Barriers and Opportunities for Private Long-Term Care Insurance in England: What Can We Learn From Other Countries?

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1. Introduction

An ageing population, together with the rising cost of services, means that long-term care expenditures will increase greatly over the next several decades. Wittenberg et al. (2008) project that the numbers of disabled older people in England will more than double between 2005 and 2041, rising from around 2.40 million to around 4.95 million. They project that public expenditure on social care and disability benefits would need to rise from around 1.2 per cent of GDP in 2005 to around 2.0 per cent of GDP in 2041 to keep pace with demographic pressures and expected real rises in the unit costs of care. This raises serious questions about how this is to be funded.

In light of increasing fiscal constraints, policymakers are particularly keen on mechanisms for incentivizing private contributions to the care system, for instance by increasing use of the private long-term care insurance market. In spite of their advantages in terms of the pooling of risks of needing long-term care, there have been substantial difficulties in the development of private long-term care insurance products in England.

In many countries, especially where the public long-term care system only plays a residual or "safety-net" role, individual and family resources pay for a substantial proportion of long-term care costs, often out of pocket at the point of need. The Personal Social Services Research Unit (PSSRU) estimates that in England in 2006 nearly 40 per cent of social care

expenditure was funded privately by individuals and their families (Comas-Herrera et al., 2010). About a quarter of that expenditure was as a result of user fees for publicly subsidized care and the rest was expenditure by people who faced the full cost of their long-term care (self-funders).

Recent estimates suggest that the expected average lifetime costs of care for people aged 65 or more in England, including hotel costs for those in care homes, were £50,300 in 2009/10, £34,300 for men and £64,800 for women (Fernández and Forder, 2010, p. 11). However, averages do not give a full picture of the financial risk that long-term care can present for some families. Around a third of people aged 65 and over will spend little on care. For a small proportion of people, however, long-term care costs will represent so-called 'catastrophic' levels of expenditure: 7 per cent of people aged 65 will face lifetime care costs of at least £100,000, and 5 per cent of at least £200,000. In England, dependent people in residential care homes are often required to deplete their assets, including having to sell their homes to contribute to their care costs[1]. Buckinghamshire County Council, for instance, estimated that 15 per cent of the self-funders in their area deplete their capital every year (Birchley, 2010). Partnership Insurance, a firm specialized in immediate needs annuity products, has estimated that meeting the costs of care of

[1] Usually this applies to people who were living alone before moving to a care home. Some councils offer the possibility of deferring the costs of an individual's care, under a 'deferred payment agreement'. These are loans, provided by the local authority, which covers those costs of care and accommodation that individuals are unable to fund themselves from their income. The loan is set against the home of someone who has gone into residential care. Under a deferred payment agreement, the local authority pays the costs of residential care, and places a lien on the person's home. When the person dies, the debt is repaid from the person's estate. Deferred payment agreements are not universally available, and are subject to the discretion of local authorities.

people who deplete their assets in England costs nearly £1 billion a year (Partnership, 2010). In some of the cases where individuals are unable to continue to pay privately for their care, the transition into the public support system leads to a move to a cheaper care home.

Because not everyone will need care, and many people will only need care for a short period, in principle, some form of risk pooling through insurance seems a more attractive way of financing long-term care than individual savings. Risk pooling would mean that people who would be self-funders, or would be required to pay copayments under the current scheme, could limit the amount that they would have to pay for their care to a lower, known amount. This would mean that those people who require care for long periods (and whose care costs exceed the average in the insurance pool) would be prevented from having to spend down their assets or go without the care they need.

Despite the very substantial levels of private expenditure involved in funding long-term care in England, the market for private long-term care insurance is very small. Only 22,000 people had private long-term care insurance in 2008 (Association of British Insurers, 2009). Instead, care is usually publicly funded for those with few resources and funded from the income, savings and housing assets for those with resources. At present no

prefunded long-term care insurance is being sold in England. There are two companies selling immediate needs care annuities[2].

There are a number of countries where the markets for long-term care are substantially bigger than that in England. The two countries with the biggest markets for long-term care insurance are the United States and France. In the United States, about 10 per cent of the population aged 60 and over have private long-term care insurance (Brown and Finkelstein, 2009); it has been estimated that in total there are around 7 to 8 million policyholders. There are currently around 3 million policyholders in France (FFSA, 2010), which represent about 24 per cent of the population aged 60 and over.

There are substantial private long-term care insurance markets in other countries too. Swiss Re reported that, in 2007, Germany had the third largest private insurance market (Swiss Re, 2008), comprising mandatory private long-term care insurance and private supplementary long-term care insurance, which represented about 15 per cent of the in-force premiums volume in 2007. Nearly 1 million German people were covered by supplementary long-term care insurance in Germany in 2006 (PKV, 2007), which is sold as a supplement (or top-up) to the benefits of the social long-term care insurance system.

[2] Immediate needs annuities are insurance products purchased at the point of need and which provide a stream of funds for the duration of the period of disability.

The size of the private long-term care insurance market in Israel is relatively large compared to other countries because half the adult population have private long-term care insurance (Brammli-Greenberg and Gross, 2010) and policy holders are often unaware that they are covered. This is predominantly bought with other forms of health insurance. The market for long-term care insurance grew quite rapidly in Italy in 2007 and 2008, after a new collective wage agreement for insurance and bank employees which provided automatic compulsory long-term care coverage (funded, totally or partially, by employers), the number of people covered by long-term care insurance grew very rapidly, to approximately 355,000 in 2009 (Rebba, 2010).

This paper is part of a research project titled "How can private long-term care insurance supplement state systems: the UK as a case study", funded by the AXA Research Fund and involving researchers from the London School of Economics, the University of East Anglia, the Nuffield Foundation and the Universitat de Barcelona[3]. The paper is an early summary of an ongoing literature review, combined with interviews with international experts in private long-term care insurance (including academics, policymakers and insurance representatives).

The paper begins by considering the rationale for insuring against the costs of long-term care, arguing that there appears to be strong rationale for the purchase of long-term care

[3] More information about this project is available from http://www.pssru.ac.uk/axa/index.php.

insurance by individuals (Section 2). It then considers the barriers to the development of an efficient long-term care insurance market (Section 3), followed by Section 4, which considers the types of insurance products available. The final two sections consider the effects that the underlying public system can have on the structure and success of private long-term care insurance schemes, and what the state can do to encourage the development of private long-term care insurance (Sections 5 and 6).

2. Rationale for insuring against the costs of long-term care

The potential cost to the individual of long-term care, when not insured against its cost, is highly uncertain. Insurance works as a mechanism for pooling the risks of catastrophic costs, so that the risks of all the people insured by the scheme are collectively borne by the insurance scheme. This works only when the loss of the group as a whole can be predicted (i.e., when the costs, on average, are broadly certain). When group costs are known, statisticians and actuaries can calculate the contribution that should be made by each insured individual, in exchange for the security of knowing that the group will cover the costs of their care in the eventuality of needing care. The insurance scheme therefore receives premium contributions from all its enrollees and makes payments to those who suffer the risk specified in the policy. This allows individuals to pool risks, despite some future uncertainties.

There are a number of rationales for using long-term care insurance to finance long-term care. Insurance, unlike reliance on individual or family savings, redistributes costs from those with lesser to those with greater care needs. By pooling risks and reducing the uncertainty faced by an individual, risk-averse individuals would be better off purchasing an actuarially fair insurance policy. In principle insurance is also a more efficient approach than private savings because it removes the need for every single individual to save up to the maximum possible lifetime cost of their care (see, for example Barr, 2010 and Rivlin and Wiener, 1988). Finally, in theory, long-term care insurance could also potentially promote choice, independence and dignity[4].

The potential role for private long-term care insurance is highly dependent on the characteristics of public sector coverage for long-term care in that particular country (see, for example, Foubister et al., 2006). Where the public sector role is to act as a safety net for people who cannot afford to pay for their own care (as, for example, in England and the United States), only people without enough resources to pay for their own care needs are covered by the public system. In those countries, private insurance can potentially substitute for the lack of public coverage by protecting against the probability of having to pay for care in the event of needing care, or, for people who are at the point of needing

[4] Interviews with insurers highlighted that prepaid private long-term care insurance policies in England, when they were available, were often purchased by single or widowed people without close relatives who wanted to ensure that arrangements would be made on their behalf to guarantee them good quality care should they need it.

care, against the catastrophic costs involved in requiring a very long duration of care (preventing asset depletion).

Where the public sector offers full (or near full) coverage of the risks and costs of long-term care, the role for private insurance is nearly nonexistent. In some countries, however, the public sector offers partial universal coverage so that everyone is entitled to a certain level of publicly funded care (given a certain level of need). Usually these systems also offer means-tested benefits for people who cannot cover the rest of the costs of their care. In countries with this type of "quasi-universal" public coverage (for example Germany, France and Spain), private long-term care insurance is often marketed as a "top-up", or complement, to the public system.

3. Barriers to the development of private long-term care insurance

Despite there being a clear rationale for the role of private long-term care insurance, there is a substantial body of theoretical work on the economics of long-term care insurance (see, for example, Barr, 2010 for a recent review) which lists several conditions under which private insurance will be inefficient or nonexistent. These market failures lead to doubts about how far voluntary private insurance is feasible as the principal means to finance long-term care. This section briefly discusses the theoretical barriers to private insurance and reviews the evidence about the effect of these barriers. We distinguish

broadly between supply barriers that affect the risk to insurers and as a result the costs of premiums and types of products on offer, and demand barriers.

Supply barriers

Insurers face major risks when providing long-term care insurance, which can be summarized under three headings: uncertainty about future costs, adverse selection and insurance-induced demand.

Uncertainty about the future numbers of people needing care and the unit costs of care

Economic theory has long identified as one of the fundamental conditions for an insurance market to work well that the risk insured should be independent and have a known distribution (Barr, 2010). This is not the case for long-term care, which is complicated by the fact that insurance is often purchased decades in advance of its use[5]. The Association of British Insurers (ABI) identify five major sources of uncertainty: the probability of living to an advanced age[6], probability of needing care, length of time care is needed, future indexation of benefits, and investment returns (ABI, 2010, p. 5). Other important sources of uncertainty include the future extent of public coverage, the type of services that will be available and preferred by future cohorts of older people, and future rates of lapse.

[5] For example, in the United States, the average age of buyers was 61 in 2005 (LifePlans, 2007).
[6] A representative from an insurance company we interviewed gave the example of the impact that a cure for all cancers would have on the future numbers of people needing long-term care.

Unlike the risk at the individual level, these group risks are subject to uncertainty, with the distribution of probability unknown. This means that insurers cannot forecast expenditures with any certainty, and therefore cannot set actuarially fair premiums based on expected lifetime costs with certainty. This has a major effect on the insurance products available and their affordability.

Adverse selection

Economic theory suggests that people who know they are more likely to need care are more likely to wish to buy premiums; this is particularly a problem when people buy policies later in life and therefore may have more information on their individual probability of needing long-term care. If insurance were predominantly bought by those with higher risk, to compensate for the high levels of benefit payouts insurance companies would need to increase the prices of premiums. Higher premiums could potentially make insurance even less attractive to people with better risk, exacerbating the problem. To combat adverse selection insurers seek to protect themselves by using medical screening and rejecting applicants who represent a bad risk. In the United States, 15 to 20 per cent of those who apply for coverage are denied (Tumlinson et al., 2009, p. 12).

The evidence suggests that people who buy long-term care insurance do tend to perceive themselves at higher risk of needing care than those who do not purchase (see, for example, Courbage and Roudaut, 2008; Schaber and Stum, 2007; Sloan and Norton, 1997).

Some authors interpret this as a confirmation of the presence of adverse selection. However, this could just be a result of having better information about the risks. Also, Mellor (2000) warns that this increased awareness about the risk of needing care may be a result of having purchased insurance. Finkelstein and McGarry (2003) examined the relationship between insurance coverage and the likelihood of entering a nursing home and found no relationship. They argue that people are more likely to opt into an insurance scheme for long-term care if they (a) have private information that suggests that they are more likely than average to require long-term care in the future, or (b) have a higher preference for insurance than the average individual (i.e., are more risk averse). They suggest that these two tendencies work in opposite directions and may cancel each other out. Interpreting the empirical evidence from the United States is complicated by the fact that there is medical underwriting that screens out people with known risks by not allowing them to purchase policies.

In the United States, men and women pay the same premiums[7], irrespective of the fact that women have a much higher risk of needing long-term care. Adverse selection would suggest that women, when facing the same price, would be much more likely to buy long-term care coverage than men. However, Brown and Finkelstein (2009, p. 13) show that there is almost no difference in the rates of purchase of long-term care insurance by men

[7] Although in the United States and France there is no gender differentiation, in other countries such as Austria, Italy, Spain and the UK, men and women can be charged different premiums. In Spain, for example, the cost of buying a particular policy that pays out €1,000 per month in case of severe dependency, if spread over 10 years, would be €265 per month for men and €492 per month for women (INESE, 2010). In

and women (10.1 and 10.7 per cent, respectively), even though they estimate that men are implicitly being charged between 25 and 50 cents per dollar more than women for the same benefits. It is important to consider, though, that women on average earn less than men over their lifetime, potentially making the insurance premiums less affordable for them (Holdenrieder, 2006).

Another way in which adverse selection could have an impact, in principle, would be if individuals chose to cancel the insurance held with an insurer if they obtained new information suggesting that they are at lower risk (Brown and Finkelstein, 2007; Hendel and Lizzeri, 2003). This has been described as the "dynamic contracting" problem: under a voluntary insurance scheme, individuals may opt out when they receive more information on the likelihood of requiring long-term care, so that good risk types may be inclined to leave the insurance pool over time. This could potentially affect the pool of risk types held by the insurer. Critics of this proposition argue that, in practice, individuals rarely receive information that they are at lower risk. Recent US evidence suggests that the primary reason for terminating the policies is financial, and that individuals who cancel their insurance (or 'lapse') are likely to be in poorer health (Konetzka and Luo, 2010). However, evidence from a sample of Spanish long-term care policy holders, who faced much lower premiums than those in US policies, suggests that people who lapsed had better health histories than those who remained (Pinquet, et al., 2010).

Insurance-induced demand

When people are covered by long-term care insurance they experience care services either free or at a low cost, which may encourage them to use more care than they would in the absence of insurance. Insurance-induced demand for care could potentially also lead to market failure for long-term care insurance. Scanlon (1992) argues that the issue of moral hazard is more pronounced in the market for long-term care insurance (compared to health insurance) because it is difficult for the insurer to detect an individual's preference for receiving care from family members, as opposed to formal services. It is therefore difficult to predict how individuals' preferences might change when insured. Insurers are likely to introduce copayments to limit the effects of insurance-induced demand. Controlling for disability level and other variables, analyses by Cohen et al. (2000) show that people with insurance were using significantly higher amounts of care.

Although insurance companies use high prices in excess of an actuarially fair premium and medical underwriting to protect themselves from the risks they face, they also use other mechanisms. For example, a study by Brown and Finkelstein (2007) found that most policies in the United States have an 'elimination period' or deductible (typically 30 to 100 days), which is the number of days a person has to receive care before insurance payments commence. This measure aims to minimize the effect of insurance-induced demand. A number of measures have also been taken to reduce the intertemporal risk

faced by insurers by shifting the risk to the individuals. For example, policies in the United States typically provide payments equal to the cost of care, but only up to a specified maximum daily benefit (most frequently $100 per day in 2002, substantially below the average daily cost of $143 per day in a shared room in a nursing home). In addition, about 60 per cent of policies have a daily benefit maximum that is fixed in nominal terms and does not increase over time with inflation. Most policies also specify a maximum 'benefit period', often 1 to 5 years, which caps the total number of days that an individual can receive benefits.

Another important supply issue that was mentioned by interviewees in all the countries covered so far in this study (England, Austria, Spain, Italy, France and the United States) was that regulatory framework for long-term care insurance is a major barrier to the development of the private long-term care insurance market.

Demand barriers

From a consumer's point of view, private long-term care insurance is not an attractive product to buy because of high costs and poor affordability, unrealistic risk perceptions, misconceptions about the generosity of the public care system and low preference for insurance. The saying in the United States is that long-term care insurance "is sold, not bought".

High costs and poor affordability

It has been shown that, even if long-term care insurance premiums that covered the full costs of care were actuarially fair, they would they would still be unaffordable for large sections of the population (Wiener et al., 1994). In practice, policies at an actuarially fair price are unlikely to be offered in the market for long-term care insurance. Private insurers protect their companies from uncertainty about the future, insurance-induced demand and the potential for adverse selection by increasing the cost of the premiums (or curtailing benefits in some way). Evidence suggests that the prices of typical long-term care insurance policies are substantially more than those of other private insurance products (Brown and Finkelstein, 2007). This limits even more the affordability and attractiveness of insurance products to potential purchasers.

As discussed earlier, different types of insurance and different ways of selling have a major impact on their cost. In the United States in particular, the administrative costs of private long-term care insurance are very high, in great part because in the United States the vast majority of long-term care insurance policies are sold at an individual level. The proportion of the premium that is accounted for by benefits is known as the loss ratio. In general, individually sold private long-term care insurance in the United States is believed to have a loss ratio of about 60 per cent[8]. This means that, for each £1 spent on the

[8] Note that the loss ratio for long-term care insurance is less than for acute health care insurance in the United States. This is likely to be, at least in part, because the take-up rate for employer-sponsored long-term care insurance is only about 5 to 8 per cent of people eligible in the United States, compared to 80 to 90 per cent for acute care insurance, so there are fewer economies of scale. In contrast, Medicare, the

insurance premium, the individual receives back, on average, 60p in benefit. Employer-sponsored long-term care insurance is believed to have a loss ratio of around 70 per cent. The loss ratio for employer-sponsored long-term insurance is assumed to be higher because, for example, group markets may be able to take advantage of economies of scale. Employers are also likely to bear some of the costs of administering the policy themselves, for example, collecting premiums through payroll deductions and helping to market the policies (Wiener, 1998).

Le Bihan and Martin (2010) argue that monitoring and predicting the outgoings of insurance schemes is more difficult when assistance is in the form of in-kind benefits, which may result in policies where the benefits are in-kind (as is more common in the United States[9]) having higher administrative costs than those that offer cash benefit (as is predominant in France and other European countries, or in-kind. Taleyson (2003) and Kessler (2008) also argue that because of the type of insurance product design in France (cash benefits, as opposed to reimbursement of provider fees, and the fact that benefits are triggered by fixed thresholds of disability which are often based on the same disability scales and thresholds as the public system), the administrative costs of long-term care insurance in that country are considerably lower than those in the United States.

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government health insurance program for older people in the United States, spends about 3 per cent of its total expenditures on administration, substantially lower than that seen in the private sector.

[9] In the United States insurers assume that not everyone wants a stranger coming into their house to provide paid services, but everyone wants cash. As a result, private long-term care insurance benefits have higher premiums than in-kind benefit policies (Stevenson et al., 2011).

It has been estimated that only 10 to 20 per cent of older people in the United States can afford good-quality private long-term care insurance (Wiener et al., 1994). Crown et al. (1992) add that although there is potential for the market for long-term care insurance to be significant, this might involve individuals in the 65–69 age group spending up to 50 per cent of their discretionary income on such insurance[10].

Risk perception and misconceptions and uncertainty about public system coverage

A common explanation for the lack of long-term care insurance purchasing is that individuals ignore low-frequency, high-severity events that have not occurred recently (Kunreuther et al., 1978). A recent experiment in Germany suggests that increased awareness of risk is likely to result in higher rates of purchase of long-term care insurance (Zhou-Richter et al., 2010), with about 30 per cent of interviewees who were previously not willing to purchase (supplementary) long-term care insurance in the past indicating a willingness to purchase after being informed about the risk associated with long-term care. Courbage and Roudaut (2008) also found that having provided informal care positively affected the probability of contracting long-term care insurance in France.

[10] For example, the 2008 annual premiums for a policy with $150 per day, 3 years' comprehensive coverage, 5 per cent automatic compound inflation protection, 90-day elimination period, from the three major insurers in the United States range from $1,485 to $1,701 for people aged 40, to $4,359 to $4,680 for people aged 70 (Tumlinson et al., 2009, p. 6).

Experts from the United States, England and Italy interviewed for this project emphasized that a very important barrier to the purchase of private insurance is that people wrongly believe that they are covered by the public long-term care or health care systems. Thus, they see no need to purchase additional coverage. A study of nonbuyers of long-term care insurance in the United States shows that 20 per cent of nonbuyers considered the statement "if I need long-term care services, I believe that Medicare (and Medicaid) will pay" an important or very important reason they did not buy long-term care insurance (LifePlans, 2007). However, it appears that US initiatives to educate people about their risks of long-term care and extent of public coverage have had some effect, because in 1990 the percentage answering that they believed Medicare and Medicaid would cover them was 58 per cent.

Also, when there are expectations that the public system will be reformed to provide additional public coverage, people may be reluctant to buy insurance to avoid over-insuring. Insurance companies may also be more reluctant to market their policies if they expect substantial changes. The latest figures from France show that growth in the numbers of people who buy private long-term care insurance has slowed significantly: whereas in 2005 the market grew by 12 per cent, in 2009 it only increased by 1 per cent (FFSA, 2010). Experts suggest that the French market is stagnating because of uncertainties related to the public framework for long-term care (Le Corre, 2010) because, since at least 2007, a major reform has been expected (Le Bihan and Martin, 2010).

Low preference for insurance

In addition to underestimating the probability that they will need care (and as a result resisting buying a product that they do not expect to need), long-term care (particularly in care homes) is not a "product" that people have a desire to consume. This is exacerbated by frequent reports of cases of very poor quality of care in the media (see for example, recent articles in the Guardian, 2010 and the Times, 2009). It can be expected that people will resist buying a product that they do not wish to use.

Brown and Finkelstein (2009) add to this point, arguing that insurance against long-term care essentially transfers wealth from a period where the individual is active and healthy to a period where the individual has problems with carrying out activities of daily living and so requires care. They argue that if an individual places more value on consumption in the healthy state, then equating marginal utilities across the states may not lead to equal consumption over the two periods. In such a case, the purchase of insurance would not be welfare optimizing. Whether this hypothesis holds perhaps depends on how debilitating the individual expects the "unhealthy" state to be, and his or her expectation of the contribution that care might make to improving his or her quality of life. Offering a care package that is tailored to the individual's needs (e.g., offers a choice between informal, domiciliary, assisted living and residential care) may increase the utility that the individual places on receiving care.

Particularly at the younger ages (when prefunded insurance products can be bought at a lower price) there are major competing demands on people's incomes, such as mortgages, child care, saving for general retirement income and saving for children's university fees.

Various other explanations have been put forward as to why people may not have very strong preferences for private long-term care insurance. In a widely quoted article, Pauly (1990) argued that the main reason people purchase long-term care insurance is to protect bequests. However, he argued that even if an individual receives positive utility from leaving a bequest, if he prefers informal care over formal care, he still may prefer not to purchase long-term care insurance, because private insurance may remove family members' incentives to provide informal care to protect the bequest. Pauly (1990) therefore argues that even in a market with actuarially fair prices and perfect information, opt-in rates are likely to remain low. Empirical evidence for this differs in its conclusions. Sloan and Norton (1997) find that marital states and number of children are not related to the purchase of long-term care insurance, suggesting that demand is not motivated by bequest or exchange motives (i.e., older people exchanging informal care for the bequest). However, other studies have shown that being married is positively associated with purchasing insurance (Brown and Finkelstein, 2009; Cramer and Jensen 2006) but only when assets fall within the middle range (Courbage and Roudaut, 2008). Having children and higher numbers of children were also found to be associated with purchasing

insurance when using the French sample of the SHARE survey by Courbage and Roudaut (2008). However, Schaber and Stum (2007), in the United States, found that people who bought long-term care insurance tended to have smaller family sizes. The LifePlans study on "who buys long-term care insurance" shows that, in practice, there are many factors at play behind the decision to buy long-term care insurance. It found that although asset protection was the most important reason people bought long-term care insurance, guaranteeing that they could afford services, ensuring choice of services and protecting a family's standard of living were very important factors as well (LifePlans, 2007).

Mistrust of private insurers

Mistrust of private insurers has been mentioned by interviewees as a major factor in the low demand for long-term care insurance, particularly in the United States and Italy. The main reason for concern in the United States seems to be the lack of consumer protection against premium increases[11] and the fact that if policyholders drop their policies (or 'lapse', often as a result of economic difficulties), they are not entitled to any benefits (this issue is often referred to as the lack of 'nonforfeiture benefits').

[11] There have been several recent large premium increases in the United States. Genworth Financial is seeking an 18 per cent increase on older policies held by about 25 per cent of its customers. John Hancock has filed for permission to raise premiums for about 80 per cent of its customers by an average of 40 per cent. It has also temporarily stopped offering new long-term care insurance plans through employers while it recalculates premiums (Lieber, 2010). John Hancock Financial said it would ask state regulators for an average 40 per cent increase for about 850,000 of its 1.1 million policyholders (Tergsen and Scism, 2010).

In contrast, at the time of needing care, a recent US study has shown that people covered by comprehensive long-term care insurance are rarely denied benefits and have a good choice of care settings. Interestingly, the authors of the study conclude that their findings do not support 'widespread suspicion or fears that private long-term care insurance companies routinely deny legitimate claims' and also do not support 'concerns that private long-term care insurance benefits are typically inadequate to cover a substantial share of long-term care costs in the settings where claimants have chosen to reside' (Doty et al., 2010, p. 620).

4. Long-term care insurance products

Existing public long-term care coverage is a major determinant of the types of private long-term care insurance offered. Foubister et al. (2006), Taleyson (2003), Mayhew et al. (2010) and Le Bihan and Martin (2010) discuss various aspects of this topic. Building on their work, it seems useful to distinguish between the following types of insurance products:

- Full long-term care insurance
- Top-up long-term care insurance
- Immediate needs annuities
- Disability-linked annuities
- Combined long-term care and life insurance

Full long-term care insurance

This type of insurance is predominantly found in countries with a safety-net type public coverage of long-term care. It is normally designed as a substitute to the public system, for those who are not covered by it (Foubister et al., 2006). It is typically a reimbursement product, with some limits to the daily or monthly benefits. These products are normally medically underwritten, excluding people with chronic illnesses or disability. This is the predominant type of private insurance in the United States. Until recently this type of insurance was available in the UK, but only a very small number of people bought it. There are currently no such products on offer in the UK. The administrative costs for this type of policy, particularly if sold at individual level, are typically very high because of the costs of detailed medical underwriting, expenses incurred managing the reimbursements, agent fees and marketing costs.

Top-up or supplementary long-term care insurance

This type of insurance usually coexists with a partial universal public coverage of the costs of long-term care. The insurance is normally for cash benefits that are fixed given a certain level of disability (which in some cases, such as in Spain, is sold specifically as a complement to the public long-term care system, even using the same assessment criteria as the public long-term care system, see for example INESE, 2010), making the underwriting process relatively cheap. This type of insurance is available in France,

Germany, Spain, Israel and Italy among other countries. It is relatively cheap to administer, especially in comparison with full long-term care insurance.

Immediate needs annuities

Immediate needs annuities cover people at the point of needing care and insure against the duration of care needs (to avoid catastrophic costs of care). People may buy this coverage to limit how much their estate will be depleted, or to ensure that their assets are not depleted to the point of needing to rely on publicly funded care (which may involve a move to a cheaper care home). The premium is calculated considering the individual's health and choice of care home. The fees are reimbursed directly to the care providers who are normally happy to accept a predetermined rate of growth for the insured person's care fees. This product fits well with home equity release. It is currently the only form of private long-term care insurance available in England.

The rate of coverage is low relative to the numbers of self-funders who could potentially afford it. The main provider of these annuities in England, Partnership, is currently investing in increasing awareness of this product by campaigning to improve the financial advice available to older people and their families, particularly at the point of entering a care home. They estimate that out of 53,000 people who had to pay care fees in 2009 in England, only 7,000 received appropriate financial advice. Research on the net benefit and affordability of Immediate Needs Annuities suggests that, while there will always be a limit

on the suitability of these annuities for less wealthy people, around 40% of all self-funders in England (assuming they had at least a modest degree of risk aversion) would both benefit from and be able to afford them (Forder, 2011).

Disability-linked annuities

This is a type of annuity in which the payments could increase if the beneficiary became disabled. The additional funds could be used to pay for long-term care services. Different benefit levels could be defined, according to the level of disability. Murtaugh et al. (2001) show that combining an income annuity with disability coverage has the potential to reduce the cost of both products, compared to purchasing them separately, and calculate that this could be useful to more potential purchasers. They showed that minimal underwriting, excluding only those who would be eligible for benefits at purchase, would increase the potential market to about 98 per cent of 65-year-olds, compared with only 77 per cent under usual underwriting practice. Such a product would be targeted to people with substantial savings at retirement. A major obstacle to this product in the United States is the current regulatory framework because combining an annuity with disability insurance would require complying with two different sets of regulations (Warshawsky, 2007).

Combined long-term care and life insurance

This type of insurance is a combination of a life insurance policy and disability annuity, where the benefit is paid at death if there has been no need for long-term care, or as monthly payments from the onset of the need for care until death (Mayhew et al., 2010). These contracts are available in France (Le Bihan and Martin, 2010) and Italy (Rebba, 2010).

5. The relationship between public financing and private long-term care insurance

The underlying state-funded system has a major impact on the design and success of any private insurance scheme for long-term care.

The types of insurance products offered by private sector insurers are determined, to a large extent, by the public scheme in operation within a country. For example, in France, all individuals have access to some support from the state under the *Allocation personnalisée á l'autonomie*. For those with an income below some fixed income, the state funds their entire care package. Above that income level, the proportion of the costs of care that the state funds declines as the individual's income increases, with individuals with a monthly income greater than €2,720 paying 90 per cent of their care package. Le Bihan and Martin (2010) estimate that dependency costs are, on average, €2,500 per month, with the public allowance contributing around €500. Private insurance may therefore be purchased to complement the contributions from the public system. Le Bihan

and Martin (2010) estimate that private insurance may pay for an additional €300 towards the cost of dependency, on average.

In contrast in the United States, where Medicaid only covers people's costs of long-term care if they have an income below some threshold or if they incur large long-term care costs relative to their income, private insurance products on offer are substitutive.

An important aspect of the relationship between private insurance and the public system is whether the public system is a primary payer or a secondary (safety-net) payer. If it is a primary payer, the public system does not take into account private insurance benefits when applying the means test. In such systems, which normally involve a universal needs-based entitlement, private insurance benefits tend to be used to top-up the public entitlement; this is the case, for example, in France.

If the public system is a secondary payer, then insurance benefits have to be paid first. In systems where access to public care is means-tested and the public system is a secondary payer, people who buy insurance may be "pushed" over the means test, even if they would have been eligible otherwise. In the United States, Medicaid is the secondary public payer of long-term care costs, which means that the insurance policy has to pay benefits first, even if the individual is otherwise eligible for Medicaid. Brown and Finkelstein (2009) argue that the Medicaid programme crowds out private insurance demand. They have

calculated that, even if comprehensive private insurance were available at actuarially fair prices, nearly two-thirds (60th percentile) of the wealth distribution would still not wish to purchase insurance because of Medicaid. Medicaid's crowd-out effect is a result of the 'implicit tax' that Medicaid imposes on the purchase of private policies: part of the premium that individuals pay for the purchase of private policies goes to pay for benefits that may end up duplicating benefits that Medicaid would have paid for in the absence of insurance[12]. Because Medicaid is means-tested, private insurance also reduces the probability of becoming eligible for Medicaid in the first place. They argue that a possible solution would be that Medicaid becomes the primary payer and allows the asset test threshold to vary with wealth. However, they acknowledge that although this could stimulate demand, it may not necessarily make a big difference to the overall purchase of long-term care insurance policies because other factors would still limit demand.

6. How can the public long-term care system encourage wider long-term care insurance?

There are a number of ways in which the public sector can promote demand for long-term care insurance. On the demand side, the state might make premiums cheaper through making policies tax-deductible (or providing tax credits), offering opt-outs from public or social contributions to people who purchase private insurance, increasing awareness of the risks of long-term care through educational programmes, clarifying entitlements to

[12] In practice it is likely that people do not make such accurate judgements about the impact of purchasing insurance on their Medicaid eligibility status, but that they simply do not buy private insurance because they believe they are already covered by Medicaid.

public support, ensuring that independent specialist financial advice for long-term care is more widely available, making sure that benefits are tax exempt, and encouraging access to group-based policies (which tend to be cheaper). Alternatively, the state might target the supply side, by improving the regulatory framework, and taking on part of the risk faced by insurers, for example, by defining the level of public coverage in a way that limits the risk to long-term care insurance providers. The state might also choose to intervene more directly by making private long-term care insurance compulsory, or creating a public insurance system.

Encouraging demand for insurance

Government has a number of tools at its disposal to encourage the demand for private long-term care insurance, ranging from helping make insurance more affordable, to educating the population about the risk of long-term care, to improving regulation to improve the degree to which people trust private insurance companies.

Tax incentives

In many countries there are tax incentives for the purchase of long-term care, and benefits received through long-term care insurance are generally tax-free. In the United States, since 1996, long-term care insurance premiums have been treated as health insurance when calculating an individual's federal income tax liability. Individuals may deduct a portion of their medical and long-term care expenses (including insurance

premiums) from their adjusted gross income under highly limited circumstances[13] (Courtemanche and He, 2008). At the state level, there is wide variation in the tax treatment of long-term care premiums. Some states provide individual tax deductions, others provide tax credits to employers who offer group policies (Stevenson et al., 2009; Wiener et al., 2000). In Spain, long-term care insurance premiums are tax-deductible, but the maximum amount that can be deducted is calculated in conjunction with deductions for pensions, so the amount of the deduction is limited. In Italy there are both income tax credits of 19 per cent (maximum amount of €1,291.14 per year) and tax exemptions for group policies, both for employees and employers. Premiums paid by employers are totally exempted from regional business taxes (Rebba, 2010). In France, there has been some discussion about introducing tax incentives for middle-income households to encourage the purchase of long-term care insurance policies (Le Bihan and Martin, 2010).

The evidence strongly suggests that tax relief, at least at the level that has been implemented in the United States, will only have a small impact on uptake because of price inelasticity (Brown and Finkelstein, 2009; Courtemanche and He, 2008; Cramer and Jensen, 2006). Courtemanche and He (2008) also found that the loss in tax revenue from granting the federal tax incentive in the United States exceeds the reduction in Medicaid

[13] In the United States, premiums are only deductible if total out-of-pocket health care expenditures exceed 7.5 per cent of adjusted gross income. The recent health reform bill raises that percentage to 10 per cent. If total out-of-pocket health care expenditures are less than the threshold then none of the cost of the premium can be deducted. However, on the employer side, all contributions towards the cost of private long-term care insurance premiums are tax deductible, but few employers contribute towards the cost of the policies, even when they offer them to their employees

expenditures, suggesting that from a fiscal point of view it is not cost-effective to use tax subsidies to expand the private long-term care insurance market. Stevenson et al. (2009) and Goda (2010) also found that the effects were very small. Goda's analysis suggests that the effects of state tax incentives in the United States are concentrated among the high-income and wealthy population. It is possible that bigger tax incentives could have a bigger impact on the market. Wiener (2011) argues that, because tax subsidies are unlikely to increase substantially the proportion of people with private insurance, most of the tax subsidies go to people who would have bought insurance without the incentive.

The public system takes on part of the risk of long-term care

Another way in which the public sector could potentially reduce the cost of private long-term care insurance is by effectively taking part of the risk. The partnership schemes, which were originally introduced in four US states more than 15 years ago, have this effect (Wiener, 2001). These partnerships generally allow policyholders to keep an extra dollar in financial assets for each dollar that their insurance policies pay in benefits. Wiener (2011, p. 14) gives the example that, in Connecticut, persons with state-approved private long-term care insurance policies that pay $150,000 in benefits can keep $152,000 in financial assets and still qualify for Medicaid once the insurance policy has paid all of its benefits. Essentially, the US partnership model offers asset protection to induce people to buy insurance. In 2005 the partnership schemes were extended to other US states. Nevertheless, the uptake of partnership policies in the United States has been slow (GAO,

2005). Wiener (2011, p. 15) suggests that this is because asset protection may not be as decisive a factor for the purchase of long-term care as this policy assumed it to be. Factors such as retaining autonomy and independence and having a choice of providers may be playing an important role, which suggests that purchasers of private long-term care insurance are not particularly interested in having easier access to the Medicaid system. Indeed, most private long-term care insurance is marketed as a way of avoiding Medicaid.

In countries where the public sector currently only plays a safety-net role with regard to long-term care, the state could also take on some of the risk by introducing a universal entitlement to needs-tested long-term care may have the effect of encouraging people to buy top-up long-term care insurance products that supplement the public coverage. Because top-up insurance only needs to cover part of the risk of long-term care, the premiums for long-term care insurance tend to be more affordable than the premiums for comprehensive insurance and therefore can potentially be purchased by higher numbers of people (see, for example, Bolancé et al., 2010 for an empirical exploration for Spain). The current proposals for long-term care reform in Italy seem to be converging on a long-term care system formed by a national scheme providing basic levels of long-term care services, defined explicitly and guaranteed across the country, and complementary private insurance schemes covering the costs of long-term care system not funded by the public scheme (Rebba, 2010).

Promoting awareness of the risk of needing care and of the extent of public coverage

Another approach to promote private long-term care insurance is to promote awareness of the financial risks of long-term care. A number of US states participate in a federal program to educate people about the need to plan for long-term care. The empirical evidence suggests that higher awareness about long-term care insurance and the risks of needing care increase the probability of buying insurance (see, for example, Long Term Care Group Inc. and LifePlans Inc., 2006). For example, even controlling for income and wealth, people with higher levels of education are more likely to buy private long-term care insurance (Courbage and Roudaut 2008; Cramer and Jensen 2006; Mellor, 2000).

Reforms of the public long-term care system that simplify and clarify the entitlements to publicly funded care, particularly in countries with fragmented care systems, could potentially also encourage people who become aware that they are not covered, fully or partially, by the public system to plan how they will meet their costs of care.

The most recent report produced by the French senate discussing the forthcoming reforms to the long-term care system suggest that the new reform will actively seek to improve the complementarity between public support and private insurance. The new system would also involve maintaining the current public system, but with the introduction of a recovery on inheritance, which may reduce the number of people seeking public care (Le Bihan, 2011).

Finally, experts from France suggested in interviews that in countries where adult children are liable for the costs of their parents' long-term care (as is the case in France, Germany and Austria), there is a stronger incentive for people with moderate wealth to purchase insurance, to protect their children from having to pay for their care if they run out of assets. However, it is unlikely that such a policy would be acceptable in countries where there is no tradition of adult children being financially responsible for their parents.

Encouraging the supply of insurance at lower prices

Encouraging employment-related insurance

Without requiring major reforms, the encouragement of employment or group-based long-term care insurance products, which, as discussed in the previous sections, are substantially cheaper to administer, has the potential to increase the numbers of people covered by private insurance.

In Italy, as part of the new collective wage agreements for insurance and bank employees which include automatic employment-related coverage for long-term care, the number of people holding long-term care policies has increased very rapidly. Coverage for employees of the banking and insurance sectors is provided by employer-based, professional, mutual aid and integrative health care funds, either directly or through insurance companies. Premiums are funded by payroll deductions and are low and uniform, based on group

profiles (which, in this case, are white-collar workers) and there is no individual underwriting (Rebba, 2010).

However, governments need to ensure that employment-based and other group insurance policies are portable and people are not dropped from their policies when their employment ends, as the Israeli experience has highlighted (Chernichovsky et al., in press). This issue has also been flagged in Italy, particularly with regard to the portability of group long-term care plans with wealth accumulation mechanisms.

The US CLASS Act has created a new voluntary public long-term care insurance program, administered by the federal government (Miller, 2011; Wiener, 2010). The CLASS Act involves no medical underwriting (although there is a 5-year waiting period before individuals can be eligible for benefits), premiums will vary by age and people with low incomes or students will be subsidized by other enrollees. The benefits will be in the form of cash. Although enrollment is voluntary, all people who work for participating employers will be automatically enrolled unless they choose to opt out. This is a public insurance scheme, although insurance premiums are the only source of finance. No more than 3 per cent of premiums may be used to pay for administrative costs. The design of the CLASS Act poses some interesting challenges for those who run it, particularly with regard to the choice of the initial premiums because they will have to be at a level that is high enough to guarantee the sustainability of the scheme even if few people enroll, but yet low

enough to attract a sufficient number of people to join (see, for example, Wiener, 2010 and Tumlinson, Wg and Hammelman, 2010).

Finally, improving the regulatory framework for long-term care insurance has been mentioned in interviews as a major area in which the public sector could make an impact on the development of long-term care insurance products that perform better. For example, making it easier for people to draw on housing equity to purchase care protection has been cited in England. In the United States and Italy improving portability of insurance and protection against the growth of premiums are major issues.

Compulsory private insurance

The public sector could intervene to make long-term care insurance compulsory. Barr (2010) suggests that compulsory private long-term care insurance would recognize the evidence from behavioural economics that people do not always make decisions that are in their own best interest. It would also avoid the problems associated with adverse selection, the differential expected lifetime costs of care by gender[14], and people being denied insurance coverage because of poor health. It may also result in cheaper premiums because there would be no need for medical underwriting or marketing costs. Depending on how premiums are set under a compulsory private insurance scheme, it may also allow

[14] If insurance is mandatory, there is little or no distortionary effect from charging men and women a premium based on joint probabilities. Second, there are obvious political difficulties from imposing on women a significantly higher contribution rate than men, all the more because the differential is, and is likely to remain, very large. The use of unisex tables can therefore be defended as a simple value judgement (Barr, 2010, p. 15).

for some income redistribution. For example, if premiums were unrelated to risk factors, insurance would redistribute wealth from those with low needs to those with high needs. If premiums were related to income, then insurance would redistribute wealth from people with high incomes to people with low incomes.

A compulsory insurance system raises a number of practical challenges that would need addressing. First, there is the issue of how to fund the premiums of those who cannot afford them. Should they be covered by public funds, or should they be covered by other people's premiums? Second is the issue of whether the premiums should be determined at an individual level, with medical underwriting and all the costs involved, or whether they should be determined at the population level.

Whilst compulsion is not itself inconsistent with an important role for private sector provision, a compulsory private system does raise the issue of how premiums are met for those unable to pay the premiums themselves. Mandatory premiums would require a form of subsidy for those unable to afford the private insurance premium.

The state would clearly need to play an important role in addressing these fundamental issues, which raises the question of whether such a system would be, effectively, a public system delivered by private insurance companies, and whether this would be the most efficient way to fund long-term care.

The Eldershield plan in Singapore offers an interesting example of a partnership between public bodies and private players (de Castries, 2009). The scheme, which began in 2002, is based on private insurance with automatic enrolment for persons aged between 40 and 69. It is possible to opt out during the first 3 months. If one opts out, neither subsidies from public bodies nor preferred underwriting conditions are provided in the future. Product design and claims management are the responsibility of private insurance. Products are standardized with a lifetime guarantee of an annuity in case of needing long-term care. Communication and prevention responsibilities are shared between government and insurers.

Premiums, which differ by gender, are set at the age of entry into the scheme and do not increase as people age, to give people an incentive not to opt out. The current annual premiums for Eldershield 400 at age 40 are $174.96 for men and $217.76 for women (Ministry of Health, 2011). When the system was first introduced, as older people would have faced higher premiums, the Singapore government financed a share of the premium for those aged 55 to 69. A large awareness campaign of risks was carried out to promote the plan and the products. The opt-out rate has decreased from 38 per cent in 2002 (the year the scheme was launched) to 14 per cent in 2006 (de Castries, 2009, p. 31).

The Singaporean government also has a programme called “Interim Disability Assistance for the Elderly” (IDAPE) that provides financial assistance to people who are not eligible for Eldershield because of their age or preexisting disabilities. It is also administered by a private insurance provider.

Based on the Eldershield example, de Castries (2009) proposes a cooperative public/private partnership, with automatic enrolment and the freedom to opt out. Some public subsidies could help with the transition generation and help the low-income population to fund their premiums, making the cover affordable to everyone. A simplified underwriting would be set up to reduce discrimination related to health status. Near universal coverage would spread the risk efficiently. He argues that such a system would be positive in terms of social justice and would provide robust funding of the risk, consistent with its long-term nature. It would provide an incremental financing source for the economy and ensure that individual solvency is confronting this risk.

Conclusions

The evidence from other countries suggests that private long-term care insurance on its own is unlikely to contribute significantly to the financing of long-term care, in terms of coverage or in terms of proportion of total expenditure on long-term care. Buying private long-term care insurance is complex and involves purchasing protection against events far in the future and involves many uncertainties. In addition, changes in the public funding of

long-term care may result in people being overinsured if the public system becomes more generous, or underinsured if it becomes less so (Barr, 2010). Only a minority of the population could reasonably afford long-term care insurance that covered them for the full costs of long-term care, unless they purchased it early in life (or possibly through the use of housing equity). Yet early in life people have other priorities and may not be well informed about the risk of long-term care and about the arrangements for public funding of long-term care. The use of housing equity is hampered by a lack of efficient and flexible financial products.

There are also major equity issues to consider concerning relying on private insurance to finance long-term care to any great degree. Private long-term care insurance policies are regressive in that only wealthier people are able to afford the premiums. Numerous studies conducted in the United States find evidence of a strong association between income and assets and the probability of owning insurance (see, for example, Brown and Finkelstein, 2009; Schaber and Stum, 2007). Some of the research suggests that the relationship between wealth and purchase of insurance is not linear (Courbage and Roudaut, 2008; Cramer and Jensen, 2006; Mellor, 2000). This research suggests that people in the middle of the wealth distribution are more likely to buy insurance than those at the bottom (who may not be able to afford it and are covered by the public schemes anyway), or the very wealthy (who have enough assets to self-insure and may be less risk-averse).

Additionally, groups of people with a higher probability of needing care, who are also likely to have lower incomes, would also be expected to pay higher private premiums (Holdenrieder, 2006) or are unable to purchase it at all, making private long-term care insurance yet more regressive when compared to alternative financing mechanisms, unless there are premium subsidies.

Despite these difficulties, the experience of other countries suggests that private insurance for long-term care could potentially have a bigger role to play in the financing of long-term care. Across many countries, the system of financing and providing long-term care is mixed, combining family, market and state "poles of protection" (Le Bihan and Martin, 2010, p. 393; Rebba, 2010), with a role for private insurance as a supplement to the public long-term care system.

In countries where most of the private financing of long-term care (to meet the costs of self-funding, copayments, or payments for services not covered by the public system) is drawn from savings and sometimes housing equity, with no pooling of risk or redistribution, there may be scope for private insurance, perhaps in partnership with the public sector, to improve the efficiency and equity of the private financing of long-term care.

Relying on private long-term care insurance as the main source of long-term care financing would require very substantial subsidies or compulsion. Although the private long-term care insurance markets appear to have encountered important difficulties (mostly a result of lack of affordability) in countries with safety-net types of systems where private long-term care policies are expected to cover the full costs of care, in countries with universal public benefits that cover part of the costs of long-term care, private long-term care insurance, particularly when sold at a group (or employer) level, appears to be finding a niche as a top-up or supplementary product.

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