Long Term Care in Israel

Social security cover

The national Insurance pays people over the age of 67 (64 for females) a “service annuity”. This is not money but actual help by a nursemaid or a day care facility. There are 4 levels varying from 5 to 15.5 hours per week. There is no cover by the National Insurance for people who are institutionalized. Financial help for people who are in LTC facility (every old aged home must have one) is granted by the Health ministry and is subject to availability and based on the financial ability of the family.

Long Term Care Insurance

History

1st LTCI policy was introduced in 1978 (world 1st ?) but was premature and never took off. In 1986 2 companies started to offer LTCI and later were followed by other companies. The 1st generation of LTCI was based upon reimbursement of actual care given either at home or in a LTC facility. Later the market adopted the ADLs criterion. The initial ADL based cover paid 100% of the predetermined monthly amount for inability to perform 5 or 6 ADLs and 75% for 4 ADLs. The benefit period was 3 to 5 years.

Current products

During the years the fierce competition has lowered the “gate-keepers” needed to become a claimant and most of the current policies pay 100% of the benefit if the claimant can’t perform 3 ADLs or even 2 if one of them is incontinence. Cover duration varies between 3 years, 5, 8 and unlimited. The benefit is payable after a deferred period of bewenn 30 t 90 days. There are also policies with 3 or 5 years deferred period to compliment a group policy (see below).
Group policies

All 4 sick funds offer their customers a group LTCI. This is an extra cover for an additional premium. This will typically pay an age related amount (reimbursement only) for a limited period (3-5 years). There are also more exclusions than a private policy. Many employers, as well as associations, offer their employees/members a group policy. These policies are, naturally, cheaper but are more limited than a private policy. It is estimated that between 1 to 2 million are covered by group policies.

Tax environment

The premium are not deductible (but there is a proposed bill for that) and practically the benefits are not taxed.

Regulations

Since 2 years ago the LTCI market is highly regulated. There is a minimum definition for ADLs and a minimum gate keeper trigger – 50% of cover for 3 ADLs (see attached). There is also a requirement that premiums are level from age 65 (YRT basis is popular for younger ages) and a paid-up option should be included in the policy (but not a surrender option). For group policies there is a requirement for continuation of the cover on a private basis if the insured leaves the group or the policy is not renewed. Premiums are not guaranteed but the companies need regulator’s approval in order to increase the rates. The regulated definitions have triggered a rate increase of 40-50% !

Statistics

As far as I know there is no Israeli based statistics. It will take a good few years before any Israeli company will have a meaningful data especially in light of the new regulated definitions. Unfortunately there is no professional body that collects data from the companies (like the CMI in London or the SOA).

Attached – 2 regulatory documents.

Avi Bar-Or
November 2005
Circular Letter 2003/9 - Definition of an Insurance Event for Long-Term Care Insurance

General
An insurance event in long-term care insurance is usually defined as the insured’s inability to perform activities of daily living (ADL). The existing policies may vary in their definitions of the ADL’s, as well as the insurance event.

When purchasing a long-term care policy, practically speaking the insured is unable to compare the different medical definitions, and consequently he cannot be aware of the differences between different policies that may result from these definitions in the insurance cover.

Furthermore, the insured should receive reasonable long-term care insurance cover when he is unable to perform 3 of the 6 ADL’s, or when he is defined as cognitively impaired, as detailed below.

It should be mentioned that there are similar directives in England and the USA.

1. Definition of the Insurance Event

The insurance event shall be defined in accordance with the minimal standards that are in this clause. An insurer also present other methods for determining entitlement in an insurance event, on condition that the insurer has obtained prior approval from the Commissioner. The insurance event shall be defined as at least one of the following two events:

a. Deterioration in the insured’s medical condition and ability to function as a result of illness, an accident or ailment, on account of which he is unable to perform unassisted a substantial part (at least 50% of the activity), of at least X of the following 6 activities:
1. **Transferring:** The insured is able, unassisted, to move from a lying to a sitting position and/or to get out of a seat, including performing this activity from a wheelchair and/or bed.

2. **Dressing:** The insured is able, unassisted, to put on and/or take off all garments, including to fasten and/or attach a medical corset and/or artificial limb.

3. **Bathing:** The insured is able, unassisted, to wash in a bathtub, in a shower or any other accepted manner, including getting in and out of the bathtub or shower.

4. **Eating and drinking:** The insured is able, unassisted, to feed himself in any manner (including drinking and not eating through a straw) after the food has been prepared and served to him.

5. **Continence:** The insured is able, unassisted, to control bowel and/or bladder functions. The inability to control one of these functions, which for example implies the regular use of ostomy or catheter receptacles, or the regular use of diapers or other types of absorbent pads, shall be deemed incontinence.

6. **Mobility {Ambulation}:** The insured is able, unassisted, to move from place to place. If the insured is able to perform this function independently and without help from another person, but using crutches and/or a cane and/or a walker and/or any other mechanical, motorized or electronic appliance, he shall be deemed mobile. However, if the insured is confined to bed or to a wheelchair, and is unable to move about unassisted, he shall be deemed immobile.

   b. A deterioration in the insured’s medical condition and ability to function, resulting from "cognitive impairment", determined by
a specialist in this field. In this case, “cognitive impairment” – shall mean that the insured’s cognitive activity is impaired and his intellectual ability has deteriorated, including impaired understanding and judgement, decline in long and/or short-term memory and a lack of orientation in time and place, that require supervision during at most of the daytime hours, confirmed by a specialist in this field, the cause of which is a medical condition such as: Alzheimer's disease, or other forms of dementia.

2. **The Insurance Event**

   a. If insurance event occurs due to the inability to perform 3 of the 6 activities, the insured will be eligible for at least 50% of the monthly long term care payments.

   b. If insurance event occurs due to “cognitive impairment”, the insured will be eligible for 100% of the monthly long term care payments.

3. **Application**

   a. The provisions of this circular letter shall apply to policies for long-term care insurance.

   b. Notwithstanding the above, an insurer may submit a request to the commissioner that the requirements of section 2 not apply to a specific group of insureds, if the necessary premium increase would be substantial so that the insurance will stay inforce. The commissioner will decide whether or not to approve the request.

4. **Effective Date**

   The provisions of sections 1 and 2 shall apply to policies sold or renewed as of 1.09.2003.
5. **Transition Rules**

Notwithstanding section 4 above, in policies that are sold or renewed prior to 31.12.2004, an insurance event due to “cognitive impairment” will entitle the insured to at least 50% of the monthly payment.

6. **Implementation Rules**

Insurers must submit the required changes to their policies to the Commissioner for approval not later than 1.06.2003.

Eyal Ben-Chelouche
Commissioner of Insurance

Note: In any case of discrepancy between this translation and the original circular letter in Hebrew, the original will govern.
Circular Letter 2002/6 - Individual Long Term Care Insurance

General

A long term care policy is designed to provide financial support to a person who is unable to perform vital daily activities or who requires supervision. The overwhelming majority of such cases occur in old age (ages 75 and up). Since this coverage extends over such an extended period of time, special regulatory considerations are required.

It is difficult for insurers to commit to a fixed premium scale for a long term care policy at the time of issue. This is due to the limited amount of data that is available and to the uncertainty regarding future developments that may affect the level of risk.

For these reasons, in this circular letter we are establishing a number of principles. Since we are dealing with insurance that is most needed at older ages, we are setting the coverage period to be the entire life of the insured. We are also requiring that long term care insurance be sold on its own, independent of the sale of other coverages, for the following reasons: (1) the importance of the product, (2) the fact that this type of coverage is not provided on a similar level by the social security system, and (3) the lack of any obvious connection between the need for long term care coverage and the need for other coverages.

With this background in mind, in order to deal with the particular features of long term care insurance and to guarantee proper coverage over an extended period of time, the following are requirements for individual long term care insurance policies.
Definitions
Payment Period: the number of years during which insurance benefits will be paid, as set out in the policy.
Paid-Up Value: the amount of insurance that will be in force starting at the time that premiums cease to be paid; this value is to be derived from the reserve that was accumulated for the insured, taking into consideration an appropriate expense component.
Level Premium: an amount of premium that does not change due to the age of the insured over the entire coverage period, except for regular adjustments due to changes in the Consumer Price Index (which affect the premiums and the long term care payments) and premium scale changes approved by the commissioner, as described in section 5.

1. Coverage Period
The coverage period for a long term care insurance policy shall be the lifetime of the insured. The insurer is not allowed to cancel the policy due to any condition that may appear in the policy, except for the reasons set out in the law (e.g. non-payment of premiums).

2. Premiums
   a. If the insured is less than 65 years old at issue, the insurer may offer him the choice of a level premium or a premium that varies with his attained age. In either case, beginning at attained age 65 the premium must be level.
   b. If the insured is 65 or older at issue, the insurer may only offer him a level premium.
   c. The insurer shall attach a table of premiums and examples of paid-up values to every sales offer. The paid-up values shall be shown at least for every fifth attained age. In the policy data pages, the insurer must provide tables of premiums and of paid-up values that relate specifically to the insured.
   d. Whenever a policy has level premiums, the insurer must hold appropriate reserves for the insured.
3. Paid-Up Values

a. The insurer shall provide paid-up values to the insured in every case of policy termination on or after the following dates, where X is the date when the insured begins to pay level premiums:

<table>
<thead>
<tr>
<th>Issue Age</th>
<th>Policy with payment period of three years</th>
<th>Policy with payment period of five years</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 39</td>
<td>X + 5</td>
<td>X + 3</td>
</tr>
<tr>
<td>40 – 59</td>
<td>X + 3</td>
<td>X + 2</td>
</tr>
<tr>
<td>60 – 64</td>
<td>X + 2</td>
<td>X + 1</td>
</tr>
<tr>
<td>65 +</td>
<td>X + 1</td>
<td>X + 1</td>
</tr>
</tbody>
</table>

b. If, however, an insured has paid premiums that vary by age for at least five years and then switches to level premiums, he will receive a paid-up value as soon as he switches to level premiums.

c. Regarding payment periods that differ from those in the above table, the insurer shall offer an appropriate schedule of paid-up values, subject to approval by the Insurance Commissioner.

d. The paid-up values shall vary according to the following parameters: gender, age, and length of time that level premiums have been paid. Other additional parameters may be included if appropriate.

e. The paid-up value may not be provided as a shortened coverage period. The coverage period must always be the lifetime of the insured.

f. If the paid-up value would provide less than 800 NIS (New Israeli Shekel) as a monthly benefit, then the insured shall receive the paid-up value in cash. The amount of 800 NIS is indexed to inflation and it is based on the consumer price index for January 2002. [Note: this sum is approximately equal to 170 U.S. Dollars, as of August 2002.]
4. Prohibition of Subsidies across Classes of Insureds
   a. The premiums should not be priced in a way that subsidizes across ages or
genders.
   b. Age grouping may be used in the premium scale; however, each age group
shall not contain more than five ages.

5. Changes to the Premium Scale
   a. An insurer may not raise its premium scale without permission of the
Insurance Commissioner and not within five years of the policy approval (or
approval of the last premium increase). At the time the premium scale is
changed, the insurer will be allowed to adjust its scale of paid-up values in
accordance with the change in premiums.
   b. The insurer must inform the insureds in writing of any premium increase that
has been approved by the Commissioner at least 60 days before the increase
goes into effect.
   c. Whenever the premium is increased, the insured must be offered the option of
continuing to pay the current premium and lowering the long term care
payment amounts accordingly.

6. Long Term Care Payments for Home Care
   In addition to institutional care, a long term care policy shall also cover care provided
in the insured's home. The insurer shall either pay for home care at a set rate (i.e. not
reimbursement for expenses) or it will provide the home care services itself according
to conditions set out in the policy.

7. Waiver of Premium Payments
   In a long term care policy, the insurer will waive premium payments while it is
providing long term care payments.
8. Prohibition of Conditioning the Sale of a Long Term Care Policy upon Anything Else
An insurer may not condition the sale of a long term care policy on the purchase of another insurance coverage or any other product or service. Similarly, the insurer may not condition the termination of a long term care policy on any of the above.

9. Annual Report to Insureds
The annual report requirements of Circular Letter 2001/10 apply to all insureds, both those who are paying premiums and those whose policies are paid up.

10. Applicability
The requirements of this circular letter apply to individual long term care insurance policies.

11. Effective Date
The requirements of this circular letter apply to all individual long term care insurance policies sold on or after May 1, 2003.

12. Implementation
Any insurer that intends to sell individual long term care insurance policies shall submit a policy that conforms to the requirements of this circular letter not later than January 1, 2003.

Tzipi Samet
Commissioner of Insurance

Note: In any case of discrepancy between this translation and the original circular letter in Hebrew, the original will govern.