



LONG-TERM CARE FINANCING REFORM: LESSONS FROM THE U.S. AND ABROAD

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ABSTRACT: As part of health care reform, Congress is considering the Community Living Assistance Services and Supports (CLASS) Act. The measure would mark the most significant change since 1965 in the way the U.S. finances long-term care, the personal assistance delivered both at home and in nursing facilities to the frail elderly and other adults with disabilities. As policymakers consider the CLASS Act, they may be able to learn from past experiments in the U.S. as well as from the experiences of other major industrialized countries, most of which have migrated to universal, government-run financing systems. Although those models vary markedly in their specifics, they appear to be both broadly popular and somewhat more costly than expected. By contrast, the CLASS Act is a voluntary system that attempts to meld public insurance with private long-term care coverage and Medicaid.

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EXECUTIVE SUMMARY

Broad health care reform legislation being considered by Congress would effect a major change in the way the United States finances long-term care. The Community Living Assistance Services and Supports (CLASS) Act would create a voluntary national long-term care insurance program. As lawmakers debate the potentially far-reaching proposal, they may learn from the experiences of other developed nations and from recent experiments in the U.S.

Long-term care is the personal assistance that the frail elderly and other adults with disabilities require to maintain the best possible quality of life. The assistance may be delivered at home or in a nursing facility or other congregant care setting. In the U.S., most long-term care is provided by family members, and some by paid aides. The cost of formal care is quite high, averaging \$75,000 per year for residence in a skilled nursing facility and \$20 per hour for home health aides.

In Japan and much of Europe, public benefits for long-term care of the frail elderly have become a pillar of social policy, along with retirement and health care. While many nations have enacted major reforms over the past two decades, they have taken somewhat different approaches.

Most major industrialized nations have adopted a social insurance model to provide long-term care to all who need it. Purchase of insurance is mandatory, often through payroll taxes, although some nations also finance their long-term care systems with premiums and general fund revenues. Some provide cash benefits, others pay approved service providers directly, and still others give consumers an option of receiving benefits in either form. While benefits are sometimes means-tested, all who are medically eligible receive at least some payment. These systems contrast sharply with the U.S., where Medicaid provides long-term care only for those who meet strict income and asset tests, and with the United Kingdom, which retains a similar means-tested program.

This paper reviews the experiences of France, Germany, Japan, the Netherlands, and the United Kingdom, and highlights some of the lessons the United States can learn from each. Broadly, there appear to be two. The first is that shifting from a means-tested design to an insurance model appears to be workable and quite popular. The second is that long-term care costs have increased more rapidly than expected in those nations that have adopted reforms, although in most cases these additional costs appear to be manageable.

While other nations have embraced universal, government-managed long-term care insurance over the past two decades, the U.S. has moved in a very different direction. It took modest steps to expand private long-term care insurance through tax incentives and government-funded marketing campaigns, and by tying this coverage more closely to Medicaid. These efforts, however, have met with little success, and participation in private insurance remains very low.

The CLASS Act is a significant departure from prior efforts. While CLASS builds on elements of past experience in the U.S. as well as on other nations' reforms, it is in many ways unique. In contrast to the social insurance model adopted in most developed nations, participation in CLASS insurance would be voluntary. All workers would be enrolled automatically, but would have the ability to opt out. At the same time, in contrast to past U.S. initiatives, CLASS creates a government insurance program rather than enhancing incentives for the purchase of private coverage. Yet, because it is likely to offer only a modest benefit, the CLASS design also anticipates the use of private insurance to supplement government coverage. In sum, while most industrialized countries have adopted a mandatory social insurance framework for long-term care, the U.S. is attempting to marry government insurance with a voluntary design not yet tried elsewhere.

That voluntary design presents some potentially significant problems. Would young and healthy consumers, for instance, be willing to buy the insurance through a government plan, despite their lack of interest in purchasing private coverage? If they do not subscribe, the program faces the serious problem of adverse selection that is likely to drive up premiums and further discourage low-risk buyers. Such adverse selection does not occur where participation is mandatory.

A successful national long-term care insurance system should accomplish at least three goals: more consumer choice and flexibility, a shift from the welfare-based Medicaid system to universal or near-universal insurance coverage, and a stable funding source for long-term services. While the CLASS Act is unlikely to fully achieve any one of these goals, it is a step toward each.

A caveat: This paper focuses principally on financing long-term care. Ultimately, the success of any financing system will be measured by the quality of the care it funds. While the delivery of long-term care services may itself require major reform, and is inextricably linked to financing issues, it lies outside the purview of this paper.

LONG-TERM CARE FINANCING REFORM: LESSONS FROM THE U.S. AND ABROAD

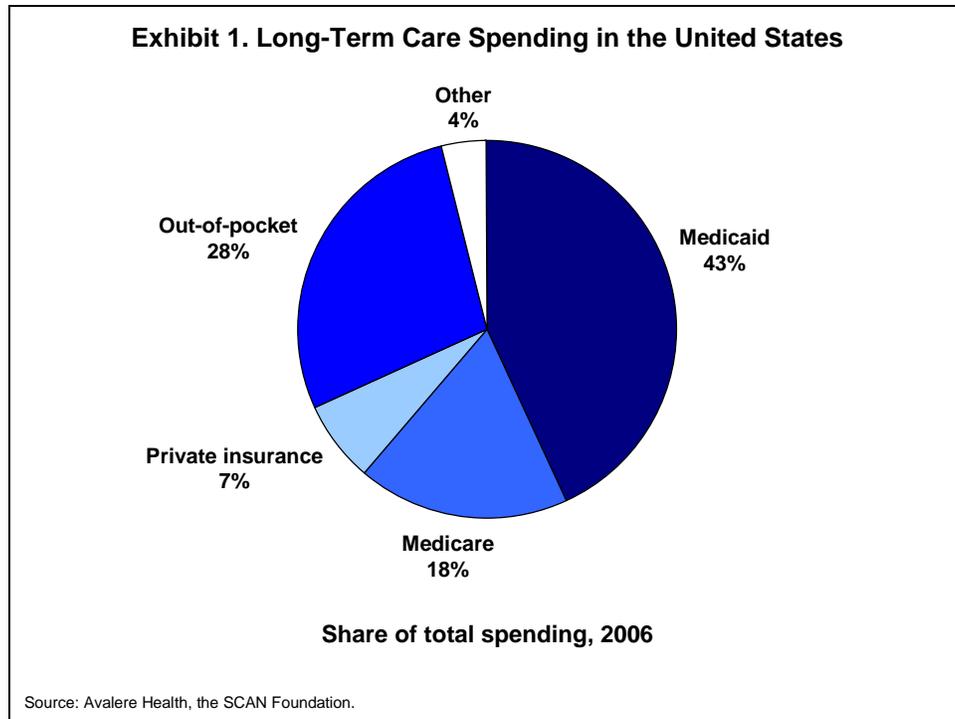
BACKGROUND

In contrast to acute medical care, long-term care helps those with chronic illnesses manage their daily lives in relative comfort and security. Such care is provided to both the frail elderly and the disabled, and may include assistance with eating, cooking, and bathing and toileting. It may be provided at home, in a nursing facility, or in another congregant care setting such as an assisted living facility or group home.

About two-thirds of those who turned 65 in 2005 need or will need some long-term services in their lives. Those 65 and older will require assistance for an average of three years over their remaining lifetimes.¹ Currently, about 10 million Americans need some form of long-term care. Sixty percent of them are 65 or older.

Long-term care can be extremely expensive. The “private pay” rate for a single room in a nursing home averages \$75,000 per year. Home health aides cost an average of \$20 per hour.² Overall, about \$230 billion was spent on long-term services in the U.S. in 2008.

In the United States, more than 40 percent of paid long-term care is funded by Medicaid, the joint federal–state health program for the poor (Exhibit 1). Less than 10 percent is financed by private long-term care insurance. Much of the remainder is paid out-of-pocket by those receiving care or by their families.³ However, it is important to note that well over half of all long-term care is informal, unpaid assistance provided by spouses or other relatives,⁴ usually daughters. AARP calculates that in 2007 the economic value of this care was \$375 billion.⁵



While the existing Medicaid-based system offers relatively comprehensive coverage for the poor, it is problematic for the middle class. To become eligible, people must effectively impoverish themselves. In most states, an unmarried individual must “spend down” financial assets to \$2,000 to qualify, and must fall within severe income limits.

Although the United States makes limited consumer-directed care available through Medicaid, most program payments are still made directly to highly regulated and licensed providers, such as nursing homes or home care agencies. In addition, Medicaid provides an entitlement to institutional services only. There is no requirement that states provide long-term care in a home or community setting. So while many states offer some Medicaid home-care benefits, such assistance tends to be limited. Many states, for example, have long waiting lists for home-based care. Many of the frail elderly and other adults with disabilities must therefore move into nursing facilities in order to receive Medicaid benefits—despite consumers’ preferences to remain at home as long as possible. In 2007, nearly three-quarters of the program’s long-term care benefits for adults with disabilities and the frail elderly were paid to nursing facilities.⁶

At the same time, growth in long-term care costs for both the elderly and disabled is driving substantial increases in government health expenditures, especially for Medicaid, which spent more than \$100 billion—or one-third of its budget—on such

assistance in 2007.⁷ This cost growth may become especially problematic as 77 million baby boomers reach old age over the next three decades. By 2050, total Medicaid spending could exceed 6.5 percent of GDP,⁸ the equivalent of \$900 billion today.

Consumers seeking to hedge against their risk of needing costly long-term services may purchase private insurance. To date, however, the demand for such insurance has been modest owing to the price and complexity of policies and the reluctance of consumers to confront the prospect of disability in old age. The existence of Medicaid may be a further disincentive to purchase private insurance.⁹ There are roughly 7 million policies in force, covering about 10 percent of those age 65 and older.¹⁰

EXPERIENCES FROM ABROAD

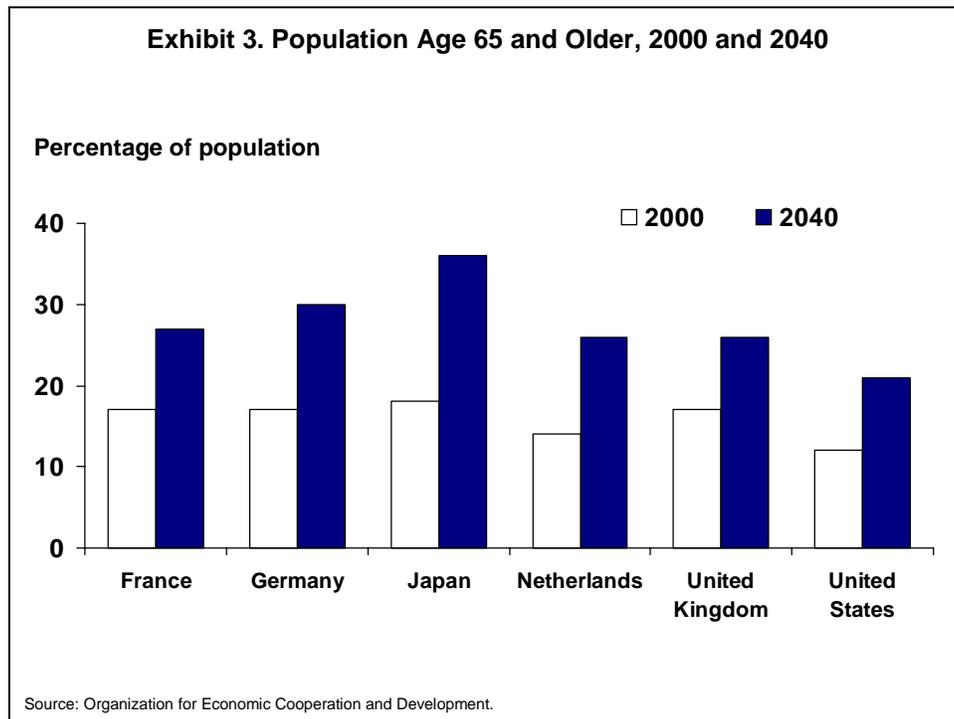
Most other major industrialized nations have remade their long-term care systems over the past two decades. Such nations as Germany, France, Luxembourg, Norway, Netherlands, Korea, and Japan have fundamentally restructured their financing programs. By contrast, while the United Kingdom has repeatedly reconsidered its existing system, it has yet to enact major financing reforms. This paper will focus on the experiences of five nations—France, Germany, Japan, Netherlands, and the U.K. (Exhibit 2).

Exhibit 2. International Models for Long-Term Care Financing

	Financing	Benefit	Eligibility	Private Insurance
United States	General revenue	Service/ Limited cash	Means-tested	<10%
France	General revenue	Cash only	Universal/Steep income-related coinsurance	25% of those 60+
Germany	Payroll tax	Cash or service	Universal	<10%, optional for high-earners
Japan	Payroll tax/ General revenue/ Income-related premium	Service only	Universal for 65+	None
Netherlands	Income-related taxes/Means-tested copayments	Cash or service	Universal	Mandatory, managed by private insurance
United Kingdom	General revenue	Service or cash	Means-tested	Very limited

Source: Author's summary of OECD data.

Most of these countries face more severe demographic pressures than the United States. In 2000, about 12.4 percent of the U.S. population was 65 or older compared with 14 percent in Netherlands, 15.9 percent in the U.K., 16.4 percent in Germany, and 17.4 percent in Japan. By 2040, the disparity will be even wider. About 20.4 percent of the U.S. population will be 65 or older, compared with 35.0 percent in Japan (Exhibit 3).¹¹



It is also important to note that these nations have developed their long-term care models in the context of well-established public health insurance systems. The chronically ill frequently receive long-term care and medical treatment simultaneously, so it may be somewhat easier for countries with national health insurance to develop public systems to pay for long-term care. While even those countries struggle to make this nexus seamless, their environment contrasts with the patchwork system in the United States, where those in long-term care may be receiving acute medical benefits from traditional Medicare, private Medicare supplement insurance (Medigap), Medicare managed care, employer-sponsored retiree health insurance, or Medicaid.

Japan and many European nations have developed long-term care financing arrangements that are quite different from those in the U.S. and somewhat distinct from one another. Germany and several other countries have established universal long-term care social insurance financed largely through a payroll tax. Japan's public insurance is funded by a combination of premiums and taxes and is available to all regardless of

income. Benefits, however, are targeted to those 65 and older. In Netherlands, long-term care insurance also is funded by a combination of taxes, but benefits are available to all. In France, assistance is funded by general revenues and available to everyone over 60. However, high-income individuals receive only a small fraction of the maximum benefit. In the U.K., those over 65 receive means-tested benefits funded through general revenues, similar to the system in the United States.

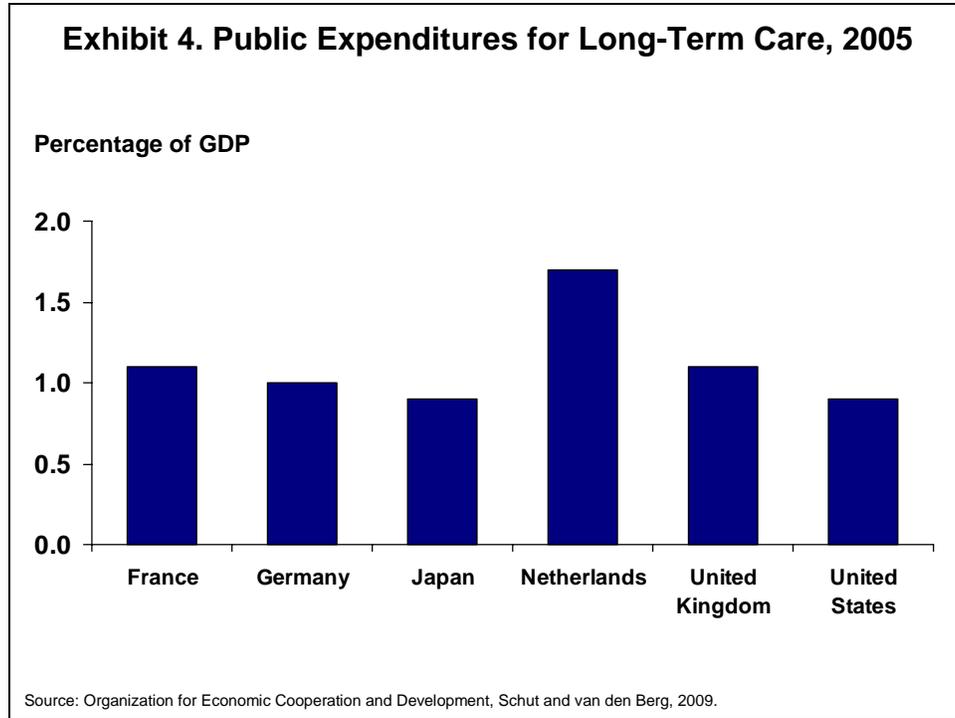
Some countries have chosen to provide extremely flexible benefits, while others have not. Japan provides only services. Seniors in France receive cash, which they may use to purchase the assistance they choose. Germany, Netherlands, and the U.K. allow either cash or services. In many of these countries, benefits are designed to encourage home care rather than institutionalization.

Private long-term care insurance is widely available in the U.S., although participation remains very low—about 7 million people have it. In Germany, this coverage is available for high-income individuals and as supplemental coverage for all, although participation rates are similar to those in the U.S. (less than 10 percent). In France, private coverage is proportionally more extensive, with about 3 million policies in force (25 percent of the population age 60 and older). In Netherlands, while long-term care is a universal public benefit, all insurance is administered by private companies (which also manage universal health insurance). By contrast, private insurance markets are far less developed in the U.K. and Japan.

A major question facing policymakers is whether the widespread availability of either private insurance or government-funded assistance will encourage a significant increase in demand for paid home care, thus driving spending to unsustainable levels. It remains unclear from the Japanese and European experiences whether this phenomenon, sometimes called the woodwork effect, is a serious concern. Netherlands saw a substantial increase in costs as it expanded its long-term care program. In Japan, long-term care costs also appear to be higher than originally expected. However, 20 percent of those certified for benefits do not participate in the program and participants use on average only half of their maximum allowable benefits. In Germany, the share of families taking cash benefits for home care has remained fairly steady over the life of the program. At the same time, reliance on institutional care has increased somewhat, especially for those with low levels of care needs.

Seen through one prism, public expenditures on all long-term care were remarkably similar across most countries studied: For 2005, those outlays were

1.1 percent of GDP in France, 1.0 percent in Germany, 0.9 percent in Japan, 1.1 percent in the U.K., and 0.9 percent in the U.S.¹² Costs were noticeably higher in Netherlands, however, where public expenditures were 1.7 percent of GDP (Exhibit 4).¹³



However, by other measures public long-term care spending in Germany may be significantly lower than in the U.S. and Japan, at least for the frail elderly. According to those estimates, government in the U.S. spends \$1,605 on long-term care for each person 65 and older, while Japan spends \$1,751 and Germany spends \$1,185.¹⁴

Germany

Germany operates a long-term care system that is parallel to but separate from its health insurance plan. The program is managed by the central government, but individual states are responsible for providing the necessary long-term care infrastructure. Benefits are uniform across the country, with no regional variation.¹⁵

Initially, the program built strong cash balances, although it was intended to operate as a pay-as-you-go system. After some years of experience, the government concluded that the ratio of benefit levels to costs had fallen to troublingly low levels, in large part because benefits were not indexed to inflation. As a result, beginning in 2008, the government raised both contributions and benefits.

Financing. In 1995, Germany instituted a mandatory, universal long-term care insurance system. The social insurance portion was initially funded with a payroll tax of 1.7 percent, divided equally between workers and employers. In 2005, an additional premium of 0.25 percent was imposed on those with no children. This was done to reflect the likelihood that they would require higher insurance benefits in the absence of children to provide unpaid care.

In 2008, the basic premium was increased to 1.95 percent of payroll (with the add-on for the childless continuing). At the same time, benefits, which were not indexed in 2005, were increased.¹⁶ Some benefits, including in-kind services and assistance for some severely disabled populations, will be raised annually until 2012. All benefits will be reviewed for adequacy every three years thereafter.

During 2007, as the government was revising its long-term care program, Germany debated whether to shift from income-related contributions to fixed premiums. Ultimately, the government chose to maintain its income-based payroll tax structure.¹⁷

Participation. Germany's public insurance covers about 70 million people. Another 9 million higher-income individuals choose to purchase private insurance rather than participate in the government program. All workers, however, must have some long-term care coverage.¹⁸

About 2 million Germans (2.4 percent of the population) currently receive benefits under the program. Two-thirds opt for home care.¹⁹ However, there has been a small increase in demand for nursing-facility care since the program was created. In 1997, the first full year in which institutional care was funded under the new program, 24.6 percent of beneficiaries chose nursing homes. In 2005, 27.9 percent were using such care. Expenditures for institutional care increased from about 42 percent to 48 percent.²⁰

Benefits. Benefits are available for both the aged and the disabled. However, applicants must show a considerable need for care before receiving benefits.²¹

Patients are first assessed for care need by regional medical board staff. Families may opt to obtain benefits in one of three ways. They may receive cash, which they can use for a wide range of purposes that include hiring professional caregivers, paying family members for caregiving, or renovating their homes to make them accessible to the disabled. They may opt for an in-kind service benefit, where care is provided directly by

an agency under contract to the insurance program. Or they may choose a combination of both.²²

The cash payment is significantly lower than the direct-service benefit. In 2008, for instance, a patient who needed around-the-clock long-term care at home was eligible for direct in-kind benefits of €1,432 (\$2,151) per month, but would receive a monthly cash payment of only €675 (\$1,014). In-kind benefits are expected to pay about half the cost of home care. Those who need full-time institutional care receive a service benefit valued at up to €1,470 (\$2,208) per month, depending on their level of disability, with an added supplement of up to €486 (\$730) for those with dementia.²³ It is important to note that the institutional benefit level is based only on the cost of care in a nursing home, and excludes room and board.

The social insurance program also provides for medical equipment, respite care, and caregiving training for family members. Facilities for caregiving training and support are somewhat limited, with quality varying widely among the states.²⁴

Lessons for the U.S. The German program has succeeded in substantially reducing the number of long-term care patients on means-tested public assistance, especially for those receiving care at home.²⁵ Germany also provides families with flexible benefits they may tailor to their individual needs at a relatively low per capita cost. Public spending for long-term care (as measured per person age 65 or older) may be 74 percent of that in the U.S., or approximately \$1,185.²⁶

However, since 1999, the system's annual cash flow has been consistently negative, albeit to a modest degree. In 2004, for instance, expenditures exceeded revenues by 4.5 percent.²⁷ Some analysts in Germany are troubled by this trend, especially as they look ahead to the nation's growing dependency ratio.²⁸ It is of particular concern because, with the combined payroll tax rate in Germany already approaching 28 percent, after-tax labor costs in Germany are already quite high.

Maintaining current standards of care could require significant payroll tax increases in coming years. According to one estimate, the payroll tax rate for long-term care insurance will have to increase from 1.9 percent to at least 3.2 percent by 2040.²⁹

In sum, Germany appears to have successfully added long-term care to its social insurance system. It remains financially viable, though long-run cost trends are potentially troubling.

Netherlands

The Dutch were the first to establish universal social insurance for long-term care. Created in 1968, the Exceptional Medical Expenses Act (AWBZ) has steadily evolved, although it remains unique in many ways. It is universal but, unlike most other social insurance models, is administered by private insurance companies rather than by the state. It should be noted, however, that while private insurers manage the program, they do not bear financial risk.

The AWBZ is closely tied to the national health system and covers some catastrophic medical costs—such as long-term hospitalizations, rehabilitation, nursing care, and even prenatal care—as well as long-term care expenses. The program is broadly popular but, even more than other nations providing national long-term care insurance, the Dutch have struggled with significant cost increases.

Financing. Netherlands has had universal health insurance since World War II, but its long-term care system was highly fragmented until 1968, when the AWBZ was enacted. The system is designed to be pay-as-you-go, so that annual revenues closely match claims. There are no reserves against future payments. Its principal source of revenue is an income-related premium that is collected through both the income and payroll tax systems. The annual premium in 2008 was 12.15 percent of the first €1,589 (\$47,400) or a maximum of €838 (\$5,700), normally collected by employers along with other social insurance contributions.³⁰ The average premium was about €320 (\$480) per month.³¹ Premiums are adjusted annually to reflect changes in costs, and while the 2008 rate was down somewhat from 2005, it was 21 percent higher than a decade earlier.³²

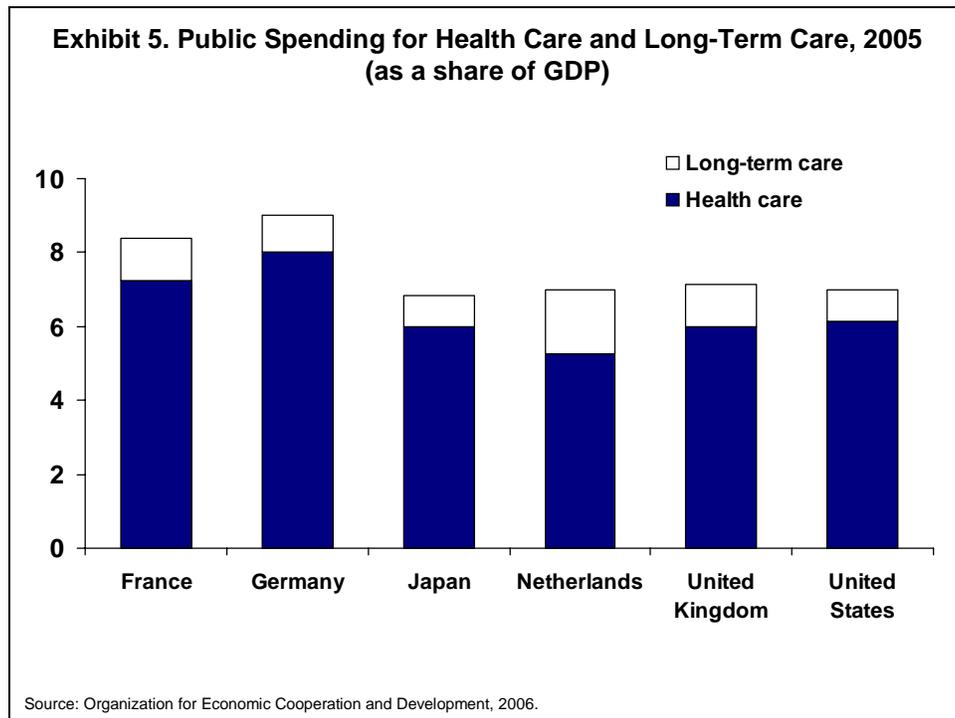
Beneficiaries are also responsible for copayments that are based on income, care setting, and family status. These can be as high as €1,800 (\$2,700) per month. Overall, individuals pay about 75 percent of the program's annual cost. General fund revenues cover the remainder.

Participation. Every Dutch citizen who is older than 15 and has taxable income pays into the system. There is no underwriting, so all are guaranteed coverage. In 2008, almost 600,000 received benefits through the program—two-thirds of whom were elderly, one-fifth disabled, and the rest with psychiatric disorders. The recipients represented about 3.6 percent of the population.³³

Benefits. Since its inception, the AWBZ has paid for a broad spectrum of care, both for those living at home and for those residing in nursing facilities or other

institutions. About 55 percent receive care at home, where they receive what observers call an “extraordinary” level of assistance.³⁴ Benefits are delivered either through in-kind payments directly to care providers or through cash payments in a system of personal budgets, which are expected to pay about 75 percent of average provider fees. In 2008, about 83 percent of benefits were in-kind and, while spending on personal budgets has been gradually increasing, there has been no decline in use of direct provider payments.

Overall costs have increased rapidly, from the equivalent of less than €1 billion when the program began, in 1968, to almost €13 billion in 1998 and more than €20 billion in 2008. As a result, public spending on long-term care in the Netherlands is significantly higher than that in other countries studied in this report, and—with the exception of Norway and Sweden—the highest among OECD countries. The Dutch also have a substantially higher ratio of public long-term care spending to acute health care outlays. For example, in 2005, the Dutch spent \$1.00 on long-term care for every \$3.00 they spent on health care. By contrast, the Germans spent \$1.00 for every \$7.80, while the U.S. spent about \$1.00 in public long-term care resources for every \$6.00 in government medical care (Exhibit 5).³⁵



The government has attempted several strategies for controlling costs. In the 1990s, it capped budgets, a step that created long waiting lists for some services. However, that effort was overturned by the Dutch courts in 1999. More recently, the

government has increased the role of informal care provided by family members and friends, and made this obligation more explicit. In 2007, funding for domestic help was shifted from the AWBZ to local municipalities. As a result, services such as home cleaning are no longer covered by insurance.³⁶

The Dutch are currently in the midst of a major debate over the future of the program. Some reformers argue that the AWBZ should be abolished and folded into the national health system—which itself was restructured as a universal system of managed competition in 2006. Others argue that long-term care should remain separate, though with major changes. This latter approach has been adopted by the government. An influential 2008 report by the Social and Economic Council recommended more carefully defining what services would be provided through the AWBZ, establishing uniform needs assessments, shifting some services such as rehabilitation to the health system, and no longer reimbursing the cost of room and board.³⁷

Lessons for the U.S. The Dutch system is a model for a public/private partnership. Insurance is universal and mandatory, and funded principally through tax revenues. However, the long-term care program is managed by large regional insurance firms.

The AWBZ appears to be quite popular. However, it is important to note that the Dutch struggle with costs, driven especially by younger people with disabilities who have opted for cash benefits through personal care budgets. As a result, the Dutch have refocused care on those most in need of assistance, eliminated some benefits entirely, and imposed stricter needs assessments. Still, premium rates have increased by more than 20 percent over the past decade.

Japan

Faced with some of the most severe pressures among the world's nations to reform its long-term care system, Japan created its own social insurance program in 2000. High life expectancy, low birthrates, and a restrictive immigration policy combined to create difficult demographic challenges.

At the same time, Japan was suffering a growing backlash from daughters (and daughters-in-law) who were expected to care for elderly parents, with little support. In addition, it struggled with challenging payment and delivery issues. For example, because Japan offered free hospital care to the frail elderly but provided few long-term care services outside of these institutions, hospitals had become the default care setting for many elderly Japanese. One-third of older patients remained in the hospital for a year or

more.³⁸ By contrast, the average hospital stay for an American 65 or older is fewer than five days.

As a result, Japan's long-term care reforms were aimed at meeting at least five objectives: 1) increasing the level of independence for the frail elderly; 2) reducing the burden of home care on their families; 3) more closely aligning benefits and premiums; 4) providing more comprehensive care by integrating medical and long-term care programs; and 5) reducing the number of hospitalized elderly.³⁹

Financing. The program is designed as a pay-as-you-go system. While it is structured as social insurance, it is financed by a combination of both contributions and general tax revenues. The general fund portion, which covers half the cost, is divided among the central government, prefectures, and municipalities. The social insurance element is financed by a combination of payroll taxes and modest monthly premiums. In some ways, this mixed payment system resembles Medicare, also funded by a combination of payroll taxes, general revenues, and beneficiary premiums.

In Japan, all workers ages 40 to 64 pay a contribution rate of 0.9 percent, divided equally between employers and employees. The contribution is an add-on to the health insurance payroll tax. Those 65 and older pay an income-based monthly premium, which averages about \$30 and covers about 17 percent of the program's cost. Together, the payroll contribution and the premium finance about 50 percent of costs. Users of long-term care are also required to contribute a 10 percent copayment for all services.⁴⁰

Participation. Unlike Germany's program, which provides assistance for all regardless of age, Japan's largely limits benefits to those 65 and older. Those who are ages 40–64 are covered only if they suffer from age-related diseases such as dementia. Among older Japanese, nearly all who apply are approved for care. However, as of September 2008, 4.47 million Japanese were certified as needing long-term care, while just 3.66 million (2.8 percent of the total population) chose to receive benefits.⁴¹ On average, home care recipients used approximately half the maximum benefit to which they were entitled.

Benefits. The system covers both institutional and home care but, unlike Germany's, it provides no cash benefits, only services. While a growing share of home care is provided by newly created for-profit firms, institutional care is delivered by nonprofits. For those with low incomes, both care and board in nursing homes are paid by

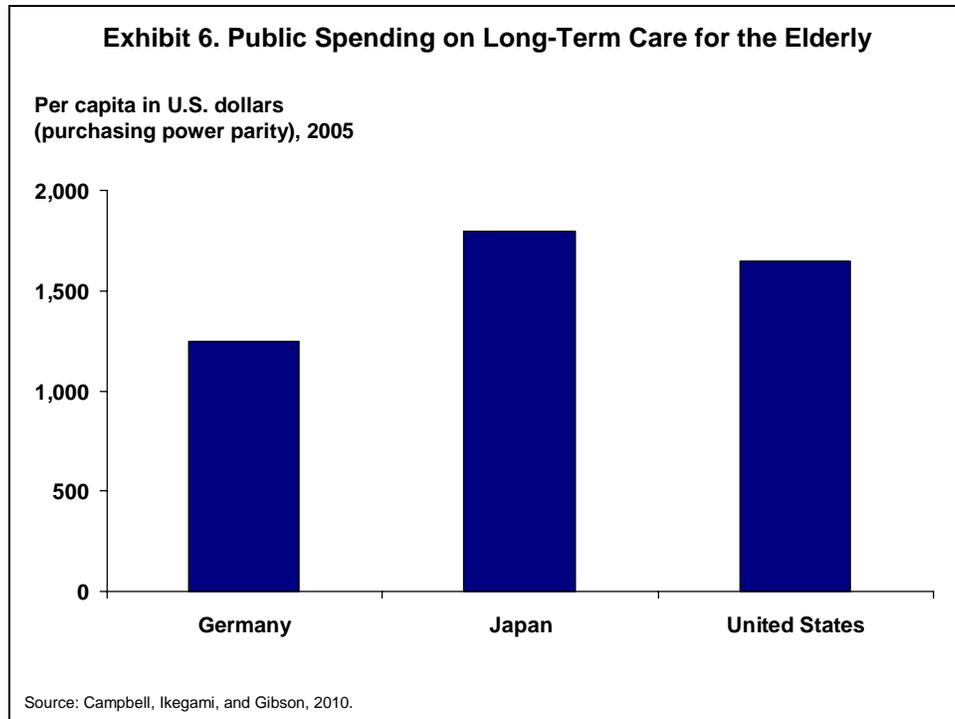
insurance. For higher-income residents of nursing facilities, insurance pays for care only; the cost of housing and meals is not covered.

Japanese long-term care insurance has achieved some of its initial goals. It has relieved pressure on family caregivers, improved the quality of life for some elderly, and put in place a framework for addressing the nation's severe demographic challenges. However, it has had little success in reducing long-term hospital utilization for those over 65. In 2007, Japan had 362,000 long-term hospital beds, roughly the same as in 2003 and down only modestly from the peak of 384,000 in 2005.

The 2000 law that created the social insurance system required regular review. Faced with higher-than-expected costs, the government made several changes to the program by both raising fees and reducing benefits. Beginning in 2006, families were required to pay an additional \$300 monthly fee for nursing home care, and benefits were limited to preventive services for those requiring the lowest levels of care. At the same time, payments to providers decreased. These changes slowed the rate of spending growth from 8.8 percent in 2004 to 0.6 percent in 2006.⁴² The government has also set a goal of reducing long-term hospital beds to 210,000 in 2011.⁴³

Public insurance for long-term care is provided by each of Japan's 1,800 municipalities. Premiums vary slightly by jurisdiction, but prices and copayments are fixed by the central government.⁴⁴

Once individuals apply for benefits, they are given an assessment and approved for one of six levels of care. They are then assigned a case manager who helps design an appropriate care plan.⁴⁵ Monthly benefits range from approximately \$550 to \$3,700 and are capped. Any costs that exceed those maximum levels are borne by the aged and their families. However, in contrast to Germany, which aims to cover roughly half of long-term care costs, Japan attempts to cover 90 percent.⁴⁶ Campbell et al. estimate total public spending per person age 65 and older at approximately \$1,751 in 2005—about 9 percent higher than in the U.S. (Exhibit 6).⁴⁷



Lessons for the U.S. Japan appears to have successfully designed long-term care as a social insurance program. However, the transition has not been without problems.

As intended, public insurance has relieved some of the burden on family members. It has also increased public costs. Japan has seen a significant increase in demand for paid care, especially at lower levels of acuity, as well as longer waiting lists for skilled nursing facilities.⁴⁸

The government has responded to these challenges by scaling back benefits without losing public support for the program. However, the insurance program's lack of coverage for most of those disabled who are younger than 65 may be problematic. In addition, it remains to be seen whether increases in preventive services will reduce demand for long-term care. Finally, while the focus in the U.S. has been on shifting to cash benefits, the Japanese services-only system appears to be working well for its population.

France

France adopted its new system, called the Allocation Personnalisée d'Autonomie (APA), or personalized independence allowance, in 2002. However, while Germany and Japan adopted social insurance as a model for providing long-term care needs, France chose a hybrid approach. The German and Japanese systems provide benefits based on care need, regardless of income, and are funded in large part by contributions and dedicated payroll

taxes. The French program reduces benefits for high-income seniors and is financed entirely through general tax revenues.

Financing. The APA is financed through general revenues, funded jointly by the central and regional governments but administered at the regional level.

Unlike many other nations, France also has a relatively well-functioning private insurance system for long-term care that covered 3 million people in 2007 through both the individual and group markets, a number equivalent to 25 percent of the population age 60 and older. Private insurance benefits average €600 (\$900) per month and are paid in cash, mimicking the public program. France provides no tax incentives for purchase of private insurance.

Participation. The APA is available for those 60 and over. Eligibility, however, is quite restricted. No benefits are paid unless a patient has suffered a “loss of autonomy,” defined as needing help with at least three activities of daily living—a test somewhat stricter than what is stipulated by private long-term care insurance in the United States.⁴⁹

In 2007, approximately 1 million people (1.6 percent of the population) were receiving public long-term care benefits under the APA.

Benefits. Institutional care is provided through the national health system. Assistance at home is covered by the long-term care program and is based on four levels of need. France offers a monthly cash benefit, which individuals may use for a wide variety of long-term care purposes, from hiring caregivers to renovating homes. The cash benefit may be used to hire family members as caregivers (though not spouses). Benefits include case management services.

Everyone who meets the minimum disability test is eligible for some benefits. The average monthly benefit in 2007 for those receiving home care was €413 (\$621),⁵⁰ representing approximately one-third of costs.⁵¹ However, the level of assistance declines sharply with higher income. For instance, an individual with resources of \$1,232 per month or less is eligible for benefits of up to \$1,436 per month. A person at the same level of medical need, but with resources of \$4,104, would receive only \$286.⁵²

While the program is managed by the administrative regions, or departments, benefits are equal throughout the country. To compensate for difference in resources across regions, the central government redistributes funds to the departments.⁵³

Lessons for the U.S. The APA was enacted amid great uncertainty about the number of families that would seek assistance. Two previous attempts at reform had failed, in part because so few elderly participated. However, both participation and program costs of the APA have been far higher than anticipated. For example, the expected first-year cost was \$3.6 billion, but actual expenditures reached \$4.9 billion.

In response to these costs, the government began trimming benefits in 2003. Among the changes: a longer waiting period before benefits may be accessed, restrictions on how they may be spent, and a reduction in the income ceiling below which one can receive full benefits.⁵⁴

Cash benefits appear to be quite popular in France, and are the basis for both public home care assistance and private insurance.

United Kingdom

In many ways, the U.K.'s long-term care system is the most similar to that of the United States. In a scheme resembling Medicaid, personal long-term care services are provided on a means-tested basis by local government. There is, however, an ongoing debate on how to restructure the system, a discussion that has taken on new urgency in recent months following two major initiatives by the government of Prime Minister Gordon Brown.

Currently, skilled nursing care is provided at no cost by the National Health Service. However, personal care, which is excluded from the NHS, is provided on a means-tested basis by local authorities and financed separately through the long-term care system. Because of broad geographic disparities in benefits and eligibility, the system is often disparagingly referred to as the "postcode lottery."⁵⁵

Financing: Long-term care is funded with a mix of central government grants, local taxes, and beneficiary copayments.⁵⁶ In 2000, the U.K. spent the equivalent of about \$30.8 billion, or 1.37 percent of GDP, on long-term care. One-third is paid privately, while the government pays the rest.⁵⁷

Participation. An estimated 4 percent of seniors in the U.K. receive government-provided home care, while about 9 percent have purchased it on their own. Approximately 5 percent of those 65 and older receive institutional care. Those with assets that exceed £23,000 (\$36,000) are not eligible for government support. Those who fall below that cap must share costs, with copayments rising with income.

Benefits. Local governments have coordinated the U.K. system since 1993. Except for nursing care, all personal assistance, sometimes known as social care, is subject to means-tested copayments that are set by local governments.⁵⁸ Provider fees are set by contracts with local governments and vary widely throughout the country.

Following the recent trend in Europe, local governments have been required since 2003 to provide a cash alternative to traditional in-kind service benefits. Participation has been very low, however—only 0.5 percent of those over 64 after the first year.⁵⁹ The U.K. also provides an additional Carer’s Allowance—an extra cash benefit for provision of intensive levels of care by members of low-income families.⁶⁰

The level of government support for long-term care has been the subject of intense policy debate in the U.K. for a decade. In 1999, a royal commission proposed that both nursing and personal care be paid through general tax revenues, with no means test for beneficiaries. An asset test would be imposed only for room and board.⁶¹ While Scotland adopted these recommendations, England dropped its means test only for nursing care.

In 2006, an important study by the Joseph Rowntree Foundation determined that “the public finds the present system incomprehensible and considers its outcomes unjust.” It recommended fundamental reform, but also suggested some incremental changes. These included providing more flexible benefits, increasing the personal allowance for those in nursing homes, requiring those who are admitted to nursing homes under the NHS to pay for room and board, and using program savings to increase benefits for all nursing home residents.⁶²

Also in 2006, the King’s Fund recommended what it called a partnership model. Under this plan, authored by Derek Wanless, a former chairman of NatWest and an outside adviser to then-Prime Minister Tony Blair, those 65 and older would receive a minimum guaranteed level of care at no cost. This care would represent about 66 percent of need. Additional assistance would be funded by a 50–50 match between individuals and government. This proposal would have substantially increased both overall costs and government expenditures.⁶³

In July 2009, the Brown government issued a green paper titled “Shaping the Future of Care Together”⁶⁴ that builds on the Wanless plan. The 2009 report recommended replacing the current income-based benefit system (which resembles Medicaid in many respects) with one of shared responsibility. It also proposed more

preventive care, expanding the use of cash benefits, and making benefits more uniform across the country. However, the paper did not specify a design, but rather outlined a series of broad options for reform. Financing proposals included a government insurance scheme or the purchase of private coverage.

In November 2009, while the “Future of Care” paper was still being considered, Prime Minister Brown proposed a bill to guarantee free personal care at home to the approximately 280,000 frail elderly and younger people with disabilities who require the highest level of care.⁶⁵ The cost is expected to be about £670 million in 2011–2012. The proposal is generally supported by advocacy groups but has come under sharp criticism from both Conservative and Labour MPs.

Lessons for the U.S. In contrast to the rest of Europe, there has been insufficient public support for broad long-term care reforms in the U.K., principally as a result of concerns about cost. In addition, in contrast to Germany and, especially, France, relatively few consumers are receiving cash benefits.

RECENT INITIATIVES IN THE UNITED STATES

While most developed countries have created public long-term care insurance programs in recent years, recent efforts to reform long-term care financing in the U.S. have focused largely on enhancing private insurance. They include expanded state and federal tax incentives and a federally funded marketing campaign to encourage consumers to purchase private coverage, the offer of insurance to federal employees, and an expansion of the Medicaid Long-Term Care Partnership Program. This program makes Medicaid benefits more readily available to consumers who purchase specially designed private long-term care insurance.

While these initiatives may have encouraged some consumers to purchase private policies, none have materially changed the nature of this coverage.

Tax Subsidies. Both the federal government and at least 34 states provide tax credits or deductions for the purchase of long-term care insurance.⁶⁶ The amount of the federal tax subsidy is based upon age, but in 2009 a taxpayer between ages 60 and 70 could deduct up to \$3,180 in premiums for approved long-term care policies.⁶⁷ However, the benefit of this deduction is limited, since it can be used only if total medical costs exceed 7.5 percent of adjusted gross income. In addition, benefits received through private policies are generally tax-free.

Premium subsidies for long-term care insurance may have only modest incentive effects. David Stevenson, Richard Frank, and Jocelyn Tau compared purchase rates in states that have tax subsidies with those that do not. They found that sales are about 10 percent higher where buyers can get a tax break. Credits increase the participation rate by about 20 percent, while deductions make no significant difference.⁶⁸ Cramer and Jensen have estimated that a 25 percent reduction in premium costs would increase demand by only about 11 percent.⁶⁹ In 2006, fewer than 300,000 individual policies were sold. This implies an increase in sales of only about 30,000, even with an extremely generous 25 percent credit.⁷⁰

As of 2005, seven states were offering tax credits, but most design their incentives as deductions. This structure provides the largest subsidy to the highest-income buyers, many of whom could be expected to purchase insurance even without tax incentives. For many other potential consumers, the cost of a policy is still too high, even with the tax break.⁷¹

The Partnership Act. This program, introduced in four states in the late 1980s and expanded in 2005, offers long-term care insurance buyers a trade-off. Normally, a senior living alone becomes eligible for Medicaid long-term care benefits only after spending down assets to \$2,000 (excluding a principal residence, a car, and certain other personal property). However, under the provisions of the Partnership for Long-Term Care, a buyer of a government-approved long-term care policy may become eligible for Medicaid while retaining financial assets equal to the total value of her insurance policy—substantially more than a Medicaid beneficiary who has not purchased a Partnership policy. For example, once she has exhausted her insurance benefits, a buyer of a \$200,000 Partnership policy could retain \$202,000 in assets and still qualify for Medicaid. She would still have to satisfy her state’s income and functional disability requirements, however.

As of 2007, 23 states were participating in the enhanced program.⁷² However, early evidence suggests that Partnership policies are not likely to reduce state Medicaid expenditures by a significant amount. In the four states that initiated the program in the 1980s,⁷³ only 218,000 policies were purchased over nearly 20 years. The Government Accountability Office estimates that as many as 80 percent of those purchasers would have bought long-term care policies with or without the Partnership provisions. In addition, because the law permits Partnership buyers to preserve more assets, they become eligible for Medicaid sooner than they would if they had purchased traditional

long-term care policies. As a result, government spending for those policyholders may increase.⁷⁴

Marketing Initiatives. The federal government has also embarked on a series of marketing initiatives in an effort to enhance take-up of private policies.

In 2001, the federal Office of Personnel Management began making coverage available to federal employees and retirees. As with most group long-term care insurance (and in contrast to health insurance), enrollees pay full premiums. There is no employer subsidy, but benefits are more generous than those of many private policies. On May 1, 2009, the OPM announced a rate increase of between 5 percent and 25 percent for current enrollees whose policies include inflation protection.⁷⁵ As of May 1, 2009, approximately 224,000 federal employees had purchased coverage, a take-up rate of less than 10 percent,⁷⁶ quite similar to the private market.

In 2005, the U.S. Department of Health and Human Services initiated the “Own Your Own Future” campaign, a major joint marketing effort with participating states to encourage consumers to purchase private long-term care insurance. The effort included mailings to those ages 45 to 70 and the development of state Web sites. As of April 2008, 18 states were participating.⁷⁷ To date, there is little evidence that the initiative has resulted in significantly more sales. According to industry data, sales of private policies have been flat or down in the years since the project began.

In 2009, only about 7 million Americans owned private long-term care insurance policies.⁷⁸ Industry surveys of nonbuyers suggest that consumers are reluctant to purchase for several reasons, including the perception that costs are too high in relation to value, the belief that government already covers those costs, and a lack of willingness to plan for long-term care needs that may occur many years in the future.⁷⁹

Given the limited success of these relatively modest efforts to expand the private long-term care insurance market, policy analysts have proposed more far-reaching financing reforms. While Congress has focused on the CLASS Act, it is not the only model lawmakers could have chosen.

Alternatives proposed in recent years have followed three basic designs:

- Allowing private carriers to sell simplified long-term care benefit packages through Medicare, similarly to the way Medicare Supplement (Medigap) health insurance is marketed today.⁸⁰
- Creating a universal tax-funded insurance program that could be managed as a new Medicare benefit or through a new independent, quasi-governmental entity.⁸¹
- Requiring individuals to finance a large share of long-term care costs before receiving the benefits of government social insurance. There are many variations of this design but, in each, individuals would pay what amounts to a very large deductible of perhaps the first \$100,000 of care or the first two years of care before receiving federal benefits.⁸² Many of these public/private partnership schemes assume that consumers would purchase private insurance to supplement government coverage (Exhibit 7).

Exhibit 7. Reform Proposals in the United States

	Mandatory	Government Insurance	Private Insurance	Funding Source
Private coverage sold through Medicare	No	Replaces Medicare LTC	Yes, at 50	Premiums
Expanded Medicare	Yes, universal for 65+	Yes, Medicare Part E	Supplement only	Income tax surcharge
CLASS Act	Available at 18, opt-out	Yes	Supplement	Premiums/ payroll deduction
Government insurance as secondary payer	Yes	Catastrophic only	Yes	Premiums

THE CLASS ACT: HYBRID COVERAGE

While these ideas all have some merit, Congress has been considering the Community Living Assistance Services and Supports (CLASS) Act,⁸³ first introduced by the late Senator Edward M. Kennedy. In 2009, both the House and Senate passed versions of the CLASS Act as part of their respective health reform bills. While the measures differ in their details, each creates a voluntary government insurance benefit that anticipates the purchase of private supplemental coverage. Enrollment would be automatic starting at age 18, but consumers could choose to opt out of coverage.

In the Senate bill, after a five-year vesting period, CLASS would provide a lifetime benefit for individuals unable to perform at least two activities of daily living (such as bathing or toileting) without assistance. Benefits would be paid in cash,⁸⁴ would

increase to reflect future cost growth of long-term care, and could be used for a wide range of services. Premiums generally would not be tied to income, although students and the poor would pay deeply discounted premiums. Contributions could be made through payroll deductions, although employers would not be required to participate.

Coverage would be available to everyone who works. Policies would not be underwritten for health status, but older buyers would pay higher premiums than the young. Those living either at home or in nursing facilities would be eligible for benefits. CLASS insurance would become the primary payer for low-income beneficiaries. However, low-income participants would continue to receive Medicaid assistance to supplement the CLASS benefit.

The CLASS Act grants broad authority to the Department of Health and Human Services (HHS) to design specific insurance plans. However, the Congressional Budget Office and other analysts assume an average benefit of about \$75 per day, which would cover the costs of hiring a home health aide for about four hours per day. But because the benefit would cover significantly less than total long-term care costs, especially for those in nursing homes, the CLASS model anticipates that many consumers will purchase supplemental private insurance.⁸⁵

While early versions of CLASS attempted to fix a monthly premium, more recent iterations leave that task to HHS as well. The premium cost is highly uncertain.

Neither benefits nor premiums are income-related (except for the student and low-income subsidy), so CLASS should “feel” more like insurance than a government program. This reframing may make CLASS policies more attractive to some buyers. However, CLASS also attempts to hold down administrative costs, a choice that may limit the government’s ability to market the new insurance.

The CLASS Act would provide cash benefits, as does the French model or Social Security disability insurance in the U.S. Such a design affords the elderly, the disabled, and their families the flexibility to spend the funds for such purposes as supporting family caregivers, renovating a home to accommodate a wheelchair, or obtaining assistive devices without having to navigate complex government regulations or limitations in private insurance contracts.

Cash benefits, however, raise at least three important issues. The first is that families of the aged and disabled are often poorly equipped for the challenges of

providing long-term care. Second, a guaranteed revenue stream might make it more likely that providers, such as nursing homes and home health agencies, will raise prices.⁸⁶ Today, those fees are negotiated by Medicaid, the dominant payer. In a social insurance model, Medicare could serve the same function (as it does for post-acute care today). However, it is not known how providers will react to an environment where millions of consumers who receive cash benefits must negotiate a complex marketplace on their own.

The third concern is how a cash-based CLASS benefit will meld with private insurance, where most coverage is structured on a reimbursement or indemnity model.

More than any of these issues, however, the success or failure of CLASS will depend on the public's response to a voluntary insurance scheme. Other countries studied here chose mandatory, universal insurance as the framework for their long-term care financing programs. The greatest uncertainty with CLASS may be the behavioral response to its opt-out provision. Insurance industry actuaries,⁸⁷ along with both the Congressional Budget Office⁸⁸ and the Office of the Medicare Actuary,⁸⁹ assumed a very low participation rate—no higher than 5 percent—and relatively high average monthly premiums for earlier versions of CLASS. In private discussions with the author, others believe the participation rate could approach 15 percent to 20 percent. It seems likely, however, that adverse selection would result in significantly higher premiums than would a mandatory program.

LESSONS FOR THE UNITED STATES

There are multiple lessons to be learned from the experiences of Europe and Japan, as well as recent experiments in the U.S. They include:

Americans are reluctant to buy long-term care insurance. To date, there is little evidence that tax credits, government-funded marketing, or a redesigned relationship between Medicaid and private coverage have significantly increased demand for private long-term care insurance in the U.S. These incentives may encourage some modest additional participation, but without a major expansion in the risk pool to drive down premiums, it is unlikely that the product will ever be sufficiently attractive to many middle-class consumers. As designed, private insurance alone does not appear to be a policy solution to the problem of financing long-term care services.

Not all government insurance is popular. The experience in Germany, France, Netherlands, and Japan suggests that many industrialized nations will embrace universal,

tax-funded long-term care insurance. However, the history of the U.K. suggests that significant political opposition remains, even in a country that has had universal acute-care medical coverage for many years.

Most reforming nations have chosen income-related premiums. Several considered, but ultimately rejected, the idea of a premium unrelated to income. Rather, they chose to fund their insurance with payroll taxes or other levies explicitly tied to income. In contrast, the CLASS Act adopts a premium that, for most buyers, is not income-related, and therefore resembles private insurance.

Most also chose universal benefits. Those nations that have adopted reforms over the past two decades have overwhelmingly shifted from a strictly means-tested, welfare-type benefit toward universal coverage. The shift is particularly notable in Germany and Netherlands. Japan provides universal coverage for those 65 and older. Even France, which sharply reduces benefits for those with higher incomes, still provides some assistance for all those age 60 and older who are functionally eligible.

Here, too, the CLASS Act is something of a hybrid. All would receive CLASS benefits without regard to income, as they would with traditional social insurance (or private insurance). However, those with limited earnings and few assets would continue to receive Medicaid long-term care assistance, although CLASS insurance would be the primary payer.

Costs have been higher than anticipated. The experiences of Germany, France, and, especially, Japan and Netherlands suggest that, where there is universal insurance, long-term care costs have been higher than expected. This trend is evident whether the system offers a cash benefit, a service benefit, or a combination of the two. The most significant cost growth appears to be for those with relatively modest care needs. However, with some adjustments in both financing and benefits, those costs appear to be manageable, at least in the medium term. This phenomenon could prove to be extremely significant as the U.S. shifts to a CLASS system. However, effects on demand for paid care under the relatively modest CLASS benefit remain to be seen.

Cash matters. The choice of a cash benefit versus a service benefit appears to be extremely important. For home care to function at an optimal level, families will need to be trained both in personal-care skills and in hiring and managing home care workers. In the U.S., only a handful of training programs are operational. In Germany and

Netherlands (as well as in countries such as Sweden), caregivers receive far more extensive support and training.

Cash benefits appear to be extremely popular in France, somewhat less so in Germany, and are rarely used in the U.K. In the U.S., a Medicaid cash benefit has been well received, but is available for relatively few participants. Private long-term care insurers charge a substantial additional premium⁹⁰ for a cash benefit, so few consumers have purchased such policies.

Many countries now exempt institutional room-and-board costs from social insurance benefits. Germany excludes the “hotel” costs of institutional care. Japan now limits those benefits to people with low incomes, and the Dutch are considering scaling back such payments as well. While the CLASS Act does not make this distinction, its very modest benefit implicitly leaves the burden of paying for room-and-board costs to a beneficiary.

Varying benefits by jurisdiction. Finally, in most industrialized countries, long-term care benefits are managed—at least in part—at the regional or local level, rather than through the central government. Each of the countries studied relies on some level of local involvement. However, this design appears to produce variable results. For instance, in Germany, the U.K., and the U.S., residents in some jurisdictions receive much more extensive family support than in others. In Japan, premiums vary by region, but benefits do not. The CLASS Act would provide a uniform, national benefit.

ISSUES FOR FURTHER RESEARCH

Costs. It will be essential to investigate why France, Japan, Netherlands, and Germany all faced higher-than-expected long-term care costs following recent reforms.

Opt-out coverage versus a mandate. Most industrialized nations have designed their long-term care reforms as an individual mandate. This structure avoids adverse selection, which drives up premiums. However, the CLASS Act allows consumers to opt out of coverage. Little is known about the behavioral response to such an option, especially by the young. However, if large numbers of potential buyers decline to participate, and the risk pool is skewed by high numbers of those most likely to go to claim, the program risks failure.

Cash benefit. Further research is needed in order to understand to what degree the wide variation in different countries' levels of acceptance of cash benefits is a result of cultural norms, plan design, or a combination of the two.

Genetic testing. Will a voluntary insurance market continue to be viable if reliable genetic tests become widely available for diseases such as Alzheimer's? This question may be as relevant to a voluntary government program as to the private market.

Effects on provider prices. Currently, Medicaid negotiates provider prices. In an insurance-based environment, how would those prices change? Would insurers establish networks of nursing homes and home health agencies, and negotiate prices on behalf of beneficiaries for those services? How would consumers respond to such networks? What effects would the resulting revenue stream have on both compensation and labor supply of health aides?

CONCLUSION

With nearly half of all long-term care financed by Medicaid and less than 10 percent paid by private insurance, the U.S. system for financing this care may be unsustainable over the long run. Growing deficit pressures may increasingly limit Medicaid benefits even as the financial constraints leave the aged unable to support their own care needs. Financing will be especially challenging once 77 million baby boomers reach their 80s.

Long-term care appears to be a risk that is well suited to insurance. However, as currently designed, private long-term care insurance may be unable to serve more than a small fraction of the aging population. Similarly, it provides virtually no benefits for younger people with disabilities because few consumers purchase before age 50. So far, government efforts to enhance public acceptance of this product have met with limited success. As a result, public insurance options or public/private coverage may be an appropriate solution.

The European and Japanese experiences may provide useful lessons for the U.S. However, those models have not yet proved to be replicable in the U.S., where cultural norms suggest voters may be more reluctant to accept tax increases to fund long-term care than citizens of other industrialized nations. The CLASS Act reframes coverage as premium-funded insurance, rather than tax-funded social insurance. However, the key question is whether such voluntary insurance can be sold with sufficiently low premiums and can generate enough consumer interest to avoid the problem of severe adverse selection.

NOTES

¹ Kemper, Komisar and Alecxih, 2005.

² MetLife, 2009.

³ Komisar and Thompson, 2007.

⁴ Johnson, Toohey, and Weiner, 2007. In a separate study, Houser and Gibson estimated the value of unpaid family care at more than \$350 billion in 2007.

⁵ AARP, 2007.

⁶ AARP, 2009.

⁷ Burwell, Sredl, and Eiken, 2008. For a review of Medicaid long-term care spending, see Gleckman, Center on Retirement Research at Boston College, 2007.

⁸ Kronick and Rousseau, 2007.

⁹ Brown and Finkelstein, 2004.

¹⁰ Data on long-term care policies are uncertain. However, LIMRA International estimates that 4.8 million individual policies were in force at the end of 2008 and about 2.1 million lives were covered under group policies through 2007. LifePlans Inc. estimates between 6.75 and 7.75 million policies are in force in 2009.

¹¹ OECD, Long-Term Care for Older People, 2005. Another way to look at the aging population is to measure the number of people 65 and older relative to those aged 20–64—those of prime working age who generate the bulk of national income (and pay most taxes) needed to support public programs for the aged. In the U.S. in 2000, this dependency ratio was 21.1 percent, compared to 27.5 percent in France, and 27.9 percent in Japan. By 2040, this ratio will rise to 37.9 percent in the U.S. but will grow to 50 percent in France, 54.5 percent in Germany and 59.9 percent in Japan. This will place intense pressure on government's ability to finance long-term care in the future.

¹² OECD, 2006.

¹³ Schut and van den Berg, 2009.

¹⁴ Campbell, Ikegami, and Gibson, 2010. Data are based on care for 65 and older, and are adjusted for purchasing power parity. Cost estimates for the U.S. exclude Medicare post-acute care, but include Medicare spending for Part B home health care and for assistive devices.

¹⁵ Gibson and Redfoot, 2007.

¹⁶ Gleckman, 2009.

¹⁷ Arntz, 2007.

¹⁸ A description of the German system is available through the Federal Ministry of Health and Social Security at <http://www.bmg.bund.de>.

¹⁹ M. von Schwanenflugel, Directorate of Long-Term Care Insurance, Federal Ministry of Health, 2006, available at <http://www.bmg.bund.de>.

²⁰ Ibid.

²¹ In Germany, as in the U.S., need is measured by the ability to perform activities of daily living (ADLs), such eating, bathing, getting in and out of bed, or going to the bathroom without assistance. The minimum requirement for receiving benefits in the German system is needing help with at least two ADLs.

- ²² Those who opt for private insurance receive cash benefits only.
- ²³ Currency conversions are as of November 30, 2009.
- ²⁴ Gibson and Redfoot, 2007.
- ²⁵ Arntz, 2007.
- ²⁶ Campbell, 2010.
- ²⁷ German Ministry of Health and Social Security, 2006.
- ²⁸ Arntz, 2007.
- ²⁹ Hacker, J. and B. Raffelhuschen, 2004, cited in Arntz.
- ³⁰ Ministry of Health, Welfare and Sport, 2008.
- ³¹ Glendinning and Moran, 2009.
- ³² Ministry of Health, Welfare and Sport, 2008.
- ³³ Ibid.
- ³⁴ Norwood and Kendall, 2009.
- ³⁵ OECD, 2006.
- ³⁶ Glendinning and Moran, 2009.
- ³⁷ Schut and van den Berg, 2009.
- ³⁸ Campbell and Ikegami, 2000.
- ³⁹ Mitchell, Piggott, and Shimizutani, 2004.
- ⁴⁰ A description of the Japanese system is available through the Ministry of Health, Labour, and Welfare at <http://www.mhlw.go.jp/english/topics/elderly/care/index.html>.
- ⁴¹ Japan Ministry of Health, Labour, and Welfare, “Long Term Care Insurance Operational Situation Report (Provisional),” cited by John Campbell in correspondence with author. The report, in Japanese only, is available at <http://www.bm.mhlw.go.jp/topics/kaigo/osirase/jigyom08/0809.html>.
- ⁴² Speech by Dr. Naoki Ikegami to AARP Global Aging Program Idea Exchange, 2006. Summary available at http://www.aarp.org/research/international/events/apr19_06_ikegami.html.
- ⁴³ Jones, 2009.
- ⁴⁴ Shimizutani, 2006.
- ⁴⁵ For an excellent description of the inner workings of the program, see Campbell and Ikegami, 2000.
- ⁴⁶ Campbell, 2010.
- ⁴⁷ Campbell, 2006. The Japanese spending projection includes the cost of long-term care in hospitals that is paid by health insurance.
- ⁴⁸ Mitchell, Piggott, and Shimizutani, 2004.
- ⁴⁹ Merlis and Van de Water, 2005. Private insurance benefits in the U.S. are normally triggered by an inability to perform two ADLs.
- ⁵⁰ Abraham, Loida, 2009. Swiss Re Life & Health North America, Powerpoint Presentation, Intercompany Long-Term Care Insurance Conference.

⁵¹ Courbage and Roudaut, 2008.

⁵² International Reform Monitor, 2007.

⁵³ Morel, 2004. This paper also provides a good history of the political environment in both Germany and France as these countries reformed their long-term care programs.

⁵⁴ Ibid.

⁵⁵ Wall, Emma, “Long-Term Care: Life is Still a Postcode Lottery” *The Daily Telegraph*, November 12, 2009, accessed Nov. 15, 2009, at <http://www.telegraph.co.uk/finance/personalfinance/insurance/longtermcare/6554702/>.

⁵⁶ OECD, 2005.

⁵⁷ Hancock, Wittenberg, Pickard et al., 2006.

⁵⁸ For a basic description of benefits and means-testing, see www.lifetimecare.co.uk/ltc People who have no spouse or partner are expected to contribute all of their income, less a small personal care allowance, to the cost of a nursing facility. Those who are married must contribute their state pension, along with half of any personal pension.

⁵⁹ King Fund, 2006.

⁶⁰ Weiner, Tilly, and Cuellar, 2003; also Gibson, 2003.

⁶¹ Royal Commission on Long-Term Care, 1999.

⁶² Joseph Rowntree Foundation, 2006, available at <http://www.jrf.org.uk>.

⁶³ Kings Fund, 2006, available at http://www.kingsfund.org.uk/resources/publications/securing_good.html.

⁶⁴ Secretary of State for Health, 2009, “Shaping the Future of Care Together” Accessed at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_102732.pdf.

⁶⁵ Gheera and Booth, 2009.

⁶⁶ Stevenson, Frank, and Tau, 2009.

⁶⁷ More than 95% of all policies sold in 2006 were tax qualified.

⁶⁸ Stevenson, Frank, and Tau, 2009.

⁶⁹ Cramer and Jensen, 2006. While the authors did not specifically look at the impact of tax subsidies, their analysis of Health and Retirement Survey data found that the demand for coverage is relatively price inelastic. They concluded that even a 25% price discount—far more than is available through tax incentives—would increase demand by only 11.2%.

⁷⁰ Other papers have reached broadly similar conclusions. See Johnson et al., 2008, “Modeling the Decision to Purchase Private Long-Term Care Insurance” Washington, D.C., The Urban Institute. However, a third paper has found somewhat larger incentive effects. It concluded that presence of a tax subsidy is associated with a 30 percent increase in the probability of private insurance coverage. However, this paper also concluded that the subsidy cost to the state exceeded its Medicaid cost savings. See Goda, Gopi Shah, 2009, “Do Tax Subsidies for Private Insurance Reduce Medicaid Costs/ Evidence from the Market for Long-Term Care Insurance.”

⁷¹ A 60-year-old can expect to pay an annual premium of roughly \$2,000 for a comprehensive policy that pays \$150-a-day for five years. Premium is for policies offered to federal employees through the Office of Personnel Management. Tax deductions reduce taxable income, but the reduction in the after-tax cost of a policy is much lower than the deduction. Also, deductions are

more beneficial to those in higher tax brackets than those in lower brackets. Imagine two taxpayers paying \$2,000 annually for a policy. The deduction would reduce tax liability by \$700 for a buyer in the 35 percent bracket. A taxpayer paying a marginal rate of 10 percent would lower their tax liability by just \$200. Credits, by contrast, reduce tax liability dollar-for-dollar and by an equal amount regardless of the buyer's marginal tax rate. Thus, a 10 percent credit on \$2,000 in premiums would reduce the after-tax cost of the policy by \$200. Tax qualified policies must meet certain basic consumer protection standards.

⁷² Long-Term Care Partnership State Tracking Map, 2007, Thomson-Reuters. Available at <http://www.dehpg.net/lcpartnership/>.

⁷³ New York, California, Indiana, and Connecticut.

⁷⁴ Government Accountability Office, 2007, "Long-Term Care Insurance: Partnership Programs Include Benefits that Protect Policyholders and are Unlikely to Result in Medicaid Savings" (GAO-07-231), Washington, D.C.

⁷⁵ News Release, May 1, 2009, OPM Awards New Long-Term Care Insurance Contract. Available at <http://www.opm.gov/news/opm-awards-new-long-term-care-insurance-contract,1462.aspx>.

⁷⁶ May 1, 2009, estimate: personal communication with John Cutler, Office of Personnel Management. For an earlier analysis of the program, see U.S. Government Accountability Office, 2006, "Long-Term Care Insurance: Federal Program Has a Unique Profit Structure and Faced a Significant Marketing Challenge" (GAO-07-202).

⁷⁷ National Clearinghouse for Long-Term Care Information Web site, accessed April 18, 2009, at http://www.longtermcare.gov/LTC/Main_Site/Planning_LTC/Campaign/index.aspx.

⁷⁸ Cohen, 2009.

⁷⁹ America's Health Insurance Plans, 2007.

⁸⁰ Cutler, Shulman, and Litow, 2007.

⁸¹ Burman and Johnson, 2007.

⁸² See Bishop, Christine, 2007, "A Federal Catastrophic Long-Term Care Insurance Program" Georgetown University Long-Term Care Financing Project and Tumlinson, Anne and Jeanne Lambrew, 2007, "Linking Medicare and Private Health Insurance for Long-Term Care" Georgetown University Long-Term Care Financing Project.

⁸³ The Senate version of CLASS is available at <http://democrats.senate.gov/reform/patient-protection-affordable-care-act-as-passed.pdf>.

⁸⁴ A cash benefit could be paid directly to beneficiary or made available through a fiscal intermediary that would distribute payments to providers.

⁸⁵ http://kenedy.senate.gov/newsroom/press_release.cfm?id=dd333696-31c1-412c-aa47-0c3d138fa4bb. For the most recent version of CLASS, see H.R. 3590.

⁸⁶ Finkelstein (2006) found that such a steady revenue stream through Medicare drove up prices of health care providers.

⁸⁷ American Academy of Actuaries, 2010.

⁸⁸ CBO, 2009.

⁸⁹ CMS, 2009.

⁹⁰ Industry experts estimate that premiums for a cash benefit average 40 percent higher than for otherwise identical reimbursement policies.

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