Long-term care insurance in Germany

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&

European Observatory on Health Systems and Policies

It took a long time for long-term care insurance to be created as the fifth pillar of social insurance

- 1883: Health Insurance

+ 1 year

- 1884: Work-related Accidents and Diseases Insurance

+ 4 years

- 1889: Pension Insurance

+ 38 years

- 1927: Unemployment Insurance

+ 68 years

- 1995: Long-Term Care Insurance

Early 1990s: the situation before the creation

Underlying problem perception

- Demographic change: number of dependent elderly was expected to grow
- Socio-structural change: care capacities of families were expected to decrease
- Increasing numbers of dependent elderly in nursing homes were relying on (means-tested) social assistance

Early 1990s: the situation before the creation

LTCI was fostered by two distinct discourses

- Welfare state discourse
  - German welfare state aims at status maintenance.
  - It is “unworthy” if citizens with after a normal working life depend on welfare just because of needing long-term care
  - High share of social assistance recipients was perceived as social scandal
- Fiscal policy discourse
  - Municipalities were increasingly suffering from high expenditures for people in nursing homes. Federal states acted as advocates.
  - As social assistance is means-tested, municipalities with a higher share of poor population were especially affected → growing disparities among municipalities

Early 1990s: the situation before the creation

Reshaping of the welfare state rather than expansion

- Introduction of LTCI was accompanied by cuts in other welfare state areas
- LTCI marks break with German tradition of service provision according to needs (as in health insurance)
- LTCI Act was shaped in order to prevent any “cost explosion” thereafter
  - Tight definition of dependency plus assessment by a third party (unlike most health benefits)
  - Capped benefits (nominally fixed in € per month)
  - Discretionary adjustment of benefits

Early 1990s: the situation before the creation

Compromise between Christian Democrats and Liberals: two-pillar system with

- Social LTCI as PAY-AS-YOU-GO system, but
- Private mandatory system as funded system

i.e. using the two separate systems (and financing logics) as in health insurance

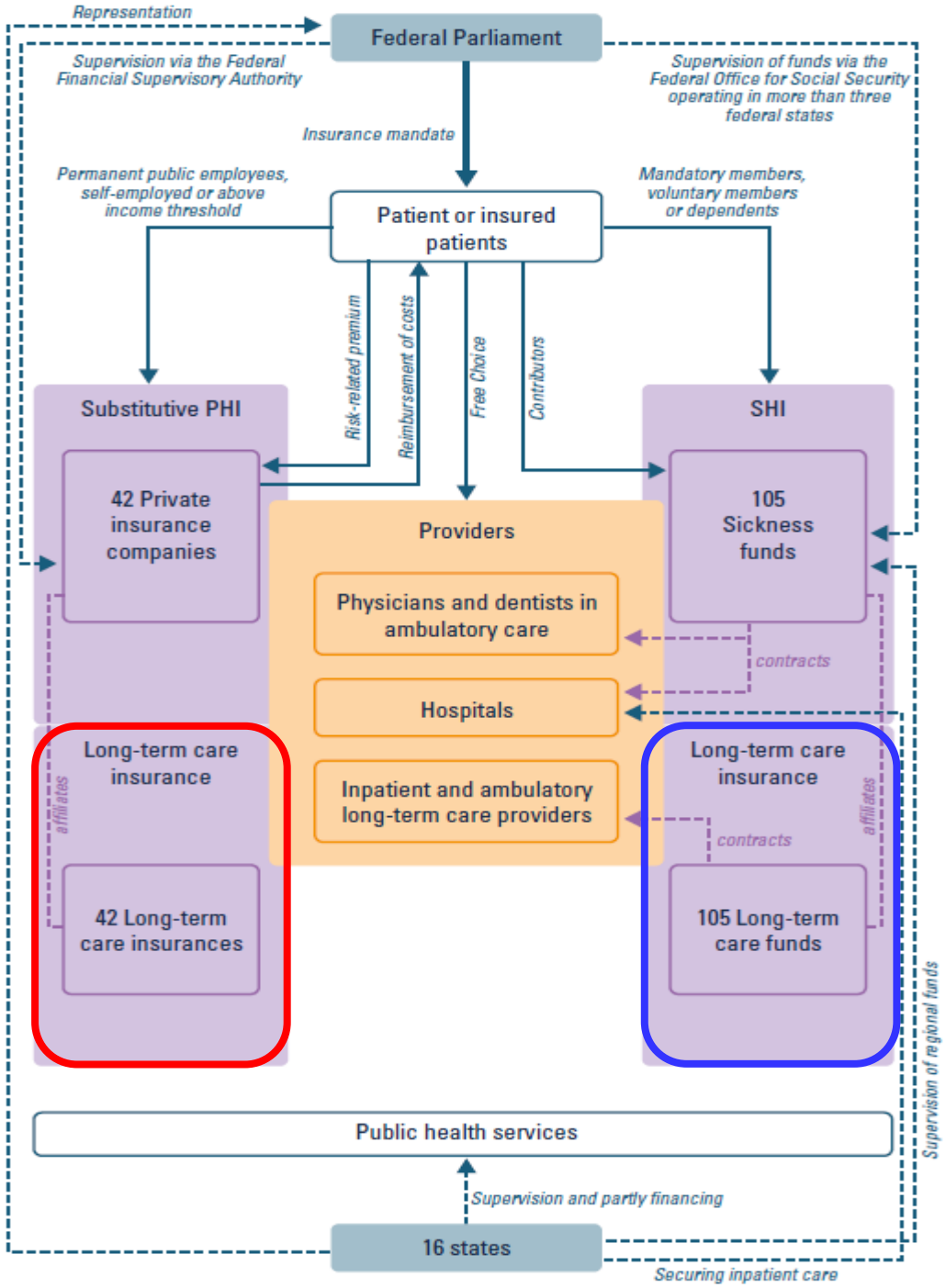
LTCI basics

- Mandatory insurance for the total population:
  - Almost 90% Social Long-term Care Insurance (LTCI)
  - Around 10% private mandatory LTCI
- Financing:
  - PAY-AS-YOU-GO system in Social LTCI, contributions levied on income from wages and salaries up to a certain income cap. Parity between employers and employees, extra contribution for the childless since 2004.
  - Funding by premiums in private mandatory LTCI, but with strong elements of PAY-AS-YOU-GO as premiums are capped (for the elderly)
- Eligibility:
  - According to ADL scheme, differentiated according to three levels of care, no age limit, assessment by Medical Review Board

LTCI basics

- Benefits:
  - Cash benefits (for informal care), in kind benefits (for home care) and benefits for nursing home care with choice for the beneficiary
  - Capped benefits with caps below need, no provision for automatic adjustment of nominally fixed benefits
  - In nursing home care: only capped benefits for care costs, nothing for room and board or for investment costs
- Administration:
  - Social LTCI is administered by LTCI funds founded as branches of sickness funds. LTCI is independent but under the umbrella of health insurance
  - No competition between funds as all contributions go into one fund which covers all expenditure → difference to health insurance

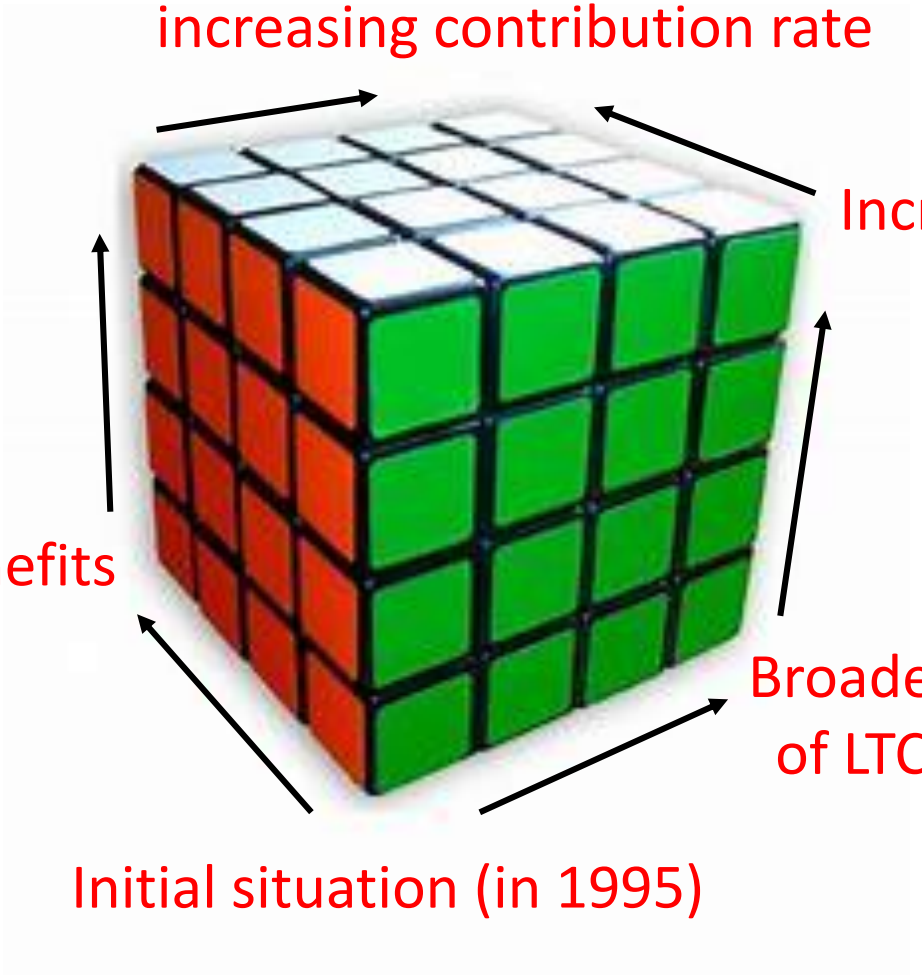
LTC insurers: separate but under the same roof as health insurance: every sickness fund and private insurer maintains a “daughter” for LTC (board of directors identical)



LTCI trends

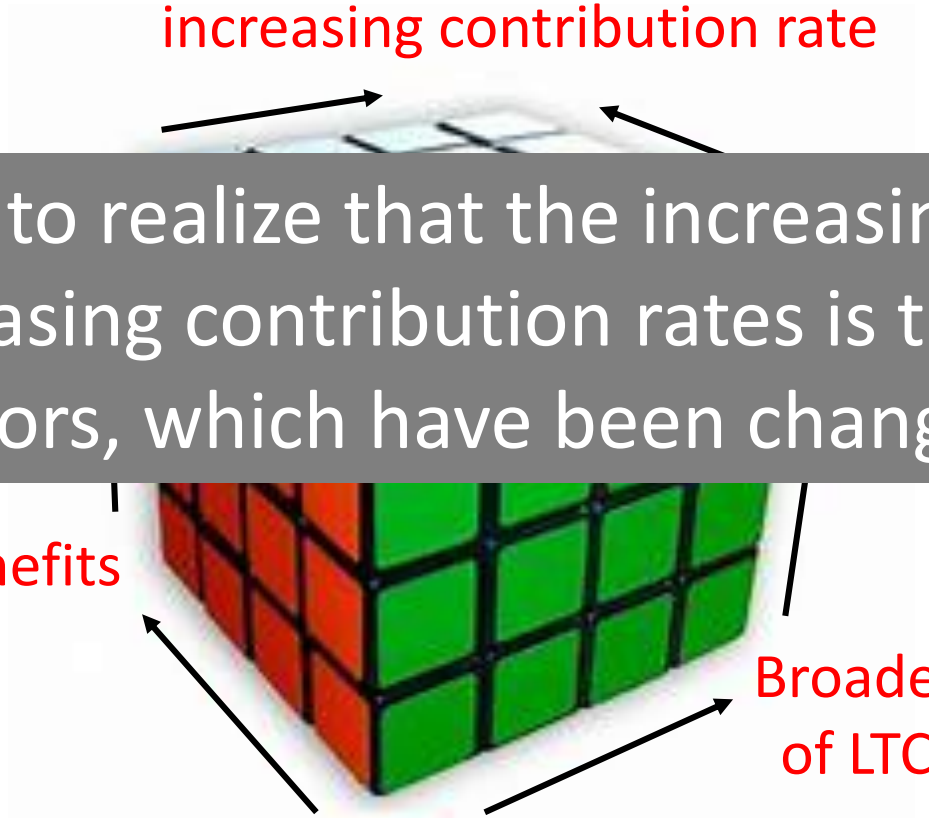
- Expenditure side
  - Number of eligible dependent people is going to increase
  - Nurse shortage might lead to more than average wage rises
- Contributory side
  - Number of people in gainful employment is going to decline (demographic transition)
  - Wages will increase at least with productivity gains
- Dilemma
  - Increased contributions can be used to adjust benefits (care costs rise in line with wages) --> contribution rate goes up
  - Increased contributions can be used to finance additional number of beneficiaries → real value of capped benefits declines

LTCI trends and challenges



LTCI trends and challenges

Increasing expenditure -->
increasing contribution rate



It is important to realize that the increasing expenditure, and thus increasing contribution rates is the result of the other three factors, which have been changed deliberately!

Increasing benefits

Broader definition
of LTCI eligibility

Initial situation (in 1995)

Eligibility criteria

Before 2017:
“in need of care” legally referred to those individuals who have a physical, psychological or mental disease, and/or a handicap that requires a significant amount of help to carry out daily activities of everyday life.
The Medical Review Boards assessed the care needs according to a standardized and complex assessment procedure and categorized the applicant into one of three care levels (1 – 3, and in practice, applicants suffering from dementia “only” were classified as level 0).

Definition of dependency

	Level I	Level II	Level III
Need of care with basic ADLs	At least once a day with at least two ADLs	At least thrice a day at different times of the day	Help must be available around the clock
Need of care with instrumental ADLs	More than once a week	More than once a week	More than once a week
Required time for help in total	At least 1.5 hours a day, with at least 0.75 hours for ADLs	At least 3 hours a day with at least 2 hours for ADLs	At least 5 hours a day with at least 4 hours for ADLs

Source: §15 Social Code Book (Sozialgesetzbuch XI, SGB XI).

Eligibility criteria since 2017

The new evaluation instrument for determining the need for care comprises six modules that are weighted differently in the final overall score:

1. Mobility (10%)
2. Cognitive and communicative abilities (higher value from modules 2 and 3, in total 15%)
3. Behaviour and psychiatric problems (higher value from modules 2 and 3, in total 15%)
4. Self-care (40%)
5. Dealing with requirements due to illness or therapy (20%)
6. Organisation of everyday life and social contacts (15%)

Each module consists of various items. For each item, the assessor records how independently the applicant can perform an activity, if or to what extent an ability is present or how often a certain behaviour occurs. The applicant receives one of the five care grades if the total score is above 12 points of a total of 100 points. For the highest care grade, a special rule applies. It is granted if the applicant has a score of at least 90 points or has lost the use of both arms and both legs.

Eligibility criteria since 2017

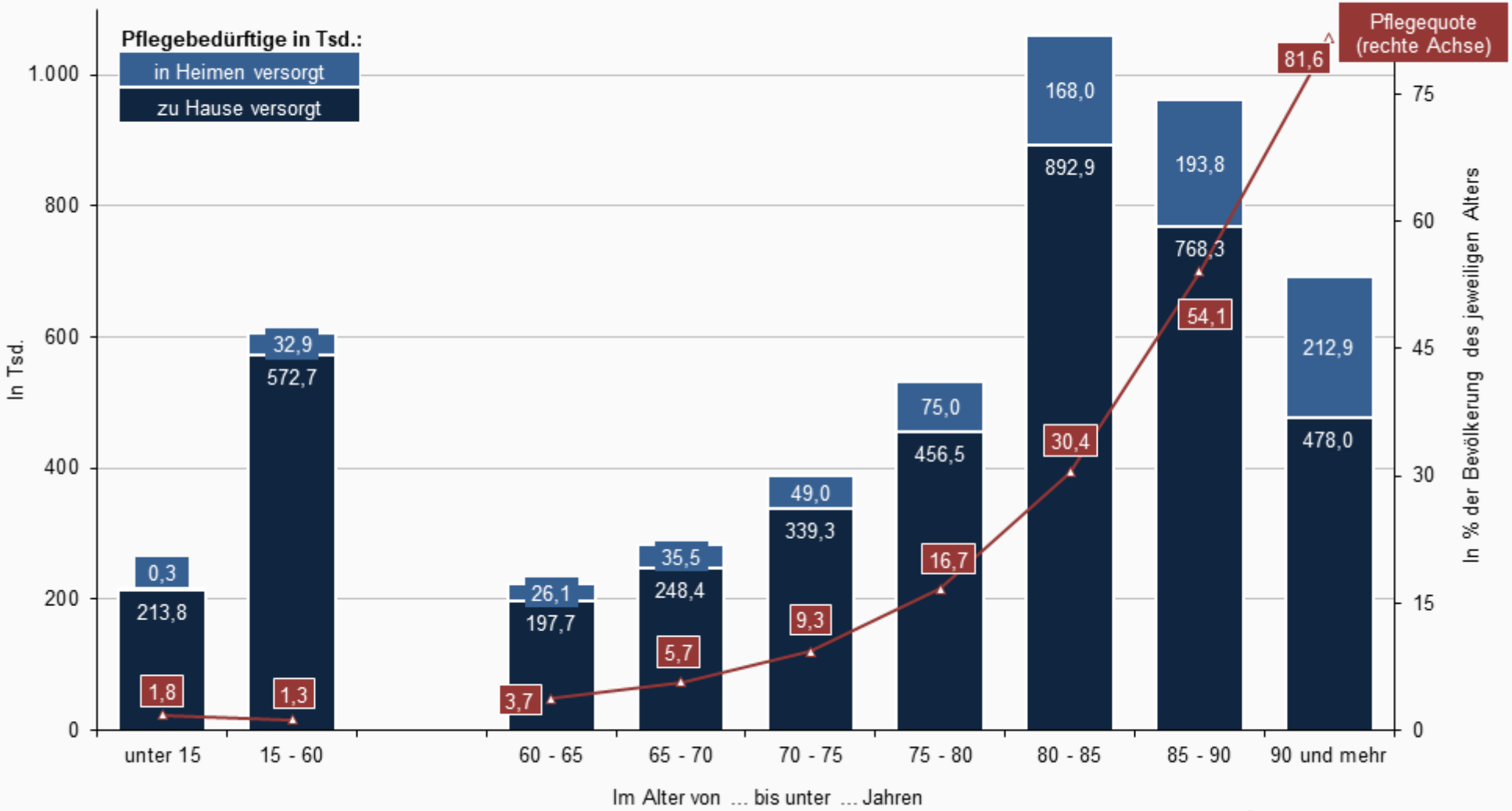
The assessment philosophy is characterised by fundamental changes:

1. The allotment of time required for care was replaced by the **degree of independence**. Heretofore, the evaluation was based on how often and how long the dependent person needed assistance. To that end, the assessor drew on benchmarks as reference points, a complete takeover of the activities by a lay caregiver being assumed. For example, a full-body wash was graded with 20 to 25 minutes. From now on, to what extent the applicant can shower or bath independently will be captured.
2. The former deficit orientation is replaced by a **resource orientation**. It is therefore not a question of what the person in need of care can no longer do, but rather what he or she is still able to do.

Eligibility criteria since 2017

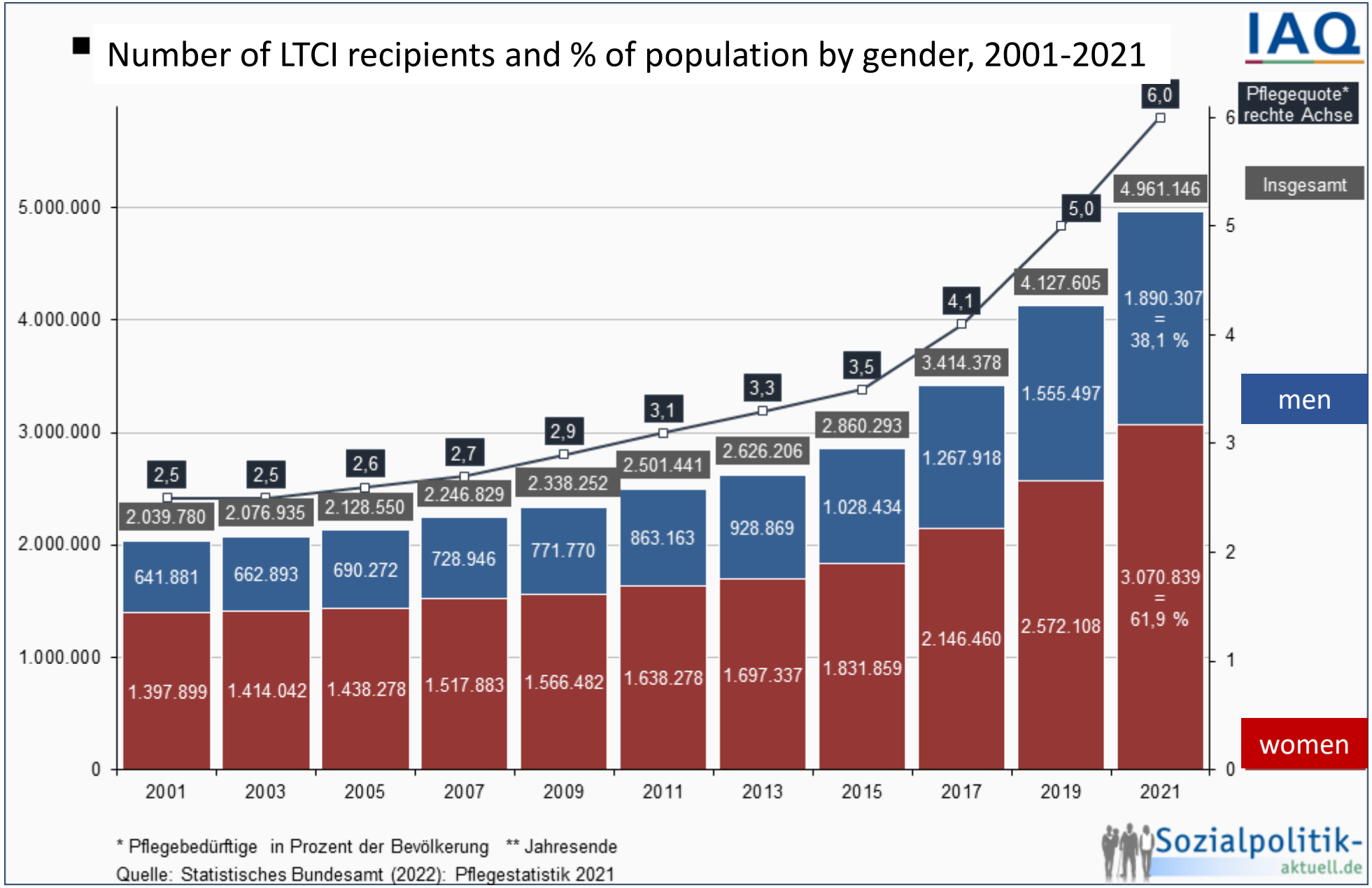
3. Previously, the need for care in some activities of daily living (ADL) was taken into account which consisted of personal hygiene, nutrition, mobility and household assistance. In the future, there will be a **comprehensive consideration of the care need**. Cognitive and psychiatric impairments will be considered especially in the modules 2 and 3 and to some extent in the modules 5 and 6. In the modules 1 and 4, on the other hand, special emphasis is placed on physical impairments which continue to be of great relevance due to the high weight of these modules in the total score.
4. The earlier three care levels have been replaced by **five care grades**. The lowest care grade only serves as a type of preliminary level, though, with an easy-to-achieve minimum score and relatively low-cost reimbursement benefits that can be used only for their specified purpose.

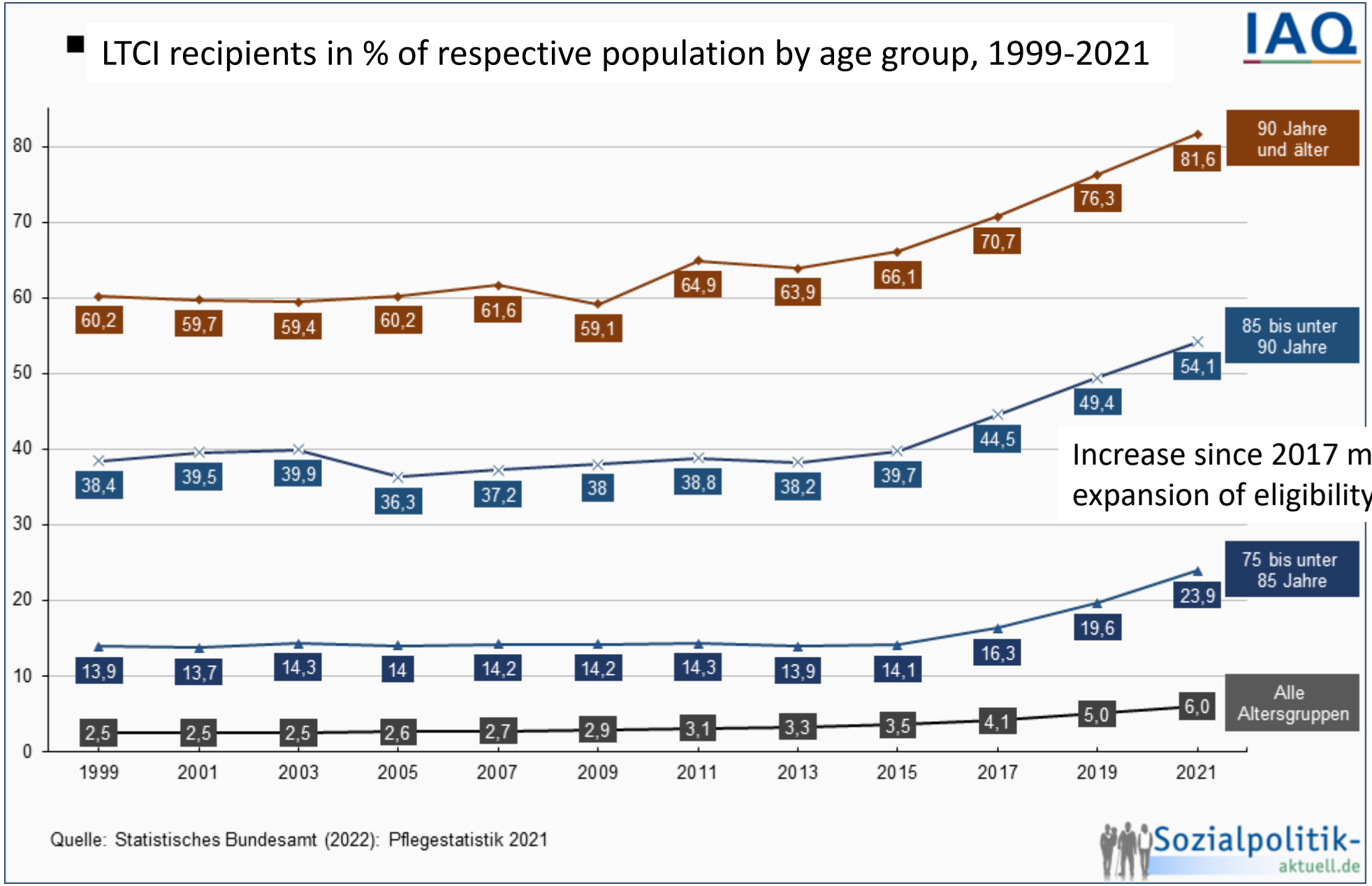
Number of LTCI recipients and % of population by age groups, 2021



Quelle: Statistisches Bundesamt (2022): Pflegestatistik 2021

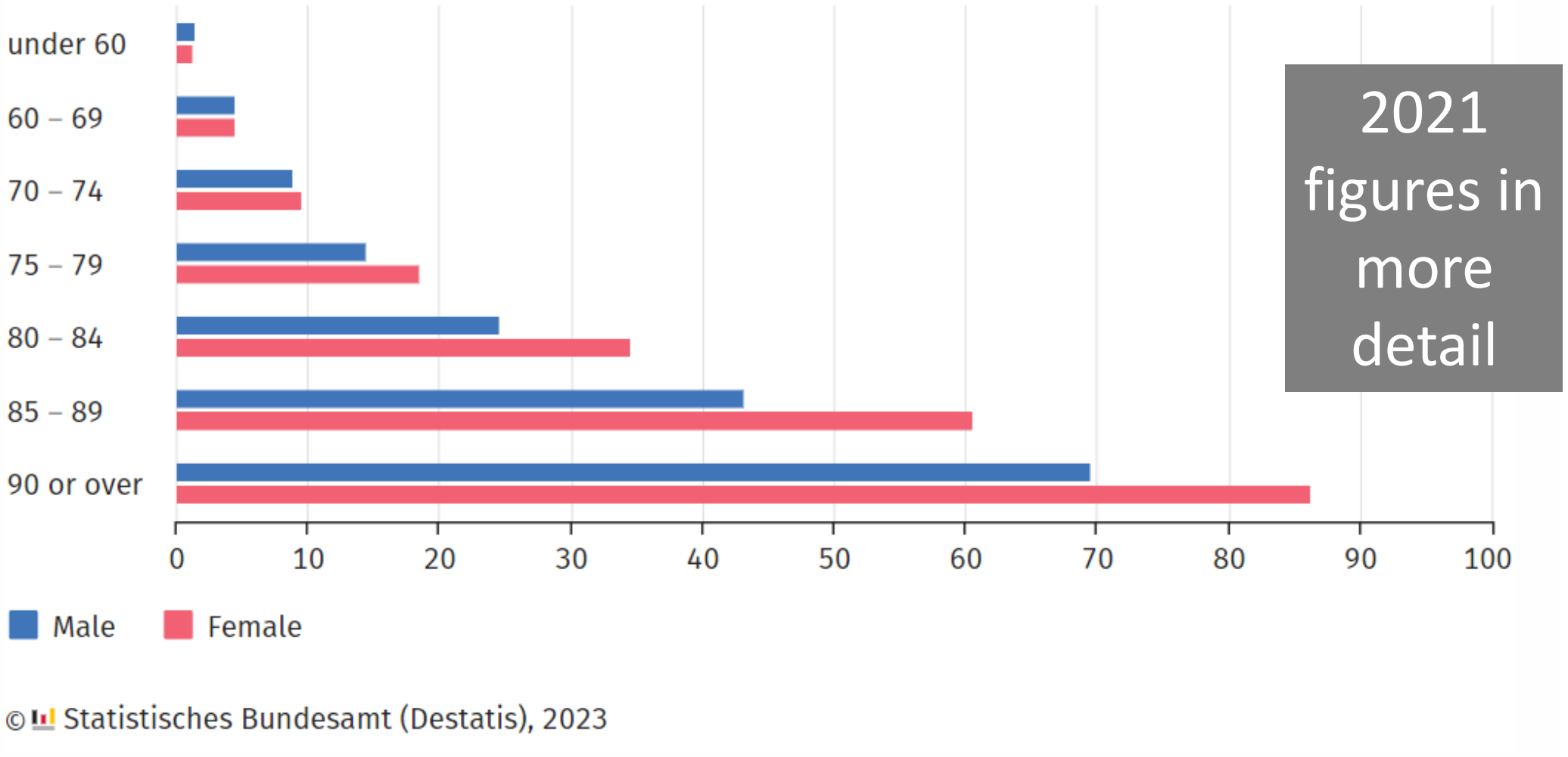
Number of LTCI recipients and % of population by gender, 2001-2021





Increase since 2017 mainly through expansion of eligibility definition

LTCI recipients in % of respective population by age group, 2021

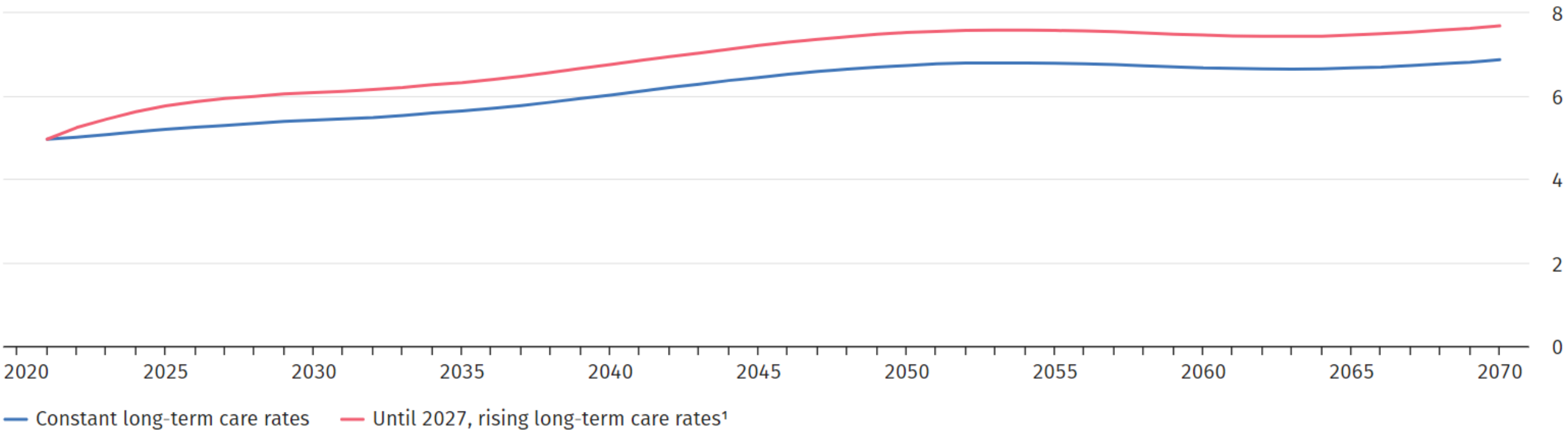


2021 figures in more detail

A projection into the future

People in need of long-term care, 2021 to 2070

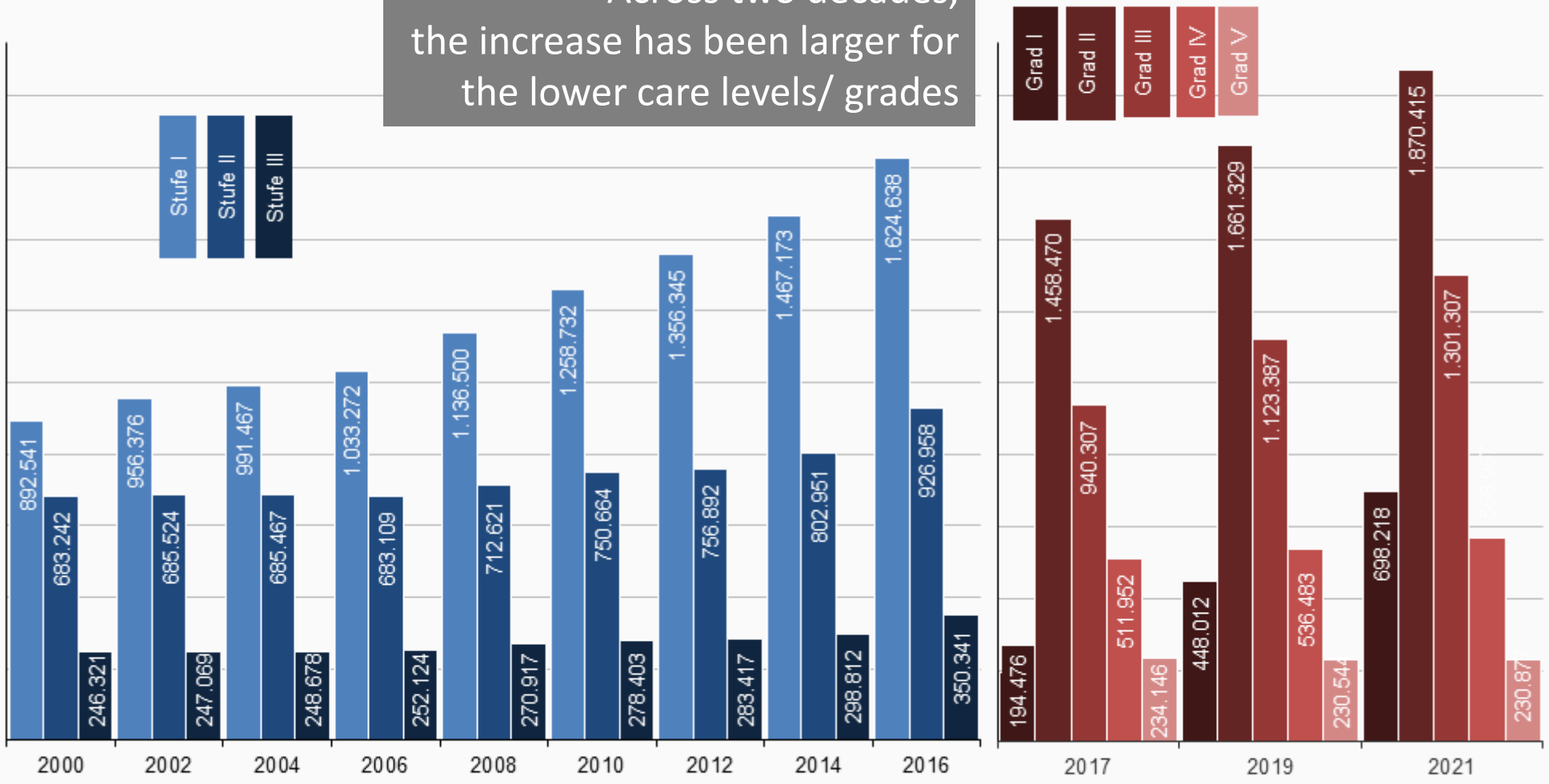
From 2022, long-term care projection variants with moderate demographic development, millions



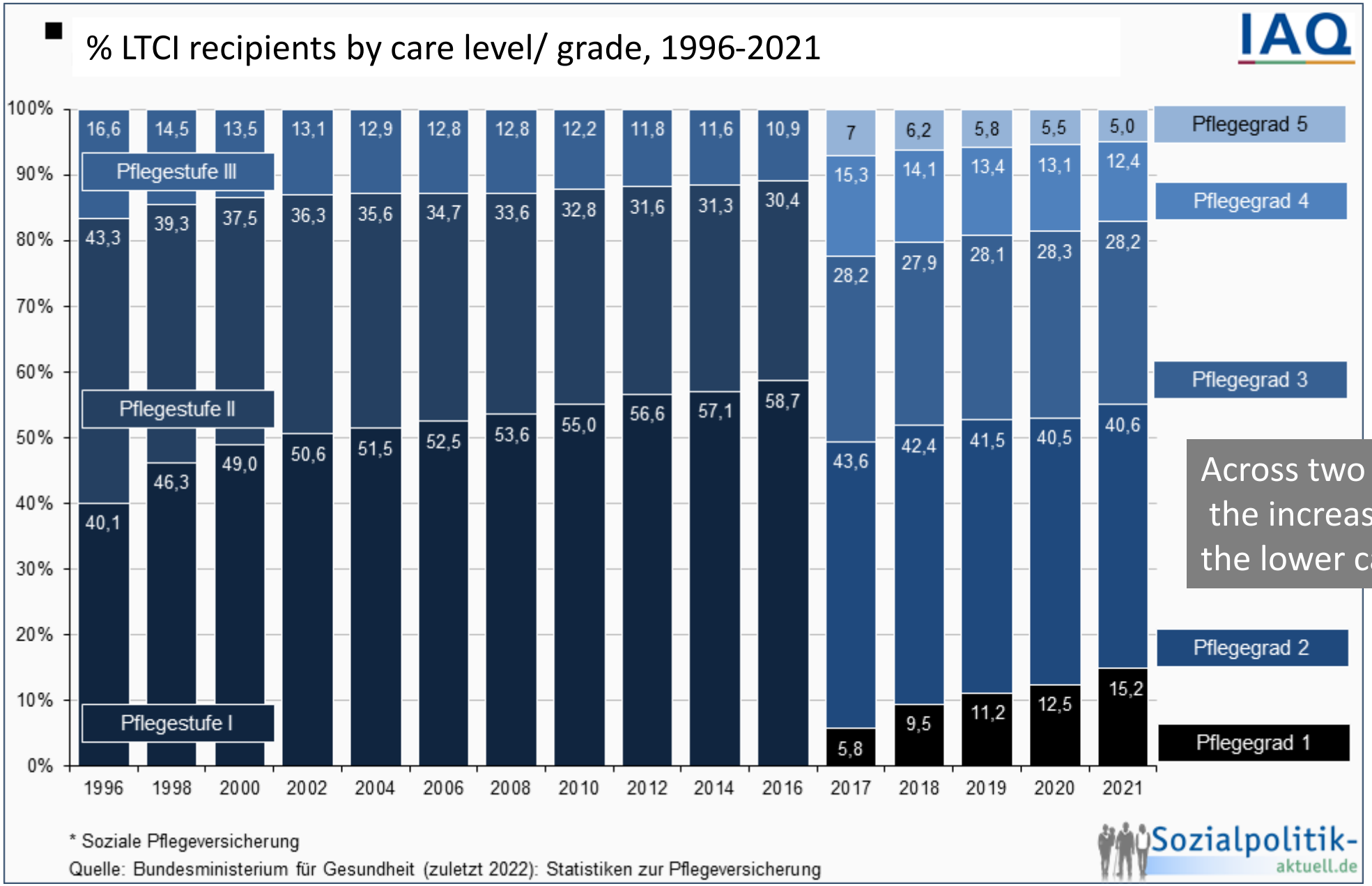
1 ongoing effects of introducing a broader concept of the need for long-term care

% LTCI recipients by care level/ grade, 2000-2021

Across two decades, the increase has been larger for the lower care levels/ grades



Quelle: Bundesministerium für Gesundheit (zuletzt 2022): Statistiken zur Pflegeversicherung



Across two decades,
the increase has been larger for the lower care levels/ grades

Basic benefit categories (with choice for all eligible persons)

- Care allowance (a fixed amount of money per month for those receiving informal care at home) AND/OR
- Benefits-in-kind for professional nursing care provided at home

OR

- Payment of nursing care provided in nursing homes

All three benefits vary by care grade!

Benefits-in-kind and support of nursing home care are capped!

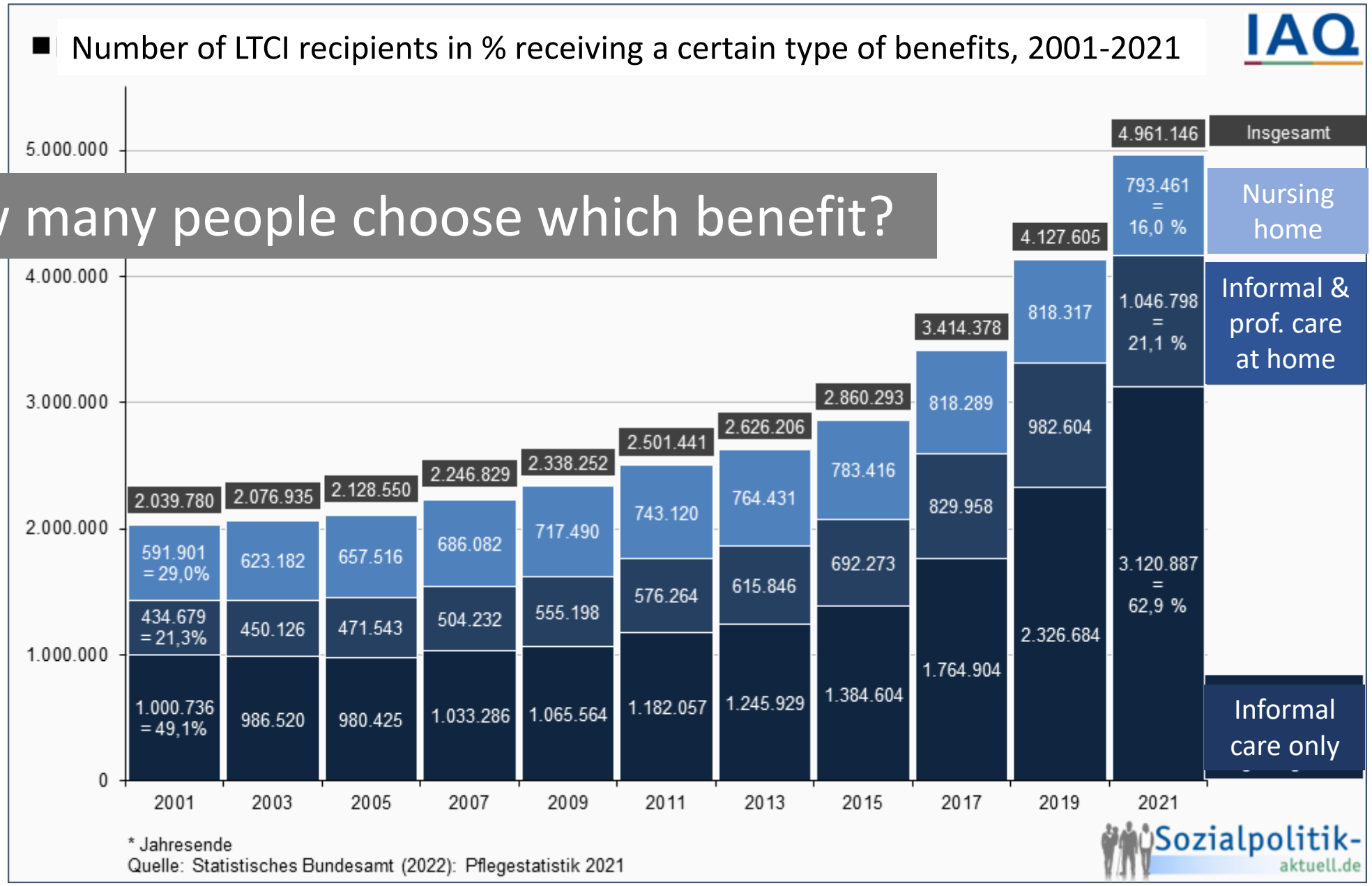
Adjustment of monthly sums/ caps

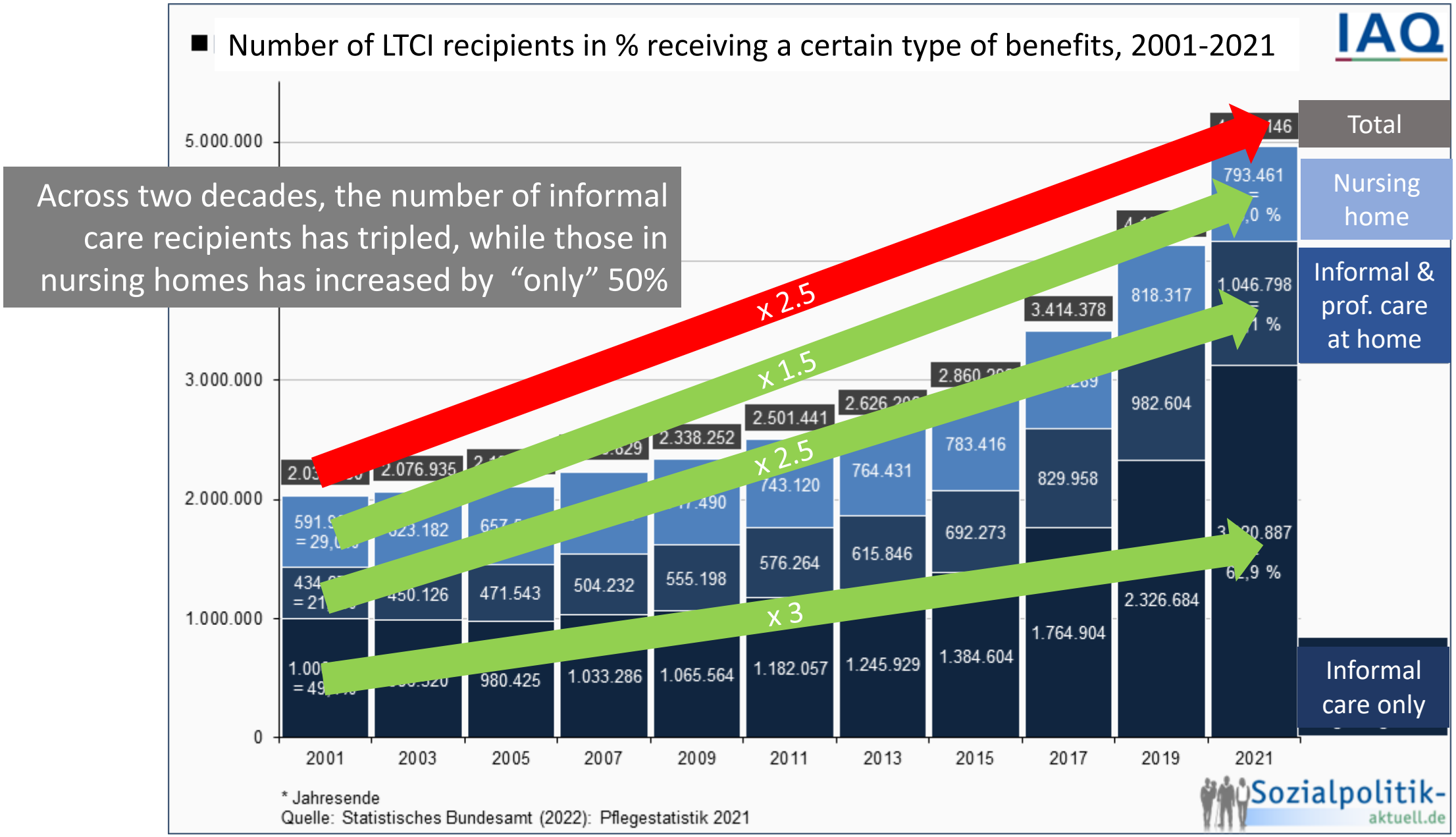
- From 1994 to 2008 LTCI benefits were kept constant in nominal terms
  - Real purchasing power has been decreasing considerably and out of pocket payments increased.
- Only 2008 a first adjustment was introduced
  - Increase: 1.4 per cent per year for 2007-2012, about inflation rate
  - Financed by an increase in contribution rate from 1.7 to 1.95 percent
  - For some benefits there is no increase at all
  - In nursing homes nevertheless we see increasing copayments
- 2015: next adjustment by 4 % for all benefits in order to adjust for the inflation 2012-15
- Since then, further adjustments, also to compensate for higher costs in nursing homes (due to higher nurse salaries)

Benefits in €/ month (2023), i.e. cash benefits or caps for services in-kind

	Informal care	Professional care at home	Care in nursing homes
I	-	-	125
II	316	724	770
III	545	1.363	1.262
IV	728	1.693	1.775
V	901	2.095	2.005

How many people choose which benefit?




Number of LTCI recipients in % receiving a certain type of benefits, 2001-2021
IAQ
Across two decades, the number of informal care recipients has tripled, while those in nursing homes has increased by "only" 50%
x 2.5
x 1.5
x 2.5
x 3
Total
Nursing home
Informal & prof. care at home
Informal care only
5.000.000
3.000.000
2.000.000
1.000.000
0
2001
2003
2005
2007
2009
2011
2013
2015
2017
2019
2021
2.076.935
2.338.252
2.501.441
3.414.378
818.317
982.604
783.416
764.431
743.120
829.958
692.273
615.846
576.264
555.198
504.232
471.543
450.126
980.425
1.033.286
1.065.564
1.182.057
1.245.929
1.384.604
1.764.904
2.326.684
793.461
1.046.798
* Jahresende
Quelle: Statistisches Bundesamt (2022): Pflegestatistik 2021
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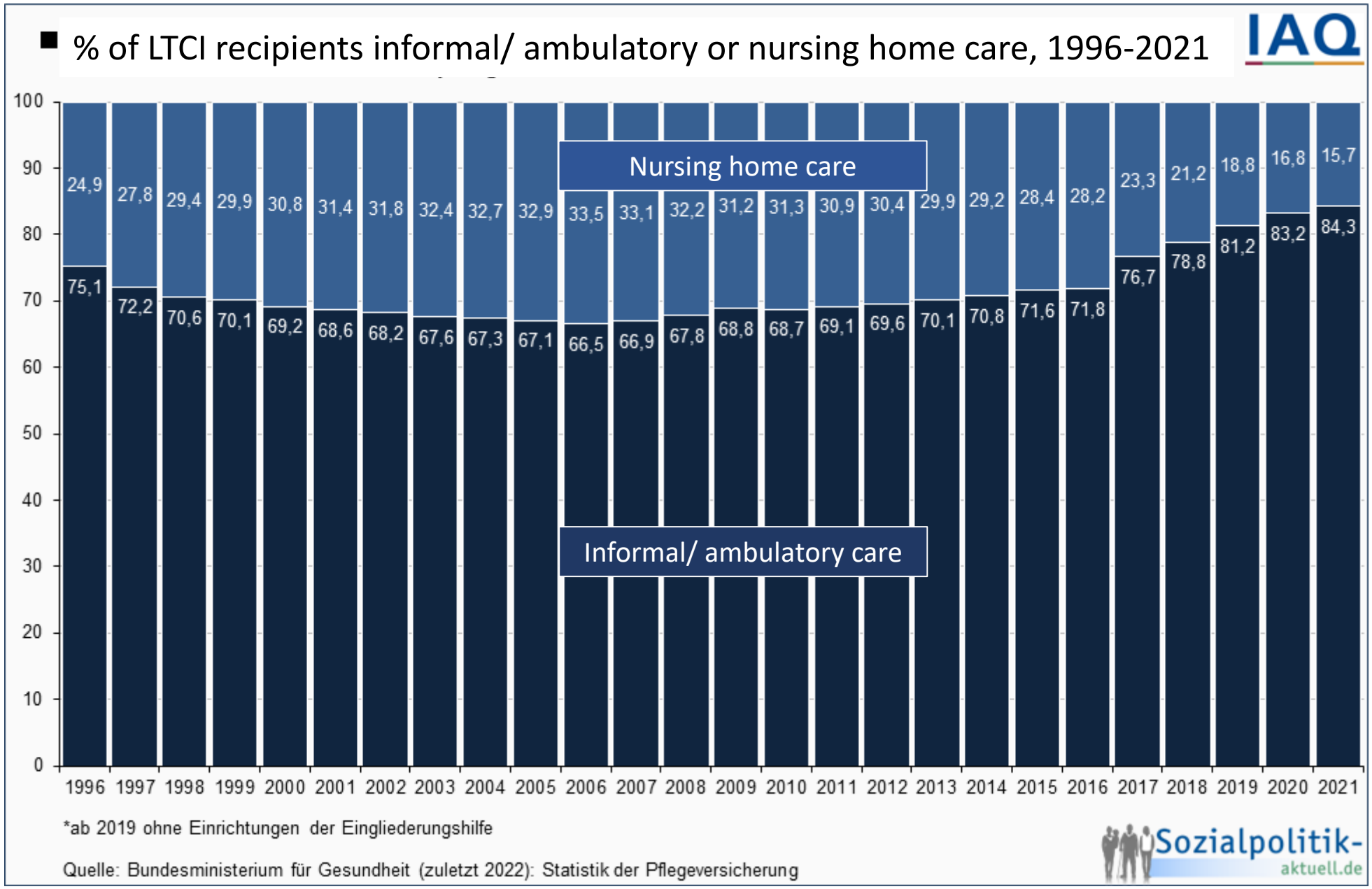
% of LTCI recipients informal/ ambulatory or nursing home care, 1996-2021
IAQ
Nursing home care
Informal/ ambulatory care
100
90
80
70
60
50
40
30
20
10
0
24,9 27,8 29,4 29,9 30,8 31,4 31,8 32,4 32,7 32,9 33,5 33,1 32,2 31,2 31,3 30,9 30,4 29,9 29,2 28,4 28,2 23,3 21,2 18,8 16,8 15,7
75,1 72,2 70,6 70,1 69,2 68,6 68,2 67,6 67,3 67,1 66,5 66,9 67,8 68,8 68,7 69,1 69,6 70,1 70,8 71,6 71,8 76,7 78,8 81,2 83,2 84,3
1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021
*ab 2019 ohne Einrichtungen der Eingliederungshilfe
Quelle: Bundesministerium für Gesundheit (zuletzt 2022): Statistik der Pflegeversicherung
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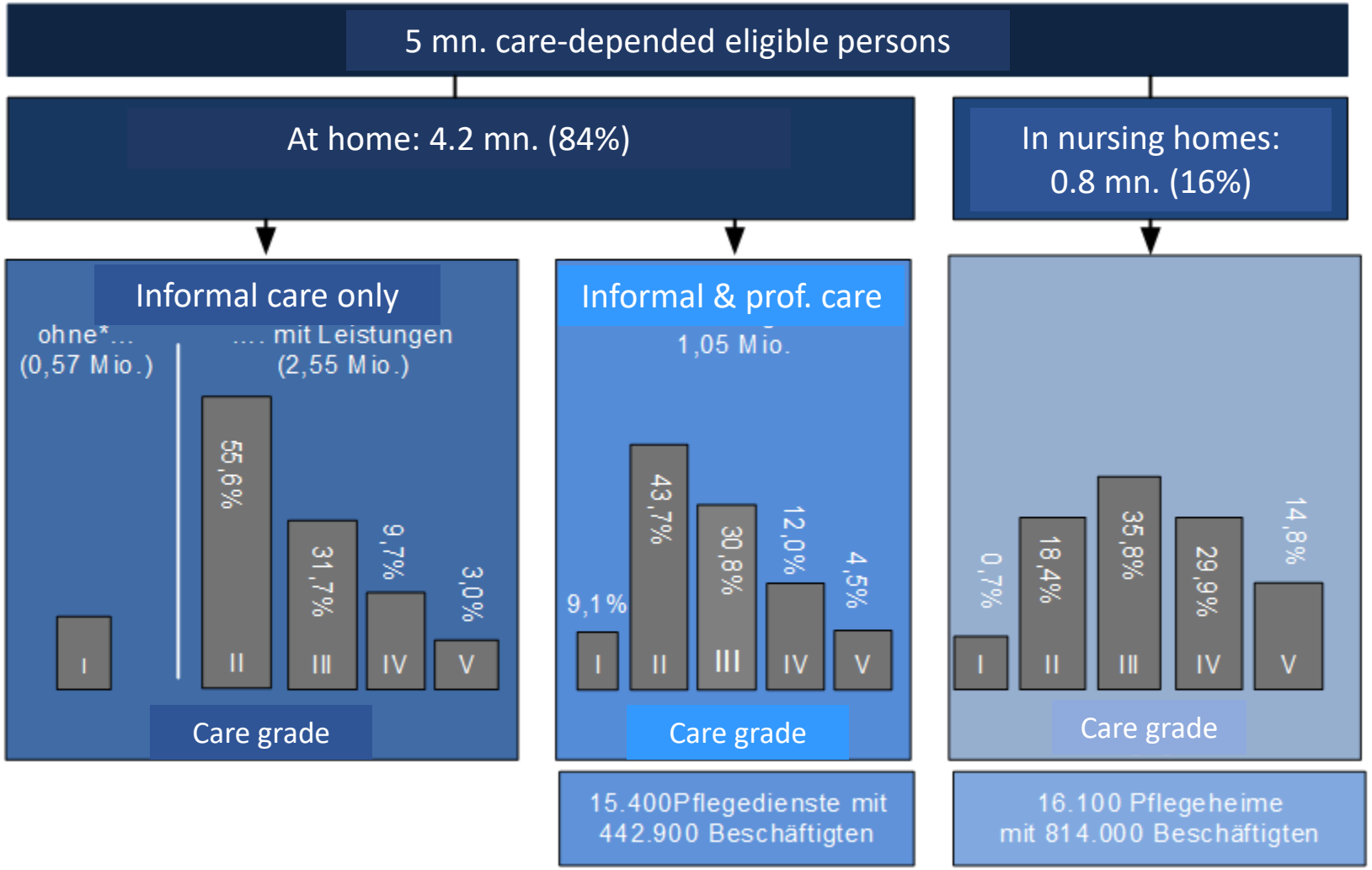
LTCI recipients in numbers and % by type of care & care grade, 2021

2021 figures in more detail



* Mit Pflegegrad I und ausschließlich landesrechtliche bzw. ohne Pflegeleistungen
Quelle: Statistisches Bundesamt (2022): Pflegestatistik 2021

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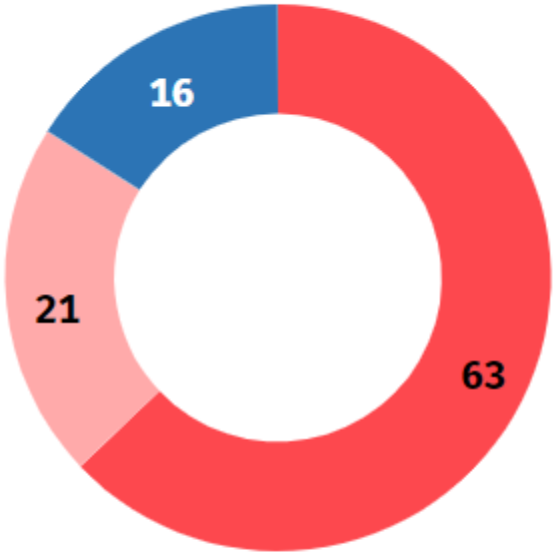
Kommentierung und methodische Hinweise > Seiten 2 - 3

2021 figures in more detail

People in need of long-term care, by type of care, 2021

Percent, total of 5.0 million



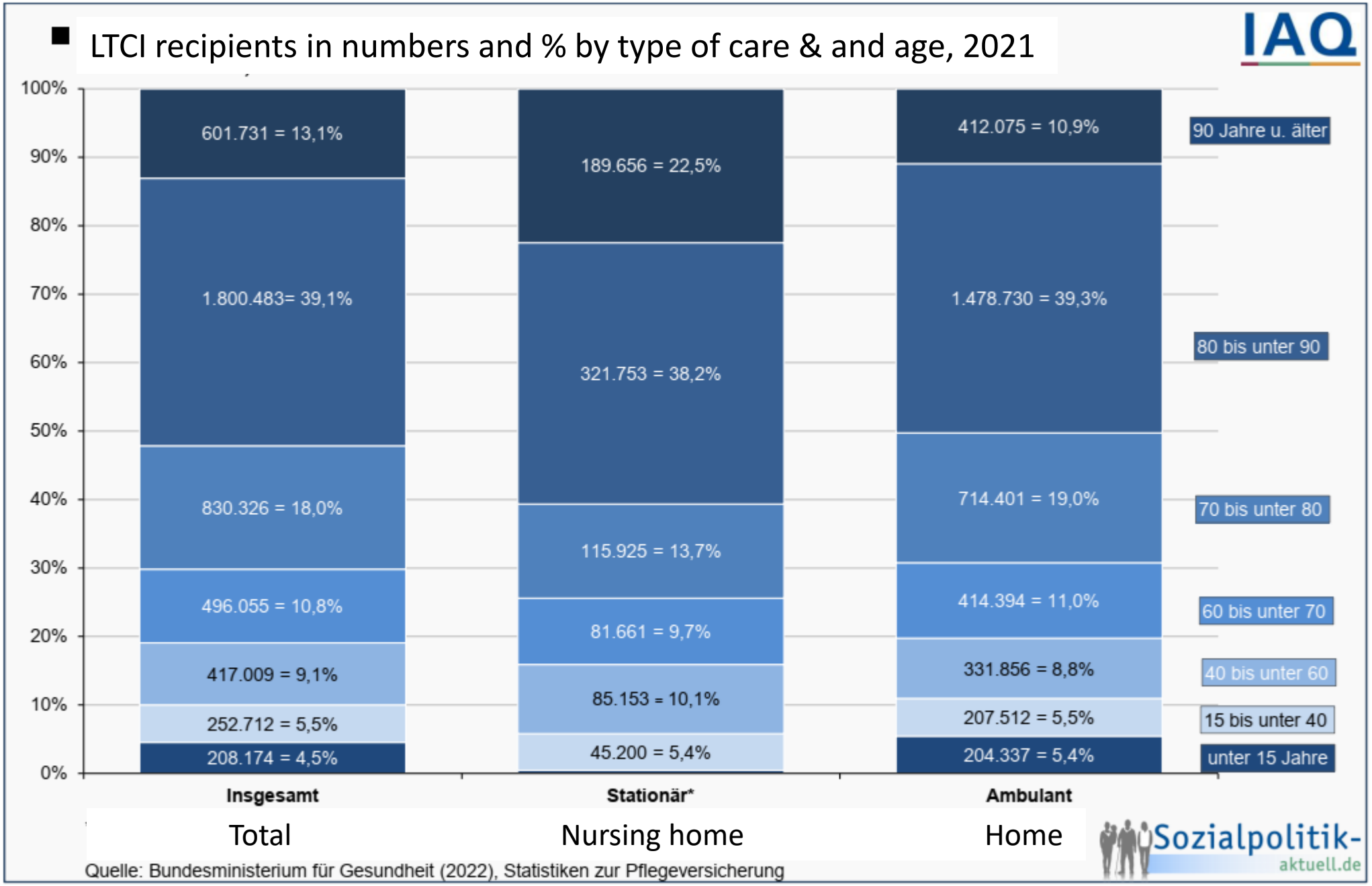
People in need of long-term care, domiciliary care (provided mainly by relatives)

People in need of long-term care, domiciliary care (home care / home assistance services)

People in need of long-term care, full-time residential care

Differences may occur due to rounding.

2021 figures in more detail



Other benefit categories added over time

- Short-term and preventive care
- Day or night care
- Professional nursing care in times of illness or holidays of informal carer (up to 6 weeks)
- Social insurance contributions for informal carers (especially pension and unemployment insurance)
- Additional amounts for care equipment, both devices (up to 100%) as well as consumables (€125/ month); necessary investments in houses (up to € 4.000)

Expenditure

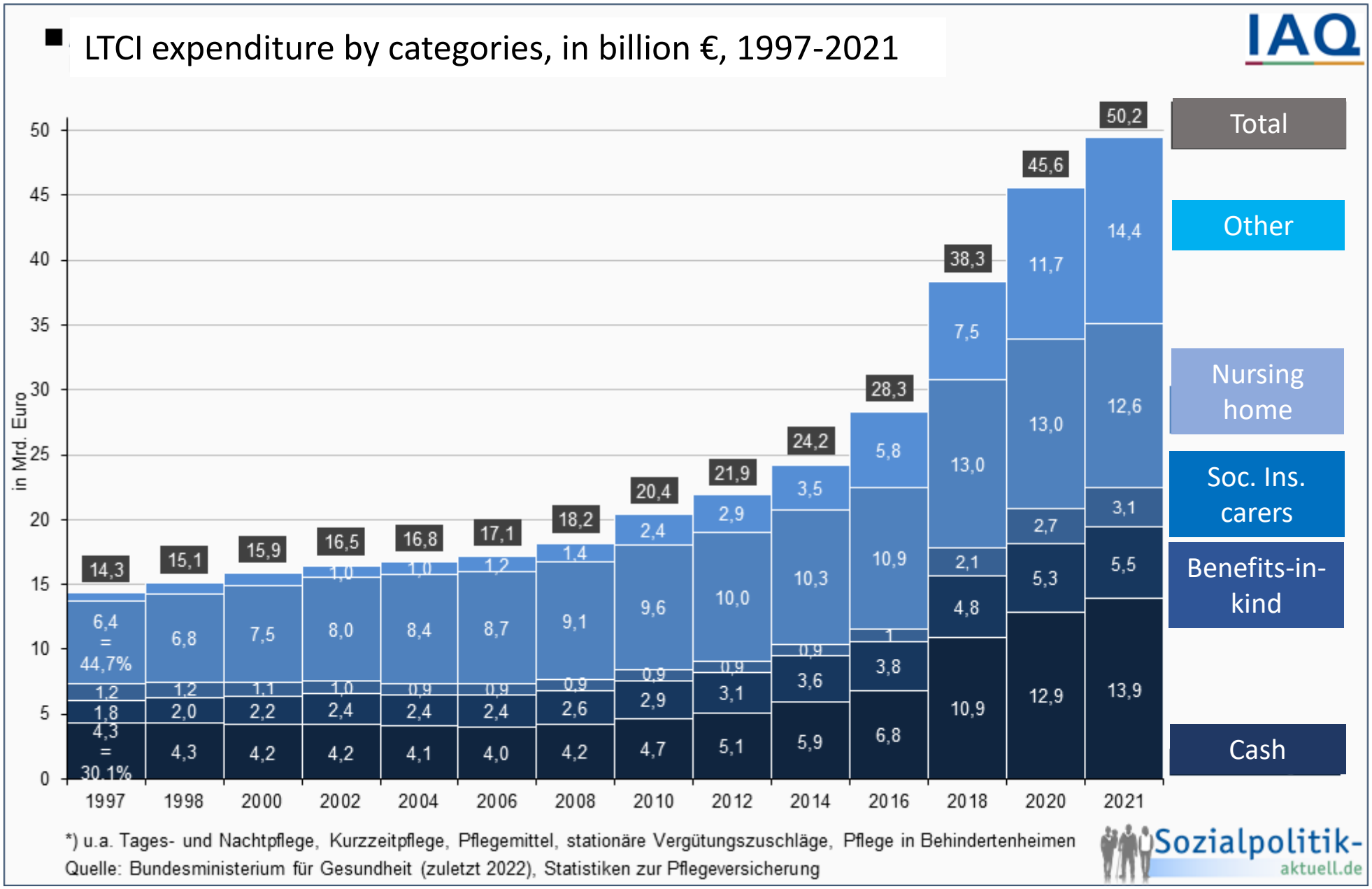
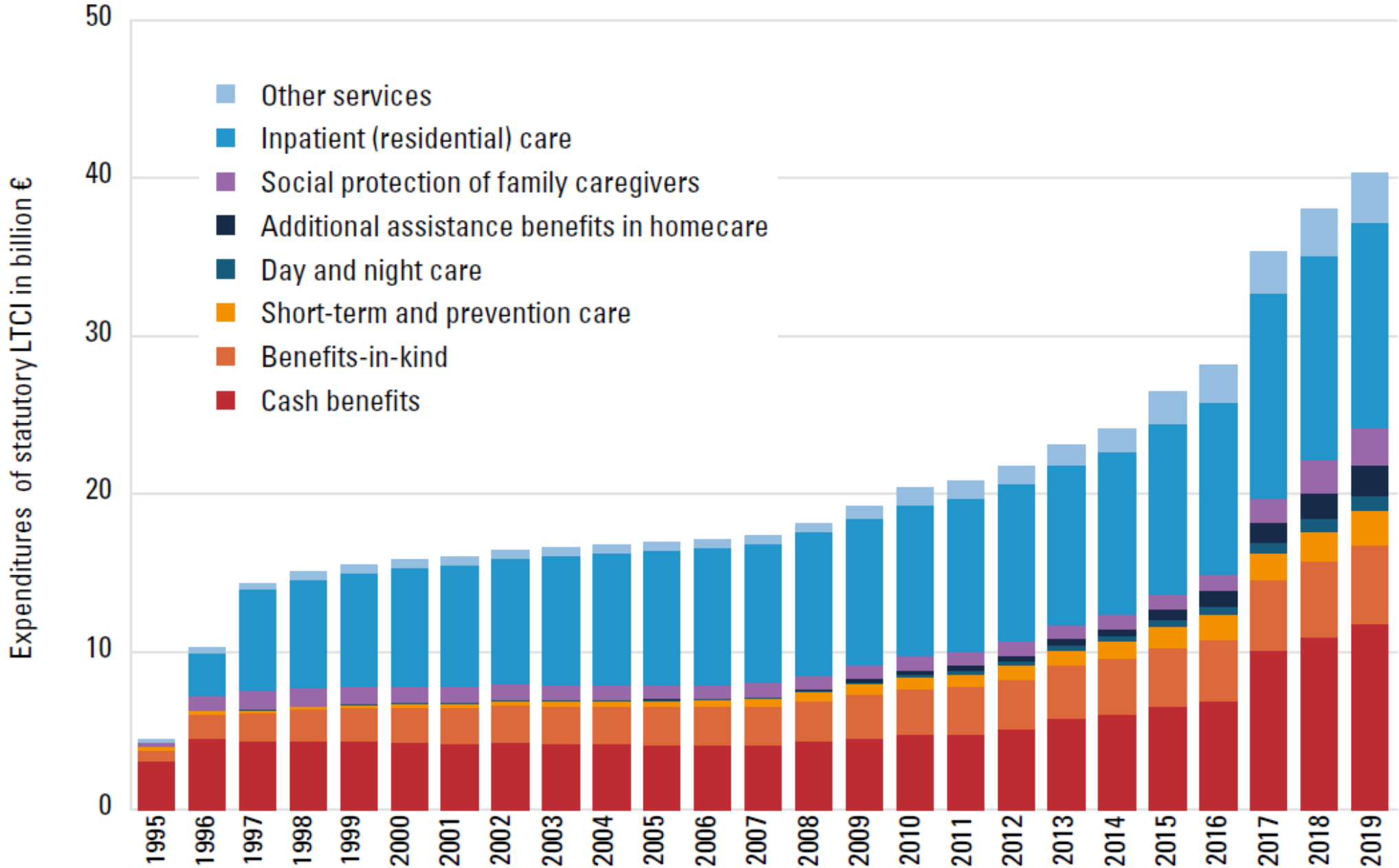
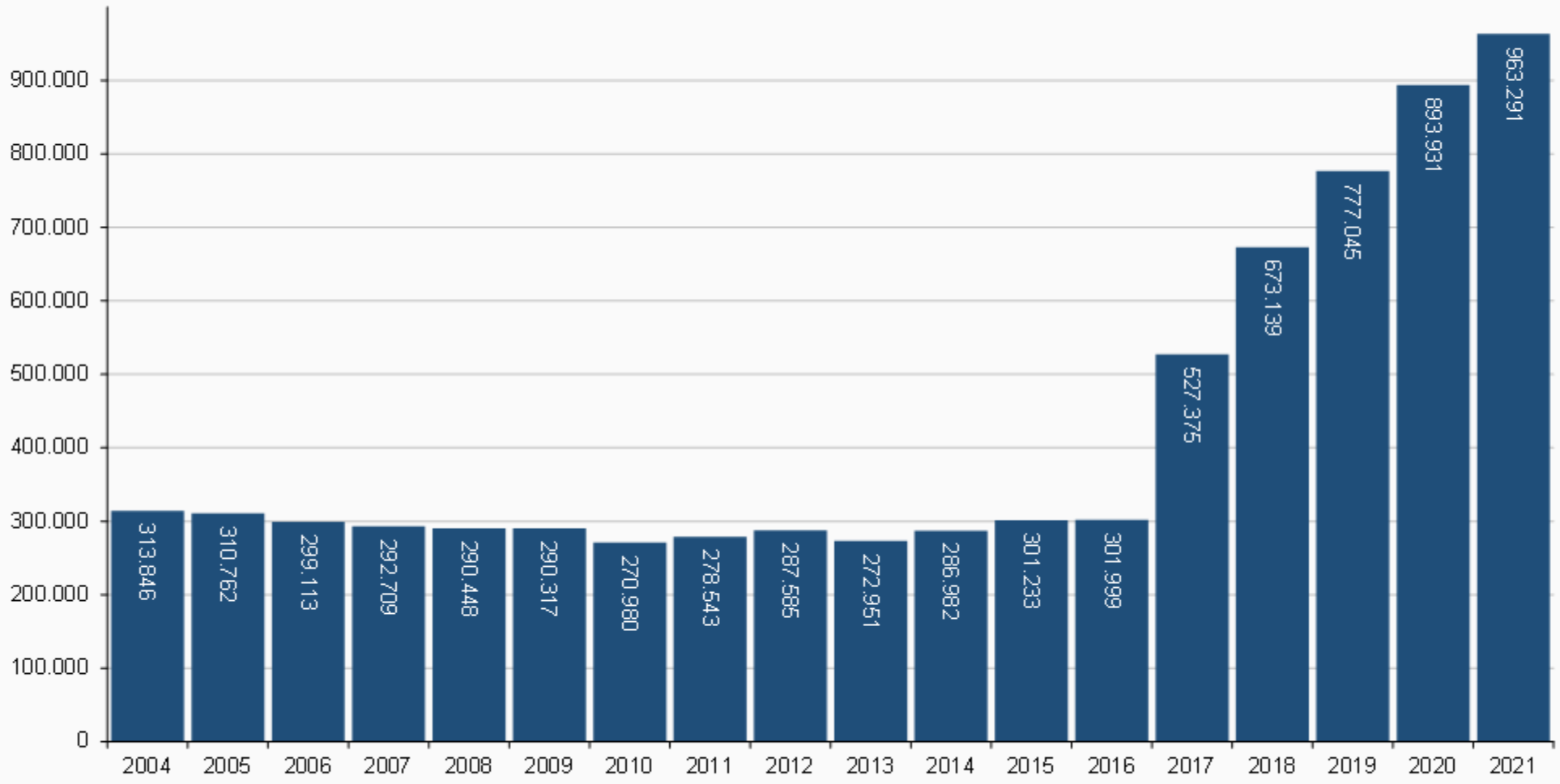


FIGURE 5.5 Expenditures of social long-term care insurance in billion €, 2000–2019



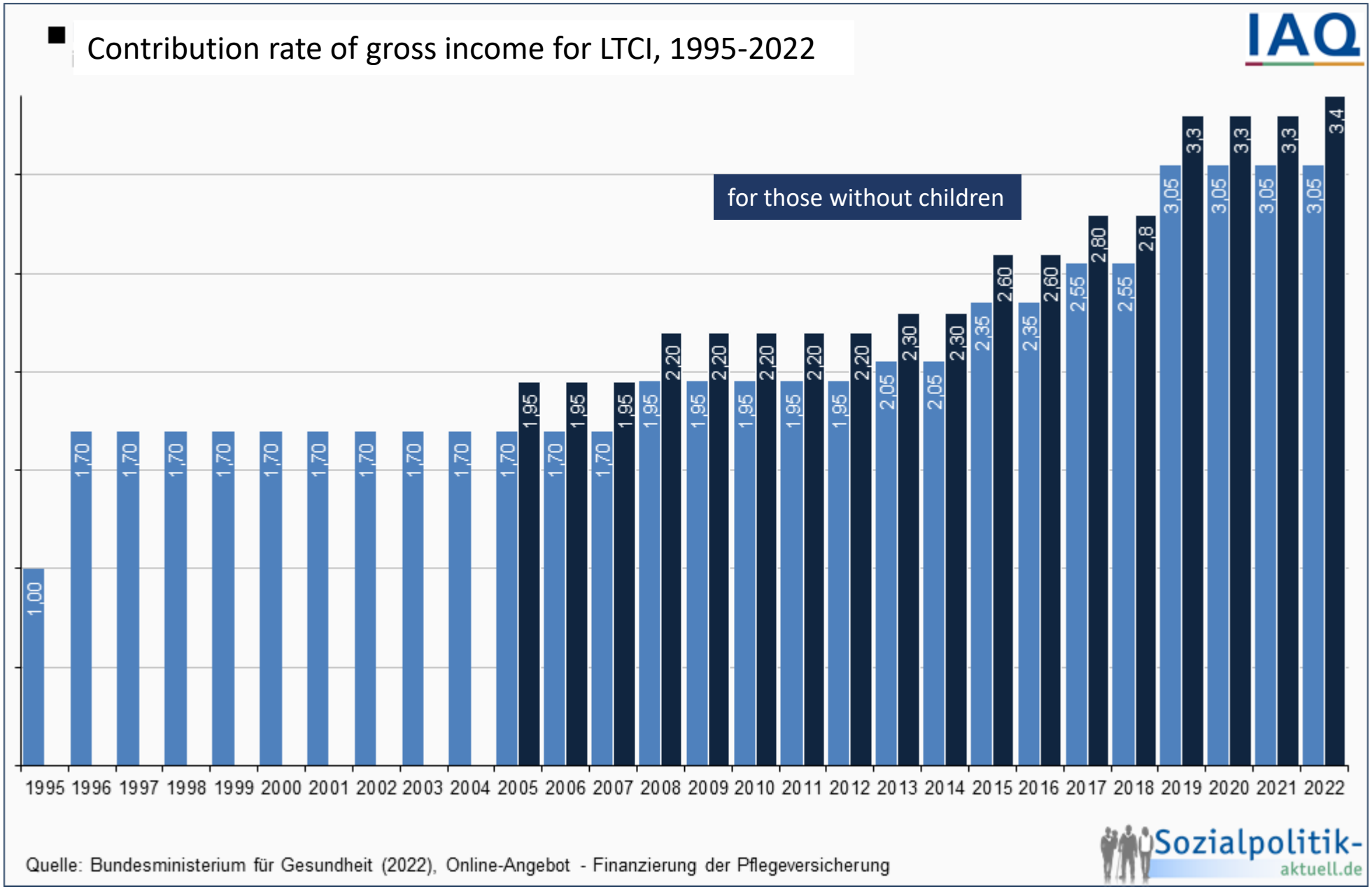
Informal carers with LTCI-paid pension insurance contributions, 2004-2021



Quelle: Deutsche Rentenversicherung Bund (2023), Statistikportal

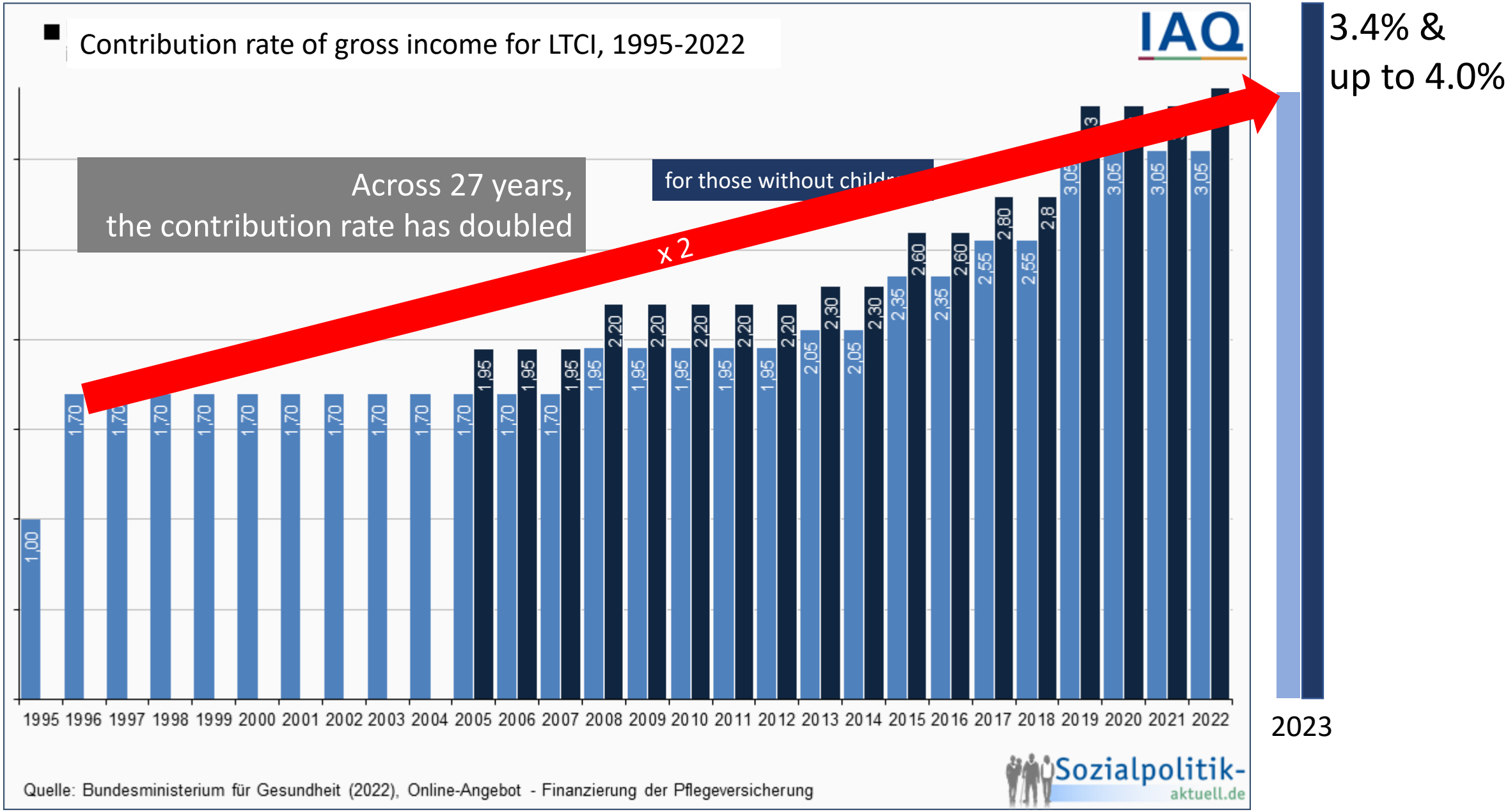
Financing

- Main form of financing: contributions as a % of gross income up to a certain limit, split equally between employees/ insured and employers/ pension fund
- Upon LTCI start, one holiday was cancelled to compensate employers for their 50% part of contributions
- Since 2004, insured without children pay an increased contribution rate (since 2023, this takes the number of children into account)
- Rates and conditions are set by law



3.4% &
up to 4.0%

2023



3.4% &
up to 4.0%

2023

To compensate for the shortfalls (limited benefits, increasing ratio of care dependent : working), additional mechanisms have been introduced:

- Two new mechanisms for introducing funding in LTC
  1. 2013: Supplementary subsidised voluntary LTC insurance ("Pflege-Bahr"), introduced by a Christian Democrats / Liberals government
  2. 2015: Collective provident fund within Social LTCI ("Pflegevorsorgefonds"), introduced by a Christian Democrats / Social Democrats government

1

What is the “Pflege-Bahr”?

- Tax-financed subsidy of 5 Euro per month on contracts
  - with a premium of at least 10 Euro / month
  - benefits of at least 600 Euro in care level III
  - obligation to except every applicant not yet in need of LTC
  - no medical underwriting, but age specific premiums
  - Waiting time no longer than 5 years

1 Effects and problems of the new subsidy ("Pflege-Bahr")

- Number of insurees will be limited
  - For 2013: Government put 90 million Euro aside → 1.5 million contracts
  - By the end of 2015: still around half a million contracts (about 1% of working population)
  - In the long run: < 5% of working population
- Due to social welfare: insurance is unattractive for households with low income
- Redistribution from the bottom to the top as those with lower income will finance tax-subsidy for better off households that buy insurance

2 What is the “Pflegevorsorgefonds”?

- Pflegevorsorgefonds is a funds collected within the S-LTCI
- Starting in January 2013 contribution rate is increased by 0.1 percentage point → revenue of about 1.2 billion Euro
- This additional contribution rate is collected until 2033 and managed by the Deutsche Bundesbank
- From 2035 onwards a maximum of 5% of the capital reached then is given to Social LTCI every year to prevent increasing contribution rates
- Once all is spent the fund will be closed

2 Effects and problems of the “Pflegevorsorgefonds”?

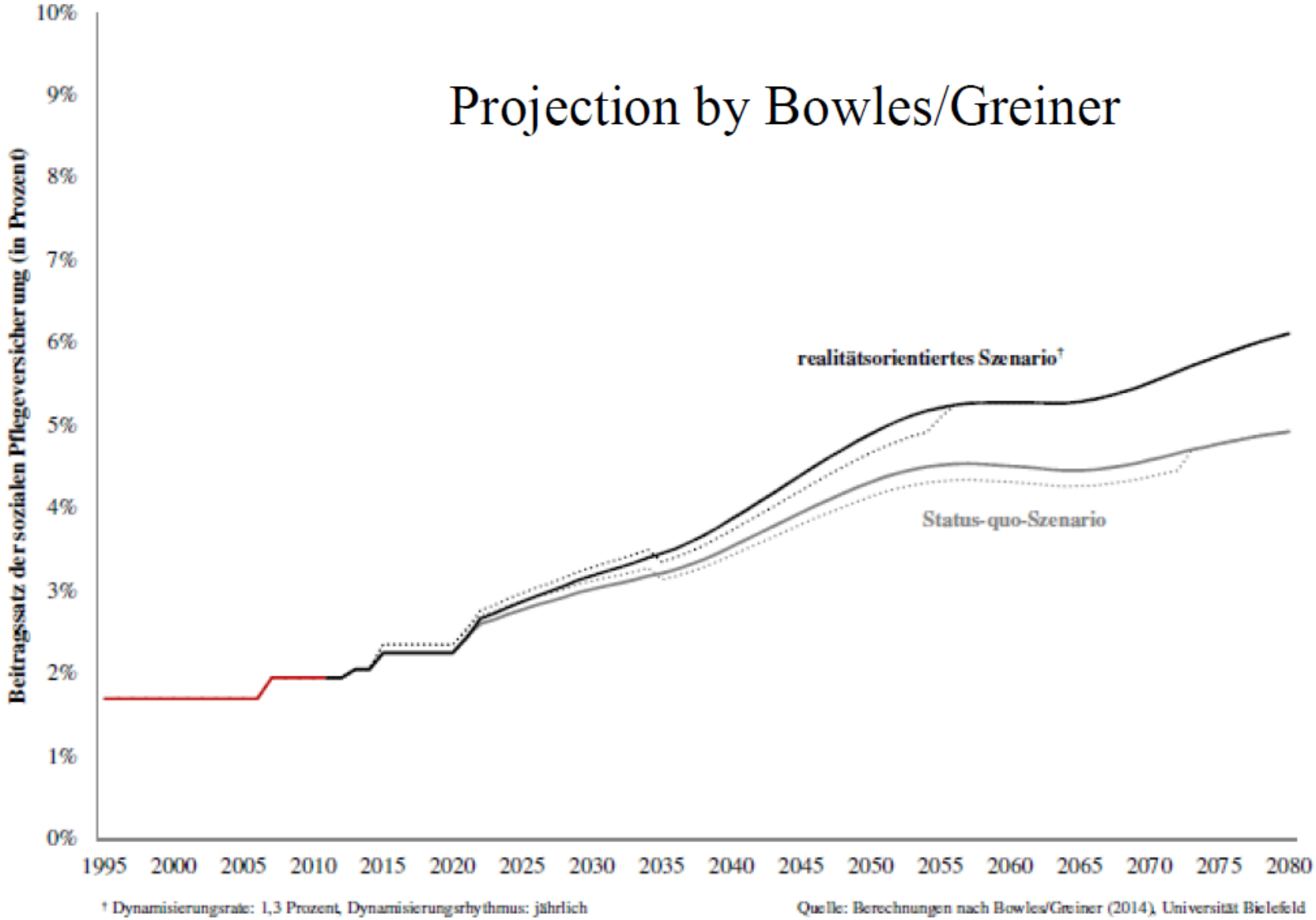
1. The effect is very small
   - For 20 years the contribution rate is increased for 0.1 percentage point
   - For another 20-25 years the contribution rate is then reduced by 0.1 percentage points

2. It is difficult to protect such a fund against politicians once there is a fiscal crisis → the recent reform reduces liquidity as much as the “Vorsorgefonds” is filled

3. The fund will be empty when we have the highest number of LTCI beneficiaries. While number of beneficiaries will decrease then, contribution rate will not.

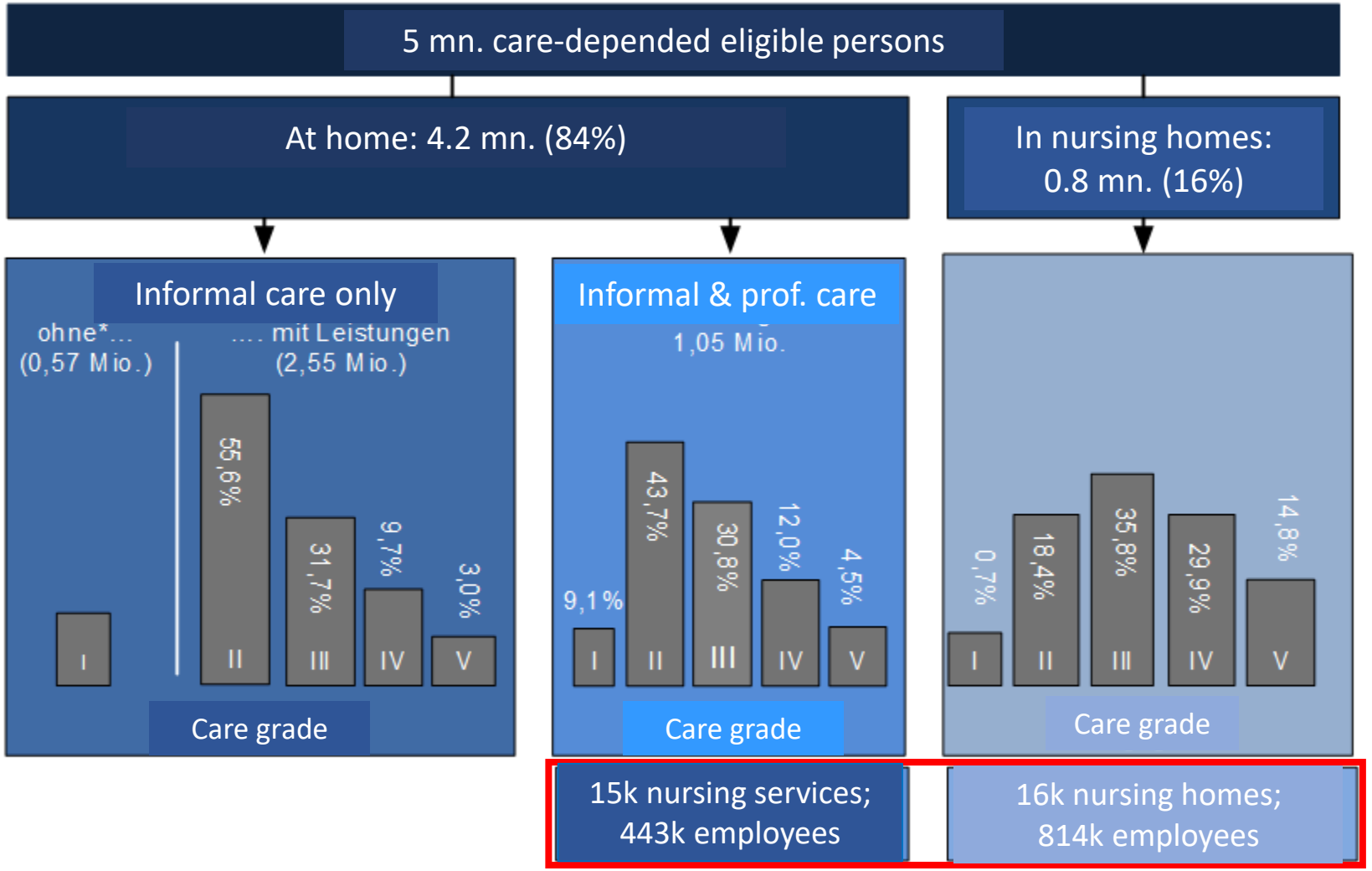
2

Long-term projection with/ without “Pflegevor-sorgefonds”



We now turn to the providers

- LTCI recipients in numbers and % by type of care & care grade, 2021



* Mit Pflegegrad I und ausschließlich landesrechtliche bzw. ohne Pflegeleistungen
Quelle: Statistisches Bundesamt (2022): Pflegestatistik 2021

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Kommentierung und methodische Hinweise > Seiten 2 - 3

How are the providers qualifications and invoices checked?

- Nursing homes are checked once a year by the Medical Review Boards in order to be eligible for contracts with LTCI funds; a long list of structures, processes and outcomes are assessed; if results are insufficient, they are re-checked
- Invoices of nursing services are regularly checked by Medical Review Boards
- Since 2022, contracts are also dependent upon proof by nursing homes and nursing services that they pay their nursing staff according to collective wage contracts (which, in return, has increases LTC costs)

What are the challenges of the program and lessons for China?