1. Long Term Care Benefit - General

The long-term care insurance plan was approved by the Knesset in 1980 within the framework of the National Insurance Law, and came into effect in April 1988. Long-term care insurance is designed to enable the elderly to continue living in the community for as long as possible by providing personal care to those requiring assistance for daily functions or supervision, and assisting families caring for them. The Law applies to anyone who is insured under old-age and survivors' insurance, homemakers (married women who do not work outside the home) and new immigrants who are not insured under old-age and survivors insurance.

All elderly persons, Israeli residents living in the community (at home, spouse's home or assisted living) are eligible for the long-term care benefit if their physical or cognitive functioning is impaired and they satisfy the means-test pursuant to the Regulations. Those residing in a nursing home or long-term care ward in an old-age home are not eligible for the benefit. The means-test examines the elderly person and his/her spouse's income only. The Law distinguishes between those receiving the benefit in-kind (see Section 6 below) and those receiving the benefit in cash since they cannot be provided a service (benefit in-kind). The latter undergo a means-test similar to that conducted for those receiving the benefit in-kind. As a condition of receiving the cash benefit, the income of the relative caring for the elderly person and residing with him/her is also examined.

The long-term care benefit for the most part is not paid in cash, but is given to those eligible in the form of services by organizations which the NII pays (benefit in-kind); personal care or supervision at home, transport and personal care at a day-center, providing absorbent products, laundry services and funding the utilization of panic buttons. Since June 2014, those eligible for a benefit in cash can receive additional services as part of the benefit.

The Dependency Test (Activities of Daily Living)

The dependency test (ADL) assesses the degree of assistance a person requires to perform basic daily actions: bathing, dressing, mobility (moving around the home and preventing

falls), toileting and feeding (including ability to heat food and drink). The dependency test also assesses the need for supervision due to impaired cognitive ability, deterioration in mental health or due to a physical condition. The dependency test for a third party's assistance is executed by professional assessors - nurses, occupational therapists and physiotherapists who undergo suitable training.

Whoever has reached 90 years of age can undergo a dependency test by a geriatric doctor as part of his/her public health work, at his/her clinic or in the claimant's home.

Box 1

Changes In The Dependency Assessment Following The Ben Yehudah Committee [1]

Half way through 2012 a Committee was appointed headed by Prof. Arieh Ben Yehudah, Clinical Lead of the Internal Medicine Ward at Hadassah Ein Kerem and an expert in Geriatrics, to examine the dependency test for the long-term care benefit (and the attendance allowance for general disability insurance). The members of the Committee consisted of additional geriatric expert doctors, representatives from the Ministry of Health and Welfare, academia representatives and the National Insurance representatives. The Committee was established on the backdrop of the public scrutiny relating to the dependency tests for the long-term care benefit and attendance allowance, and as part of the Institute's response to such scrutiny[2].

During the course of 2013 the Committee published its conclusions[3], and in respect of the long-term care it was decided to leave the dependency as is, however to make several changes thereto to improve it. The National Insurance made the proposed changes in August 2014, including the awarding of points in several fields without the need to accumulate points in other fields:

- Examinees who are completely dependent on others due to mobility difficulties or treating secretions receive a score making them eligible for a benefit at a level of 150% (168% for individuals).
- Examinees requiring constant supervision according to the new questionnaire that was integrated into the dependency assessment receive a score making them eligible for a benefit of the highest level, as in the past, and their dependency to perform ADL (Activities of Daily Living) is not examined.

1 Credit to Irna Zamir, Head of the Long-Term Care Department at the National Insurance Institute, Asher Battleman of the Long-Term Care Division and Roni Dinor, National Supervisory Nurse of the Long-Term Care Division who assisted in preparing the box.

2 The National Insurance Institute – Long-Term Care Division: Tools to perform the dependency assessment - Ben Yehudah Committee, Letter 283, July 3, 2014.

3 The National Insurance Institute: The Committee Report on examining the long-term care and attendance allowance test tools within the framework of the National Insurance Institute, April 2013.

- Individual blind persons are eligible, at the very least, to a benefit of the lowest level[4].

Breakdown Of Examinees According To Gender And Age

A comparison of the test results (only those performed by the Institute's assessors in the claimants homes), shows that the breakdown pursuant to gender and age before the changes were introduced in the dependency test and after the changes were introduced, are similar.

Table 1

The Examinees In The Dependency Tests According To Gender And Age - Before And After The Reform

	All The Dependency Tests	
	2013	2015
Gender		
Women	71.2%	70.3%
Men	28.8%	29.7%
Total	100.0%	100.0%
Total (N)	116,255	119,956
Age Group		
Up to 64	3.3%	3.2%
65-69	10.3%	10.8%
70-74	17.3%	16.1%
75-79	25.3%	25.5%
80-84	24.0%	24.0%
8-89	15.1%	15.3%
90-94	3.9%	4.4%
95+	0.7%	0.7%
Total	**100.0%**	**100.0%**
Total (N)	**116,255**	**119,956**

Table 2

Average And Median Age Of Examinees Pursuant To Gender - Before And After The Reform

	Average Age	Median Age
Pre Reform		
Total	**78.57**	**78.78**
Women	77.88	78.14
Men	80.29	80.29
Post Reform		
Total	**78.72**	**78.97**
Women	78.04	78.38
Men	80.35	80.34

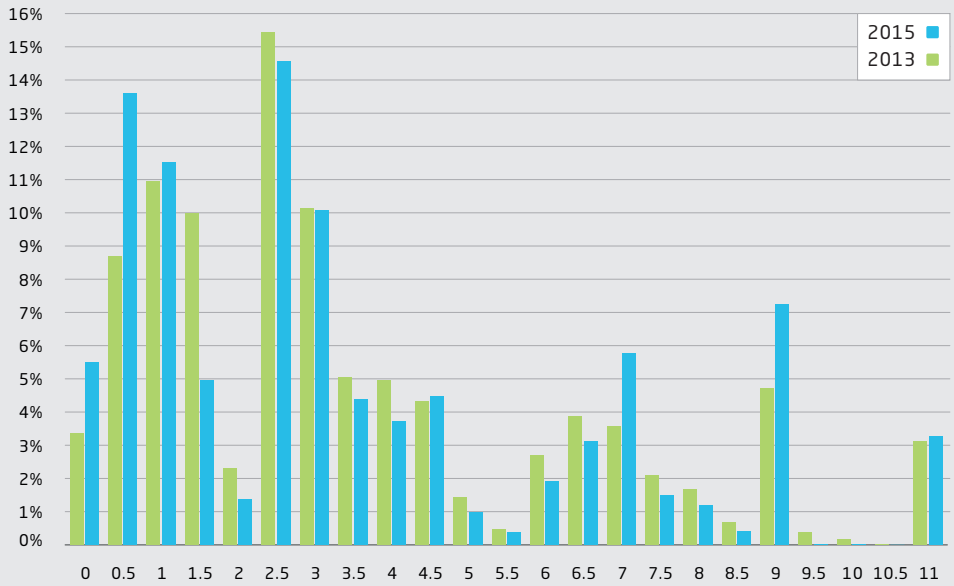
4 The National Insurance Institute – Long-Term Care Department: Dependency Assessment Form (NI 2610 Revision 7/2014), General Memo 12/2014, Long-Term Care Memo 1431, August 3, 2014.

The Assessment Results: Final Score

After introducing the changes in the dependency test the recommendation rate to dismiss the claim grew, however the assessments with a high score (7 or 9) also grew.

Chart 1

The Final Dependency Scores - Pre and Post Reform



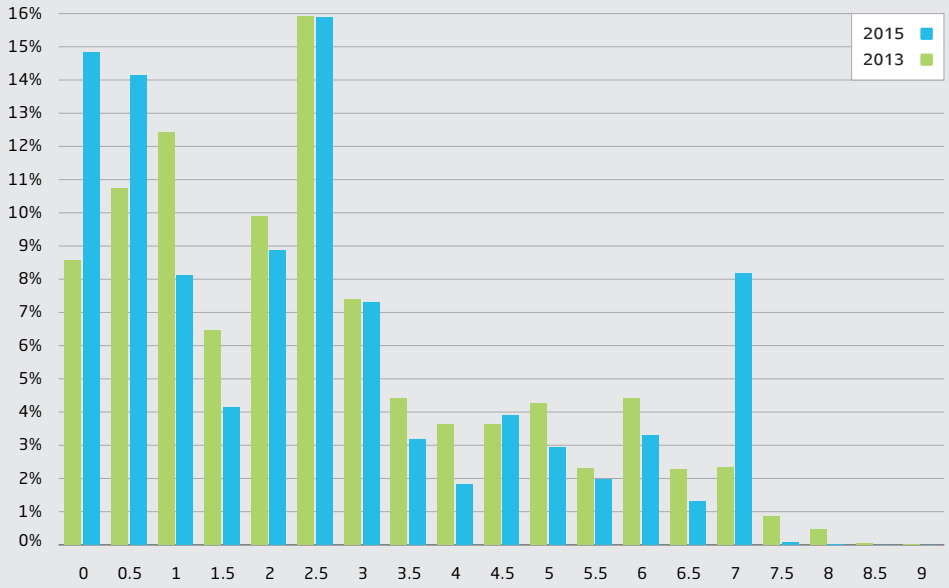
The Assessment Results: The ADL Scores

Pursuant to the new guidelines, no ADL score was recorded for those eligible for constant supervision, and therefore a comparison was made between 2013 and 2015 between the assessments in which eligibility to constant supervision was not granted (108,561 in 2013 and 111,675 in 2015). From the results it appears that there was a slight decline in the number of recipients of the minimum score necessary for eligibility - 2.5 points for those who were not single - and 2 points for single - as opposed to the period preceding the changes. On the other hand, the rate of those eligible who received a score of 7 - some for the maximum points in the mobility at home or treatment of secretions - there was a considerable increase.

In the event of maximum score for treating secretions, if comparing the period before and after the change, the score 2.5 points and the 3 points (maximum score before the change) was substituted with 7 points. In 2013 (before the change) 13,257

Chart 2

The ADL Scores - Pre and Post Reform



eligibility decisions received 2.5 or 3 points for this section[5], in which only 3,191 eligibility decision received a sum of 7 points in the ADL test (accumulative score in the dressing, bathing, feeding, movement at home, falls and treating secretions fields), - 24.1%, respectively (see Table 3). We will therefore see that the change made

Table 3

The ADL Scores For Persons Severely Disabled In The Treatment Of Secretions Section Before The Reform (2013)

Total Score For ADL Pre Reform	Score For Treating Secretions		
	2.5 Points	3 Points	2.5 Or 3 Points
Less than 7 points	73%	20%	49%
7 points	19%	31%	24%
More than 7 points	8%	49%	27%
Total	100%	100%	100%

5 For comparative purposes, in 2015 only one third of this number received the maximum score of 7 point in this section. Nonetheless, it is noted that the dependency test in the mobility section was examined before the treating of secretions, and if the maximum score was given to treat secretions this was not examined. This being the case one can assume that the number of persons eligible for the maximum score for treating secretions had they been examined - would have been higher.

to the dependency test tool increased the 7 points recipient rates in the ADL part and reduced the other high score rates. Table 3 shows the breakdown of the total score for ADL for those receiving 2.5 or 3 points in 2013.

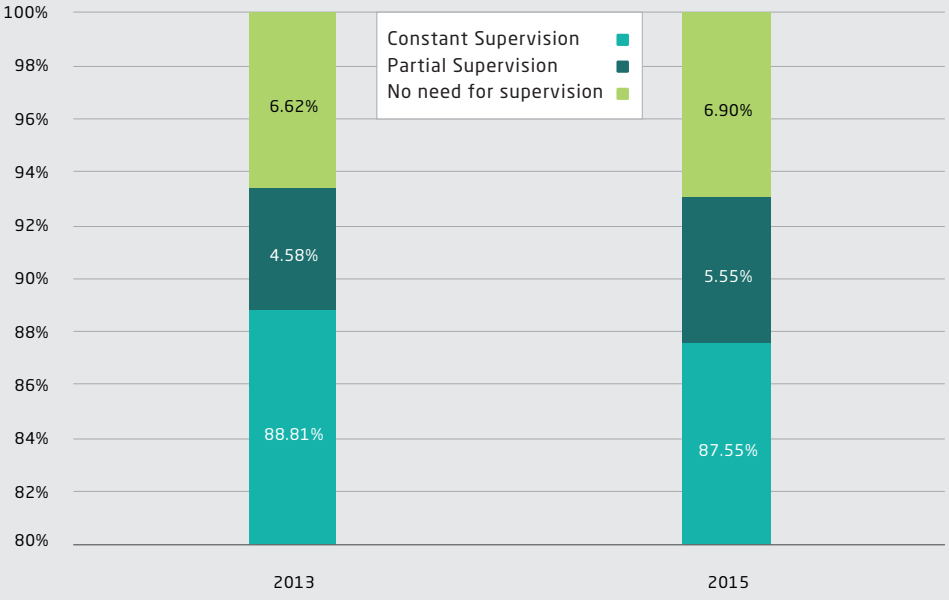
Nonetheless, one should remember that the range entitling a benefit at the medium level, 150% is 6-8.5 points and that single persons receive a supplement of 2 points from the 7 points entitling a benefit at the high level, 168%.

The Assessment Results: The Need For Supervision

The number of examinees who received a score for the need for constant supervision or partial supervision decreased only slightly post reform and therefore it is difficult to attribute this to the affect thereon (Chart 3).

Chart 3

The Need For Supervision Scores In All Assessments - Pre And Post Reform



Following the Committee's recommendations, the National Insurance introduced complementary changes that also affected the number of eligible persons, for example simplifying the tests, primarily in the dressing field. Thus, for example whoever finds it difficult to put on socks before the change received one-half a point, and after the change never received any points (Table 4). all the comparisons of the score results in 2015 in comparison with 2013 indicates that the number of persons who did not receive a score in the dressing field or receive 1 point in 2015 increased, and in

all cases the number of persons receiving a half point in 2015 as opposed to 2013 decreased- i.e. the meaning of the score as an expression of dependency became clearer.

Table 4

Clothing Score - Pre and Post Reform* (Percentages)

Total Score	2013			2015		
	Score: 0	Score: 0.5	Score: 1	Score: 0	Score: 0.5	Score: 1
Up to 2 points (100%)	62.1	31.6	6.2	90.8	1.2	8.0
2 points (100%)	3.9	47.0	49.1	12.0	4.9	83.0
2.5 points (100%)	0.7	12.0	87.3	3.6	2.1	94.4
All of the dependency assessments (100%)	22.4	16.1	61.5	48.5	2.8	48.6

* The score includes the supplement for a single person if given. The meaning of the data in this table is that the changes made to the dressing test has an effect on the threshold score necessary to be eligible in the long-term care system - 2.5 points.

2. The Benefit Levels

In January 2007 three levels for the long-term care benefit were determined which correlate with three levels of dependency: a benefit of a rate of 91% of the full disability pension for a single person - to fund 9.75 hours of care at home per week, 150% for 16 hours and 168% for 18 hours of care at home per week.

A Single Person Claimant is eligible for a full long-term care benefit according to the dependency level that was determined, if his income does not exceed the average wage (NIS 9,260 in 2015), and one-half the benefit - if his income is higher than the average wage and up to 1.5 times the average wage. If his income is higher than 1.5 times the average wage, he is not eligible for a benefit.

A Claimant with a Spouse is eligible for a full benefit if the shared income does not exceed 1.5 times the average wage, and to one-half the benefit if his/her income is higher than 1.5 times the average wage and up to 2.25 times the average wage. A couple whose income is higher than 2.25 times the average wage is not eligible for a long-term care benefit. When a couple files a claim for a benefit, their shared income is divided by two and the means test is executed for each of them as if they were single.

In January 2015 and January 2016, the long-term care benefit was not revised since consumer prices did not increase in 2014 and in 2015.

Those receiving the long-term care benefit at the two highest levels hiring Israeli workers only, and who do not hold a valid permit to hire a foreign worker, are eligible for additional hours per week: three hours for those receiving a benefit at a rate of 150% and four hours for those receiving a benefit at a rate of 168%. Whoever is eligible to one-half the benefit due to income, is eligible to one-half the extra hours according to the dependency level determined.

Temporary Eligibility

The long-term care benefit is given to those eligible as a permanent or temporary benefit. Where an improvement in functioning is foreseen (for example following a hip replacement operation or after a stroke that happened a short time before the test), a temporary benefit is given for six months. For those 80 years old and older a dependency test is executed again around the time the temporary period ends; for those younger than 80 eligibility ends at the end of the period without a test unless they asked to be tested. When in doubt, the benefit is given temporarily. Similar to the permanent benefit, the temporary benefit starts on the 1st of the month after the claim is filed.

Those discharged from hospital, usually due to orthopedic problems or operations, and not eligible in the past for the long-term care benefit, may claim and receive a benefit for two months, pursuant to the documents that are filed (**short term fast route**) or if the individual is dependent on another, pursuant to the dependency test. Eligibility in such a case starts after the claim is filed, even during the course of the month. In contrast with regular temporary eligibility, this benefit is given where a considerable improvement is foreseen short-term, and therefore no additional dependency test is performed at the end of the eligibility period. An eligible person who is of the opinion that his/her functioning has not improved, may file a claim again at any time during the eligibility period for the short-term benefit also.

3. Legislative and Administrative Changes

Changes in Dependency Scoring

Since March 2015, an added score is given to a single claimant residing with a spouse 90 years old and older, even if the spouse is not eligible for the long-term care benefit. The assumption is that at this age it is very difficult to assist a person eligible for a long-term

care benefit. Since July 2015 situations were defined in which an added score as a single person is given without conducting an additional functioning assessment, for example in the event a spouse dies or to grant a long-term care benefit to a spouse[1] as well. Nonetheless, as in the past, the score as an individual without conducting a functioning assessment is not deducted.

Payment of Cash Benefit

Since October 2015, those eligible for the benefit may choose to receive a benefit in cash provided their long-term care services are supplied by a caregiver who is not a relative, six days a week, 12 hours a day at least. The benefit rate is 80% of the benefit in-kind rate. A trial accompanied by a study preceded the change in the Law from March 2008 to June 2015.

4. Claims for a Benefit and Deterioration Applications

Claims for a benefit

The number of claims for long-term care benefits (including pending claims) increased in 2015 by 2.9% in comparison with 2014 and reached 85.4 thousand; 39.6% of which were initial claims and 60.4% - repeat claims (Table 1). The number of initial claims increased by 0.4%; 52.2% were approved (47.8% were rejected). The number of repeat claims increased by 3.3%; 37.3% were approved (62.7% were rejected).

The number of futile claims by those ineligible for the benefit before filing the claim (claims receiving a score of 0 or 0.5 in the ADL section of the dependency test[2], where no eligibility was determined for supervision) of all the claims for which a dependency test was performed, increased from 32.0% in 2014 to 37.6% in 2015. Those receiving 2.5 points in the dependency test - the eligibility threshold for the benefit - of all claims decreased from 17.4% to 17.0% between the two years. The number of futile initial claims increased from 28.4% to 32.3% and repeat claims from 34.3% to 40.9%. Those receiving 2.5 points in the dependency test in initial claims remained 18.1%, and in repeat claims decreased from 17.0% to 16.4%.

1 A couple who are both eligible for a long-term care benefit receive the additional score as a single person in addition to their dependency scores.

2 See **Annual Review 2011**, Page 125.

Table 1

Claims Filed, Claims Approved, Initial and Repeat Claims*
(Absolute Numbers and Percentages), 2011-2015

Year	Total Claims (Absolute Numbers)	Annual Increase Rate	Percentage of Approved Claims	Percentage of Initial Claims Approved	Percentage of Repeat Claims	Percentageof Repeat Claims Approved
2011	79,468	2.1	44.9	52.0	61.1	40.3
2012	80,769	1.6	46.8	55.0	59.5	41.3
2013	83,084	2.9	44.4	53.4	59.4	38.2
2014	82,992	-0.1	43.0	51.6	60.6	37.4
2015	85,437	2.9	43.1	52.2	61.2	37.3

* Initial eligibility claims are presented. Total claims do not include those not completed in 2015. The rates of claims according to their results only include those dealt with in 2015.

Deterioration Applications

Those eligible for a long-term care benefit at a low and medium level who believe that their dependency upon others has increased to such a degree that necessitates the benefit level to be increased, can file a deterioration application including a new dependency test.

In 2015, 39,253 deterioration applications in respect of permanent eligibility decisions were filed (including applications that are still pending) - a decrease of 0.5% in comparison with 2014 (Table 2). For 48.7%, it was decided to increase the benefit and for 1.3%, the benefit was reduced or cancelled (as opposed to 47.0% and 1.4% respectively in 2014).

Table 2

Deterioration Applications and the Results*
(Absolute Numbers and Percentages), 2011-2015

Year	Total Deterioration Applications (Absolute Numbers)	Annual Increase Rate	Benefit Increased	Benefit No Change	Benefit Reduced	Benefit Cancelled	Total
2011	35,445	0.7	46.2	52.6	0.4	0.9	100.0
2012	37,669	6.3	47.9	51.0	0.3	0.7	100.0
2013	39,321	4.1	45.8	52.9	0.4	0.9	100.0
2014	39,453	0.6	47.0	51.6	0.4	1.0	100.0
2015	39,253	-0.5	48.7	50.0	0.4	0.9	100.0

* The total number of applications does not include those from people who have died or whose eligibility was suspended, and includes applications still pending in 2015. The rates of applications according to their results only include claims whose handling ended in 2015.

5. Scope and Characteristics of the Eligible

Scope of those Eligible

The number of persons eligible for the long-term care benefit continued to grow in 2015 and reached 160.8 thousand on average per month - an increase of 1.0% (Table 3). In 1991-2015, the number increased 5 fold notwithstanding the higher eligibility age. This is the highest growth rate and is considerably higher than the growth in the number of elderly at that time. A possible explanation for this may be a rise in uptake of rights to the allowance in light of an increase in awareness. In 2009, the eligibility age for women was 62 and will remain so until the end of 2016. In 2009, the eligibility age for men stopped rising when it reached 67. In 2015 like 2014, the eligibility age for men and women did not change from the beginning to the end of the year.

The eligibility age for long-term care benefits among the elderly increased by approximately 6% in the first years of the Law's operation until it peaked at 17.6% in 2012, and since then the trend declined: to 17.0% in 2014 and 16.6% in 2015 (according to an estimate). Factors for the decline in the number of eligible persons are an accelerated growth in recent years in the number of younger elderly (aged 60+ reaching retirement age), their relative proportion of all the elderly, and the fact that they are not eligible for the long-term care benefit since they are healthy and function well.

Table 3

Those Eligible for Long-Term Care Benefits, Elderly in Israel and the Cover Rate, 2011-2015

Year	Eligible For Long Term Care*		Elderly In Israel**		Cover Rate***
	Numbers (Thousands)	Annual Increase Rate	Numbers (Thousands)	Annual Increase Rate	
2011	144.9	2.7	840.3	3.4	17.2
2012	152.1	5.0	861.9	2.6	17.6
2013	156.2	2.7	895.3	3.9	17.4
2014	159.2	1.9	934.2	4.3	17.0
2015	160.8	1.0	967.8****	3.6	16.6

* Monthly Average.
** The data for the years 2011-2015 is for men aged 67 and older, and women aged 62 and older, according to Central Bureau of Statistics data.
*** Number of those eligible for benefit as a percentage of the number of elderly.
**** Estimate.

Box 2

Temporary Eligibility for Long-Term Care Benefit[1]

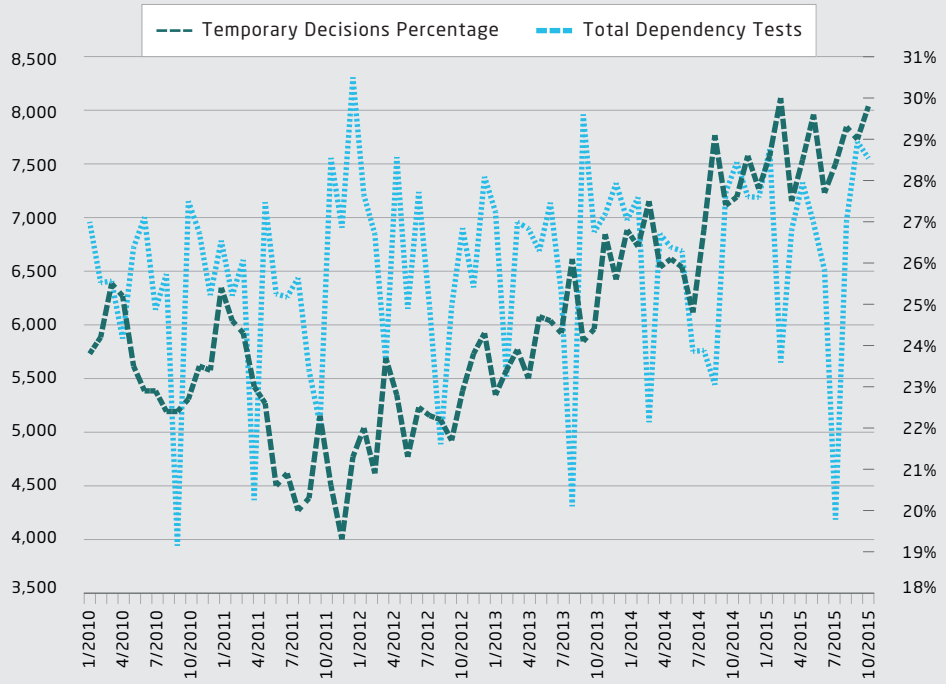
In this box we will display the results of the trend review relating to claims for long-term care benefits that were approved temporarily - where there changes, and if so, did this affect the growth rate of the benefit recipients.

Decisions

In 2012-2015 the number of decisions relating to temporary eligibility increased of all the eligibility decisions in the long-term care insurance (Chart 1). In November 2011 the rate was lowest in this period - 19.3%, and in April 2015 the highest - 30%. It is noted that only after March 21, 2016 was it possible to be awarded temporary eligibility that was not short-term and at all benefit levels based on documents (**fast route**).

Chart 1

Eligibility Decisions And Temporary Eligibility Decisions, January 2010 - December 2015



1 Credit to Irna Zamir, Head of the Long-Term Care Department at the National Insurance Institute, and Roni Dinor, National Supervisory Nurse of the Long-Term Care Department who assisted in preparing the box.

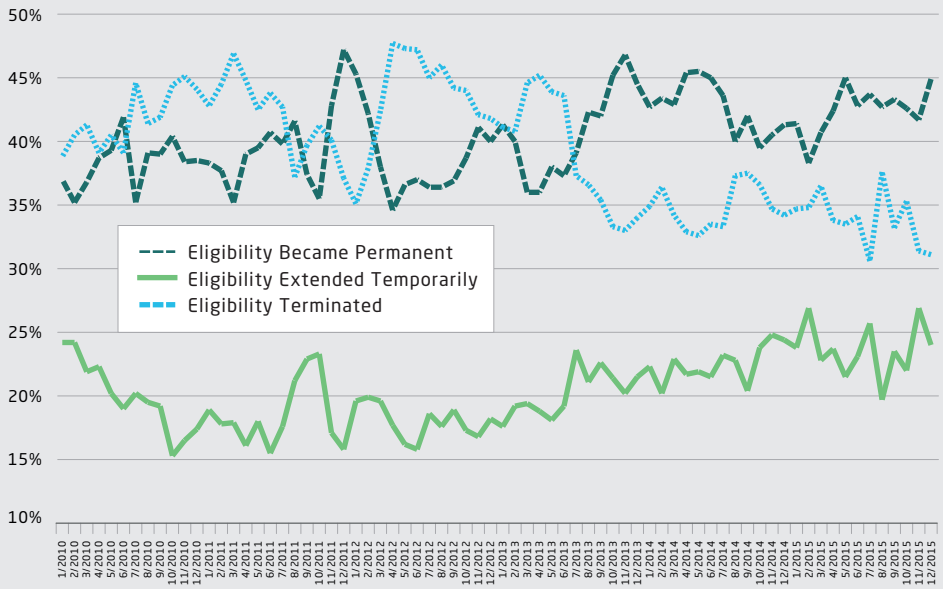
At the end of the temporary eligibility, three options are possible: the eligibility ends, temporary extension of eligibility, eligibility becomes permanent. If eligibility is extended, the benefit level depends on the result of the new dependency test.

The number of cases where eligibility was extended temporarily increased from 18.9% of all decisions in June 2012 to 27.0% in November 2015 (Chart 2). Until mid-2013 the number of permanent eligibility decisions was usually slightly lower than the number of decision to end eligibility, however since then the trend has reversed and the permanent eligibility decision was higher than the ending eligibility decisions - 45.2% as opposed to 30.8% in December 2015.

During the years 2010-2014, approximately 14 thousand of approximately 80 thousand eligibility decision were temporary following earlier temporary eligibility decisions.

Chart 2

Eligibility / No Eligibility Decisions For Benefit At The End Of The Temporary Eligibility Period



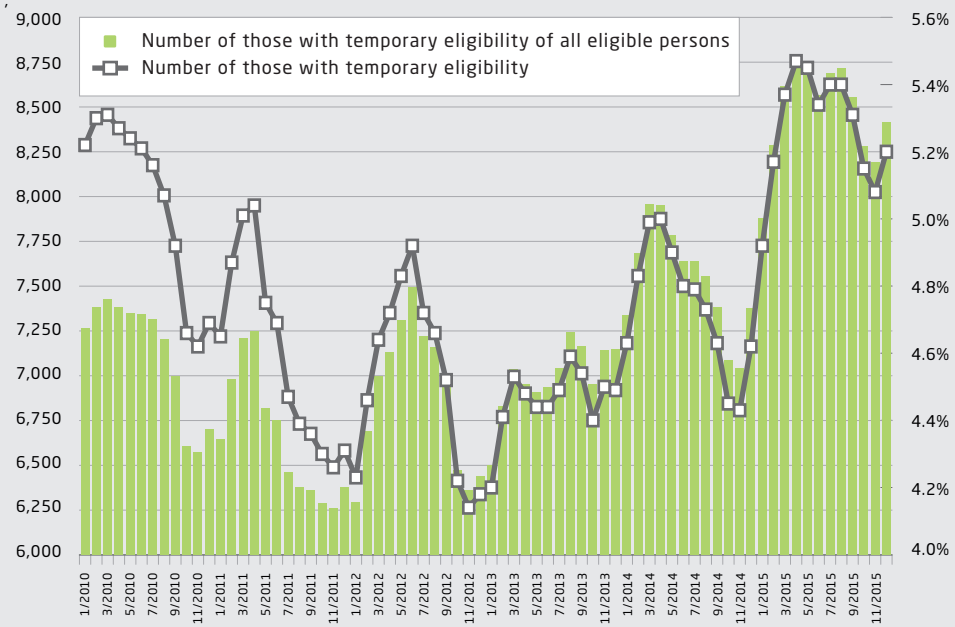
Eligibility for Benefit

At any given time, those temporarily eligible for the long-term care benefit constitute a small minority of all eligible persons since following a short period of time some of them stop receiving the benefit and some receive a permanent benefit. The number of those persons with temporary eligibility and the rate of all persons eligible changed

between the years 2010-2015 (Chart 3). In 2015, the number of all persons eligible to the long-term care benefit increased and peaked in April: 8,781 were eligible for the temporary benefit in this month, and constituted 5.47% of all persons eligible to the benefit.

Chart 3

Temporary Eligibility As A Percentage Of All Persons Eligible For Long-Term Care Benefit

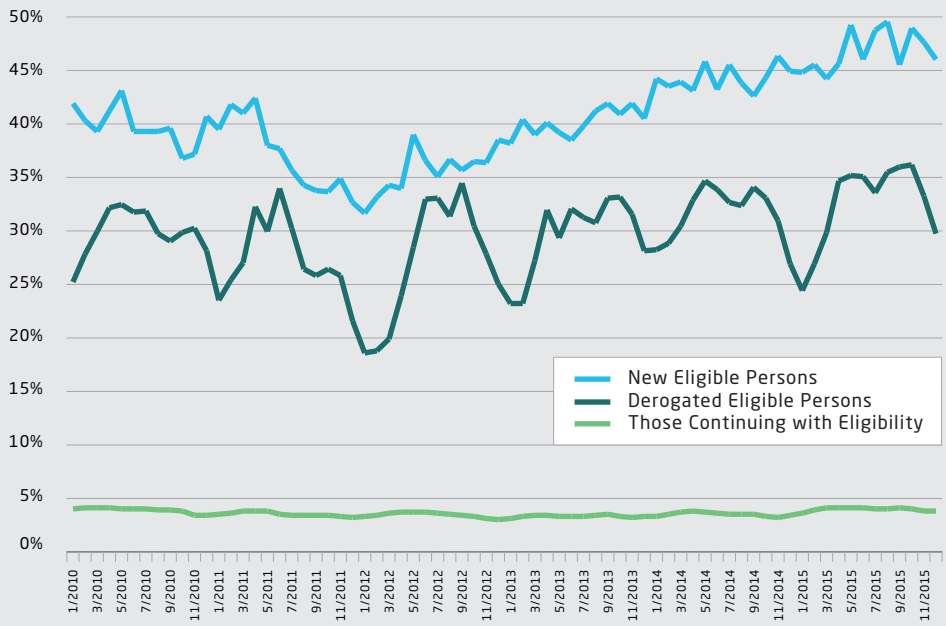


Those Detracted And Those Added

Although the number of persons with temporary eligibility constitute a very small minority of all those eligible at any given time, they constitute a much higher percentage among those being added or detracted from the system. Chart 5 presents the percentages in three eligibility groups: those continuing to be eligible (received a benefit in a given month and during the months before and after), new eligible persons (never received a benefit in the month before) and those no longer eligible (never received a benefit after the given month). Whereas among those whose eligibility continues the number was stable, among new eligible person the number increased from the beginning of 2012 and those who were detracted the number increased more moderately at the beginning of 2013.

Chart 4

Number Of Those With Temporary Eligibility Of All Eligible Persons, Those Continuing To Be Eligible, Those Detracted And New Eligible Persons



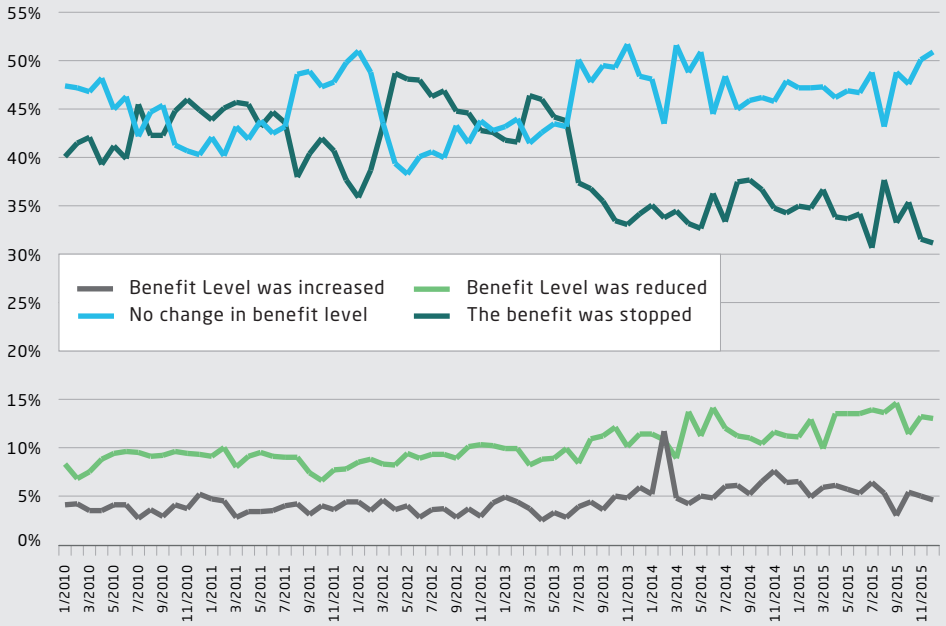
Type Of Benefit Following Temporary Benefit

As stated above, temporary eligibility is given in cases where an improvement is expected in the person's health to warrant the benefit being stopped, even though it refers to the elderly and in many cases their condition does not improve over time. By mid-2010, more than 40% of the temporary benefits were stopped. From mid-2013 the percentage of the number of temporary benefits that were stopped decreased to approximately one-third (Chart 5). Parallel, by mid-2013 the cases where the benefit level was reduced further to receiving a temporary benefit constituted less than one-tenth of the cases, whereas from the second half of 2013 they constituted approximately one-eighth of the cases.

Until mid-2013 in approximately 40%-50% of the cases the eligibility period for the long-term care benefit was extended permanently or temporarily after receiving a temporary benefit of the same benefit level, and from the second half of 2013 the number these cases increased slightly and was in the range of 45%-50% (Chart 5). Broadening the use of the temporary benefit in recent years led to an increase in the number of temporary benefits that were extended permanently or temporarily. The

Chart 5

Decisions Made After Temporary Benefit



number of temporary benefits becoming permanent or temporary at a higher benefit level between 2010-2015 remained approximately 5% (Chart 5).

In the years 2010-2015, approximately 100.7 thousand decisions were made pertaining to temporary eligibility following temporary eligibility: in approximately 39.7 thousand cases the temporary benefit was not extended, in approximately 40.4 thousand cases it became permanent, and in approximately 20.6 thousand cases it was again temporarily extended. In 95.2% of the cases eligibility in which eligibility was not extended, the benefit level was the low level (91%). Among the recipients of a permanent benefit following a temporary benefit in these years, 71.5% received a benefit of the same level, 21.0% of a lower level and 7.5% received a benefit of a higher level. Among the recipients of an additional temporary benefit, the rates were 84.9%, 8.3% and 6.9%, respectively.

Temporary Benefit According To Various Characteristics

The breakdown of the eligibility decisions for the period between January 2010 and December 2015 shows that the number of women eligible for a temporary benefit was considerably higher than the same number of women eligible for a permanent

benefit - 76.7% as opposed to 66.1%. The main reason being the age of the women and men at the time the decision was made: the average age for women receiving temporary eligibility was 74.4 and men 76.5; the average age of women receiving permanent eligibility was 81.1 (82 for men). The median ages were similar in all cases for the average ages.

The average age of persons who stopped receiving the temporary benefit was 74.4: men 76.5 and women 74. The average age of persons whose temporary benefit was extended were slightly lower. On the other hand, the average age of persons whose temporary benefit became permanent was older - 77.5: women 77.2 and men 78.1. In all cases, the median age was similar to the average ages.

After reviewing the breakdown of benefit levels pursuant to types of eligibility it appears that whereas 77.4% of the decision pertaining to temporary eligibility granted the lower benefit level, only 59.8% of the decisions pertaining to permanent eligibility granted this benefit level. The opposite is true in respect of the higher benefit - 17.8% of the decisions pertaining to permanent eligibility as opposed to 5.5% of the decisions pertaining to temporary eligibility.

For those whose temporary eligibility ended most were at a low benefit level - 95.2%. On the other hand, the rate of the two highest benefits among those whose temporary eligibility was extended for an additional defined period was 22.2% and those whose temporary benefits were substituted with permanent benefits - 43.3%.

Did the changes in scope of temporary eligibility affect the number of those eligible for the long-term care benefit? Table 1 presents the monthly averages of the number of eligible persons and the number of eligible persons at the end of the year between 2010 and 2015, from which it derives that in the years 2014-2015 the increase in number of eligible persons became more moderate.

Table 1

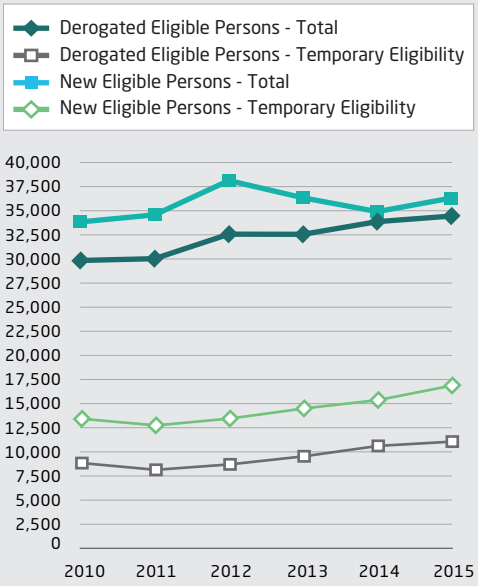
Those eligible for long-term care benefit - monthly averages and end of year data, 2010-2015

Year	Monthly Average	Change From Previous Year	End Of Year	Change From Previous Year
2010	141,078	4,912	143,123	4,507
2011	145,075	3,997	148,268	5,145
2012	152,096	7,021	154,098	5,830
2013	156,183	4,087	158,260	4,162
2014	159,198	3,015	159,598	1,338
2015	160,761	1,564	161,877	2,279

In the years 2014-2015, a number of changes occurred in comparison with the years 2010-2013: the increase in the number of eligible persons that were added became more moderate whereas the number of eligible persons that were detracted increased - and these two changes affected the slowdown in the growth pace of the number of eligible persons (Chart 6). The increase in the number of decisions pertaining to temporary eligibility and the rate thereof had a moderate effect on the growth in the number of eligible persons for the long-term care benefit in the years 2014-2015.

Chart 6

Eligible Persons Who Were Added And Those Who Were Detracted - Total Number Of Persons Eligible For Temporary Benefit, 2010-2015



Characteristics of those Eligible

Gender, Age and Family Composition

Women constitute most of those eligible for the long-term care benefit - 70% of those eligible are women, and their rate of all persons eligible decreased slightly in comparison with 2014 (Table 4).

The **aging** trend in those receiving the benefit continues: like 2014, in 2015 the main increase in the number of eligible persons was 85 years and older, whereby their portion of the total number of recipients increased from 41.7% to 43.1%, whereas the portion of those 84 years old or younger continuously declined. For comparative purposes, in 2001 those 85 and older constituted less than one-third (32.1%) of those eligible. This trend reflects the aging of Israeli society, and particularly the growth in proportion of older persons.

In 2015, **family composition** remained stable in comparison with 2014: nearly one-half of those eligible live alone, two out of five live with a spouse, and one out of every nine lives with someone else - usually a son or daughter.

Seniority in Israel

Stability between the two years was maintained in relation to seniority in Israel too: the proportion of those who immigrated after 1989 of all those eligible remained stable - 25.1%, and the proportion of those who immigrated after 1999 increased from 3.7% to 3.9%.

The Ministry of Finance funds the long-term care benefit for those who immigrated to Israel at 62 or older. In recent years, the relative proportion of the eligible whose benefits are funded by the State Treasury, has declined. The average monthly number dropped in 2015 by approximately 1,250 in comparison with 2014, and the average monthly rate dropped from 19.1% to 18.2% between the two years.

Table 4

Those Eligible for the Long-Term Care Benefit According to Demographic Characteristics and Benefit Level (Monthly Average), 2015

Characteristics	Absolute Numbers	Percentages
Total	**160,760**	**100.0**
Gender		
Men	47,709	29.7
Women	113,051	70.3
Age		
Up to 64*	1,104	0.7
65-69	6,790	4.2
70-74	13,868	8.6
75-79	29,138	18.1
80-84	40,518	25.2
+85	69,342	43.1
Family Composition		
Men living alone	77,937	48.5
Living with spouse	64,785	40.3
Living with their sons or with others	18,038	11.2
Seniority in Israel		
Veteran	120,419	74.9
Immigrants** - Total	40,341	25.1
Of which: immigrated After 1999	6,235	3.9
Benefit Funding Source		
National Insurance	131,557	81.8
State Treasury	29,203	18.2
Benefit Level		
Low (91%)	82,459	51.3
Medium (150%)	40,808	25.4
High (168%)	37,494	23.3
Eligibility For Supplement		
3 Hours	25,436	62.3***
4 Hours	16,695	44.5***

* Age group includes only women.
** Immigrants to Israel from 1990 and onwards.
*** Eligible for extra hours as a percentage of all those eligible at the benefit level.

Benefit Level

With population aging, a trend evolved regarding a change in the composition of the eligible according to the benefit level expressed between 2014 and 2015: the weight of those receiving the benefit at the low level declined, from 52.7% to 51.3%, while those receiving the highest level increased from 21.9% to 23.3% (Table 4).

The portion of those eligible to a benefit at the highest level continuously increases from 17.6% in 2008 to 23.3% in 2015. The growth rate of this group is the highest. The portion of the benefit recipients at the lower level decreased in 2015 by 1.8% in comparison with 2014, the medium level increased by 1.0%, and the highest level increased by 7.5%.

In March 2009, care hours were added for those who employ an Israeli worker only. The number of those receiving a benefit at the medium level, increased in the two years by approximately 500 and at the highest level by approximately 1,000.

6. Benefit in Cash

Since October 2015, those eligible for the benefit at the two highest levels may choose to receive it in cash provided their long-term care services are provided by a caregiver who is not a relative for six days a week, 12 hours a day at least. They may choose a benefit in cash or to return to the benefit in-kind format at any time they please. A benefit in cash is also granted to the eligible who do not have available services, or services that can be rendered on the dates stipulated in the Law, at a rate of 80% of the in-kind benefit rates[3]. Those eligible can receive additional long-term care services, and then from the value of their full benefit, additional services are deducted and from the difference, 20% is deducted.

A professional committee determines a treatment plan - which services will be furnished to the elderly and who will furnish them, and also checks that the services are in fact furnished, or determines that the services are not available.

The committee may refuse to confirm an application for a benefit in cash if it is of the opinion that the elderly person and his family are not competent to use the money for the purpose for which it is awarded, and may determine whether the caregiver is suitable and whether the long-term care services received by the elderly person are adequate. The committee may also negate the payment of the benefit in cash and ensure receipt of the benefit in-kind.

In December 2015, most of those who chose the cash benefit (95.2%) were among the eligible for one of the two highest benefit levels hiring a foreign caregiver, the main potential group. Namely, 5.6% of this group elected to receive a benefit in cash as opposed to 4.8% in December 2014 (Table 6).

Table 5

Select Data Pertaining to Recipients of the Long-Term Care Benefit in Cash - December 2015

	Absolute Numbers	Percentages	Absolute Numbers	Percentages of Reference Group
All those eligible	161,877	100.0		
Chose and received cash benefit	2,169	1.3	345	15.9
Received cash benefit without available personal care services at home	356	0.2	23	6.5
Those eligible at two highest levels hiring foreign caregiver	36,824	22.7		
Chose and received cash benefit	2,064	5.6	330	16.0

* The data in the last row of the third column refers to all those eligible in the 'potential group' and not all those eligible.

Only 71 of those eligible (3.3%) received the low benefit level. 1,379 (63.6%) received the highest level and 719 (33.1%) received the medium level. Of the 2,169 eligible who chose the cash benefit and received it in December 2015, only 34 had no valid permit to hire a foreign caregiver (1.6%) - 24 of whom were at the highest benefit level, 10 at the medium level, and none at the lowest level.

7. Providing Services

Services that are provided within the framework of long-term care insurance, are furnished through companies based on an agreement with the NII. At the end of 2009, the results of the last public tender were published with the names of the authorized vendors.

At the end of 2015, there were 121 long-term care service providers: 51 non-profit (42.1% of all the companies) and 70 private companies (57.9% of all the companies). In total, the organizations provided approximately 8.262 million hours of care on average per month in 2015 - 73.6% by private companies and 26.4% by non-profit organizations (Table 6).

Table 6

Hours of Personal Care Provided, According to Type of Service Provider (Monthly Average), 2015

Type of Services Provider	Number of Hours (Thousands)	Percentages
Total	**8,262**	**100.0**
Private Organization	6,079	73.6
Non-Profit Organization	2,183	26.4

The total number of care hours on average per month increased between 2014 and 2015 by 1.1% - from 8,171 million to 8,262 million: private companies increased by 1.6% and non-profit organizations decreased by 0.1%.

Nearly all those eligible[4] in December 2015 received personal care at home by a domestic or foreign caregiver. 7.4% received personal care at day centers, 18.4% received absorbent products and 11.4% received a panic button[5] (Table 7). For 67.5 % of those receiving care at home it was an individual item in the basket of services, while the rest combined it with other services. One must remember that a person eligible for the benefit can receive more than one type of service and therefore the total number of recipients of long-term care services is higher than the number of eligible persons for the benefit.

Table 7

Recipients of Long-Term Care Services According to Type of Service, December 2015*

Type of Service	Number of Recipients	Percentage of Recipients	
		Total Persons Receiving Benefit	As a Single Item for Recipients of this Service
Total**	**219,386**	-	-
Personal Care at Home	159,115	98.9	67.6
Personal Care at Day Center	11,931	7.4	5.7
Absorbent Products	29,566	18.4	0.9
Panic Button	18,346	11.4	0.7
Laundry Services	428	0.3	0.7

* A person eligible for the benefit can receive more than one type of service, therefore the total number of recipients of long-term care services is higher than the number of eligible persons (without those refusing to receive services) in December 2015 - 160,848.

** Until the annual review of 2013, the data was published for the number of absorbent products services that were given - i.e., if an eligible person received two different types they were considered two different recipients. The number of recipients are presented in this report, and an eligible person receiving more than one type is only counted once.

8. Scope of Payments

In addition to direct benefits payments, National Insurance Law compels payment for additional items relating to long-term care insurance. Fifteen % of the annual receivables (for each item) are allocated to the Ministry of Health and the Ministry of Welfare and Social Services, to fund an increase in the number of persons institutionalized. In practice, the Ministry of Health usually utilizes the full allocation and the Ministry of Welfare only utilizes a very small fraction thereof. Monies are also budgeted for the development of community and institutional services for the elderly fund. Expenditure in the long-term care branch also includes administrative expenses such as payments to local committee members and for dependency tests.

In 2015 the total payments remitted to fund long-term care insurance reached approximately NIS 5.6 billion (2015 prices): approximately NIS 5.3 billion to render services to those eligible and the rest for the development of institutional and community services and to conduct dependency tests (Table 8). Approximately NIS 120 million was transferred to the Ministries of Health and Welfare to increase the number of beds in long-term care institutions, and approximately NIS 112 was transferred to the Ministry of Welfare, to health funds and assessors, to prepare care plans for the eligible and conduct dependency tests.

Table 8

Payments in the Framework of Long-Term Care Insurance According to Type of Payment (Millions of NIS, Prices 2015), 2011-2015

Year	Total	Long Term Care Benefits	Transfer to Foreign Entities*	Service Development	Hospitalization in Long-Term Care Institutions	Agreements with the Ministry of Finance
2011	4,343.2	4,119.6	92.8	31.3	97.0	2.5
2012	4,742.7	4,520.8	99.0	26.2	93.8	2.9
2013	5,041.0	4,798.4	101.7	30.8	106.8	3.3
2014	5,248.9	4,988.5	103.5	33.2	119.8	3.9
2015	5,590.6	5,317.1	111.6	36.4	120.3	5.2

* Transfers to the Ministry of Welfare and Social Services and to the Clalit Health Fund to prepare care plans for the eligible, and transfers to conduct the dependency tests.

In 2015, payments increased within the framework of long-term care insurance by 6.5% at fixed prices (2015 prices) and benefits payments by 6.6%. The increase in benefit payments derives from a rise in the number of eligible for the highest benefit, from a moderate increase in the number of all those eligible and from an increase in benefit payments in-kind following the increase in the minimum wage in April 2015. The average benefit level realistically increased in 2015 by a rate of 1.8%.