PENSION NOTES

No. 27 - JULY 2018

Experiences with coverage programs for financing the care of dependent senior citizens

Executive Summary

Dependency is defined as limited functional, physical or cognitive capacity, which implies that the affected individual needs help to perform the basic activities of daily life for an extended period of time.

Failure to define and implement policies for supporting and financially covering the population against the contingency of dependency could entail significant costs for the labor market and the welfare system, because it causes a reduction in the labor supply and fewer contributions to financing the pensions of the family members who must assume the long-term care (hereinafter LTC) of dependent individuals. It also increases the risks of the individuals who suffer from this condition and their family members falling into poverty, results in a greater prevalence of mental issues among them and has fiscal effects due to the lower taxes and contributions collected, as well as higher government transfers to individuals who fall into poverty.

The challenge of caring for the dependent elderly and financing their costs will increase in Latin America in coming decades, due to population aging and life expectancy increases. This will result in a greater demand for care services for dependent individuals and an increase in the number of years in which such services will be required. To meet this challenge, it is essential to assess the implementation of public policies that provide adequate basic coverage against the financial risk of dependency, with a systemic and comprehensive approach that ensures the financing of benefits and the sustainability of the respective programs.

Protection against this contingency is an issue that the State must address with prevention activities for reducing and delaying situations of dependency among the population, through the creation of financial and health care programs for supporting dependent individuals and their families.

In terms of financial protection, there are powerful reasons for creating programs for covering dependency, that complement family support. Risk-pooling mechanisms are required, i.e., mechanisms that share the risk of having to finance the long-term care of

dependent individuals amount large sections of the population. These mechanisms must provide protection against this risk at a reasonable cost. Without them, the cost of protection could be very high and inaccessible for the majority of people, especially for lower-income families with higher degrees of dependency. The creation of pre-paid risk sharing programs among groups of insured individuals could be an effective response to the high degree of uncertainty and high costs. In fact, the benefits of LTC risk pooling for the largest possible numbers of the population have been widely documented.

In international experience, private LTC insurance plans have little importance in the coverage of such services, but its relevance will probably grow in future given the need to ensure the sustainability of the programs and protect intergenerational equity. The low level of development of private dependency insurance markets is due to both demand and supply factors. On the supply side, the financing of the costs of providing long-term care and the returns that insurance companies can obtain on the investment of the reserves established for backing up the payment of future benefits are subject to a high degree of uncertainty. There are also adverse selection and moral hazard issues. [1]. Hence, companies protect themselves by limiting coverage or increasing prices. On the other hand, the demand for dependency insurance is weakened by the customary myopia of individuals when planning and covering long-term financial risks, and the fact that they usually consider such risks to be very remote. The perception of individuals that they will be supported by the state should they be faced with the contingency of dependency, could also be a factor that reduces demand.

There are insurance designs that are presented in this document that can reduce the effects of the aforementioned problems. The policies implemented in Europe and Asia for protecting the population from the risk of dependency are described, also presenting the experience of Singapore and general proposals for the creation of a dependency insurance in Chile. Singapore was chosen because it is among the countries with the highest voluntary insurance coverage of dependency in the world, and Chile was chosen because the dependency insurance issue is currently being discussed within the framework of the proposals for reforming the pension system.

I. Introduction

The care of dependent senior citizens is resolved primarily within families in Chile, and probably in most Latin American countries. According to the Chilean agency Comunidad Mujer, this task is assumed by female members of the family in Chile on a voluntary basis.

In general, people who interrupt their working lives, or who have not been able to hold down a job because they have had to care for dependent senior family

[1] Adverse selection issues arise when only people with high dependency risks take out or extend insurance policies. On the other hand, moral hazard occurs when the insured use the insurance benefits more than necessary, just because they are covered.

members, are not only affected by a reduction or total absence of income, but also by the reduction in the frequency of their contributions and their savings for financing their future pensions. These people also face greater difficulties in returning to their jobs when they are no longer caring for an elderly family member, a meaningful number suffer from depression or stress, increasing the chances of becoming adults suffering from some degree of physical or economic dependency later on in life. In fact, these people have usually suffered from isolation and a lack of support, and have been subjected to financial pressure, which could give rise to health problems and mental illness.

The financial cost of caring for the elderly can be high, putting a heavy burden on the individuals entrusted with this task, or their families, what is especially worrying in the mid and lower income sectors, due to the insufficient pension amounts being granted by the pension systems in our region. According to the OECD (2011), the expenses associated with a relatively low level of care for a dependent elderly person (10 hours a week), can exceed 60% of the disposable income of people of low and moderate income, up to the fourth decile. The cost of just one week of institutional LTC care in the OECD and European Union countries, on the other hand, ranges from 100% to more than 300% of the median disposable income for people over 65 (OECD 2017) (Graph No. 1).

This high cost increases the risk that, in the absence of adequate financial protection against dependency, the costs of caring for seniors in this condition can impoverishment them or their families.

In coming decades, the challenge of caring for dependent seniors and financing its cost will increase in Latin America due to population aging, which will give rise to an increase in the demand for long-term care services. This is what has happened in the OECD countries, which in almost all cases have experienced an increase in the percentage of the population receiving LTC services in the last decade, particularly among senior citizens, with significant differences between countries (Graph No. 2). The increased life expectancy of the population will also result in an increase in the number of years in which LTC services will be required.

All of this requires evaluating the implementation of public policies that provide adequate basic coverage against the financial risk of dependency, with a systemic and comprehensive approach that ensures the financing of benefits and the sustainability of the respective programs.

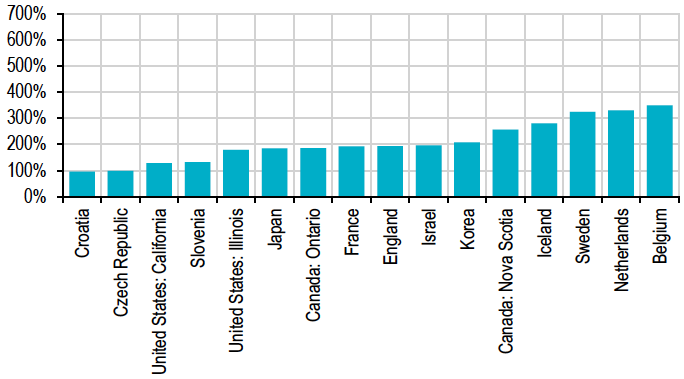
If this challenge is not addressed, many dependent individuals will continue to be looked after by their families or by informal caregivers, with the resulting effects on their health and employment opportunities. Between 1% and 2% of the total workforce in the OECD countries is currently employed in LTC services, and more than 10% of adults over 50 provide personal care to people with functional limitations (Joshua, 2017). However, many people who become dependent are at risk of being completely unprotected, since the availability of family and informal care is expected to drop due to reduced family sizes and the

full participation of women in the labor market.

The lack of definition and implementation of policies for assisting dependent individuals has costs for the labor market, since it implies a reduction in the labor supply. The risk of individuals and families in this situation falling into poverty also results in a greater prevalence of mental issues among them and has fiscal effects due to the lower taxes and contributions collected, as well as higher government transfers to individuals in that condition.

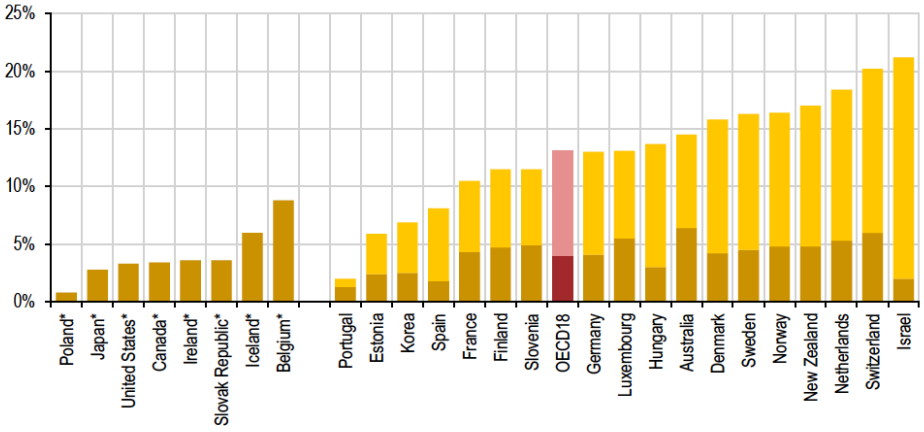
The importance of the issue led the authors of this document to summarize the main experiences and discussions of public policies that provide coverage for the long-term care of the elderly, mainly in Europe and Asia, where these policies have been applied for decades.

Graph No. 1: Weekly cost of institutional LTC care in OECD countries and the European Union
(% of the average disposable income for people over 65)



Source: Muir (2017).

Graph No. 2: Proportion of the population over 65 receiving LTC services in institutions and at home, 2014 (1)



(1) Or the nearest year.
Source: Muir (2017).

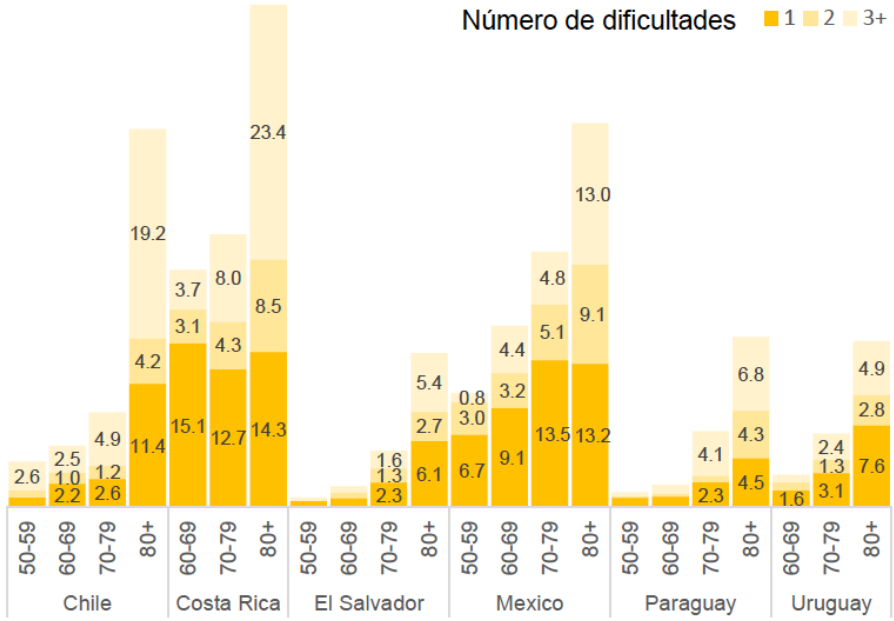
II. Definition of dependency

Dependent individuals are those who require help in carrying out the basic activities of daily life for an extended period of time, due to a reduction in their functional, physical or cognitive abilities. According to the Chilean National Senior Citizens Service (SENAMA), there are different levels of dependency: mild, moderate and severe. This category includes people in any of the following three conditions: (i) prostrate; (ii) dementia of any degree; and (iii) inability to perform a basic activity of daily life, except for bathing, or inability to perform two [2] instrumental activities of daily life.

SENAMA's statistics show that 24% of seniors over the age of 60 have some degree of dependency, whereas CLAPES UC says that 12.4% of the population of 60 or more, and 37% of people of 80 or more are severely dependent. Aranco et al. (2018), on the other hand, consider that 46.2% of women aged 80 or more in Chile have one or more difficulties in performing basic activities of daily life. This percentage drops to 33.8% for men. Graphs No. 3 and No. 4 show the figures for other ages and other Latin American countries.

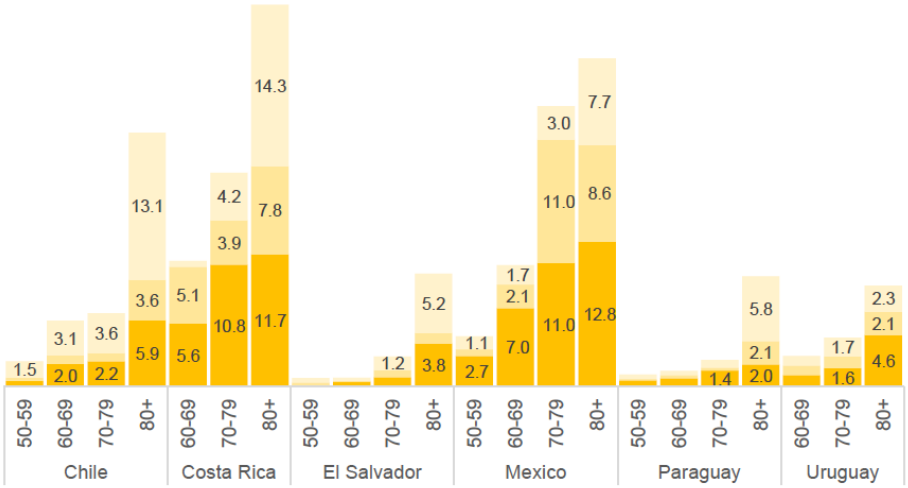
[2] These activities are more complex than the basic activities of daily life, and a higher degree of personal autonomy is required for performing them. For example: preparing a hot meal; managing their own money; going to other places alone; buying food; using their phones to make a call; performing light house chores; and organizing and taking medications (see CLAPES, 2018).

Graph No. 3: Dependent individuals and degree of dependency as a percentage of the population by age - women



Source: Aranco et al. (2018).

Graph No. 4: Dependent individuals and degree of dependency as a percentage of the population by age - men.



Source: Aranco et al. (2018).

III. Importance of creating programs for caring for dependent senior citizens

Despite the extensive evidence regarding the high probability of requiring long-term care due to dependency at some point in life, the vast majority of people are not financially protected from this contingency for various reasons, such as: myopia; they have other present needs and consumption preferences; they are not properly informed; existing products are not within their reach; or they trust that they will receive family and government support should they become dependent. Lack of coverage can have a catastrophic impact on people and their families, especially among lower income groups with high risk levels. Coverage of this contingency is an issue that must be addressed by the government through prevention measures for reducing and delaying situations of dependency among the population, and the creation of financial and health care programs for supporting dependent individuals and their families.

There are powerful reasons for creating financial protection programs that complement family support to dependent individuals for covering dependency. In general, people have high levels of uncertainty regarding their LTC requirements in future, the time in life at which dependency can occur, and its duration and intensity. For most people, merely saving for the purpose of accumulating funds for providing protection against dependency will not suffice. Risk-pooling mechanisms are required, i.e., mechanisms that share the risk of having to finance the long-term care of dependent individuals in a large section of the population. These mechanisms must provide protection against this risk at a reasonable cost. Without them, costs could be very high and inaccessible for the majority of people, especially for lower-income families with higher degrees of dependency. Thus, the creation of pre-paid risk sharing programs in a large group of insured individuals could be an effective response to the high degree of uncertainty and high costs. The benefits of LTC risk pooling for the largest possible numbers of the population have been widely documented.

IV. Models implemented in LTC programs

International experience shows that the risk of dependency has been covered primarily with government-funded protection mechanisms. In general, private coverage covers only a small segment of people, for the reasons indicated below.

International studies distinguish different types and models of applied programs, based on the following characteristics:

- *Coverage:* universal; means-tested schemes.
- *Sources of financing: S*ocial Security contributions depending on salaries and the general resources of the public budget.

- *Target population:* senior citizens; the entire population

– *Type of benefits provided:* Cash and services subsidies.

a) Coverage

In programs with universal coverage, implemented in most OECD countries (see table below), benefits are provided to all individuals who are eligible due to their dependency status. These types of programs typically provide for co-payments and user deductibles and many are subject to ceilings, partial or total payment exceptions, or social assistance mechanisms for the poorest.

The advantage of this type of coverage is that it ensures broad access to LTC services by the population. This access does not depend on the income or level of assets of users or their families, although these variables can be taken into account to determine the co-payments required for the services received. Universal systems are generally more expensive, above 1.5% of GDP, and up to levels close to 4.0% of GDP in countries with more generous benefits (Netherlands, Sweden).

Main characteristics of the public LTC programs in the OECD

Country	Eligibility	Financing	Target population	Type of Benefit
Germany	UN	TAX / PM	POB	CA/ES/CUHI
Australia	UN	TAX	AM	ES/CUHI
Austria	UN/MT	TAX	POB	CA/CUHI
Belgium	UN	SSC	POB	CA/ES/CUHI
Canada	(2)	TAX	POB	ES/CUHI
Korea	UN	TAX / PM	65 + / 65 - D	CA/ES/CUHI
Denmark	UN	TAX	POB	CA/ES/IC
Spain	MS	TAX	POB	CA/ES
United States	MT/SI/V	TAX/PM/PP	LI / AM / POB	CA/ES/CUHI
Finland	UN	TAX	POB	CA/ES/CUHI
France	MS	TAX / SSC	POB/60 +	CA/ES/CUHI
Greece	MS	TAX / SSC / PP	AM	ES/IC
Holland	UN	TAX / SSC	POB	CA/ES/CUHI
Hungary	MS	TAX / SSC	POB	ES/CUHI
Italy	MS	n.a.	POB	CA/ES/CUHI
Japan	UN	TAX / SSC	AM/40-64 D	ES/CUHI
Mexico	MS	TAX / SSC	65+	CA/ES/IC
New Zealand	MS	TAX	n.a.	ES/CUHI
Norway	UN	TAX	POB	CA/ES/CUHI
Poland	NS	TAX / SSC	75 + / D	CA/ES/CUHI
Portugal	MS	TAX	POB	ES/IC
United Kingdom	UN/MS	TAX	18 (B)	CA/ES/CUHI
Sweden	UN	TAX	POB	CA/EN/CUHI/V
Switzerland	MS	TAX/PM/PP	POB	CA/ES/CUHI

Note: UN = universal; MT = means testing; MS = mixed system; NS = non-separate health system; SI = social security; V = voluntary insurance; TAX = taxes; SSC = social security contributions; PM = premiums; PP = private payments; AM = senior citizens; POB = the entire population; D = disabled or ill; LI = low income; CA = Cash; ES = in kind; CUHI = home and institutional care; V = coupons for financing care; IC = institutional care.

(1) Some countries have a number of programs. The one that appeared to have the most coverage was chosen.

(2) Depends on each province.

Source: OECD (2011).

Means tested programs, on the other hand, prioritize the coverage of individuals and families with the most pressing care requirements, which would not be able to finance the costs of dependency. They are selected by means of an income and/or assets test to determine those eligible to receive the established. Benefits. This type of program is more effective in limiting costs but may lead to inequities as well as incentives to use the public health system for the purpose of achieving the care that dependent individuals require, and that are not obtained from the special programs for financing this contingency. The qualification and eligibility assessment processes can also be expensive, inefficient and lacking in uniformity, leaving individuals and families that exceed the income and assets limits uncovered and vulnerable to impoverishment.

In practice, most of the systems that cover LTC combine features of universal and means testing programs. Universal systems usually do not cover all costs, which is why they are complemented with social assistance components using means testing.

b) Financing

One of the financing models used is a social insurance policy specifically designed for LTC coverage. Based on the experience of OECD countries, a feature of this model is that it has a separate system for financing dependency coverage, by making it mandatory for the entire population, or a large part thereof, to participate in the benefits program, and because it is predominantly financed by contributions based on corporate payrolls. In some cases, senior citizens must also finance the program, and part of the benefits are also financed with general taxes in the majority of countries. This type of model has the advantage of providing a dedicated and predictable means for financing LTC coverage. The fact that contributions are associated with a particular risk coverage can also make the population more willing to pay, because people appreciate the fact that they acquire certain rights and have greater assurance that will receive the respective benefits.

Some analysts see additional advantages in this funding model, in that contributions are related to income. According to them, this makes benefits accessible to all individuals if one accepts an implied distribution from those with higher earnings to the poor or the unemployed. Others also argue that risks can be distributed not only among the population of a single generation, but among different generations.

Social insurance systems may also have some potential disadvantages. If they are universal and involve public financing, they are usually more expensive. Furthermore, the PAYGO type systems particularly generate a heavy financial burden for future generations, which will only get worse with existing demographic trends. Models based solely on contributions on wages, on the other hand, have a limited collection base, eliminating capital flows from sources of funding, which gives rise to equity issues when they contain redistributive components. Moreover, social security contributions could be perceived as a tax

on wages, especially when their benefits are not valued, or the ratio between premiums paid and individual risks breaks down, giving rise to distortions and losses of competitiveness in the labor market.

Financing on a tax basis, widely used in OECD countries, offers a broader collection base, by taxing labor and capital. Hence, companies perceive it to be more equitable, although this depends on the relative scale of the different types of tax. In international experience, this type of financing has entailed greater discretion in the eligibility and availability of services, which are also subject to the availability of public resources.

c) Target population and type of benefits provided

According to the OECD (2011), the majority of public programs for long-term care coverage are aimed at the vast majority of the dependent and disabled population. Notwithstanding the above, in some countries the target population is the segment over a certain age, like in Mexico, a country where there are multiple programs for senior citizens over 65.

In terms of benefits provided, programs in most of the OECD countries provide subsidies in cash and in-kind, as well as care at home and in specialized institutions.

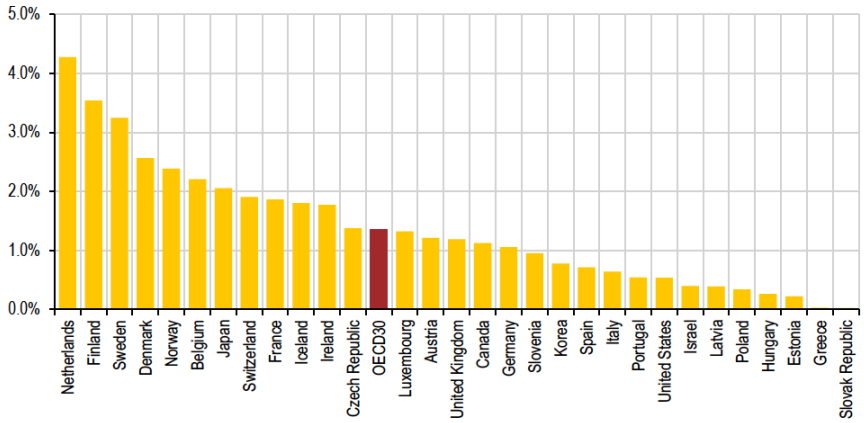
V. Trends observed in international experiences

The use of long-term care services for dependent or disabled individuals is growing and exerting pressure on the fiscal accounts of the OECD countries. Public expenditure on LTC exceeds 1% of GDP in the majority of countries, and 3% of GDP in some cases (Graph No. 5). There is also a growing trend of expenditure on this type of care, exceeding health care costs in these countries. Most of them are not sufficiently prepared for assuming the projected required costs of assisting the increasing number of senior citizens that population aging and the increase in life expectancy will generate.

Although systems have evolved towards universal coverage and models favoring designs that allow greater flexibility in the choice of benefits by users, such benefits have simultaneously focused on the neediest, thus ensuring greater equity and efficiency of the programs.

As countries get older, the existing "trade-off" between universally adequate basic coverage and the sustainability of programs becomes more evident. This is leading countries that fund their programs via PAYGO to consider the implementation of other financing systems that weigh the need for ensuring the sustainability of their programs and reducing the impact on future generations. Some possible methods that have been proposed are broadening the financing base of the programs, together with a greater focus on the eligibility of universal programs.

Graph No. 5: Public expenditure on LTC as a percentage of GDP, 2014 [(1)]



[(1)] Or the nearest year.
Source: Muir (2017).

On the other hand, private long-term LTC insurance plans for the elderly have little bearing on the coverage of such services, but their relevance will probably increase in future, given the need for making programs sustainable and safeguarding intergenerational equity.

VI. Reasons for the low penetration of private insurance

The low level of development of private dependency insurance markets is due to both demand and supply factors.

On the supply side, the financing of the costs of providing long-term care and the returns that insurance companies can obtain on the investment of the reserves established for backing up the payment of future benefits are subject to a high degree of uncertainty. Costs in particular can vary substantially in time depending on progress and improvements in health care and the evolution of life expectancy and disability and dependency rates. This makes it very difficult to estimate the statistical probability of requiring dependency care and estimating its long-term costs.

Other obstacles present in private markets for this type of insurance, hindering their development, originate in the asymmetry of information, which can lead to adverse selection and moral hazard issues. Given this situation, insurance companies protect themselves by limiting coverage and/or raising prices or introducing mechanisms for adjusting them in their contracts. For example, they reject people with pre-existing conditions, who increase the dependency risk.

On the other hand, the demand for dependency insurance is weakened by the customary myopia of individuals when planning and covering long-term financial risks, and the fact that they usually consider such risks to be very

remote. The perception of individuals that they will be supported by the state should they become dependent, could also be a factor that reduces demand.

Added to the above is the fact that the pricing of private insurance depends on the risks posed by individuals applying for dependency insurance, resulting in premiums that are difficult to finance for mid and low-income individuals. This cohort, along with others that have insufficient income or no income at all, such as the unemployed or inactive individuals, require public subsidies for accessing or being covered by the respective insurance.

The aforementioned adverse selection and moral hazard issues can be addressed by making it mandatory to take out insurance or establishing mechanisms that increase their coverage. Low-income individuals and those who are more likely to face situations of unemployment and inactivity, or who have pre-existing conditions, can be subsidized to decrease the likelihood of failing to access or losing their insurance coverage.

However, the issue of uncertainty regarding the costs of providing financial coverage for long-term dependency persists, which can lead providers to charge excessive premiums. International experience reveals some possible ways of reducing the problem, such as moderate basic insurance coverage, or designing a compensation-type insurance instead of reimbursement of expenses. In fact, according to the OECD (2011), the dependency insurance industry in some member countries is moving towards products that provide monetary compensation that policyholders can use as they see fit.

VII. Experiences and proposals in specific countries

a) Singapore[3]

The public policies implemented in this country show that long-term dependency care can be financed with public and private funds, including government subsidies with means testing especially targeting low income residents, government concessions to LTC services providers for reducing their prices, donations, voluntary insurance and other resources of the beneficiaries and their families. Among the outstanding features of the model implemented in Singapore, is the LTC insurance coverage, which is among the highest in the world, covering 65% of individuals between 40 and 83 years of age, and the possibility of using the savings in individual health savings accounts for financing part of these insurance premiums.

Calculations by Graham and Bilger (2017) show that 40% of expenditure on long-term care and services are financed by the beneficiaries and their families; 42% with government funds; 9% with donations; and 9% with insurance covering long-term care. These percentages reflect some of the main features of the coverage policies implemented in the country, which seek, on the one hand, to emphasize the primary role of families in the provision and financing of long-term dependency

[3] This section is entirely based on Graham and Bilger (2017)

care costs and, secondly, that insurance is not the most important source of such financing. To back up these policies, the government has taken care to generate realistic expectations regarding the role of insurance.

The Government of Singapore has also avoided implementing a social insurance system for covering the dependency contingency that entails the intergenerational transfer of subsidies, which is inherent in the PAYGO-type programs. At the same time, it states that this is not inconsistent with the application of policies that help lower-income sectors. In fact, the country's social security system provides assistance for the financing of long-term care, mainly through subsidies that aim to reduce the costs generated by beneficiaries and their families. The amount of these subsidies is inversely proportional to household incomes. To limit intergenerational transfers, the Government seeks to fund public subsidies using income from trust funds built with budget surpluses.

As previously noted, part of the financing of LTC programs in the country comes from private revenue, insurance and savings. In Singapore, there are mandatory savings accounts that are managed by the Central Provident Fund (CPF). Accumulated savings belong to individuals, without any kind of redistribution. Contributions to health savings accounts (Medisave) fluctuate between 8% and 10.5% of total wages. These funds can be used to pay hospitalization expenses, a small number of ambulatory expenses associated with chronic diseases, and health insurance within limits determined by government subsidy rates.

LTC insurance is relatively new in Singapore. Automatic enrollment insurance has been in place since 2002 (LTC Eldershield). It was created by the Government after it concluded that the best way to financially protect itself against catastrophic expenses due to low probability but high-cost severe disability, is partly by means of insurance. Basic schemes of this type cover 65% of residents between 40 and 83, while 22% have complementary coverage.

Basic coverage is limited, providing a cash benefit close to us $ 300 per month for six years, regardless of the degree of disability, as long as the minimum eligibility requirements are met. Its purpose is not to provide all the necessary financing for covering LTC expenses, but merely to contribute to covering them by means of insurance with affordable premiums for most people, providing a high degree of coverage among the population, without forcing people who can depend on informal care or other available resources to take out excessive insurance coverage. Government subsidies also provide additional funding for low income individuals. This basic insurance also has the advantage of generating greater awareness of the need for coverage to address LTC expenses. Some describe Singapore’s dependency insurance as a system that achieves high coverage at the expense of less generous benefits.

Higher income individuals can choose to take out complementary plans with

higher levels of coverage. In case of contingencies, these plans pay amounts ranging between approximately USD 370 and USD 3,700 per month.

Benefits are not protected against inflation and there are no limitations on how the monies received are used; neither is it mandatory to hire specific providers approved by governmental agencies.

All residents with Medisave are automatically enrolled in the basic plan when they turn 40, even those with pre-existing medical conditions, provided that they do not have serious limitations in performing the basic activities of daily life. The insured can apply for benefits at any age once they have enrolled in the program. Simulations have estimated that in 2015, 3% of individuals over 65 had three or more limitations in performing the basic activities of daily life, which is a condition for eligibility.

New members are randomly distributed among three private insurance companies, commissioned by the Government to provide basic and complementary coverage via competitive bidding. Contracts are subject to renewal every five years, when insurers must return the excesses of collected premiums to the insured. Basic plans have the same characteristics for all policyholders, while companies have the sufficient freedom for defining the design and marketing of complementary insurance, including the benefits payment period, which can be for life. Companies that provide the basic plan do not have to be the same ones that provide the complementary plan.

New members are free to opt out of the insurance within the first three months. When Eldershield was launched in 2002, the opt-out rate was 33%, but it dropped to 14% in 2016. Those who opt out can return later, although subject to evaluation. Moreover, policyholders can switch insurers at any time, without any penalty if they do so within the initial 90-day period in which they can opt out of the program. If they opt out later on, they are subject to evaluation by the new company and lose the premiums paid to the original insurer.

As a basic principle, all residents without serious limitations are subject to the same annual premium when they are automatically enrolled in the basic plan. These premiums vary between approximately USD 130 and USD 160 for men and women, respectively, and are paid up to age 65. Annual premiums are defined by age and risk level on enrolment. The savings accumulated in individual health accounts (Medisave) can be used to pay the insurance premiums, with a limit per member. Those who do not have sufficient funds in their savings accounts can use the savings of their close relatives or in other accounts belonging to them. Although Singapore law allows the adjustment of the premiums and benefits of existing policies, an accelerated growth of premiums has not been observed.

Coverage is not associated with employment, so it remains valid in case of job changes. Policyholders have a grace period of 75 days without premium payments before losing coverage, and they can also be reinstated within 180 days after the grace period.

The government created a means-tested cash grant program to ensure access to benefits for people who were not eligible when Eldershield was launched due to severely disability or because they were 70 or older.

The main lessons learned from the coverage model implemented by Singapore are the following:

- Generation of clear expectations by the Government regarding insurance benefits.

- Default automatic enrollment, although subject to evaluation; individuals with serious limitations are excluded. Individuals with certain chronic illnesses may enroll if they accept higher premiums. It is estimated that automatic enrollment is probably the main factor explaining the high coverage of dependency insurance in Singapore.

- Determining a basic insurance coverage that is affordable for the majority of people and that can be partially paid with the savings accumulated in the Medisave plan. It is estimated that this has reduced the insurance opt-out rate.

- Reduction of the problems generated by adverse selection, with enrollment starting at age 40. An additional advantage of enrollment earlier on in life is the increase in savings time (pre-funding).

- Submission of applications for benefits from the time that people enroll, which makes default enrollment more attractive.

- Definition of the benefits in the form of cash payments, which has simplified the system. This can also cause some problems, because experience shows that this form of payment can increase requests for benefits from policyholders and the monies received may not be spent on LTC.

b) Proposal for encouraging the creation of a severe dependency insurance in Chile.

The Latin American Center for Economic and Social Policy (CLAPES UC) presented a series of proposals for extreme-old-age individuals with severe dependency in Chile in a recently published book (2018). These proposals included the promotion of insurance to address dependency in extreme old age.

The insurance proposal considers the following basic principles:

- Coverage of expenses arising solely as a result of loss of physical or intellectual capabilities resulting from severe dependency in old age;
- Prioritization of most urgent and basic needs;

- Voluntary enrollment;

- Financing of those wishing to enroll via co-payment;

- Private administration; and,

- Develop protocols and allow the intervention of medical committees.

The CLAPES book also proposes the following complementary measures aimed at individuals at an advanced old age with severe dependency.

- Promulgate a severe dependency law to facilitate the implementation of proposals in this field;

- Reformulate existing home care programs to strengthen the public-private partnership and establish control of monetary aid provision;

- Create a subsidy for severely dependent individuals living in old age homes, financed with contributions and aimed at helping these homes.

- Expand the coverage of day care centers that attend to severely dependent individuals who are not prostrate, in order to facilitate the incorporation of their caregivers into the labor market; and

- **Promote teleworking for the benefit of senior citizens being cared for and their caregivers.**

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