Financing Trends Across the OECD

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Clusters of strategies, but no clear trends

- East Asia – adopting social insurance
- France, Germany, and the US – supplementation with private LTCI
- The Netherlands – retrenchment via devolution and use of health insurers
- The UK and Australia – adding catastrophic coverage

East Asia – Development of Traditional Social Insurance

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East Asia – Progress in Social Welfare Systems

Date of Legislation			
	Japan	**Korea**	**Taiwan**
Health Insurance	1958	1989, 2000	1995
National Pension	1959	1988	2008
Employment Insurance	1974	1995	2002
LTC Insurance	2000	2008	2012-14(??)

Source: Cheng, 2009

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Shared components

- Some have spoken of a unique East Asian approach to social welfare
- Universal coverage
- Social insurance financing mechanism
  - **In Japan, only those 40 or older pay in**
  - **In Korea and Taiwan, the design is that public revenue also supplements**
- Reliance on both public and private providers

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Issues

- Tweaking the financing – Japan has been successful in making adjustments to keep the program within budget
- Cash benefits – policy is officially hostile to cash benefits, but where workforce undersupply is an issue, it is allowed (Korea and Taiwan)
- Role of foreign workers – undersupply of domestic workforce means that this is an issue in all nations
  - **Japan, which has traditionally been highly restrictive, is now considering loosening regulations**
  - **Korea uses this as a mechanism for re-patriating Koreans who emigrated to China**
  - **Taiwan currently relies overwhelmingly on foreign workers for its LTC workforce – the role of such workers has been a key sticking point in the progress of its legislation**

Private Long Term Care Insurance: Developments in France, Germany, and the US

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Overall:

- France's private LTCI market is expanding consistently and is an entrenched and widespread component of their financing system
- Germany has newly allowed private LTCI where it was prohibited before: in the first year, roughly 400,000 policies were sold
- The US market is in crisis
  - **The upside: this is forcing insurers to re-think their product**

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The French LTCI market

- In 2012, 5.7 million people hold policies (out of a total population of 66 million), up from 1.6 million in 2004
- Its market is growing steadily at roughly 5 percent per year.
- Much of that growth has been seen in the group market, which comprises 75 percent of all policies.

Private LTCI supplements the public program

- The public program in France is cash-based and universal, but heavily income-adjusted
- The income-adjusted structure creates incentives for supplementation
- The French are also used to supplementing their health insurance via private insurance
- Most people obtain insurance under group policies via Mutuelles, which offer a range of insurances (including health)

But… is coverage sufficient?

- Policies are very cheap, compared to the US
  - **Individual policies cost about 345 euros per year (in 2010)**
  - **Group policies average 74 euros annually, with 40-50 percent of the cost borne by the employer**
- But coverage is limited
  - **Together, the APA and supplemental insurance are estimated to cover only about 32 percent of the average monthly cost of care.**
  - **The level of disability required to claim benefits is quite high: 75% of policies require claimants to be bed or chair-bound and require daily assistance several times a day, or require constant monitoring due to cognitive impairment.**

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Question of role of private insurance

- Sarkozy was more favorable
- Hollande's administration has been generally supportive, but more focused on regulating the market
- Public is generally supportive of the supplementary role of private insurance

Germany

- Previously, only individuals who opted out of the public health insurance program were allowed to purchase private LTCI, generally as a supplement to their health insurance – roughly 9% of the population
- Legislation opened up the market in 2014.
- An estimated 400,000 purchased policies in that year.
- Age profile of purchasers is promising:
  - **Over 40% of all policies were purchased by persons between 25 and 35 years of age.**
  - **About 65% are younger than 50**
  - **Only 13 percent are over 60**

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A heavily regulated product

- Offered via the same sickness funds providing health insurance
- No underwriting is allowed – premiums are age-related only
- Assessments are tied to the public system
- Minimum and maximum benefits are limited under law
  - **For example, the minimum would be €600 per month at care level III**
  - **The maximum cannot exceed the public benefit at each level.**

The US – a market is crisis

- Companies are dropping out of the market
- Underwriting getting stricter
- Premium increases
- Clientele narrowing

- A death spiral?

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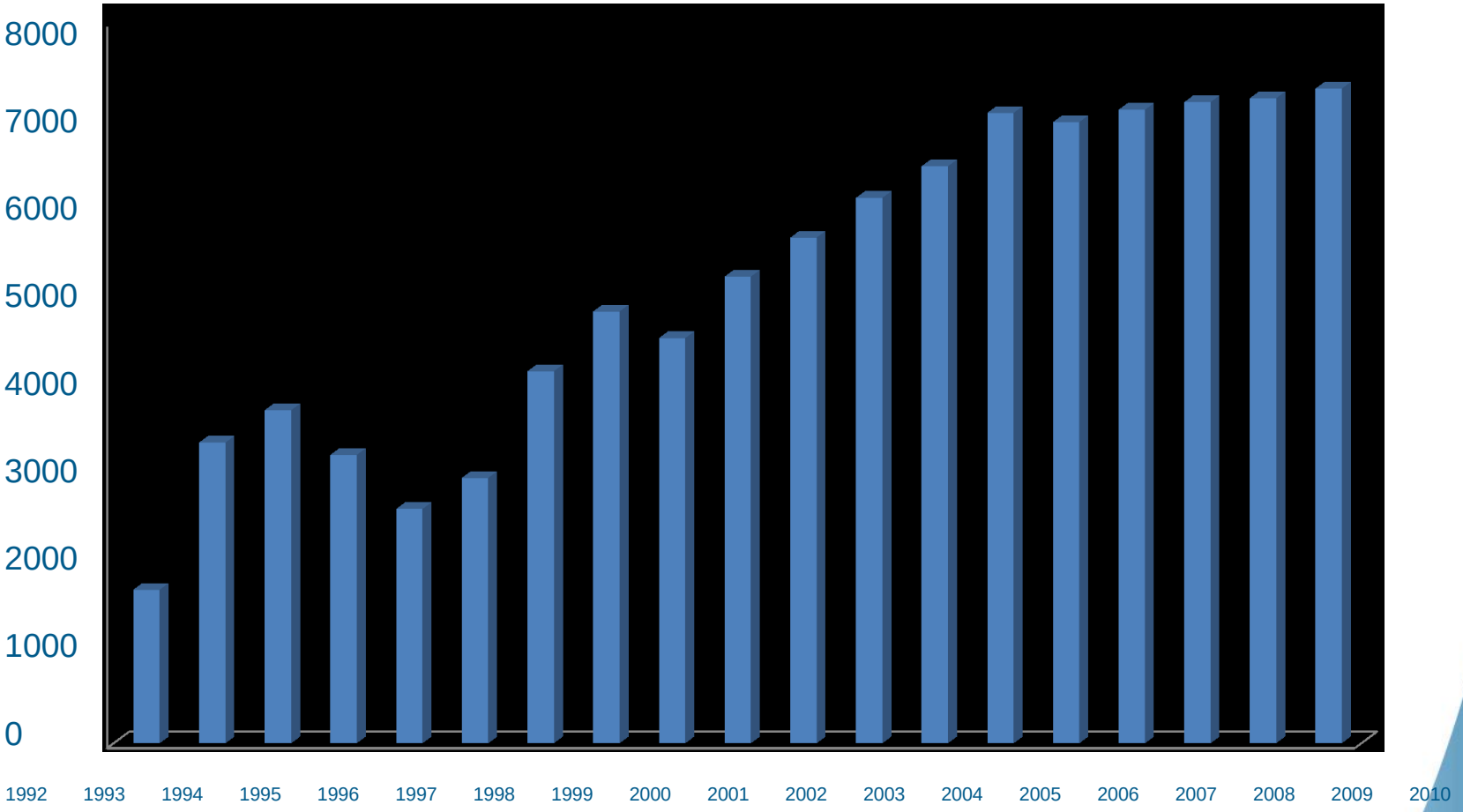
Number of insured lives has been relatively flat since 2005



Source: LifePlans data

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Companies dropping out of the market

- In 2002, there were **102** companies selling LTCI
- In 2013, there were about **12**

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Have private LTC insurers in the US finally reached their tipping point?

- Land This Plane
  - **Polled a diverse group of actuaries, public policy experts, regulators, and insurance industry executives**
  - **Found agreement re complementary roles of private and public**
- Evidence of some leaders in insurance discussing collaboration with public sector at state level
- Frank et al recommending product simplification and standardization

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The Netherlands -- retrenchment

Historically, one of the most expensive public LTC programs

- Highest in terms of per capita spending -- an average €1,209 per participant in 2010);
- Second highest in terms of proportion of GDP spent on LTC
- Costs have been rising steadily, up to €20.5 billion in 2008, from €12.8 billion in 1998.
- The proportion of GDP spent on LTC rose from 2.2% in 1985 to 3.8% in 2009

Why has it gotten out of control?

- One of the oldest universal public programs – introduced in 1968
- Relatively high levels of institutionalization
  - **In 2010, 43% of program participants lived in nursing homes and 57% at home**
  - **6.6% of 65+ population**
  - **Acuity levels are lower than in comparable countries**
- Broad eligibility levels
- Changes in other public programs = spillover
- Cash benefits?
  - **Program grew rapidly –from 13,000 in 2001 to 130,000 in 2011 – to about 18% of program participants. Costs increased at an average 23% per year**
  - **It is argued that the level of the benefit is high enough to attract participants but too low to engage private providers**

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What is being done?

- Enrollment for the cash benefit component of the program was frozen in 2010
- Eligibility criteria have been narrowed for the program overall
- Availability of family care now factors into benefit level assessments
- Big structural changes – splitting “care” from “social care”
  - **Care (outpatient nursing, personal care, and mental health services) will be financed through the public LTC program but administered through the health system**
  - **Social care (domestic help, home adaptations, psychosocial supports, mobility devices and transport) will be devolved to municipalities**
- In short, much LTC will be folded into the health system

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Summary

- No clear overall story – no much convergence
- Most interesting developments appear to be expansion of private LTCI and the new East Asian model
  - **Need more data on comparative outcomes**
  - **Raises questions of benchmarks**
  - **Also, the various public policy tools available to tweak financing**

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