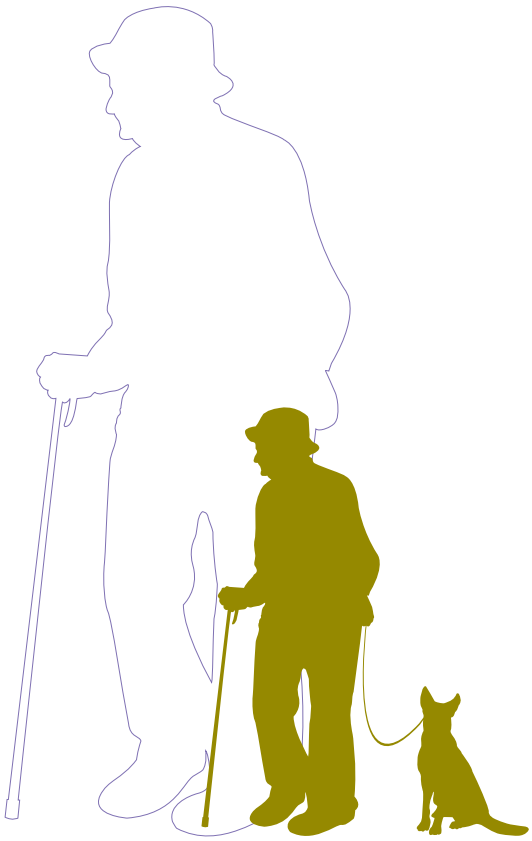
With an average age of 44.7 years, Japan can clearly be called the oldest country in the world. The average age is well over five years higher than that of other industrialised nations, and 15 years above the worldwide average. Japan has responded appropriately early to the demographic change with various reforms.

The state-run "Gold Plan" from 1989 formed the basis for the countrywide spread of LTC support in nursing and home care. However, the approach through free LTC benefits soon faced difficulties due to increasing costs and financing problems. Therefore, in 2000 a compulsory National LTC insurance system was established, which was financed equally from insurance contributions and tax subsidies. The premiums to be paid by the insured, once they reach the age of 40 years, are co-financed by the employers. The system is administered by the respective municipalities.

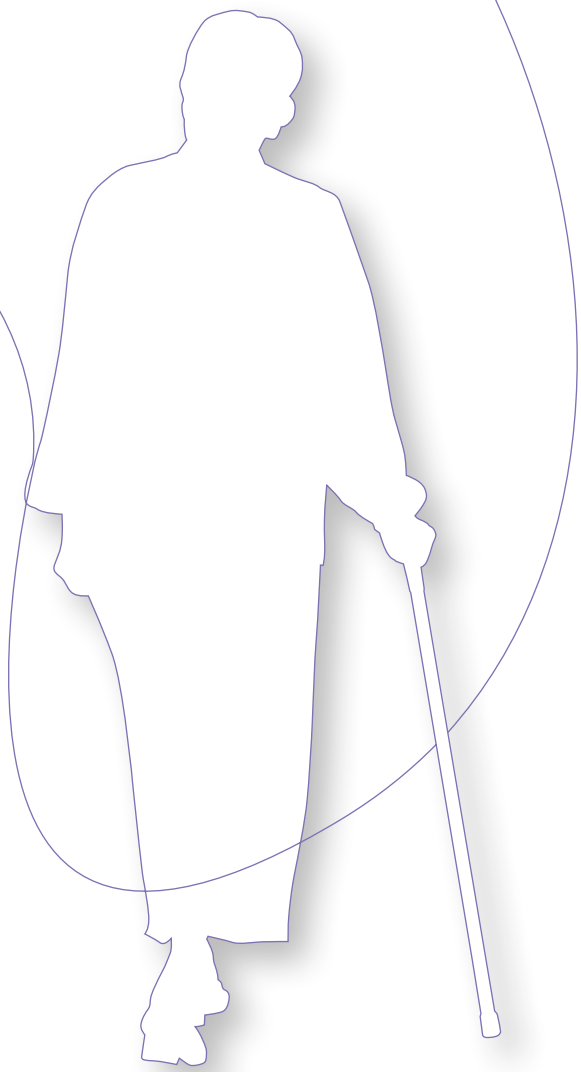
In the private insurance sector, the introduction of the compulsory National LTC insurance led to an abrupt breakdown of the private LTC market. The portfolios built during the period of 1989 to 1998 of about two million LTC insurance policies have consequently been fading out since then.

The benefits of the compulsory LTC insurance programs are geared exclusively to the actual needs and not to the financial value of the support. A six-level classification was especially introduced for the assessment of needs. The insured has to pay a deductible 10% from the benefits to be provided. Normally, no cash benefits are given, but the formal care will be reimbursed up to a certain amount. With some exceptions, insurance benefits can only be claimed by persons over 65.

It remains to be seen whether the National LTC insurance scheme will be financially viable in the future. A first reform in 2006 was introduced to reduce anti-selection and to improve the LTC service quality. A second reform in 2009 further introduced controls to prevent falsified requests for Government subsidies for services that were never provided.

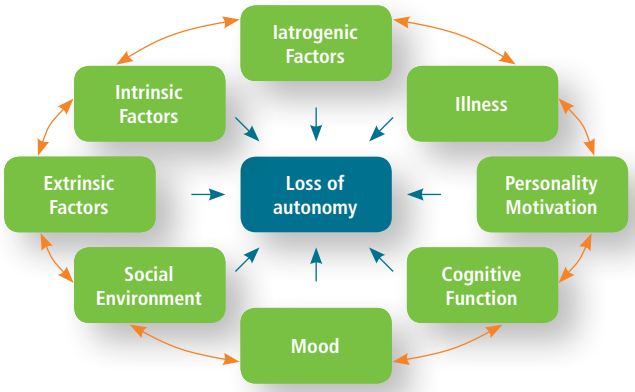


3 Causes of independence loss and social consequences



The triggering factors of loss of independence are quite numerous and are not always given sufficient attention in the often strongly aggregated benefits statistics. The following graph illustrates the relationships and interactions between internal and external factors. Every single factor affects the person directly, as well as affecting further factors, which can then reinforce their impact.

Fig. 31
Triggering factors



3 - 1 Statistics of Causes of Claims

According to the experience of French insurance portfolios, the following results regarding the average distributions of major causes for loss of independence (all age groups were aggregated) were found:

Fig. 32
Causes of autonomy loss

Causes	Percentage
Neuro-psychiatric Diseases (Dementia)	25 - 50%
Cancer	15 - 30%
Cardiovascular Diseases	15 - 30%
Other Neuro-psychiatric Diseases	10 - 20%
Rheumatism	2 - 10%
Accident	5 - 10%
Ocular Diseases	1 - 3%

A significantly higher percentage of men have cancer and cardiovascular diseases than women. Women for their part suffer considerably more often from dementia and polypathologies. It is also acknowledged that on average men lose independence one or two years earlier than women do. The remaining life expectancy after the occurrence of loss of independence is, as expected, shorter for men than for women of the same age.

3 - 2 Dementia

The statistics on the different causes strongly highlights the relevance of dementia for LTC insurance. The listed percentage of 25 – 50% refers to all age groups, but the percentage of dementia increases significantly with advancing age. For those aged 75 or older, an average prevalence of 18% can be assumed, 70 – 80% of which is accounted for by Alzheimer's disease.

Contrarily to other causes of loss of independence, dementia-related nursing cases lead to an exceptionally long benefit period. Recent research assumes that a person suffering from Alzheimer's disease still has a remaining life expectancy of eight years. Overall, one can conclude the following graduation:

Fig. 33

Benefit periods, according to causes

Cause of autonomy loss	Benefit Period
Cancer	below-average
Polypathologies	average
Dementia	above-average

3 - 2 - 1 The Mini Mental State Examination (MMSE)

Providing reliable evidence for cognitive impairments is very difficult. Nowadays the Mini Mental State Examination (MMSE) is widespread. This test was developed in 1975 by Folstein and colleagues, which is why it is sometimes referred to as the Folstein test.

It is an interview with the person affected, in which nine tasks examine the cognitive abilities of the analysed person. The interview takes approximately 10 minutes and based on the achieved score, the cognitive abilities of the affected person can be grouped. With a total score of less than 15 points, one can deduce severe cognitive dysfunctions. Scores between 15 and 17 indicate moderate cognitive dysfunction. For higher scores no cognitive dysfunction can be evidenced.

3 - 3 Rejection Rate

As with in the disability insurance, providers of LTC insurance also register a high rejection rate of the submitted claims. Depending on the market and on the insurance product design, the rejection rate can reach 75%. Experience has shown that the rejections are based on the following causes:

Fig. 34

Analysis of rejected claims

Reason for Rejection	Percentage
Conditions (benefit qualifications) not met	30 - 40%
Temporary only situation of lost autonomy	15 - 25%
Waiting period not yet completed	5 - 10%
Infringement of the pre-contractual disclosing obligation	5 - 10%
Case of death within the elimination period (90 days)	5 - 10%

The listed rejection reasons relate to experience in the French market and depend very strongly on the French product design. In other markets that have much shorter waiting periods for LTC insurance, non-fulfilment of the waiting period or of the benefit qualifications carries less weight.

3 - 4 The psychosocial risks of LTC

3 - 4 - 1 The hidden costs of informal care

From an economic point of view, the informal care provided by the family and friends of people suffering from a loss of independence may be seen as a free substitute for professional care. Such care, which may take a variety of forms, means that there is less reliance on professional caregivers, thereby reducing the financial needs of dependent people.

However, the "free" nature of this care is illusory as it has an undeniable cost in terms of the health of the caregivers and lost work opportunities. Thus, policies

encouraging people in their fifties and sixties to take care of their ageing parents themselves in order to keep them in their own homes are incompatible with other measures aimed at keeping older workers in employment for longer.

At the same time, so-called "active ageing" policies improve the financing capacity for both health and pension provision. A Canadian study entitled "Longévité: une richesse" (Longevity: a blessing) (CIRANO, January 2010) looks at the implications of an ageing population. The conclusion is clear: if economic growth is to be maintained at a desirable level, Quebec's workers will have to work longer. The study shows that an increase in the proportion of workers remaining in employment would have a positive impact on GDP.

Eventually, if European targets on the employment rate of older workers are met, demand for professional care and therefore the financial cost of LTC are likely to increase.

It is obvious that informal care reduces the time workers spend at work. It can also force some individuals to give up professional opportunities or lead them to accept less well-paid work, to have more flexible work hours so that they can be closer to their parents' home and have more time for them. However, although informal care often takes up some of a person's time that would otherwise be devoted to work, taking on a care-giving role only rarely leads individuals to leave the job market permanently (Le Bihan and Martin, 2006).

It is often claimed that the number of informal caregivers could fall in the next few years due to a relative fall in the number of children per family, the fact that they often live further away from their parents and the "breakdown" of the traditional family structure in general. However, this supposed shortfall in the number of caregivers in the next few years would seem to be more difficult to estimate than might at first be suggested. First of all, the quantity of care received by a dependent person does not necessarily increase with the number of children in the family. Furthermore, recent studies have shown that care and support within families remain strong and that the number of family caregivers has never been as high as it is today. (Cf. SCOR Papers No. 15, April 2011).

3-4-2 The impact on the health of "natural caregivers"

Informal care giving also has an effect on the health of caregivers.

Numerous epidemiological studies have demonstrated the negative effects of informal care on caregivers' own health (Sorensen et al., 2002; Brodaty et al., 2003).

When we speak of LTC, we often refer to the loss of independence of people who come to depend physically and mentally on their relatives (children or spouses), a category newly identified as "natural caregivers".

Particular attention is now being paid to these "natural caregivers", as they are finding themselves faced with a burden of responsibility that leads to chronic stress and adverse effects on their health, with some studies even suggesting an increase in early deaths.

For many years, a great deal of effort has been put into physical rehabilitation and home automation to support people with a loss of physical independence, and access to care is organised so as to help them cope with everyday tasks that have become difficult or impossible.

In spite of these technical improvements, a feeling of loneliness frequently overcomes the frail elderly and they sink into a silence that is a sign that they have reached the end of a losing battle and have given up. Maintaining an emotional relationship takes considerable effort on both sides, as the old roles change and the interpersonal balance is eventually reversed. Natural caregivers will also tend to conceal their own difficulties from health professionals because they believe it is unacceptable to mention them.

In situations where there is cognitive impairment, the efforts currently being made to diagnose dementia and other neurodegenerative diseases at an ever earlier stage will inevitably mean that younger people will have to face up to the fact that they are ill at the very beginning of the degenerative process. Of course, there is always the hope that pharmacological research will lead to new treatments, but there are bound to be delays.

Furthermore, the announcement of the diagnosis is a shock that immediately imprisons the person and their family in the notion of illness and from then on they are condemned to live in fear of the onset of the expected deterioration. For people diagnosed at a younger age, maintaining a professional activity becomes difficult as soon as the illness is announced as the impairment of the cognitive functions raises, for them and their family and professional circle, the spectre of irresponsibility and the prospect of endangerment of themselves and others. Then begins the slow descent into the abyss of loss of independence, a descent which will be vertiginous for some, occur in stages for others and progress insidiously in some cases. It will be a descent nevertheless, confronting those around the person with their fears and hopes, putting an end to any plans for the future and obliging families to readjust their lives gradually as the illness progresses whilst placing them in a state of chronic insecurity.

Until now, these realities were dealt with in the silence of family relationships, with families tending to mask how hard they found the situation, considering it normal and their duty to cope with ageing relatives.

Today, increasing longevity has led to a rise in the numbers of people at risk of requiring LTC at the same time as working lives are being extended. Thus, middle-aged workers (who may also still have teenage or young adult dependents) are finding themselves having to bear, in the last quarter of their working lives, the responsibility and financial burden of caring for a parent or spouse and of combining that role with their professional duties. This means that relatives (spouses and children) find themselves in a situation where they are managing a more and more difficult everyday life without support, as well as coping with the relational difficulties mixed with feelings of guilt induced by such illnesses.

Bearing in mind that such family caregivers also have jobs, it is easy to see how family care giving adds to professional stresses, both in quantitative terms and in qualitative terms. Care giving often represents two to three hours work a day, and the emotional and mental burden is particularly heavy, all the more so when there is cognitive impairment.

Exhaustion can easily creep up on these "behind the scenes" workers and they often live in stifling isolation.

Continuing to work outside the home is a lifeline for them, as long as it is fulfilling work. From the employer's point of view though, these workers are more likely to have professional issues (lateness, absence, impaired attention, reduced efficiency). As a result, these workers under pressure are more fragile and more exposed to psychosocial risks, mainly due to the lack of social support and the difficulties of reconciling their personal life with their professional life.

3-4-3

Preventive action

When it comes to controlling healthcare costs, the question of LTC raises issues for companies (employee stress, working conditions) and the State.

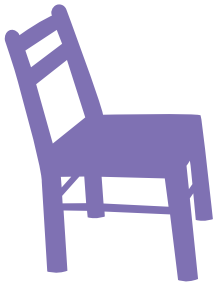
We have seen how important it is for "natural caregivers" to be supported with respite provision or on a more permanent basis by adapting their working conditions, as they can easily become a considerable social and financial burden if exhaustion precipitates deterioration in their own state of health.

How Réhalto helps natural caregivers

In the context of our prevention service and the support we provide for people on sick leave, we find ourselves dealing more and more often with employees who are also natural caregivers (and sometimes even the employees of their dependent relative) who find themselves in a state of emotional or physical exhaustion.

Our priority is to enable the person to regain optimum health so that they have the energy to handle the situation once more. This means finding a new emotional balance, but also adopting a more healthy lifestyle (nutrition, physical activity, social resources), for very often exhaustion leads to the person failing to look after themselves (they neglect their appearance, but also their own general well-being) and in some cases to a loss of empathy which can rapidly lead to mistreatment.

This is why it is important for us to look after these people and ensure that they recover their "humanity". "It is the wealth of understanding, emotion and above all the ethical standards that we set for ourselves and for others that have gradually developed over the course of evolution" (Albert Jacquard) which must accompany them in their role as caregivers.



Conclusion

Today the majority of developed countries with ageing populations are confronted with the problem of an increasing number of dependent, elderly individuals. The need for LTC, whether it be at the patient's home or at a nursing home, will continue to increase in mature as well as emerging markets. Besides, demographic and social trends, as well as inadequate State provisions encourage the insurance market to provide financing solutions for LTC. Informal care provided by family members to a person in old age is becoming less and less reliable. People thus have to plan for what would happen if they became unable to look after themselves.

LTC products ensure the payment of an annuity or a compensation for care provided to the dependent person, according to the severity of the loss of independence. The type of coverage may vary quite significantly from one market to another.

In order to help clients create and improve their LTC insurance products, SCOR Global Life monitors these products worldwide. Our R&D Centre dedicated to LTC Insurance monitors LTC trends and stays abreast of new development to help ensure our clients base their product decision on the most current information available.

Furthermore, as a reinsurer of LTC products for over 25 years, SCOR has acquired sound practical experience in dealing with problems relating to risk selection and risk management. SCOR Global Life is a firm believer in comprehensive product offering, tailored to each market. From small, targeted projects to full turnkey solutions, our experts help our clients create and adapt a wide range of LTC products.

Please contact your usual SCOR Global Life correspondents to help you design your LTC insurance products.

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