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Long-Term Care Insurance in Israel

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Introduction

The population of Israel is aging rapidly. Between 2010 and 2020, the population aged 75 and over increased by an average of approximately 9,000 individuals per year. An assessment of the actual annual growth rate from 2020, combined with the projected rate until 2040, indicates an expected average increase of 20,000 to 30,000 individuals per year (Figure 1). Life expectancy for Israel's senior citizens continues to rise as well: from 1999 to 2021, the life expectancy of a 65-year-old man increased by about three years (from 16.4 to 19.5 years), and that of a 65-year-old woman by three and a half years (from 18.5 to 22 years). This presents a significant challenge in the pursuit of enabling older adults to enjoy more years of robust health at a high functional level.[1] Current policy aims to allow the elderly to age in place, that is, in their homes and communities. However, achieving this requires a comprehensive policy that combines various factors involved in caring for this population.

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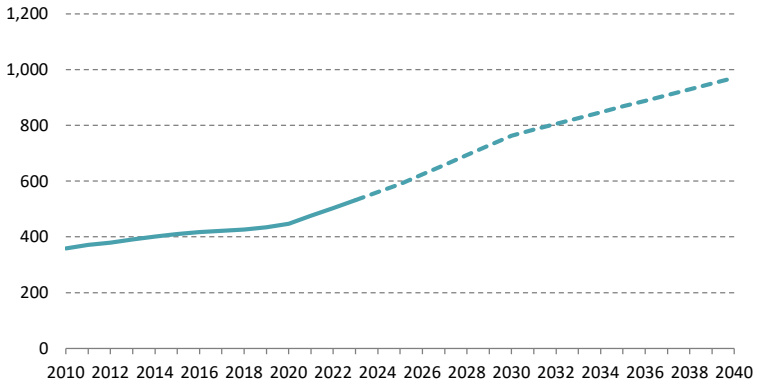
1 Several terms are commonly used to refer to the older population: senior citizens, the elderly, and the aged. In this article, we have predominantly chosen to use the term elderly.

Figure 1. Number of individuals aged 75 and over in the population
Thousands



Source Nir Kaidar, Nadav Davidovitch, Avi Weiss | Data: Central Bureau of Statistics

The period of old age, especially from age 75 and upwards, is characterized by an increase in illnesses and a worsening of existing conditions. From this age, new diseases, some of them chronic and not common in younger ages, emerge, leading to cognitive decline and sensory impairment. The outcomes of these conditions are reflected in decreased functionality and loss of independence in daily life, necessitating an increasing need for long-term nursing care in a suitable institution or continuous assistance at home (Stessman Committee Report, 2011). Indeed, there is a high correlation between advanced age and the need for nursing care.

Nursing care is defined as assistance for individuals of any age who suffer from long-term functional disabilities and require physical, emotional, or social support in their everyday activities. This assistance includes support in day-to-day activities (such as bathing, dressing, mobility, eating, etc.), in engaging in healthy activities, in creating a health-promoting environment (including dealing with loneliness), and in accessibility to medical care in order to prevent or slow further deterioration in health and functionality to the extent possible.

In recent years, we have witnessed a significant increase in the number of elderly individuals eligible for long-term care benefits due to functional decline, both from the State through the National Insurance Institute (NII) and from

commercial insurance companies. An inter-ministerial team that addressed the issue in 2022 noted that, in Israel, there is no single entity whose goal is to maintain functionality for the elderly and prevent functional deterioration preemptively, and the long-term care system is fragmented across numerous agents who do not operate in coordination. The team recommended changing the priorities in long-term care treatment and increasing investment in services to prevent deterioration (Zilbertal, 2022). According to the National Master Plan for the Healthcare Institutions (TAMA 49), the policy for the provision of healthcare services to the elderly population should encompass acute care and hospitalization, including rehabilitation in specialized hospitals and the establishment of frameworks in designated departments within nursing homes and various community institutions. Ultimately, the fundamental assumption is that the majority of elderly individuals suffering from chronic illness will be cared for in the community and at home (Ministry of Health, 2021).

The notable increase in the number of elderly individuals eligible for assistance from the NII and commercial insurance companies obligates the state to re-examine the way long-term care services are provided and funded. In this paper, we present and analyze data regarding the increase in spending on long-term care and propose several policy alternatives.

Long-term care services in Israel

The structure of long-term care insurance in Israel

Long-term care services in Israel are divided into two main areas — services provided at home or in the community, and hospitalization services. The following are the main services provided in each area:[2]

Community Services

Home care — Care provided by caregivers in the home of the elderly person (including those with mental frailty). These services are mostly funded by the National Insurance Institute through long-term care benefits, but often

2 In 2017, the Taub Center published a policy paper that addressed issues of financing and organization in long-term care in Israel (Chernichovsky et al., 2017). The study presented the challenges of the long-term care system in 2017 and mapped the long-term care arrangements in Israel as of that year. The review presented here is largely based on this mapping.

require additional funding from household resources (individuals insured for private long-term care at higher dependency levels may receive financial compensation for funding home care through their insurance company, if they have suitable coverage). The elderly person requiring care is also entitled to regular services from the health funds under the National Health Insurance Law.

Community welfare services — Services provided by daycare centers under the responsibility of the Ministry of Welfare, offering transportation from the elderly person's home, social, welfare, and health activities, and meals. Daycare centers allow the primary caregiver a respite from caring for the elderly person requiring care. Most participants in daycare center activities finance the service through the NII long-term care benefits. Others, who receive services in social service departments, do so with funding from the Ministry of Welfare and Social Affairs and the local authority. The Ministry of Welfare and Social Affairs also operates additional services for the elderly in Israel, providing partial solutions for the elderly requiring care in the community.

Hospitalization services

Long-term care hospitalization — Intended for elderly individuals with functional difficulties who cannot remain in their homes (including those with mental frailty). Nursing care hospitalization is regulated and supervised by the Ministry of Health and is primarily funded through the Ministry of Health, subject to income thresholds for the elderly person requiring care. Some of the individuals in nursing care hospitalization fully finance their hospitalization services privately. Private long-term care insurance policies from insurance companies allow for partial reimbursement for nursing care hospitalization (up to a specified limit), and the reimbursement is usually limited to five years.

Complex nursing care — Designed for elderly individuals with functional difficulties who require care and supervision by a team having strong professional skills able to address their needs for intense nursing care resulting from their medical conditions.[3] Complex nursing care hospitalization provides the elderly with both functional and health-related care. The funding for complex nursing care hospitalization comes from the health funds under the National Health Insurance Law and requires co-payment by the insured.

3 See Ministry of Health, Geriatrics Department, *Procedures for Geriatric Hospital — Comprehensive Procedures, Procedure 0.3.3*.

Assisted living facilities — This service is intended for frail elderly individuals who are not yet defined as requiring nursing care but require assistance they cannot receive at home. Nursing homes are regulated and supervised by the Ministry of Welfare. Elderly individuals receiving services in social service departments are entitled to funding from the Ministry of Welfare and the local authority, with some level of co-payment. However, more than half of the residents in nursing homes fund this with full private financing. It is noteworthy that some facilities operate nursing care hospitalization units, which are the responsibility of the Ministry of Health, and units for the very frail, which are the responsibility of the Ministry of Welfare. Another option is to reside in assisted living, which serves as the elderly person's home. These frameworks are intended for elderly individuals who require neither nursing care nor hospitalization services, and therefore are not included in the array of nursing care services.

In summary, primary community long-term care services are financed through the NII. As of September 2023, approximately 339,000 elderly individuals receive long-term care benefits from the NII (compared to about 180,000 in 2018) with a monetary value of over NIS 15 billion annually. The main service provided through NII funding is a caregiver in the home of the elderly person requiring care.

In addition, about 30,000 elderly individuals requiring care are in external care frameworks. The majority are treated in nursing care institutions under the regulation and supervision of the Ministry of Health (skilled nursing care and complex nursing care hospitalization), and about 5,000 frail elderly are treated in nursing homes under the regulation and supervision of the Ministry of Welfare. As noted, the number of elderly individuals in external care frameworks does not include the population of elderly individuals residing in assisted living.

The long-term care system in Israel is fragmented among a large number of agents. Each has its own eligibility and income criteria and a separate bureaucratic mechanism, operating without any coordination between them. Due to the fragmentation and the lack of incentives for preventing functional deterioration, there are no comprehensive strategies for reducing, delaying, or preventing functional deterioration among the elderly.

Private long-term care insurance

Another important component in the long-term care landscape is funding through private long-term care insurance. In the last decade, private long-term care insurance has undergone a comprehensive reform. Until 2017, there were three main types of long-term care insurance, but today the public can purchase only one of them.

Individual insurance — Insurance that individuals can purchase independently from a commercial insurance company, subject to underwriting approval that includes a medical examination. The premium payments are fixed in advance for each age group, and there is no risk of compromising the insured's future rights. Although the Capital Market, Insurance and Savings Authority (hereinafter the Authority) allows the sale of such insurance, currently, there are no insurance companies in Israel that actually sell these policies, mainly due to the difficulty in pricing the risk associated with this type of insurance due to future uncertainties and the challenge in finding re-insurers.

Group long-term care insurance (not through health funds) — Until 2017, it was possible to purchase group long-term care insurance through an insured's affiliation group (workplace, consumer club, etc.). Unlike individual policies, the rights in group policies are not guaranteed and depend on the actuarial balance of the policy. Insurance companies used to renew the policies and update the premium amounts and the insured's rights every few years. Over the years, due to the aging population and the failure to maintain sufficient principal for future payments, some policies were forced to degrade the insurance conditions, and some even reached a point where no insurance company was willing to continue the insurance. Due to the collapse of some of these policies, the Authority decided to stop their renewal (except for a few policies), and as of 2018, it is no longer possible to purchase or renew them.[4] Insured individuals in canceled group policies were given the option to purchase personal policies without underwriting, but few took advantage of this opportunity due to the high premiums.

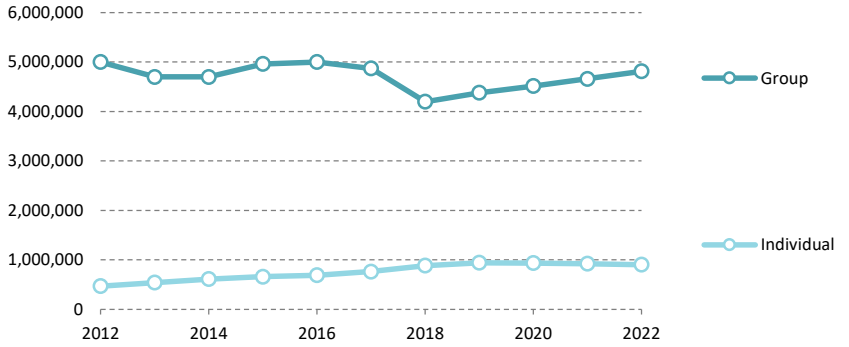
Group long-term care insurance through health funds — These insurance policies are similar to group insurance — they are renewable every few years, and the premium payments and insured's rights may be updated from time to time. Unlike other group policies, however, these policies have hundreds of

4 Financial Services Supervision (Insurance) (Group Long-Term Care Insurance for Health Fund Members) (Amendment), 2018.

thousands to millions of insured individuals across various age groups and with accumulated funds, which should make them sustainable over time.[5] Today, these are the only private long-term care policies in Israel that the general public can purchase.

The total number of insured individuals in private long-term care insurance has remained almost unchanged over the past decade (Figure 2).[6] There were changes, however, in the distribution of insured individuals between the different types of policies. To wit, during the last decade, the number of individuals insured under individual policies nearly doubled — from 0.5 million insured in 2012 to 0.9 million in 2022. The number of individuals insured under group insurance through health funds also increased, from 4.0 million in 2012 to 4.8 million in 2022. In contrast, there was a parallel significant decrease for group policies not through the health funds — from 0.9 million to about 0.2 million. Since the population grew during these years, the overall coverage rate of private long-term care insurance decreased from 69% of the population in 2012 to 60% in 2022.

Figure 2. Insured in private long-term care insurance, divided into individual and group insurance



Note: The group insurance includes both group insurances of health funds and other group insurances.

Source: Nir Kaidar, Nadav Davidovitch, and Avi Weiss, Taub Center | Data: Capital Market, Insurance and Savings Authority

5 See the Capital Market, Insurance and Savings Authority website, under Health and Long-Term Care Insurance.

6 The data represent the number of policies; it is possible that some individuals hold more than one policy.

National expenditure on long-term care

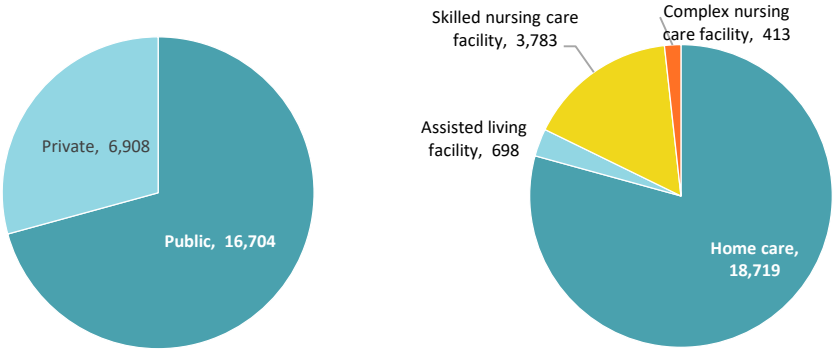
Based on our estimates, in 2022, the national expenditure on long-term care was approximately NIS 23.6 billion (Figure 3), divided as follows:

- Community care services — NIS 18.7 billion
- Nursing care hospitalization — NIS 3.8 billion
- Assisted living facilities — NIS 0.7 billion
- Complex nursing care hospitalization — NIS 0.4 billion

Out of these amounts, the share of public expenditure stood at NIS 16.7 billion (about 71%). Private expenditure was about NIS 7 billion, with NIS 4.4 billion of it directed towards long-term home-care services (Figure 4).

Figure 3. National expenditure on long-term care by funding sources and expenditure areas, 2022

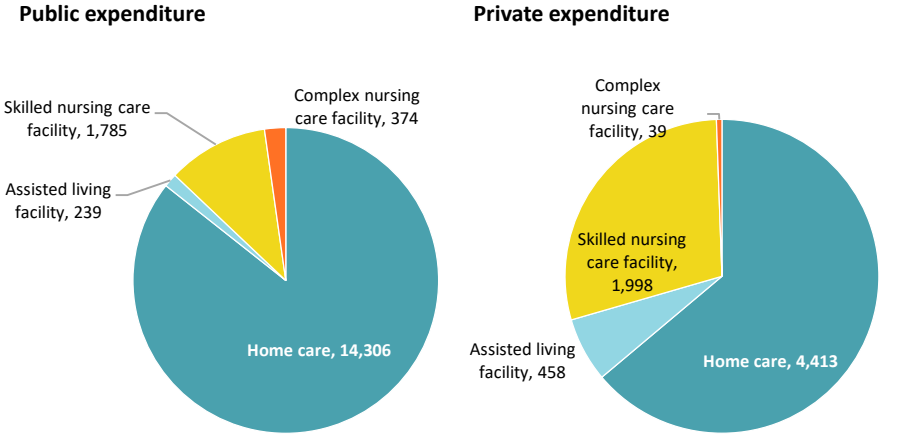
Estimate, NIS million



Source: Nir Kaidar, Nadav Davidovitch, and Avi Weiss, Taub Center | Data: Ministry of Finance; Ministry of Health; Ministry of Welfare and Social Affairs; National Insurance Institute

Figure 4. Public and private expenditure on long-term care by expenditure areas, 2022

Estimate, NIS million



Source: Nir Kaidar, Nadav Davidovitch, and Avi Weiss, Taub Center | Data: Ministry of Finance; Ministry of Health; Ministry of Welfare and Social Affairs; National Insurance Institute

Table 1 compares the national expenditure on long-term care in 2018 and 2022. The data indicate an increase of about 63% during this period, amounting to approximately NIS 9 billion. The majority of the increase was in public expenditure on home care (about NIS 7 billion). The proportion of public funding increased from 63% in 2018 to 71% in 2022.

Table 1. Estimates of national expenditure on long-term care, 2018 and 2022
NIS million

	2018			2022		
	Public expenditure	Private expenditure	Total national expenditure	Public expenditure	Private expenditure	Total national expenditure
Home care	7,026 (77%)	3,176 (60%)	10,202 (71%)	14,306 (86%)	4,413 (64%)	18,719 (79%)
Nursing homes	213 (2%)	437 (8%)	650 (5%)	239 (1%)	458 (7%)	698 (3%)
Long-term hospitalization	1,682 (18%)	1,614 (31%)	3,296 (23%)	1,785 (11%)	1,998 (29%)	3,783 (16%)
Complex long-term hospitalization	211 (2%)	57 (1%)	268 (2%)	374 (2%)	39 (1%)	413 (2%)
Total	9,132 (63%)	5,284 (37%)	14,416 (100%)	16,704 (71%)	6,908 (29%)	23,613 (100%)

Note: The percentages in each cell (except for the *Total* cells) reflect the portions out of the Total in that column, while the percentages in the *Total* row represent the portions out of *Total National Expenditure* in that year.

Source: Nir Kaidar, Nadav Davidovitch, and Avi Weiss, Taub Center | Data: Ministry of Health; Ministry of Welfare and Social Affairs; National Insurance Institute

Recipients of nursing care in the community

As previously noted, in recent years, we have witnessed a dramatic increase in the number of elderly individuals defined as requiring care and receiving long-term care benefits from the NII. From 2012 to 2022, the number of beneficiaries of the long-term care benefit doubled, while the number of recipients of the old-age benefit, which is granted upon reaching retirement age, only grew by 40%. There is no information explaining the dramatic increase in the number of benefit recipients and whether this growth is accompanied by an increase in functional deterioration. The 2022 report of the inter-ministerial team on long-term care stated:

> There is doubt as to whether the increase in the number of eligible beneficiaries necessarily reflects the actual condition of the senior citizens in Israel. That is, the benefit mechanism is a governmental system in which levels of functioning are defined in a certain way, and it is influenced by intervening variables such as motivations, incentives, bureaucracy, maximization of entitlements, and so forth. As such, while

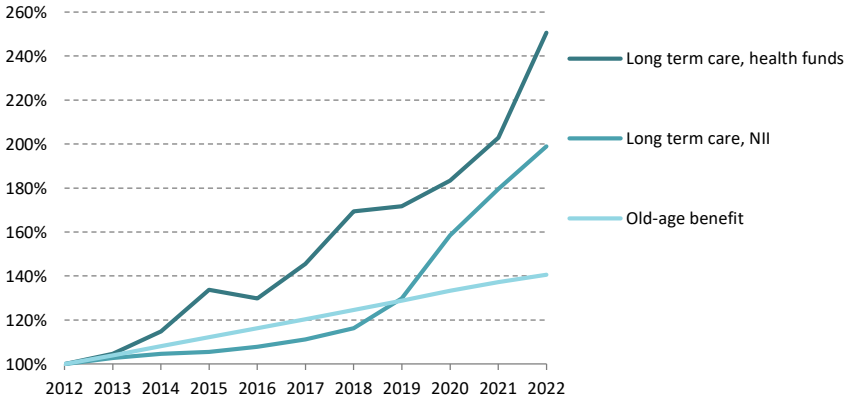
it can provide some indication of the functional status of senior citizens in Israel according to the selected definitions, it should not be seen as an accurate and absolute tool for measuring functionality, indicating deterioration or an increasing trend in the rate of decline (Zilbertal, 2022).

In addition to the increase in the number of recipients of long-term care benefits from the National Insurance Institute, there has also been a significant increase in the number of recipients of long-term care benefits from insurance companies through policies owned by health funds (hereinafter referred to as private benefits). It should be noted that these insurances cover 50% of the population and do not necessarily represent growth across the entire population. According to data from the Capital Market, Insurance and Saving Authority, from 2012 to 2022, the number of new recipients of the private benefit increased by 150%, from 7,000 to approximately 18,000.

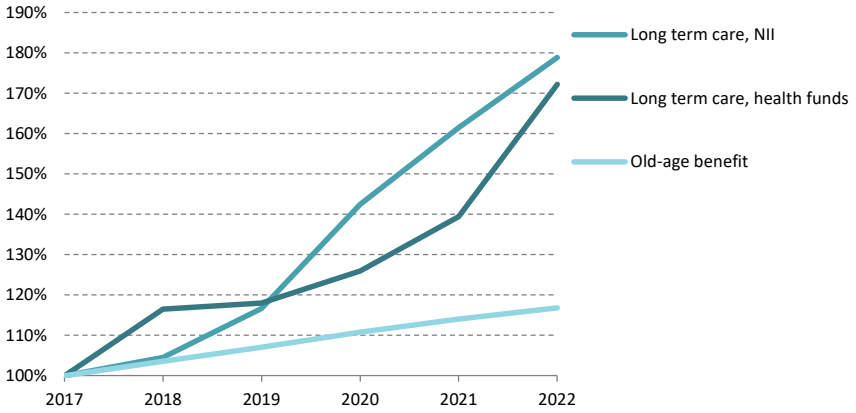
Figures 5a and 5b display the growth rate in the number of eligible recipients of long-term care benefits from the NII and those eligible for private benefits. The figures show that from 2017 to 2022, the number of eligible recipients for both public and private long-term care benefits grew at a similar rate, nearly 80%, while the growth in the relevant population was less than 20%. In contrast, examining the growth rate from 2012, it is evident that the growth rate in the number of recipients of the private benefit was significantly higher than that of the recipients of long-term care benefits from the National Insurance Institute. One explanation for this is that the regulations of the Capital Market, Insurance and Saving Authority stipulate that if the NII has conducted a functional assessment, it can also be used to determine the insured's functional ability for private insurance (Capital Market, Insurance and Saving Authority, 2021).

Figure 5. Growth rate in the number of long-term care benefit recipients, long-term care insurance, and old-age benefit recipients

a. 2012–2022



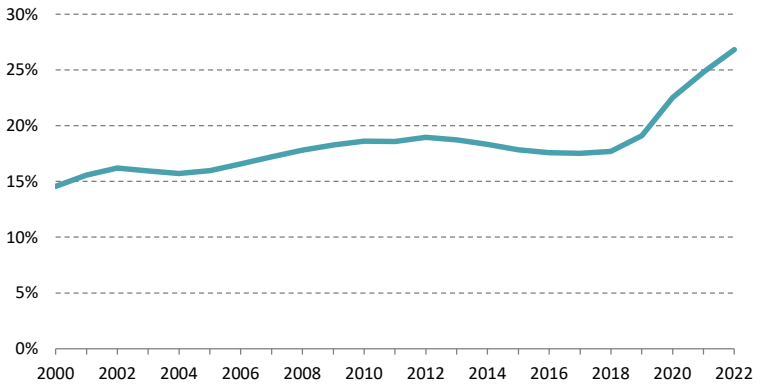
b. 2017–2022



Source: Nir Kaidar, Nadav Davidovitch, and Avi Weiss, Taub Center | Data: Capital Market, Insurance and Savings Authority; National Insurance Institute

Another way to view the increase in the number of recipients of long-term care benefits from the NII is through their proportion in the population of senior citizens. Figure 6 shows that the rate of benefit recipients rose from approximately 15% in 2000 to about 27% in 2022.

Figure 6. Proportion of long-term care benefit recipients from the National Insurance Institute among old-age benefit recipients, 2000–2022

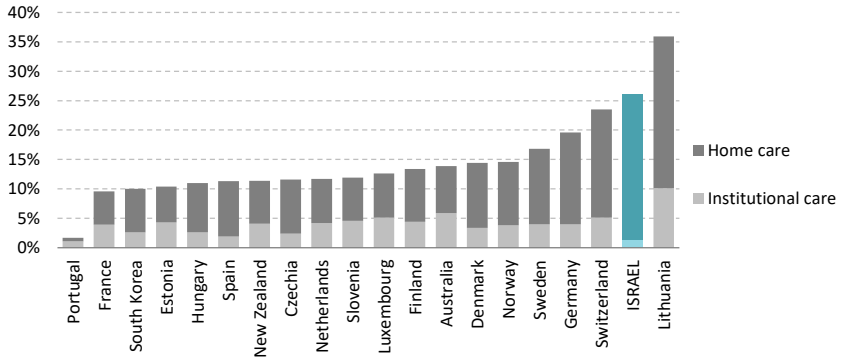


Source: Nir Kaidar, Nadav Davidovitch, and Avi Weiss, Taub Center | Data: National Insurance Institute

An international comparison of the proportion of individuals receiving long-term care among those aged 65 and over (Figure 7) shows that Israel ranks second among OECD countries. Israel's high ranking is due to the high proportion of individuals receiving long-term care in the community (and not in long-term nursing institutions; in this area, Israel is ranked among the lowest). It should be noted that the OECD data are for 2020, and since then, there has been a significant increase in the number of recipients of long-term care benefits in Israel, making the numbers even higher today.[7]

7 Given the absence of a uniform international definition for the need for long-term care, caution should be exercised in drawing conclusions based on international comparisons on this matter.

Figure 7. Proportion of senior citizens receiving long-term care in Israel and in selected OECD countries, 2020



Source: Nir Kaidar, Nadav Davidovitch, and Avi Weiss, Taub Center | Data: OECD

Private long-term nursing care insurance from the health funds

As noted, currently, the sole method to procure private long-term care insurance is through the health funds (hereinafter referred to as the insurance policy), who offer a group policy for members of the health fund. The policy is provided by one of the insurance companies following a tender issued by the health fund every few years. As prescribed by the Authority, the coverage provided by these insurance policies is uniform across all health funds in all aspects, though the monthly premium differs from one fund to another.

These insurance policies are formulated based on long-term actuarial calculations and accumulate funds in a reserve designed to ensure the actuarial balance of the policy. Should there be changes in the actuarial calculations, the fund will be compelled to alter the monthly premium payments, or the Authority will authorize adjustments in the conditions of the standard policy.

Enrollment in long-term care insurance is contingent upon a health declaration, and the insurance company is not obligated to insure individuals who do not meet the health declaration criteria. When transferring between health funds, the insurance continuity is preserved, and insurance companies are required to accept for long-term care insurance any insured individual who was previously accepted by another fund, regardless of their health status at the time of joining the new fund.

Insurance benefits are identical across all health funds but depend on the age at which one joins the insurance scheme. Insured individuals who joined before the age of 49 are entitled to full rights, whereas those who joined later are entitled to reduced rights (yet still pay the same monthly premium).

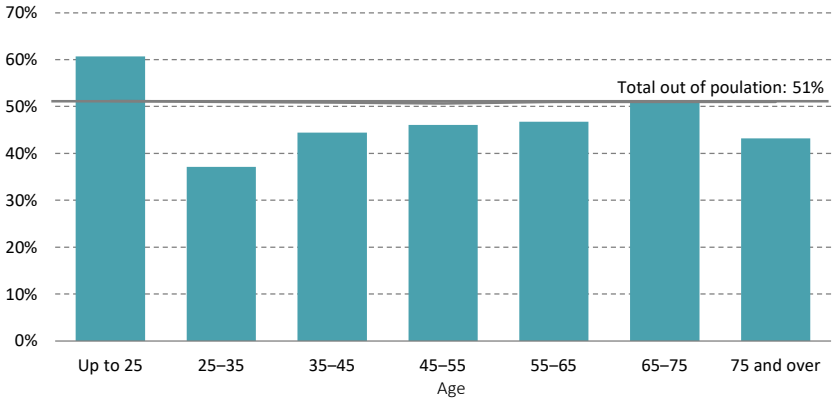
When an insured individual who joined before the age of 49, and of course met the policy requirements, transitions into a state requiring long-term care, they are entitled to benefits indexed to the cost of living: for home care, a monetary compensation of approximately NIS 5,000 per month (yielding a total of about NIS 300,000 over five years), and for institutional care, a reimbursement of 80% of the expenses up to about NIS 10,000 per month (yielding a total of about NIS 600,000 over five years).

The benefits are provided for a period of five years. After this period, the insured will no longer receive benefits from the insurance company. It is worth noting that during the eligibility period, it is possible to alternate between benefits for home care and institutional care. Since this is a group insurance policy, the benefits are subject to updates based on the policy's actuarial status. Thus, for example, at the beginning of 2024, the benefits for home care were reduced by about 20% following new regulations by the Authority.

Data collected from the health funds and published here for the first time indicates significant differences in the rate of insured individuals in long-term care insurance among the health funds. Maccabi Healthcare Services leads with a rate of 60% of its members insured, followed by Clalit Health Services with 52%, and lastly, Leumit Health Care Services and Meuhedet with 38% and 35% of their members insured, respectively.

The data from the health funds indicate that the age distribution of individuals insured under long-term care insurance is not uniform (Figure 8). The highest proportion of insured individuals is among those 25 and under. This is attributed to the fact that up to the age of 18, coverage under the health funds' long-term care insurance is free. The age group with the lowest percentage of insured individuals is those aged 25–35, at 37%. Insurance rates are higher for 65–75-year-olds (51%), and there is a decline in the percentage of insured individuals from 75, explained by individuals foregoing insurance due to the high premium payments required at these ages.

Figure 8. Percentage of individuals insured by health funds' long-term care insurance by age, 2023



Source: Nir Kaidar, Nadav Davidovitch, and Avi Weiss, Taub Center | Data: Health funds

In the OECD countries, private long-term care insurance is not widespread. According to OECD data, the United States has the largest long-term care insurance market in terms of premium payments, amounting to approximately USD 11 billion in 2017 (OECD, 2020). However, on a per capita basis (using the entire population of the country), premium payments for long-term care insurance in Israel are three times those in the United States. Another OECD review, examining the proportion of premium payments out of the public expenditure on long-term care in several member countries, found that the lowest rate was in Germany — 10% (OECD, 2021). For comparison, as shown in this paper, the rate is Israel is about 25%.

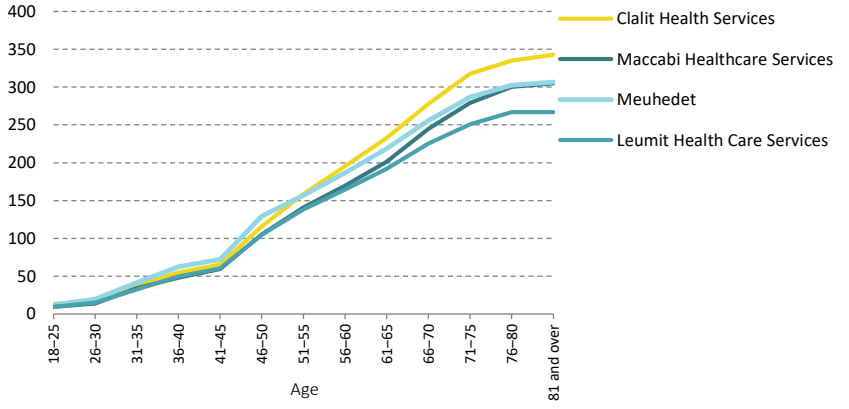
Is purchasing long-term care insurance worthwhile?

The answer to this question varies from individual to individual and depends on each person's preferences and constraints. In this section, we present data regarding the costs of the different insurance plans and the likelihood of requiring long-term care and activating them, and we will also perform an actuarial calculation as if this were an investment rather than an insurance policy.

The cost of insurance

The calculation of insurance costs was based on the premium payments across all health funds in February 2024.[8] As shown in Figure 9, premium payments rise significantly with age. The average monthly premium payment at age 30 is NIS 16, at age 50 it is NIS 114, at age 70 it reaches NIS 251, and at age 80 it amounts to NIS 301. The figure also highlights the differences in the premium among the health funds. For age groups between 25 and 50, Meuhedet charges the highest monthly premium. Beyond this age, Clalit Health Services has the highest premiums. For individuals aged 46 and above, Leumit Health Care Services offers the lowest premium rates. It should be noted that in addition to adjustments according to the consumer price index, premium payments are expected to rise in the coming years based on a framework agreed upon between the health funds and the Authority (detailed in the policy of each health fund). Upon policy renewal, the health fund is entitled to update the premium payments again (subject to regulatory approval).

Figure 9. Monthly premium by health fund and age group, February 1, 2024
NIS



Note: The calculated premium for February 1, 2024. Clalit's data are based on the expected payment in September 2024.

Source: Nir Kaidar, Nadav Davidovitch, and Avi Weiss, Taub Center | Data: Health funds

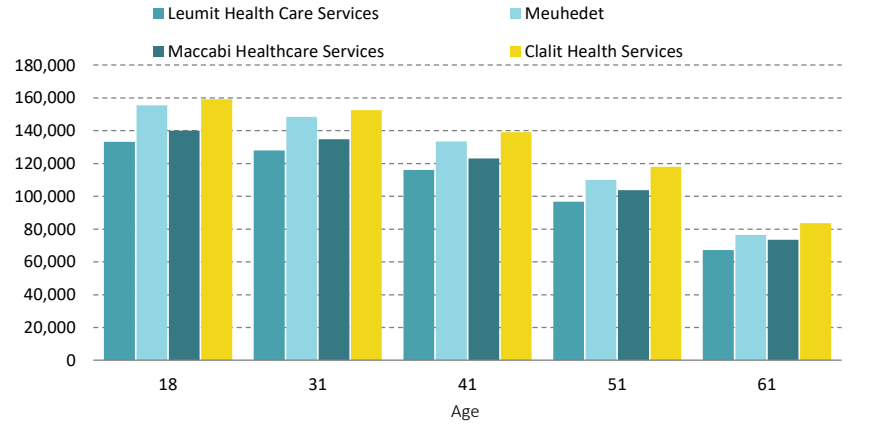
8 The data for Clalit were calculated based on the expected premium payments in September 2024.

The cumulative cost of insurance over the years of payment for the insurance can be easily calculated (premium payments by the insured stop when the person is found to require long-term care, at which point he starts receiving payouts as per the policy). For illustration, we calculated the total payments at various ages of enrollment, assuming that the payments would continue until age 80 and then cease due to death or the transition to a condition of long-term care. For this purpose, we used the current premiums, assuming no further increase. In the calculation, expected increases in the consumer price index to which the premium is linked were ignored because the insurance benefits are also indexed to the CPI, so the insurance's value is unaffected. The premium was discounted at an annual interest rate of 2%. Figure 10 displays the discounted total cost of the insurance up to age 80 by enrollment age for each of the health funds.

The average insurance cost for those joining at age 18 will be approximately NIS 147,000, at age 41 it will be NIS 128,000, at age 51 it will be NIS 107,000, and at age 61 it will be NIS 75,000. It is important to remember that people who join the insurance after the age of 49 receive reduced rights. Across all age groups the cost of insurance in the Meuhedet health fund is higher than in the other health funds, and the premium payments in the Leumit health fund are the lowest. As previously noted, premium payments are expected to rise over the years, so the amounts used here are lower than the amounts that will be in effect in a few years (even when ignoring the expected adjustment that will ensue because of increases in the consumer price index).

Figure 10. Total premium payments up to age 80 by age of enrollment and by health fund

NIS



Note: The calculation assumed an annual discount rate of 2%.

Source: Nir Kaidar, Nadav Davidovitch, and Avi Weiss, Taub Center | Data: Health funds

Insurance benefits

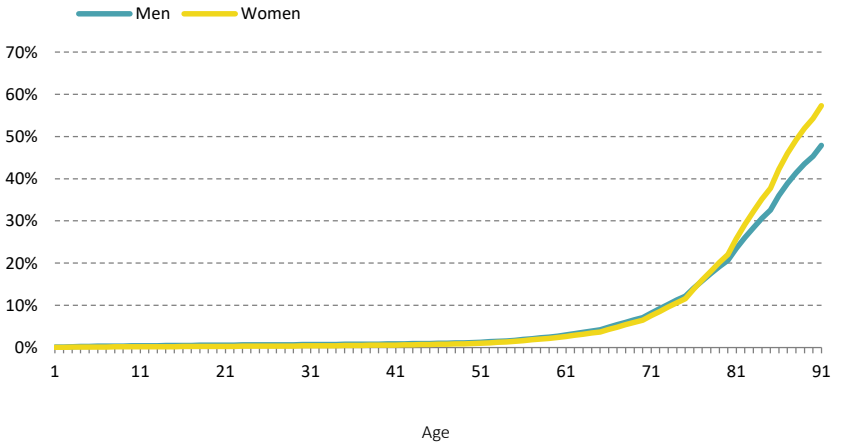
As noted, long-term care insurance provided by health funds grants the right to monetary compensation for a period of up to five years for home care or reimbursement for institutional care. According to the Authority's data, on average, 93% of the beneficiaries are in their homes rather than in institutional care, with the monthly payment for those who joined before age 49 (as of January 2024) being approximately NIS 5,000 for individuals receiving home-based care and NIS 10,000 per month for elderly requiring institutional care. If the insured is defined as requiring long-term care and remains so for the entire five years, the insurance benefits will amount to an average of approximately NIS 321,000 (not discounted).

The probability of requiring long-term care

The Capital Market, Insurance and Savings Authority collected data from insurance companies regarding the age at which claims for long-term care benefits in the health funds' insurances were approved (Capital Market, Insurance and Savings Authority, 2021). Based on these data, it is possible to calculate the cumulative probability of transitioning to a condition requiring

long-term care (according to the definitions of the insurance companies) at every age. Figure 11 shows that the probability significantly increases at older ages. The likelihood of needing long-term care by the age of 80 stands at 23% for men and 26% for women (meaning, one out of four individuals will require long-term care by age 80), while for individuals aged 90, the probability is 48% and 57%, respectively. At younger ages, the probability of requiring long-term care is very low. It is important to note that this calculation is based on data available up to 2020 and does not account for the increase in claims that has occurred since 2020 nor any future changes in the number of claims and the life expectancy of individuals requiring long-term care.

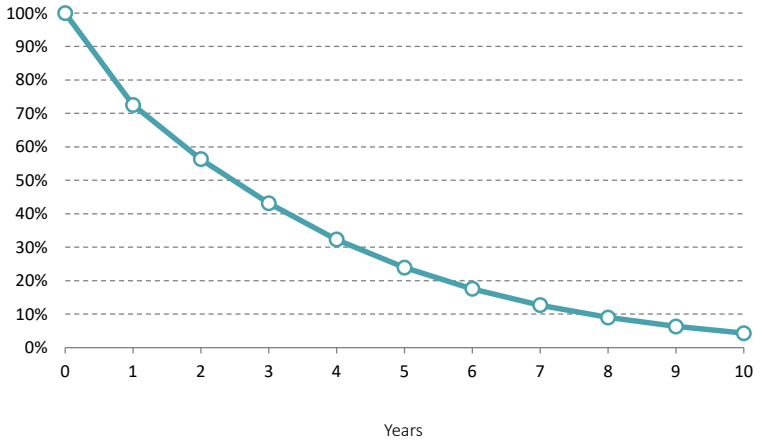
Figure 11. Cumulative probability of needing long-term care, by age and gender, 2020



Source: Nir Kaidar, Nadav Davidovitch, and Avi Weiss, Taub Center | Data: Capital Market, Insurance and Savings Authority

The Authority's data also allow for the examination of the life expectancy of individuals entitled to long-term care benefits from insurance companies, across each age group.[9] For convenience, we considered the data for individuals aged 80 who begin to require long-term care at this age. The data are presented in Figure 12. About 73% of those who begin receiving long-term care benefits at age 80 survive at least one year, while 27% die within the first year. Only 56% of survive two years, and only 24% survive the entire five years during which they receive benefits. The average life expectancy of someone who starts receiving long-term care at age 80 is 33 months.[10]

Figure 12. Proportion of remaining long-term care insurance beneficiaries from all individuals who transitioned to a condition of long-term care at age 80, by number of years since transitioning to long-term care



Source: Nir Kaidar, Nadav Davidovitch, and Avi Weiss, Taub Center | Data: Capital Market, Insurance and Savings Authority

9 This measurement of life expectancy begins on the day the insurance companies recognize an individual as requiring long-term care. It does not account for the life expectancy of individuals recognized as requiring long-term care in general (from the day recognized by the National Insurance Institute), which is likely longer (due to more lenient criteria for recognizing an individual as requiring long-term care).

10 Since the data on mortality rates each year are not continuous, we assumed that the cessation of care occurs each year after eight months. Therefore, the data presented are slightly biased upwards.

Actuarial calculation

The data above allow us to compare the expected cost of long-term care insurance with the expected benefit from it. Both the cost and the benefit depend on the age at which one joins the program — both the *nominal cost* and benefit decrease the later one joins (the latter because the period of requiring long-term care might occur before he wanted to join). To examine the *real cost* and benefit, it is essential to remember that the payment period precedes, and even substantially so, the period during which long-term care benefits are received. To calculate the economic viability of such insurance, both the payments and the receipts must be brought to the same point in time, generally the starting point. Thus, the net present value was calculated using a discount rate of 2%.[11] The size of the payment in each period is calculated, as is the probability of making or receiving that payment. Thus, premium payments are made only as long as the individual is still alive and has not yet started receiving long-term care benefits, and receipts are received only if the individual actually transitions into long-term care. The calculations regarding the receipts also include the probability that the long-term care is provided at home versus in an institution and the differences in payment amount, the average number of months that the payment is actually received, and the decrease in payments if the insurance plan was begun between ages 50–59 and after age 59.

Before presenting the results of the analysis, it is important to remember that, like all insurance, the purpose of long-term care insurance is to mitigate the consequences of the worst-case scenario, in this case, to reduce the financial burden associated with transitioning to a state of long-term care. Therefore, it is not expected that the present value of insurance costs will be lower than the expected benefit; in other words, this is not an investment for profit but rather insurance, and the justification for paying for such insurance, as with all insurance, is subjective and depends on the individual's level of risk aversion and their ability to bear the worst-case scenario without insurance.

Figure 13 presents the results of the calculation based on the average premium in the health funds, age of enrollment, and gender (for results divided by health fund, see Appendix Figure 1). At every age, the present value of the expected revenues (receipts) and expenditures (payments) are displayed.

11 This is the risk-free rate used by insurance companies.

For example, the numbers listed at age 31 show the present value of the expected income and expenditure streams over the lifetime of an insured individual who joined at age 31, discounted to age 31, i.e., to the point in time when they joined the plan.

The present value of the payments increases until the mid-forties and begins to decline from the early fifties. The reason for this decrease is clear: the later one joins, the fewer years insurance premiums are paid. Joining at a younger age, on the other hand, leads to more payments, but the higher payments made at older ages are discounted for a longer period, which reduces the present value of the payments in the event of requiring long-term care. All told, at relatively young ages, the effect of discounting is more pronounced, but as age increases, the probability of starting to receive benefits and ceasing to pay premiums grows, and the reduction in *the number of years paying premiums* outweighs the effect of discounting.

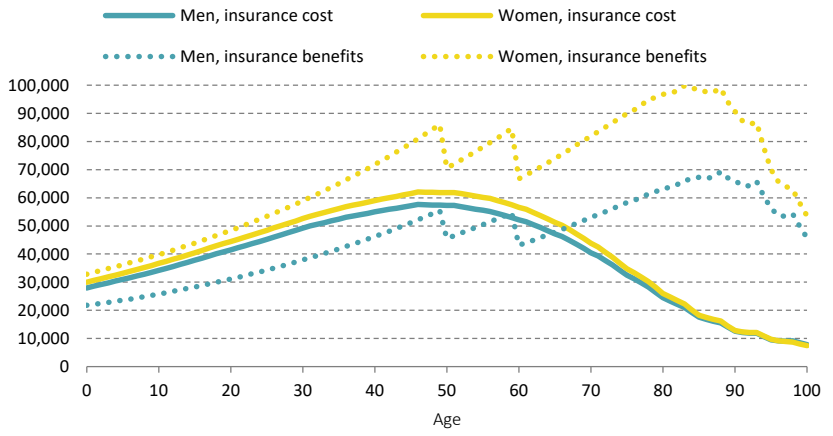
It is interesting to note that the cost for women is slightly higher than for men until the mid-seventies. This difference arises from women's longer life expectancy and the lower probability of younger women starting to receive long-term care benefits. As a result, women, on average, pay premiums over more years. However, at older ages, the probability of women transitioning to long-term care is higher than that of men (as seen in Figure 11 above), and, therefore, if one joins the insurance at these ages — assuming the applicant has passed the health assessment of the insurance company — the present value of the payment is lower for women than for men.

On the side of receipts, the differences between women and men are much more significant. These differences stem from both the gender gap in life expectancy and the differences in the probability of starting to receive long-term care benefits at older ages. As shown in Figure 11, generally, up to the age of 70, the probability of requiring long-term care is very low. It increases significantly only after age 80, and among women, it increases more than among men. Since women have a higher life expectancy, the expected receipts for women are much higher than those for men. The increase over the years is due to discounting. The jumps seen in Figure 13 at ages 50 and 60 reflect the reduction in receipts for those joining the program after these ages. As mentioned above, those who join after age 50, and even more so after age 60, receive reduced long-term care benefits.

Thus, it appears that on average, given the current data and discounting at 2%, for men joining before age 65, the expected premium payments are higher than the expected receipts, while for women the opposite is true, with the expected receipts higher than the payments. The analysis for each health fund is presented in Appendix Figure 1.

The viability of joining the insurance increases with age, but it should be remembered that it is not at all certain that a person at the age of 70 or 80 will be accepted into the program (due to their health condition), and, even if so, waiting to join is associated with the risk that the individual will require long-term care at an earlier age, and in the absence of insurance, they will not receive long-term care payments. Moreover, although the viability of joining long-term care insurance at a younger age is lower, especially for men, the program constitutes a fair insurance policy even at a young age. However, as with all insurance, payment is made before receiving the return, and not every family can afford this expense.

Figure 13. Long-term care insurance payments and receipts in present value, by age of enrollment and gender
NIS



Source: Nir Kaidar, Nadav Davidovitch, and Avi Weiss, Taub Center | Data: Capital Market, Insurance and Savings Authority

Policy alternatives

So far, we have dealt with the economic viability of joining the insurance plan from the individual's perspective. However, above and beyond this, to enable the elderly to age at home and in the community where they are integrated, in accordance with current welfare policy, the government needs to formulate a comprehensive policy that integrates the various agents involved in caring for this population and work to reduce the failures resulting from a lack of an overall vision of the elderly's situation in Israel.

To this end, the policy alternatives presented here primarily pertain to private long-term care insurance. There is also room for improvement in public long-term care insurance provided separately by the National Insurance Institute and the Ministry of Health, but it is not the focus of this paper. Nonetheless, the significant increase in spending on long-term care in recent years necessitates continuous government monitoring and the implementation of measures, both to ensure funding sources and to enhance the efficiency of public assistance to the elderly in need of long-term care.

The long-term care insurance through health funds is, in effect, the only private insurance remaining in the market for new enrollees in long-term care. The substantial increase in the number of claims in recent years requires the state to take steps to ensure that insured individuals in these programs receive adequate long-term care coverage when needed. There is a wide range of possible measures, some within the insurance domain itself (changing premiums and eligibility conditions), some necessitate a reevaluation of the nature of the insurance and an exploration of the possibility of replacing it with savings, and some relate to the quality of public long-term care insurance provided by the state. The solution could incorporate components from several alternatives.

It should be noted that some of the alternatives related to private insurance have the potential to increase disparities within Israeli society, while the alternative that proposes improvements in public care services may lead to their reduction. Below are some alternatives:

Adjusting premiums or entitlements: Due to the increase in the number of claims, stabilizing steps in the insurance plans of the health funds will most likely be required — either increasing premiums or decreasing entitlements (including redefining eligibility). The payment for individuals aged 80 is already

high, with some funds charging over NIS 300 per month, so raising this could be particularly problematic. However, under the current circumstances, despite the impact on the insured's rights, this seems to be necessary to attain long-term economic stability. Possible steps to achieve this goal might include:

- Charging a low premium for children aged 5–18 (there is currently no premium payment at these ages).
- Extending the waiting period for receiving insurance benefits (the current waiting period is 60 days).
- Lowering the age of enrollment that allows for full insurance coverage. Currently, one can join the long-term care insurance up to age 49 and receive full entitlements, as would, for example, an insured who joined at age 20. Lowering the age that allows for full coverage would encourage earlier enrollment in long-term care insurance and lead to a decrease in insurance benefits for those who join after this age.
- Increasing monthly premium payments.
- Reducing insurance benefits or shortening the reimbursement period.

These steps will lead to a loss of income for all insured, but the loss will be more critical for individuals with low income, whose ability to afford long-term care services will be impaired.

Reducing utilization rates: In the spirit of incentives commonly used in behavioral economics, the merit of using incentives to reduce the utilization rates of long-term care benefits can be examined.

Mandatory insurance: Making health fund long-term care insurance mandatory. As noted previously, about half of the Israeli population is insured for long-term care through health fund policies. The lowest insured rate is in the age group of 25–35, at 37%. If long-term care insurance becomes mandatory, the number of monthly premium payers would significantly increase, and the base of young premium payers, who are not expected to require long-term care in the short-term, would be expanded. This step is akin to imposing a regressive mandatory tax that collects a relatively higher payment from lower-income populations. Moreover, household expenses on long-term care insurance would double, reaching about NIS 6 billion per year. Following the findings presented in this paper, making long-term care insurance mandatory should be done in parallel with changing the policy conditions, as presented in the first alternative.

Mandatory savings for long-term care: Establishing a layer of mandatory savings for long-term care for the entire population. Every resident would be obligated to make a monthly designated saving for potential long-term care situations. The saving could be a fixed amount or a percentage of salary. Upon transitioning to a condition requiring long-term care, the individual could withdraw the accumulated funds as a monthly pension. If the saver does not reach a condition of requiring long-term care or dies before fully utilizing the savings, the accumulated amount would pass to their legal heirs.

If the saving is a percentage of salary, then it represents a proportional deduction that is not regressive. Those who contribute relatively less will receive a lower pension than under the current system. If the saving is a fixed amount, then it is very regressive, and the primary beneficiaries of any tax benefits on capital gains, if any, would be the wealthier segments of society.

Another possible model is that the savings would not be mandatory, but the state would provide a tax incentive for contributions to a long-term care savings account. This savings approach is more akin to the Savings for Every Child model than to pension savings. In this model, the saver would receive the amount saved (no more, no less), without actuarial risk.

Preventing functional deterioration: Implementing the recommendations of the task force for the prevention of functional deterioration of elderly citizens from September 2022. The task force proposed several recommendations related to changing the priorities in long-term care in Israel so that more resources would be directed towards the prevention of functional deterioration. The recommendations included changes in the structure of the long-term care benefit, changes in the incentive structures for long-term care companies, strengthening the programs that local authorities offer to elderly citizens, and integrating health funds into efforts to prevent functional deterioration and rewarding them accordingly. In this context, consideration should be given to allowing health funds to invest a portion of the long-term care insurance funds in programs to prevent functional deterioration.

Improving public long-term care insurance: Public long-term care insurance in the community is extensive but does not provide a complete solution for the population. The payment for the long-term care component out of the residents' National Insurance Institute payment does not cover its actual cost. Increasing the long-term care payment component in the monthly NII

payment and maintaining a fixed rate of state expenditure could allow for an increase in the public long-term care pension. It is proposed that this increase in the budget be directed towards actions to prevent functional decline and to provide additional hours of assistance or funding for individuals at the highest levels of long-term care need. The majority of public long-term care insurance is universal. Improving public eligibility will primarily benefit the weaker segments of society, as this assistance will constitute a higher percentage of their income.

Enhancing supervision of service delivery: Currently, there is no effective supervision by the National Insurance Institute over the actual receipt of services by those entitled to long-term care benefits. In 2022, the NII published a new tender for service providers in the field of long-term care, which also includes steps related to supervision, but this tender has not yet been implemented.

Summary

Israel is aging today at a faster rate than we were accustomed to in the past (see Figure 1). In recent years, alongside the aging population, we are also witnessing a rapid functional deterioration among the elderly in Israel, as indicated by data from both the National Insurance Institute and private insurance companies. The long-term care insurance system in Israel is fundamentally based on public insurance through the NII (in the community) and the Ministry of Health (nursing long-term care hospitalization), and on private long-term care insurances (primarily group long-term care policies owned by health funds), alongside additional household expenditures for financing the necessary costs for long-term care. The long-term care service system in Israel is fragmented among a large number of agents who do not operate in coordination, leading to an increase in bureaucracy for the elderly requiring long-term care and their families.

In recent years, several government policy initiatives have been proposed to reform the structure of long-term care in Israel. A plan by the Ministry of Health in 2011 suggested consolidating all services for the elderly under the health funds (Hurvitz et al., 2011). The plan presented by the Ministry of Health and the Ministry of Finance in 2017, aimed to increase community-based long-term care, expand long-term care benefits, modify eligibility criteria, and

develop community services for the elderly, and was formally adopted by the government (Ministry of Health & Ministry of Finance, 2017).[12] In 2022, a report published by the Ministry of Welfare and Social Affairs, the National Insurance Institute, and the Ministry of Health addressed the prevention of functional deterioration among elderly citizens and formulated a variety of recommendations on the matter (Zilbertal, 2022). As part of the coalition agreements for the formation of the 37th government in December 2022, it was also agreed upon to establish a "national plan to ensure comprehensive long-term care funding for the entire population" (Coalition Agreement for the Formation of a National Government, 28.12.2022).

However, despite these initiatives, the long-term care system in Israel in 2024 is not stable. The dramatic increase in the number of recipients of long-term care benefits and the surge in private insurance claims necessitate a reconsideration of the entire long-term care system, with continuous monitoring and appropriate preparation for the aging population in Israel.

12 *Government Decision No. 3379* from January 11, 2018.

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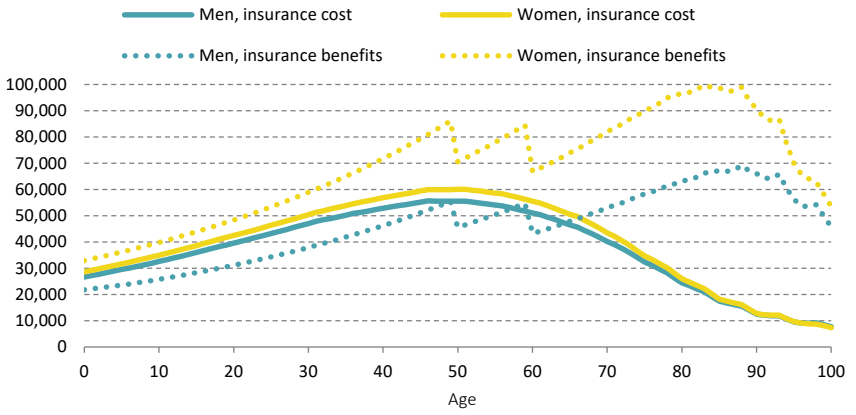
Appendix

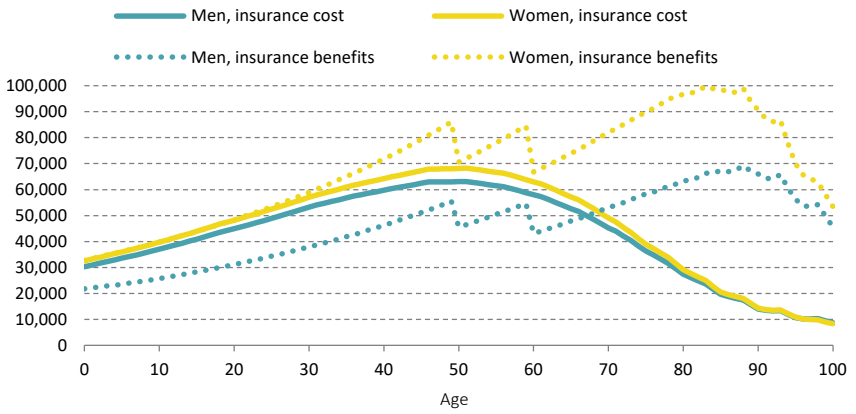
Appendix Figure 1. Present value of long-term care insurance payments and receipts by age of enrollment, gender, and health fund

NIS

Maccabi Healthcare Services



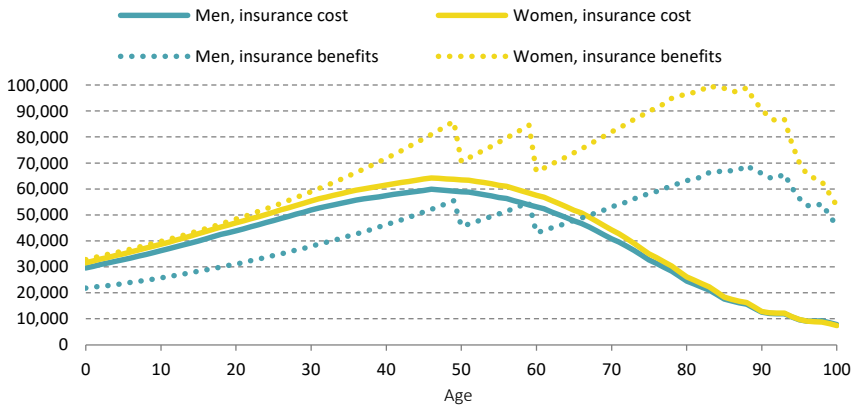
Clalit Health Services



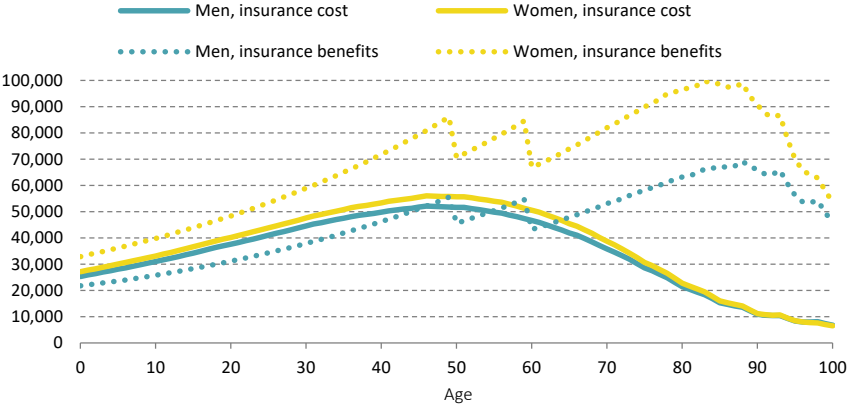
Appendix Figure 1 (continued). Present value of long-term care insurance payments and receipts by age of enrollment, gender, and health fund

NIS

Meuhedet



Leumit Health Care Services



Source: Nir Kaidar, Nadav Davidovitch, and Avi Weiss, Taub Center | Data: Capital Market, Insurance and Savings Authority