Dependency Insurance (II)
International Experience and Reinsurance

As stated in the last edition, we now present the second part of the work on dependency insurance in which we analyse its position in those countries which have a higher level of development in this product as well as the role played by reinsurance.

Dependency insurance products were first marketed in the United States at the beginning of the 1970s. Germany and France timidly began selling them in 1985 and the United Kingdom in 1990. The socio-demographic changes which are occurring in most of the developed countries generate the need to take out this type of insurance which means that many insurance companies have substantial sales expectations over the next few years. We analyse below public and private dependency insurance cover in some of the more representative countries.

The role of reinsurance in the development of this type of insurance has been significant, providing statistical support and training for this new risk.

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1. International experience

The need for dependency insurance in developed countries, motivated by demographic and social changes, is a reality which has not experienced uniform development in all markets. The awareness of social need in each country, combined with tax legislation and the public dependency cover offered, has caused a very disparate development in this type of insurance from one country to another.

We give below a brief description of the state of dependency insurance in a few countries with reference to both public cover and the degree of development of private insurance.

1.1. United Kingdom

Introduction

Dependency insurance is currently an emerging business with few insurance companies involved and a very small number of policies taken out. In the main, dependency cover is the responsibility of the Government and for it the needs of the individual are assessed. The state makes a great effort in providing any available services for the most dependent and there is an increasing trend towards emphasising rehabilitation.

While 11.5% of the population has health insurance, only 32,000 people have taken out private dependency insurance. In 1999, about 600,000 people were receiving home dependency care from the local authority.

Public cover

Traditionally, dependency risk cover was provided through a public system with non-contributory benefits. The public cover system is based on the intervention of local authorities. They assume responsibility for assigning residential homes and other specialist institutions to those people who need them because they are in a situation of dependency.

Home assistance provided by local authorities basically concentrates on cases of severe dependency.

There are two main sources of financing for dependency:

- Local Authorities.
  They have two basic financing instruments, state subsidies and local taxes. The resources managed by local authorities are assigned individually to those people who need dependency assistance according to their personal assets.

- Social Security.
  The state finances both residential assistance and home assistance services.

The custom of receiving informal care is very well established in English society. Here, most of the care services provided are received in the dependent person's own home.

Traditionally, thanks to the role played by volunteer workers, informal care is more emphasised than in other countries. It is currently estimated that 80% of the elderly receive informal care.

Private cover

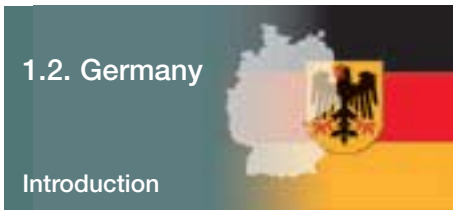
Private cover against dependency is very limited and so far sales have been very thin on the ground. There are many problems in marketing these policies to the under-fifties. However, immediate dependency income with residential services has been more successful.

There are currently about 20 insurance companies marketing dependency insurance in a market with a very high concentration level, since 85% of it is controlled by only two companies.

The private dependency insurance market primarily offers two types of product:

- **Benefits** aimed at people who enjoy good health, to protect them against the cost of possible future dependency.

- **Financial benefits** aimed at people who are already dependent.



Germany was the pioneer European country in marketing dependency insurance. This insurance began to be sold in Germany from 1985 providing the following cover:

- Daily assistance allowance

- **Reimbursement of up to 80%** of hospital and homecare charges due to a state of dependency

- **Daily benefit** plus reimbursement of assistance costs where ongoing assistance is required

The level of take-up of voluntary subscription dependency insurance was initially low and this encouraged the German authorities to opt for introducing a new type of compulsory dependency insurance.

With the coming into force of the Federal Law on dependency insurance of April 1994, home dependency assistance was first introduced on 1st April 1995 followed by care in specialist institutions on 1st July 1996. This compulsory dependency insurance can be public or private and can be supplemented with voluntary private life or health insurance.
It is currently the largest market for this type of cover on the whole continent. At the end of 2000, it was estimated that public dependency insurance covered more than 70 million people and private insurance more than 8 million people.

In 2001, nearly 1.9 million people received benefits from compulsory dependency insurance, of whom about 1.3 million received assistance in their own homes and 600,000 were cared for in specialist centres.

Public cover

This insurance has its own specific regulations and its own financing, different from the rest of the social welfare system. Compulsory dependency insurance is structured as an extension of compulsory health insurance. Those people who have the benefit of public health insurance, or similar, workers who earn less than EUR 3,375 per month and civil servants remain within the scope of public dependency insurance. People who earn more than EUR 3,375 can choose between voluntarily taking out public health insurance or taking out private health insurance.

Approximately 90% of the population are covered by public dependency insurance.

Dependency insurance is jointly financed by employees and employers in equal measure. Initially, a contribution rate of 1% was established. This rate has now been raised to 1.7%, with 0.85% being paid by the employee and the remaining 0.85% by the employer. The basis of

contribution is the same as that used for health insurance. Retired people are also obliged to contribute to dependency insurance. In such case 50% of the contribution is paid by the pensioner himself and the remaining 50% paid by the Institute of Pensions.

The contributions collected are placed in so-called Dependency Funds which are a resource separate from the rest of the social security system and are managed by health funds with claims-equalisation and compensation funds.

To be entitled to receive dependency insurance benefits you need to have contributed for a minimum number of years[1] with the provision that if entitlement to dependency insurance benefits cannot be granted due to a shortfall in necessary prior contributions, you can continue contributing until you reach the appropriate level.

With regard to the type of benefits provided, there are three separate possibilities: professional home assistance, care in specialist institutions (day centres, homes) and financial benefits.

The latter are designed to pay for informal assistance received from family members and friends who assist the dependent person. Benefits are not dependent on the dependent person's level of income. Financial benefits are not counted as income for tax purposes.

1. *In 2002, five years out of the last ten.*

Private cover

People with monthly incomes of more than EUR 3,375 who have private health insurance can take out private dependency insurance with the same company. The Federal Law on Dependency Insurance requires that this private insurance must guarantee that its benefits and conditions are equivalent to those of public dependency insurance and that its premiums are reasonable.

1.3. France

Introduction

Private dependency insurance began to be marketed in 1986, being one of the most developed markets in terms of policy take-up as there are currently more than 1.5 million policyholders.

In 2002, there were 700,000 elderly dependents and between 800,000 and 1.2 million are forecast for 2020.

The average cost of a dependent in France varies between EUR 30,000 and 35,000 per annum.

Public cover

With the coming into force of Law 97-60 of 24th January 1997, public dependency cover known as "Specific Dependency Benefit" (PSD) was introduced, aimed at the over sixties with low income and with any type of dependency.

In order to determine the level of dependency, the law produced a national reference table: the AGGIR table which assesses loss of independence on the basis of ten parameters.

The amount of public benefit is defined according to the level of dependency that the aforementioned classification assigns to the dependent person, access to that benefit being very restrictive.

The amount of that benefit was established differently in each region of France.
There used to be very stringent economic requirements (for example income of less than EUR 11,419 for a single person) which limited access to that pension to a little over 135,000 people in March 2001. The amount of the benefit depended on the degree of severity of the dependency and the interested party's income.

To avoid different treatment according to the resources and political priorities of each region and because that benefit covered the needs of nearly 500,000 people in 2002, the old benefit was replaced in January 2002 by a new one called "Personalised Independence Allowance" (APA). APA is financed out of general taxation without the introduction of a specific contribution within the social security system. Access to public dependency benefits does not require contributions to the social security system for a specific number of years. The beneficiary may not be under 60 years of age. With the new APA, benefit is granted regardless of the beneficiary's income or the family unit to which he belongs.

Private cover

Dependency Law 97-60 offered substantial tax incentives for taking out private depen-

dency insurance. This legal framework stimulated the appearance of an extensive range of private dependency insurance products. The French private dependency insurance market is currently very well developed. At the end of 2001, more than thirty companies were offering dependency insurance and there were in excess of 1.5 million policyholders.

In 2001, there were more than a million policies, 50% of which were group policies. Premium income in 2001 amounted to 180 million euros, with 80% of the business being concentrated in three insurance groups.

In group policies, membership is compulsory and the benefits and subscription ages are lower than those of individual policies. In group policies, it is usual to price on the basis of levelled, mutualised premiums (regardless of age).

The products have passed through various stages since the initial launches in the second half of the 80s. They began by covering total dependency. Then they began to cover partial dependency as well (50% of the benefits paid for total dependency). In some cases, they have changed to paying the benefit in the form of an income to cover assistance as well.

France, together with the United States, countries which have extensive experience in handling dependency insurance, are the principal non-compulsory private dependency insurance markets.

1.4. United States

Introduction

Dependency insurance started in the United States in 1974. The first companies to market dependency insurance were medium sized companies with a certain degree of specialisation.

According to Feder (2000), in the dependency field, a figure of close to 67 billion euros was spent on residential care and 33 billion euros on home assistance (1.3% of American GDP). Despite the considerable increase in home assistance over the last few years, care in residential homes and specialist institutions is still predominant.

In 1998, there was a total of 17,458 residential homes in the United States which represents a 22% increase on the number of homes in existence in 1978.

Of the total residential homes, 65% belong to profit making companies, just under 30% are in the hands of non-profit making companies and the rest, just 6.7%, are publicly owned. There are enormous differences between states.

The US dependency cover system is basically private and individual. In 1999 there were approximately 6.7 million policies split between 120 companies, the first ten of which held 75% of the market share.

The distribution of the over 65 population and rates of prevalence of dependency are shown in the table below.

Public cover

The public system consists of two assistance programmes designed for access to two public health institutions: Medicare (for people with financial resources) and

Dependency prevalence rates in USA

	Population	Rate of prevalence
>65	33.127.000	16,7%
65-69	9.815.000	6,5%
70-74	8.787.000	9,7%
75-79	6.553.000	15,0%
80-84	4.348.000	27,1%
85-90	2.450.000	43,2%
90-94	889.000	66,7%
>94	285.000	80,5%

Source: AHRQ (2000).

Medicaid (for people with no financial resources or who have exhausted those resources they had).

- Medicaid
  There is universal risk cover since any person lacking financial resources receives protection through Medicaid. Each state sets its own benefits. In most states Medicaid offers institutional assistance among its social benefits.

- Medicare
  Medicare is a nationwide social programme which is funded by workers' contributions and additional premiums paid after retirement. The contribution rate is 2.9% of gross salary (half payable by the employee and the other half by the employer). There is no upper contribution limit. Currently, Medicare supplementary premiums amount to EUR 200 per month in general. For those people who have contributed for 30 to 39 quarters, that figure is reduced to EUR 110. A minimum of 40 quarters is required for entitlement to be a beneficiary of Medicare. Having contributed for more than those 40 quarters, most employees are not obliged to pay those supplementary premiums.

All benefits granted by Medicare are limited in time. Thus, for example:

- Residential care for seniors and home assistance
  There is a requirement for having been admitted to hospital three days earlier, requiring professional care and that the residential home is approved by Medicare. During the first 20 days of cover, it is 100% of the approved amount, from day 21 to 100 there is a deductible of EUR 95 per day. After that, the patient cannot obtain any additional help from Medicare.

- Hospital stay
  Medicare only provides financial cover for the first 60 days. The cost of any additional days is to be paid by the patient.

The assistance provided by Medicare covers a very large segment of the elderly population: 33.9 million out of a total of 35 million seniors in the 1999 census.

Private cover

The private dependency insurance market has grown significantly. In 1985 there were approximately 100,000 policies while in June 1999 this figure stood at 6,776,100 policies.

Some insurance companies forecast that the number of policies in force will grow to 20 million by 2015. The reason is the demographic change being experienced by the American population: it is expected that the number of people over 65 will increase from 32 million in 1990 to 52 million in 2015.

Private dependency insurance is particularly designed for those people who have exhausted their Medicare dependency benefits, which are limited in time, and who have more financial resources than those specified for receiving Medicaid assistance. This insurance is normally taken out on an individual basis.

The private insurance market offers a wide variety of products. Currently, cover is much more comprehensive and policies cover not only payments for specialist homes but also day care centres and even home assistance.
It is customary to offer a flexible product which combines several types of cover with daily or weekly limits of cover with a maximum reimbursement ceiling.

"The awareness of social need in each country, combined with tax legislation and the public dependency cover offered, has caused a very disparate development in this type of insurance from one country to another."

1996 saw the introduction of new legislation on health insurance which had a determining influence on dependency insurance. The said legislation offers tax benefits to dependency policyholders which are the so-called "Tax Qualified LTC plans".

Most policies taken out in the United States limit the period of cover to a maximum of two to five years. If the duration of the benefits is indefinite, the cost of the premiums is usually very high, even prohibitive for a large part of the public who take out dependency insurance. In order to be able to offer lower premiums, many companies do not limit the period during which benefits will be paid, but do limit the total amount of benefits that the policyholder can receive.

In addition to being sold as a stand-alone product, dependency insurance has also been marketed as additional cover to a life assurance policy. In such cases, the monthly dependency cover is expressed as a percentage of the sum

assured on death, normally 2%. Thus, the sum assured on death reduces as it is being used up by paying dependency benefits. It is felt that this product is more attractive to young people. In fact, the average age on taking out a policy is only 51, much younger than the average age of stand-alone dependency insurance policyholders: 68.

2. Reinsurance

As has been stated in the course of this article, in order to be able to market dependency insurance you need to resolve a major technical problem: that of a new risk which has to be insured, statistics for which are not always available. In fact, until relatively recently, there were very few statistics for the senior population. In addition to official or national statistics on health, covering the level of incapacity in relation to ageing, it is claims, once they have occurred, which give a more reliable measurement of that risk. Now, we have to wait on average about ten years for claims to arise because the average age for becoming dependent is about 80 to 85 while policies are mostly taken out up to age 70.

Even though the uncertainty as to assessing this risk is high, insurance companies understood that they had to accept this major challenge, because they are faced with a social insurance need to which they have to respond. In addition, many pensioners, despite major differences in their financial positions, have the resources to finance such policies. On the other hand, there is the question of encouraging long term savings by married couples with a view not only to retirement but also covering this new stage in life.

Dependency insurance is a major challenge for private insurance. This benefit will have to play a supplementary or substitute role to that of the authorities (social security) in those countries where they cannot deal with this problem.

Dependency Insurance comes up against many difficulties:

- Those inherent in insurance, such as adverse selection, which in this case can sometimes be increased by "subjectivity" in defining dependency.
- Future changes in the mortality of healthy people and dependents and rates of incidence of becoming incapacitated, which are difficult to anticipate due to continuous medical advances.
- Estimates of the future cost of benefits to the elderly and their correlation with inflation.

How can reinsurance help with these problems?

The advantage of an international reinsurance company is that it knows the working methods and characteristics of different world markets. This knowledge is used to mutualise the risk by working with different companies in different countries. Also, tra-

ditionally, one of its jobs is that of R&D in the insurance field, which insurance companies absorbed in their day to day work

frequently do not have the time to carry out. In this, reinsurance has always been one step ahead of insurance companies in terms of technical development. Dependency insurance was no exception and in the two countries in which it has been and is still developing more significantly (USA and France) it was introduced by reinsurance companies of those countries.

The reinsurance company, with its experience and having a more globalised portfolio in this type of risk, can reduce all these "uncertainties" of the ceding companies.

The reinsurance scheme normally used in this type of product is a quota share of risk premiums, which the reinsurance company normally sets, with a large cession of at least 50%.

Reinsurance can also help direct insurance companies by providing its know-how in order to:

- Reduce exposure to risk, suggesting exclusions of certain high risk people, by prior selection with medical questionnaires.
- Limit adverse selection, advising on the suitability of including waiting periods and deductibles.
- Adjust the development of future costs, suggesting periods and percentages for reviewing the initial conditions.

If all the above is transferred to undeveloped markets in which, for the moment, there have only been timid introductions of this type of product, reinsurance can offer "knowledge" acquired over more than 20 years in this type of insurance in different markets, adjusting its experience to the characteristics and peculiarities of each country. ■

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