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Long Term Care Reform in Germany – At Long Last

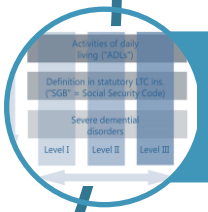
Sabrina Link

16 May 2017

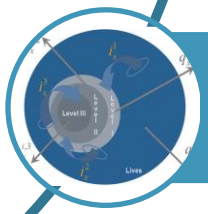
Overview

LTCI in German Social Security System

The (latest) reform of LTCI



LTCI in the private insurance industry



Implications of the reform

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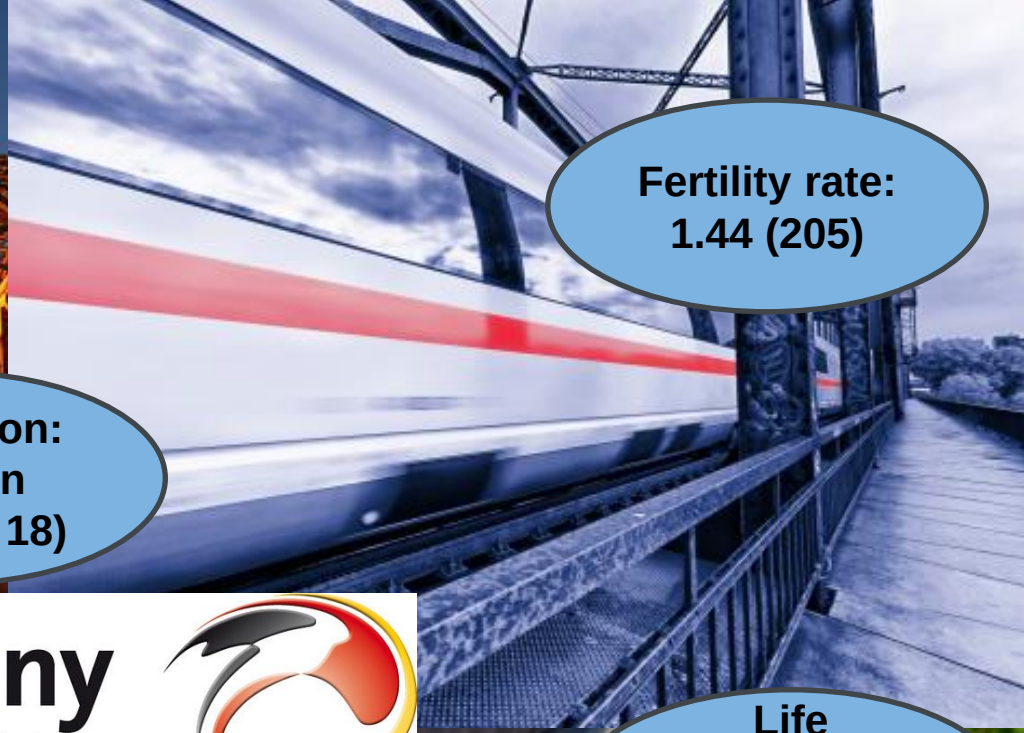

Fertility rate: 1.44 (205)

Population: 80.7 mn (ranked: 18)

Germany

Simply inspiring

GDP per capita PPP: $48,200 (27)

21.8% of population: 65+

Life expectancy: 80.7 years (34)

The 5 Pillars of Social Insurance in Germany

The latest pillar was the introduction of a compulsory LTC scheme on 1 January 1995

- LTC coverage is compulsory
  - Citizens with compulsory public health insurance are insured through sickness funds
  - Citizens with private health insurance must obtain compulsory private LTCI coverage

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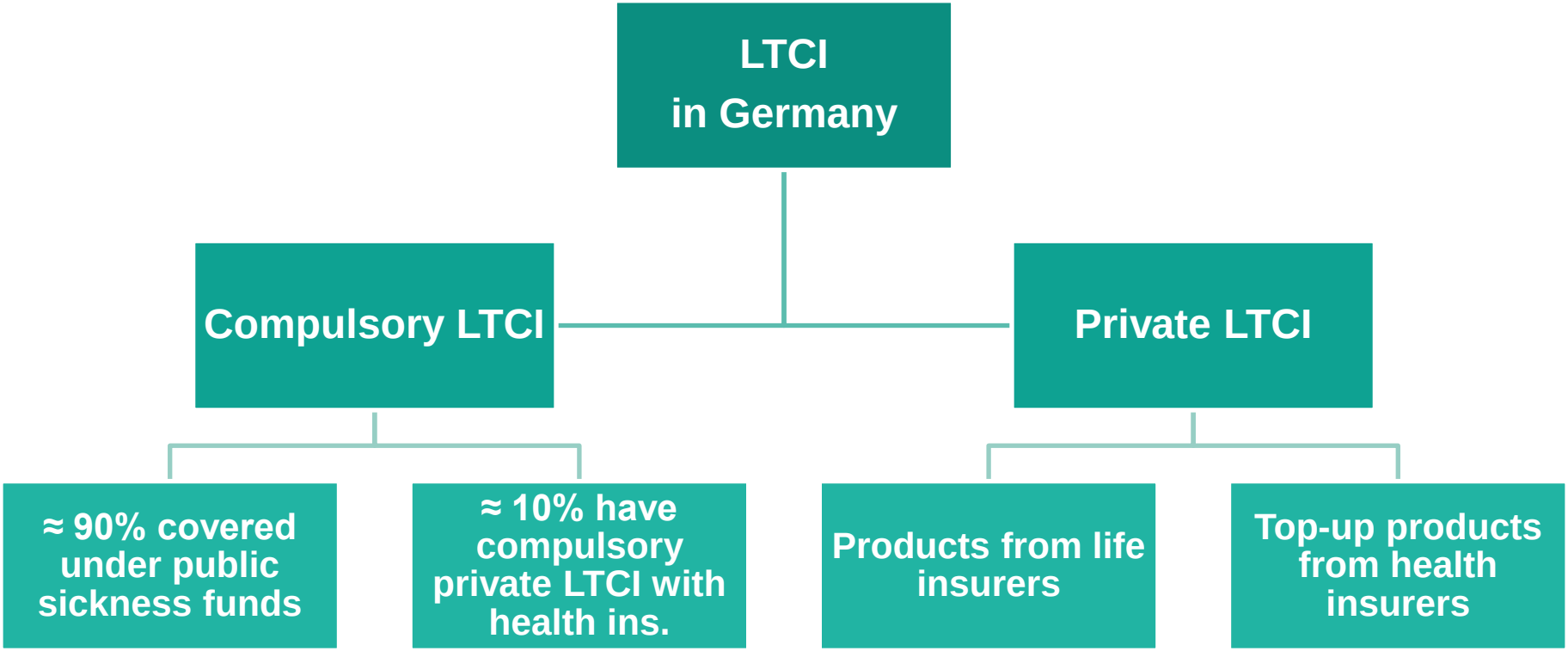
Compulsory and Private Coverage for LTC



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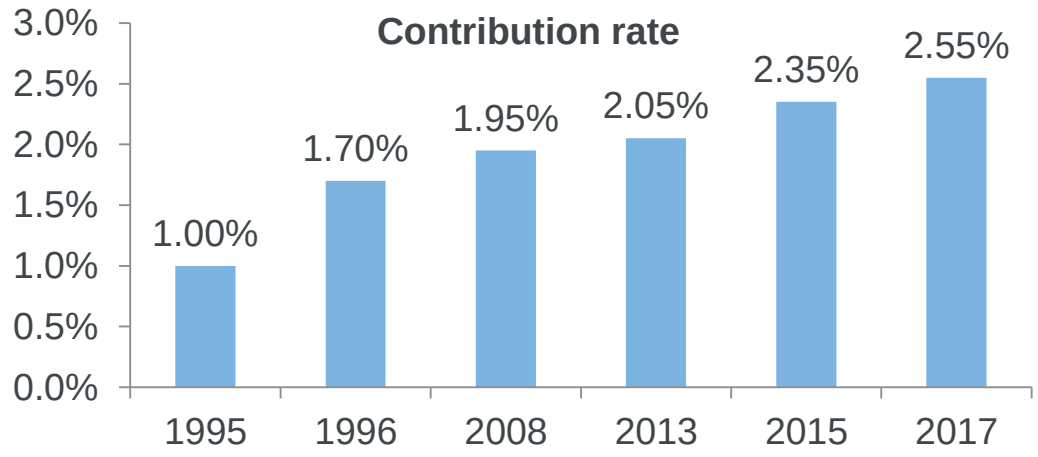
Principals Underlying the Compulsory Public LTCI

- Principles of the compulsory LTCI

"Home Health Care over Nursing Home"	Partial coverage insurance

- Financing*



- Pay-as-you-go system
- Not means-tested
- Contribution is shared equally between employer and employee

* For publicly insured, in % of gross income up to the contribution assessment ceiling, without surcharge for those without children

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Care Definition Until End 2016

Principle

"For the assessment of care needs according to SGB XI only a permanently existing need for assistance (6 months) is relevant. It is crucial

- for how many of the in § 14. Abs. 4 SGB XI stated **activities**,
- how **often**,
- at what **times of the day** (possibly "around the clock") and
- for what **duration** for each activity

a regular need for assistance exists."*

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* Richtlinien des GKV-Spitzenverbandes zur Begutachtung von Pflegebedürftigkeit nach dem XI. Buch des Sozialgesetzbuches, 2013, S. 43

Care Definition Until End 2016

- The activities of daily living which are taken into account when assessing the care need according to SGB XI § 14 Abs. 4 are:
  - **Personal hygiene**,
  - **Nutrition**,
  - **Mobility** and
  - **Household assistance**.




- "Other activities of daily living, for example measures to promote the communication and the general care, are not taken into account."*

	Care required	Duration per day	Of which ADLs
Care level I	≥ 1x per day	≥ 90 min	≥ 45 min
Care level II	≥ 3x per day	≥ 3 hours	≥ 2 hours
Care level III	permanent, also at night	≥ 5 hours	≥ 4 hours

* Richtlinien des GKV-Spitzenverbandes zur Begutachtung von Pflegebedürftigkeit nach dem XI. Buch des Sozialgesetzbuches, 2013, S. 65

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The benefits of the compulsory LTCI did not cover the actual need

Maximum benefits From 01/01/2015 (in Euro per month)	Care level I	Care level II	Care level III
Home health care			
Cash benefit	244	458	728
Cost reimbursement	468	1,144	1,612
Nursing home care	1,064	1,330	1,612

No benefits are provided for lodging, food, etc.

- Adjustments are planned every three years
- The benefits contrast to the following actual monthly expenses for care*

Professional home health care	1,000	2,400	3,900
Nursing home care	2,500	3,000	3,500

- Compulsory LTCI covers about 40% - 50% of the actual care cost
  - Remaining portion must be paid by person with care needs themselves

*Source: Finanztest 5/2015, 5/2013; Makler&Pflege Nov 2013; PKV-Info: Die Private Pflegezusatzversicherung Jan 2015; own estimate

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Assessment for Body Care – Washing

Need for assistance at	Frequency per		Time needed per day (min.)
Washing	**Day**	**Week**	
Fully-body			
Upper body			
Lower body			
Hands / Face			

- Benchmarks to assess time needed for care as reference points for the assessor*. A complete takeover of the activities by a lay caregiver is assumed.

- Example Body care – Washing
  - Full-body: 20-25 min.
  - Upper body: 8-10 min.
  - Lower body: 12-15 min.
  - Hands/Face: 1-2 min.

©Thinkstock: Martin Poole

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* Richtlinien des GKV-Spitzenverbandes zur Begutachtung von Pflegebedürftigkeit nach dem XI. Buch des Sozialgesetzbuches, 2013, S. 111

Criticism of the Previous Definition

- Somatic orientation through focus on activities of daily living
- Unequal treatment of geriatric psychiatric need for assistance, especially of people suffering from cognitive impairments
- Counting minutes as a criterion to assess need for care is not really suitable

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LTC Insurance Being Continuously Reformed

- Introduction on 1st January 1995 with initially three care levels
  - extended by “Care level 0“ for people with limited ability to cope with everyday life (“PEA”)
  - extended by “Care level IV“ – Hardship provision

- Various legal extensions:
  - 2002 Pflegeleistungs-Ergänzungsgesetz
  - 2008 Pflege-Weiterentwicklungsgesetz (“PfWG”)
  - 2013 Pflege-Neuausrichtungs-Gesetz (“PNG”)
  - 2015 Erstes Pflegestärkungsgesetz

- “Bahr-Pflege“ since 2013
  - Government initiative to promote private insurance by small subsidising premium

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The Latest Reform: Let's Go

- 2006 Coalition government initialises "Advisory committee to review the care definition"
- 2009 Report from the advisory committee to Federal Minister of Health Schmidt
- 2009 Fixing in the coalition agreement of CDU, CSU and FDP
- 2012 Federal Minister of Health Bahr appoints the "Expert advisory committee to develop concretely the new care definition"
- 2013 Final report from the expert advisory committee
- 2014 Two studies regarding the "Neue Begutachtungsassessment" (NBA) are conducted
- 2015 Final reports of those studies are published
- 2015 Government draft regarding the new care definition is presented
- 2015 PSG II is passed

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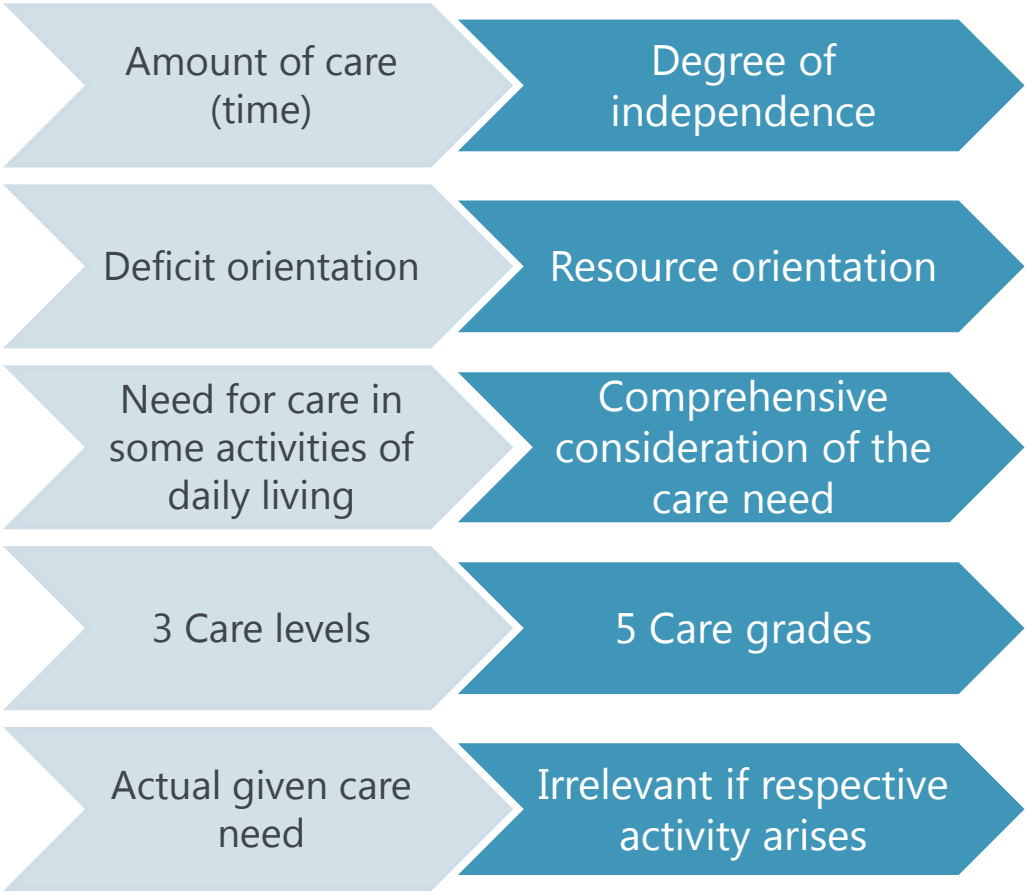
The Reform of the Care Definition

Fundamental changes



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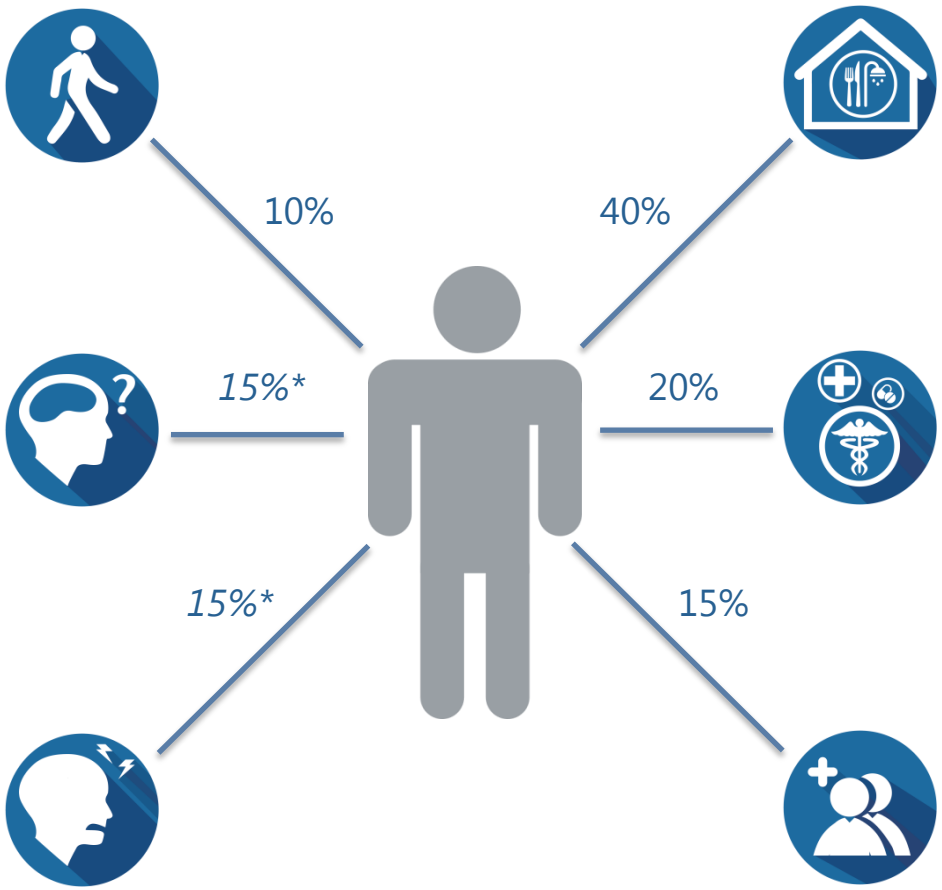
Introduction of the New Care Assessment

Module 1
Mobility

Module 2
Cognitive & communicative abilities

Module 3
Behaviour & psychiatric problems



Module 4
Self-supply

Module 5
Dealing with requirements due to illness or therapy

Module 6
Organisation of everyday life and social contacts

**Higher value from Module 2 or 3*

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Thresholds and Care Grades

Highlights

- The 6 modules are weighted differently.
- Overall there are 100 points.
- Classification into the care grades by points:

Thresholds

No care grade	Care grade 1	Care grade 2	Care grade 3	Care grade 4	Care grade 5
0 - 12	12.5 - 26.5	27 - 47	47.5 - 69.5	70 - 89.5	90 - 100

- Special rule for care grade 5:
  - either ≥ 90 points

  or
  - loss of use of both arms and both legs

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Do the Benefits of the New LTCI Cover the Actual Need?

Maximum benefits From 01/01/2017 (in Euro per month)	Care grade 1	Care grade 2	Care grade 3	Care grade 4	Care grade 5
Home health care					
Cash benefit		316	545	728	901
Cost reimbursement		689	1,298	1,612	1,995
Relief benefit	125	125	125	125	125
Nursing home care	125	770	1,262	1,775	2,005

- Adjustments are planned every three years
- The benefits contrast to the following actual monthly expenses for care

Professional home health care	1,000	2,400	3,900
Nursing home care	Deductible in care homes independent of care grade (except grade 1) – ca. 580 EUR (on average)		

Intention of partial coverage

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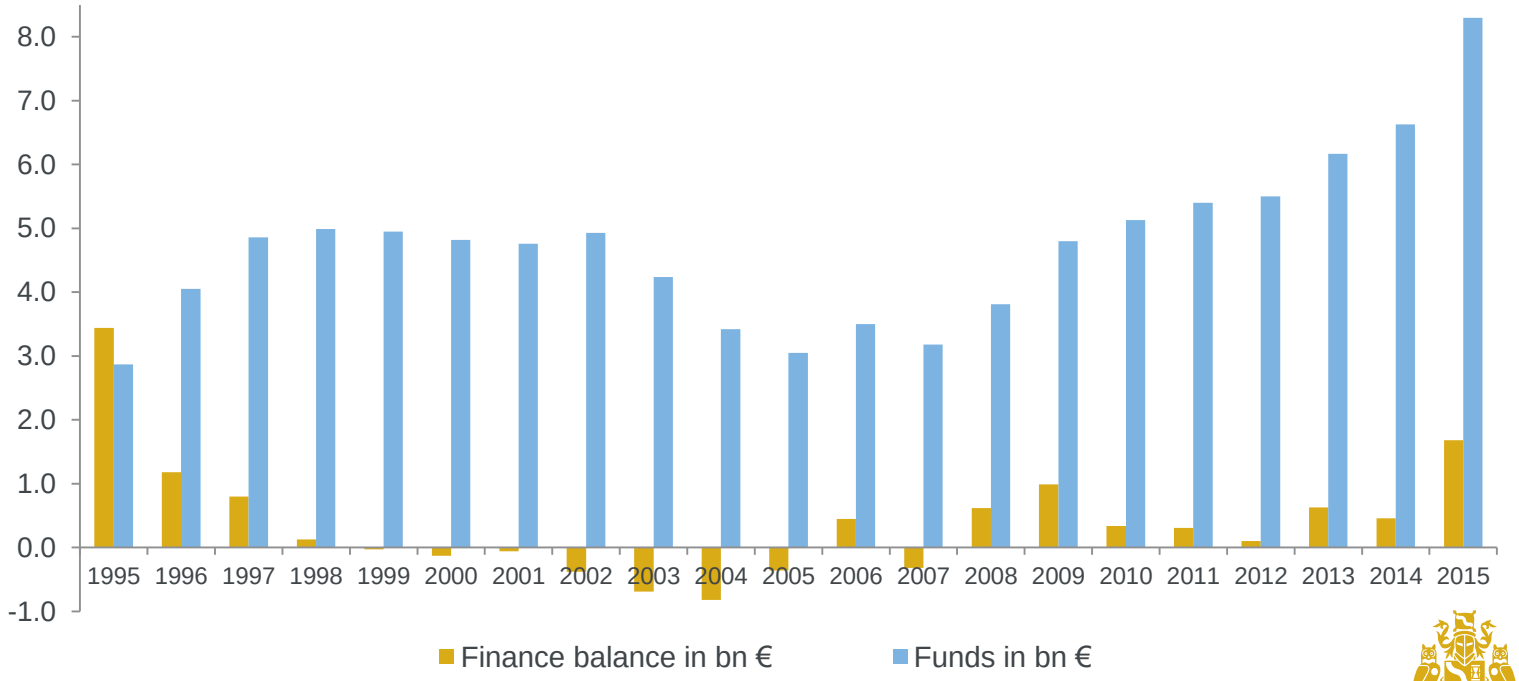
Funding

- Contribution rate is increased by 0.2%-points
  - “From the Federal Government’s point of view together with the positive income development owing to the good economic situation the LTC insurance is overall equipped with a sufficient financial scope to introduce the new care definition.“*



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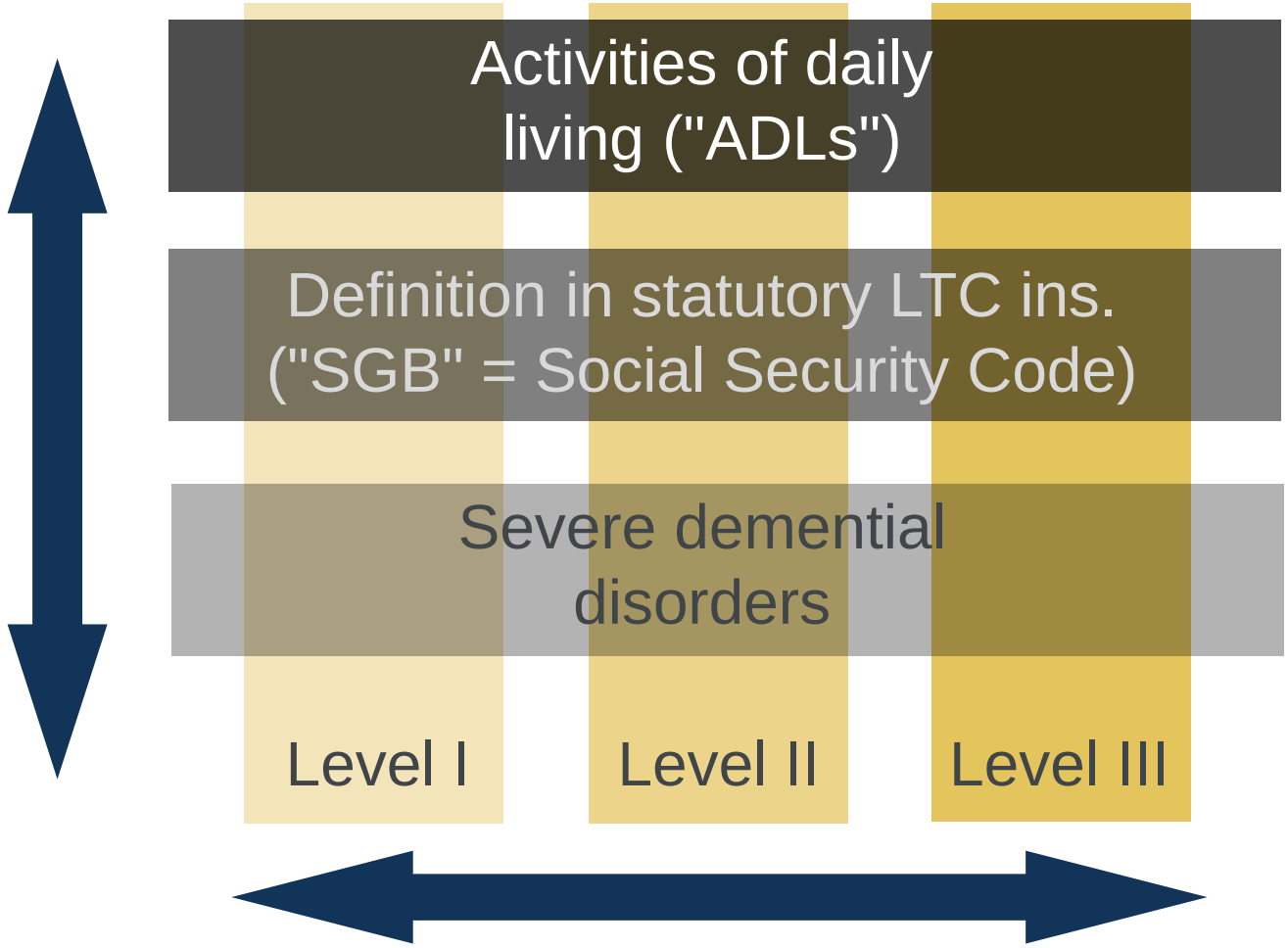
* The Federal Government‘s response to the minor interpellation of delegate Pia Zimmermann, further delegates and the fraction DIE LINKE from 3.4.2015

Benefit Triggers for LTC in Life/Health Insurance



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Tiered Benefits Very Popular

- Idea: The benefit amount depends on the number of failed ADLs / care level
- Motivation: The need for financial support typically increases with the level of dependency

- Example:
  - Full benefit pay-out (100 %) when failing 6 out of 6 ADLs / care level 3
  - Partial benefit (e.g. 50 %) when failing 4 out of 6 ADLs / care level 2
  - Waiver of premium when failing 3 out of 6 ADLs / care level 1
- The benefit amount can also depend on whether the claimant suffers from dementia
  - E.g.: Partial benefit (50 %) when failing 4 out of 6 ADLs or when suffering from dementia

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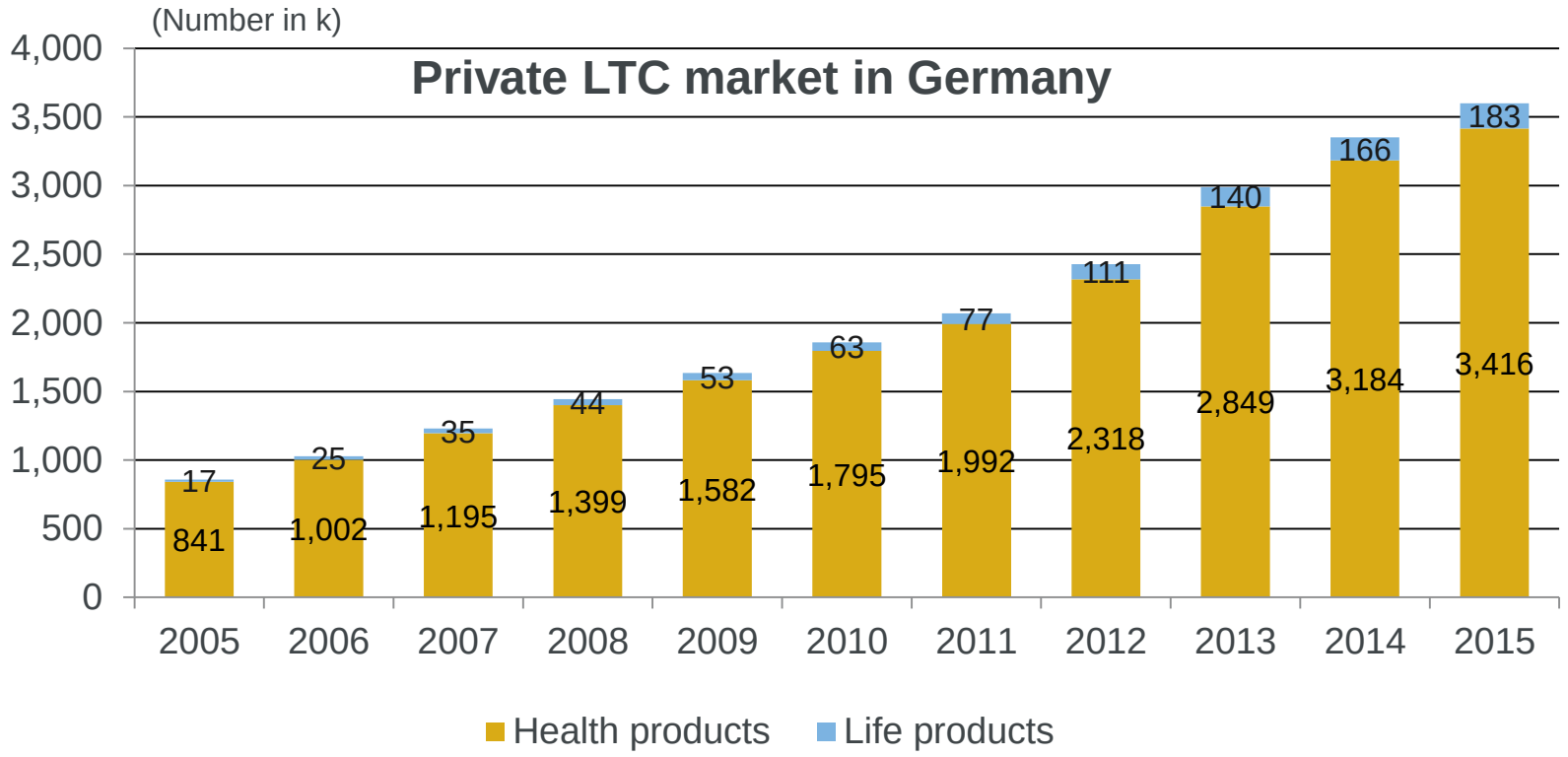
Are Additional Private LTCI Policies Sold Successfully?



Average growth of number of policies in force (life insurance products) 2005-2015:

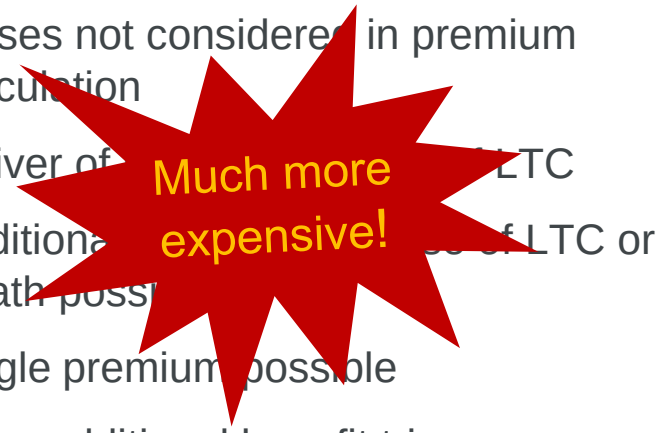
+27 % p.a.

Sources: GDV, PKV-Verband

LTCI at Life and Health Insurers

Life insurers

- annuity benefits
- lifetime guarantees
- surrender values payable
- lapses not considered in premium calculation
- waiver of [illegible] LTC
- additional [illegible] of LTC or death [illegible]
- single premium possible
- often additional benefit trigger: failure of n/6 ADLs
- typically higher benefit for dementia



Health insurers

- annuity benefits or reimbursement
- reviewable premiums
- calculation and product design subject to detailed regulations
- higher interest rates accepted by regulator
- no surrender values
- no waiver of premium

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What happens to the already dependent people? (Relevant for Social Security only)

Protection of status quo?

- Politically the protection of the status quo for already dependent people under the old definition is intended.

"Those who already receive benefits today will automatically be transferred into the new care grades and continue receiving at least the former benefits."

Hermann Gröhe*
German Health Secretary

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* Pflegereform stellt keinen schlechter, SZ, 23. Mai 2014

How does the transfer for already dependent people look like? (Social Security)

Current assessment		Transfer to
Care level I	→	Care grade 2
Care level II	→	Care grade 3
Care level III	→	Care grade 4
Hardship case	→	Care grade 5

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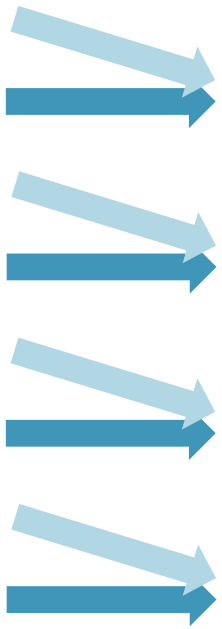
How does the transfer for already dependent people look like? (Social Security)

Current assessment	Transfer to
Care level 0 with eA	
Care level I	Care grade 2
Care level I with eA	
Care level II	Care grade 3
Care level II with eA	
Care level III	Care grade 4
Care level III with eA	
Hardship case	Care grade 5



eA: limited ability to cope with everyday life (“PEA”)

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Implications for Product Design for Private Insurance

Questions resulting from the new definition

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- How do old and new definition compare?
- How shall tiered benefits be designed for care grades?
- How can pricing rates be derived?
- How can the policy wording be phrased?
- What happens to in-force business based on the old benefit trigger?
- How do we deal with the additional ADL and dementia definition?
- …

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What can private insurers do with in-force policies?

Starting situation

- Life insurers have copied the benefit trigger from SGB
- Plus commentary that changes in the public definition do not lead automatically to changes of the tariff
- Per se no need to adjust in-force policies
- But:
  - Most recent tariffs offer option to switch to a tariff with the new benefit trigger (if offered by the company at all)
  - no extension of the cover and no new uw required
- But:
  - tiered benefits very common
  - reduced guaranteed interest rates in new tariffs
  - unisex calculation for new tariffs mandatory
  - cognitive impairment (often) new benefit trigger

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No Easy Solution – Different for Each Company

Depending on policy terms & conditions

"A prerequisite is that no benefits due to care needs have been applied for before…"

"The conversion can lead to a changed premium…"

"The change of tariff must not lead to an extension of the cover…"

"If in future we offer a new LTC tariff…"

- Different claims management requirements
- Anti-selection possible for conversion option
- No prediction of proportion to exercise the option

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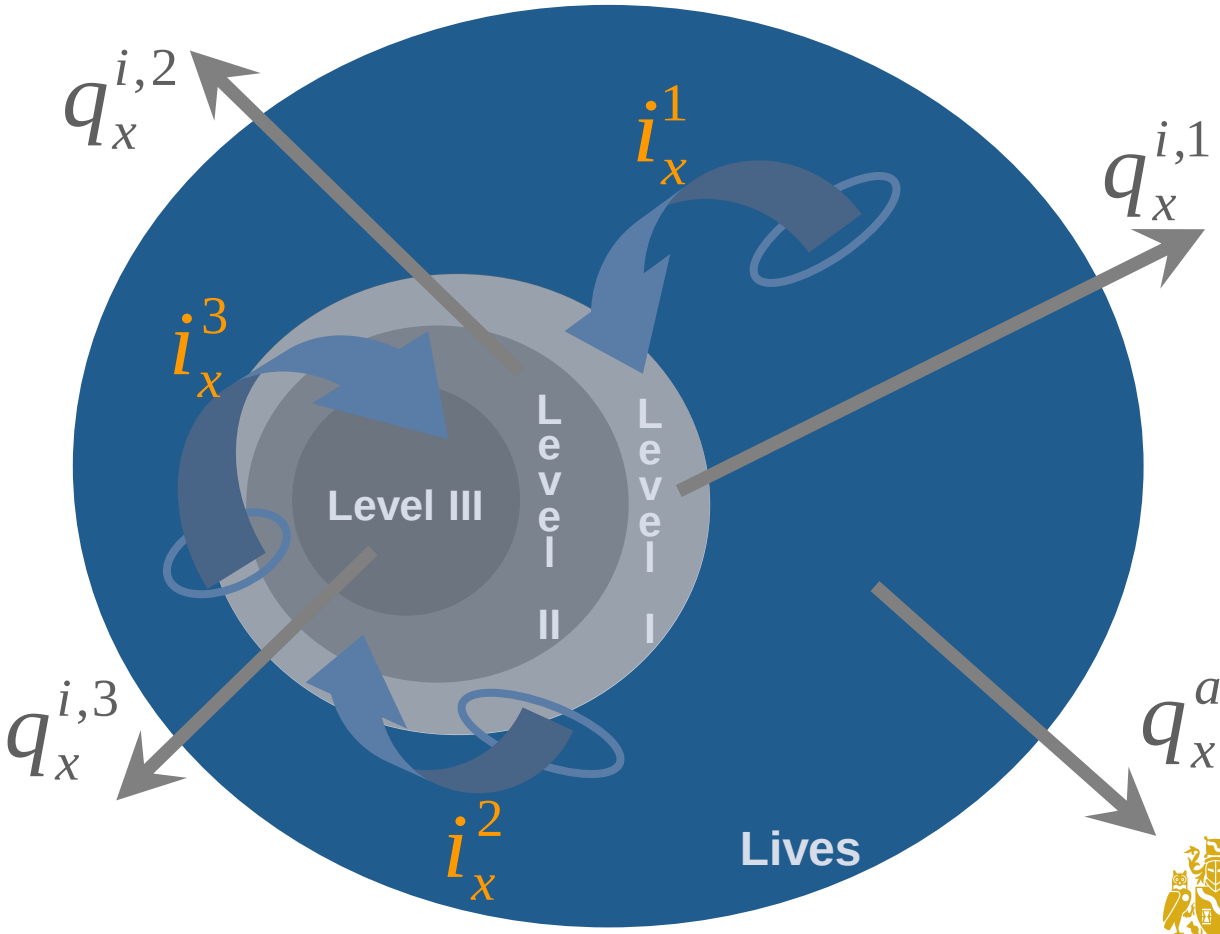
Pricing Implications: From 3 Tiers to 5 ???

Actuarial model for 3 care levels



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Sources

- Final report of "**Hauptphase 2**" from 2008
  - Comprises assessments at home and in care homes
  - Comprises initial assessments, upgrading assessments and repetition assessments

- Final report of the "**Praktikabilitätsstudie**" from 2015
  - Comprises assessments at home and in care homes
  - Comprises initial assessments, upgrading assessments and repetition assessments
  - Unfortunately no detailed information (matrix) available

- Final report of the "**Studie in stationären Einrichtungen**" (study in care homes) from 2015
  - Comprises only assessments in care homes
  - For half of the participants the initial assessment took place more than 1.5 years ago

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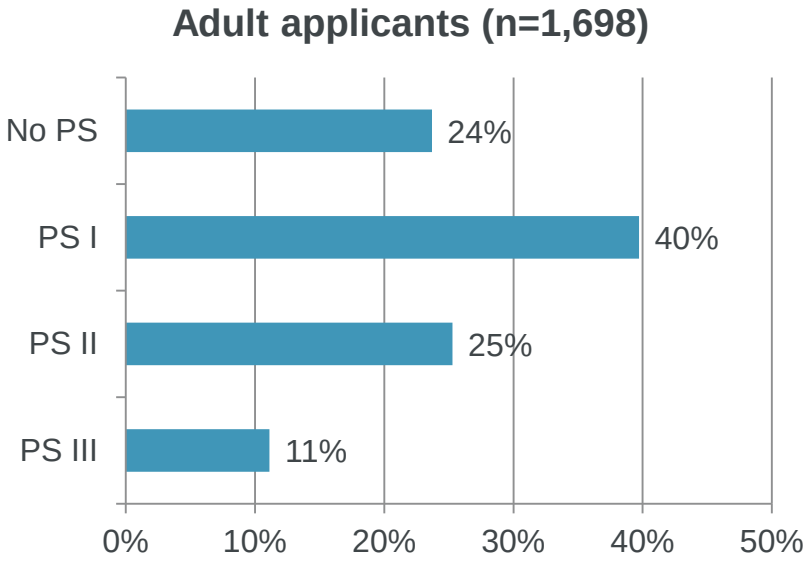
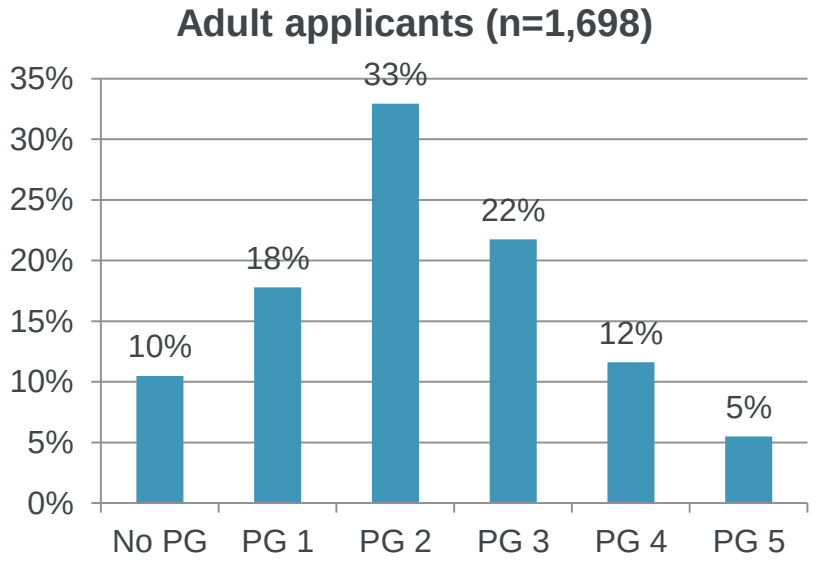
Care Levels vs. Care Grades

Praktikabilitätsstudie*





- Unfortunately without contingency table of care levels and care grades

–

maybe with good reason….

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* Praktikabilitätsstudie zur Einführung des Neuen Begutachtungsassessments zur Feststellung der Pflegebedürftigkeit nach dem SGV XI, Abschlussbericht, April 2015, S. 41

A First Reaction to the Study in Care Homes

This hard is how the new LTC reform hits people in need


EXKLUSIV: SCHOCK-STUDIE

ue

rftige

Durch die geplante Pflegereform würde jeder fünfte Pflegebedürftige künftig weniger Leistungen bekommen

With the planned LTC reform every fifth care recipient would receive less benefits.

Source: Bild

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Care Levels vs. Care Grades

“Shock study“ Bremen*

Contingency table of care levels and care grades with **all** residents of a nursing home

	No PG	PG 1	PG 2	PG 3	PG 4	PG 5	Total	Share
No PS	27%	29%	31%	13%	0%	0%	100%	3%
PS I	8%	19%	42%	31%	7%	2%	100%	37%
PS II	1%	4%	22%	36%	31%	7%	100%	37%
PS III	0%	0%	2%	7%	46%	45%	100%	23%
Total	4%	9%	25%	24%	24%	14%	100%	N=1,586

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* Evaluation des NBA Erfassung von Versorgungsaufwänden in stationären Einrichtungen (EVIS), Endbericht, Bremen, März 2015, S. 89

What do the tariffs look like for in-force policies? How can claims be managed in the future?

Level	Social security def.	ADL	Dementia
1	Public care level I	3 out of 6 ADLs	
2	Public care level II	4 out of 6 ADLs	Separate dementia definition
3	Public care level III	6 out of 6 ADLs	

?

We assume that one can draw conclusions about the ADLs from the future assessment reports.

Like before

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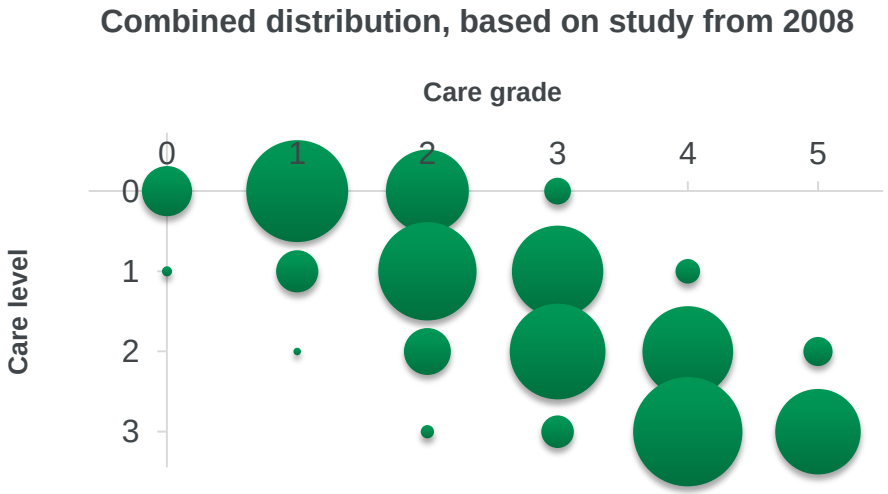
Pricing Rates for Care Grades
Essential: Contingency Table

- Based on the study from 2008
- Numerous adjustments necessary:
  - Changed thresholds
  - Effect of “Lifting-over-the-threshold“
  - Upgrading from care level 3
  - Transition probability from no care level



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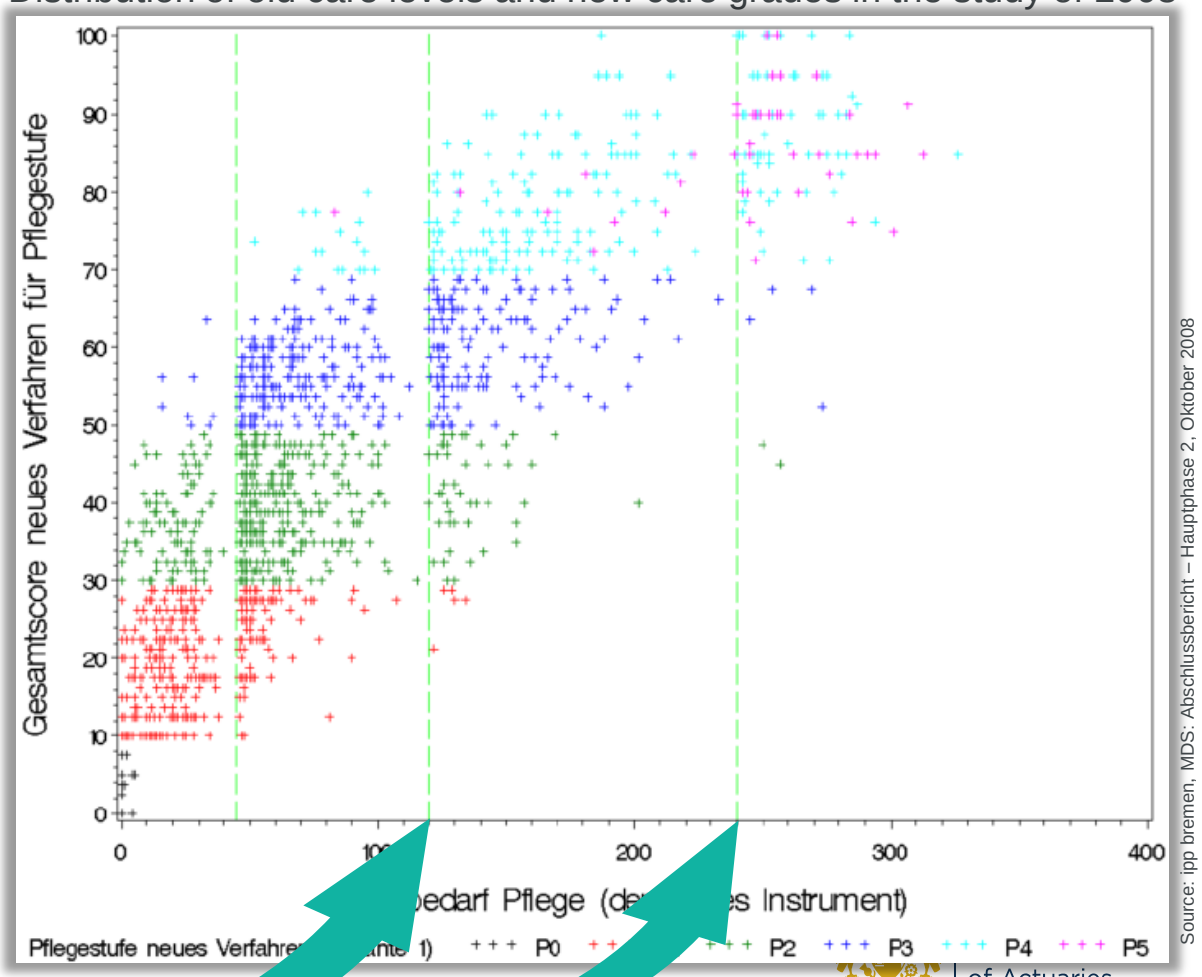
“Lifting-over-the-threshold“

- Risk of change:
  - Study setting vs. reality
- There is a cliff in the assessment of claimants at the threshold to the next higher care level
- Solution:
  Take 3-points-band before the respective threshold

Distribution of old care levels and new care grades in the study of 2008



Source: ipp bremen, MDS: Abschlussbericht – Hauptphase 2, Oktober 2008

Additional Claimants / Benefit Recipients

- How big is today's care level 0, meaning those who are not care dependent today, but will be granted a care grade in the new system?

Group A:
Up to now rejected in care level system

- Easier to estimate:
  - Declines in the social security system
  - Limited ability to cope with everyday life without care level
  - Handicapped people in institutions of the "work with the handicapped" who qualify for benefits under § 43 a SGB XI
- Ca. 400.000 additional benefit recipients

Group B:
Never have claimed

- Extremely uncertain estimate
  - Other persons in need (estimated via data from the "MuG studies" & taking into account the legal extensions (PfWG & PNG) since then)
- Ca. 445.000 additional benefit recipients

- Estimated number significantly higher than the number of 500,000 persons flatly stated by Ministry of Health

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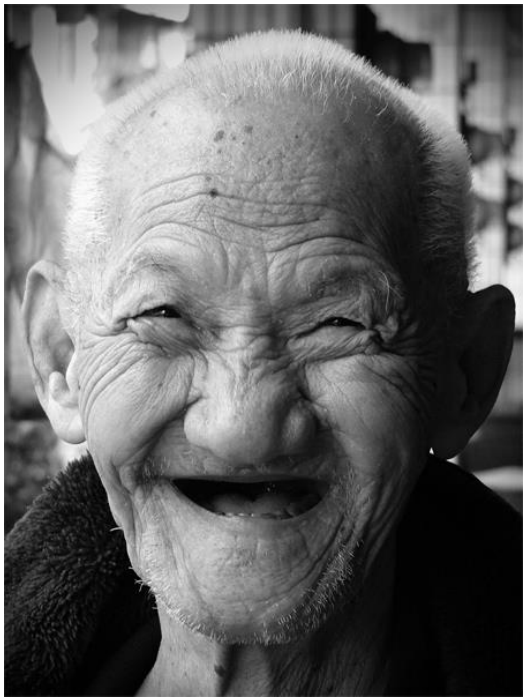
The New LTC Definition

Conclusion



© Microsoft

- Many questions had to be clarified for the practical implementation of the new care grades.
- The goal of an appropriate care assessment as part of the LTC reform seems to have been successful.
- Care touches the whole society – as a result it is complex and very political.

"Getting old is still the only possibility to live long."
Hugo von Hofmannsthal

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Social care reform in the UK – it wasn't just about the cap

Adele Groyer

16 May 2017

What changed with The Care Act 2014

- Came into effect April 2015
- National eligibility criteria
- Local authority duties
  - Promoting wellbeing and preventing / delaying needs
  - ‘Needs assessment’ for anyone who appears to have care needs
  - Provision of / signposting to information and advice around care services and financial advice
  - Facilitation of care services but may charge for self-funders
  - Promoting wellbeing of carers, must provide carer assessment
- Act does not cover NHS continuing care
- See https://www.gov.uk/government/publications/care-act-statutory-guidance

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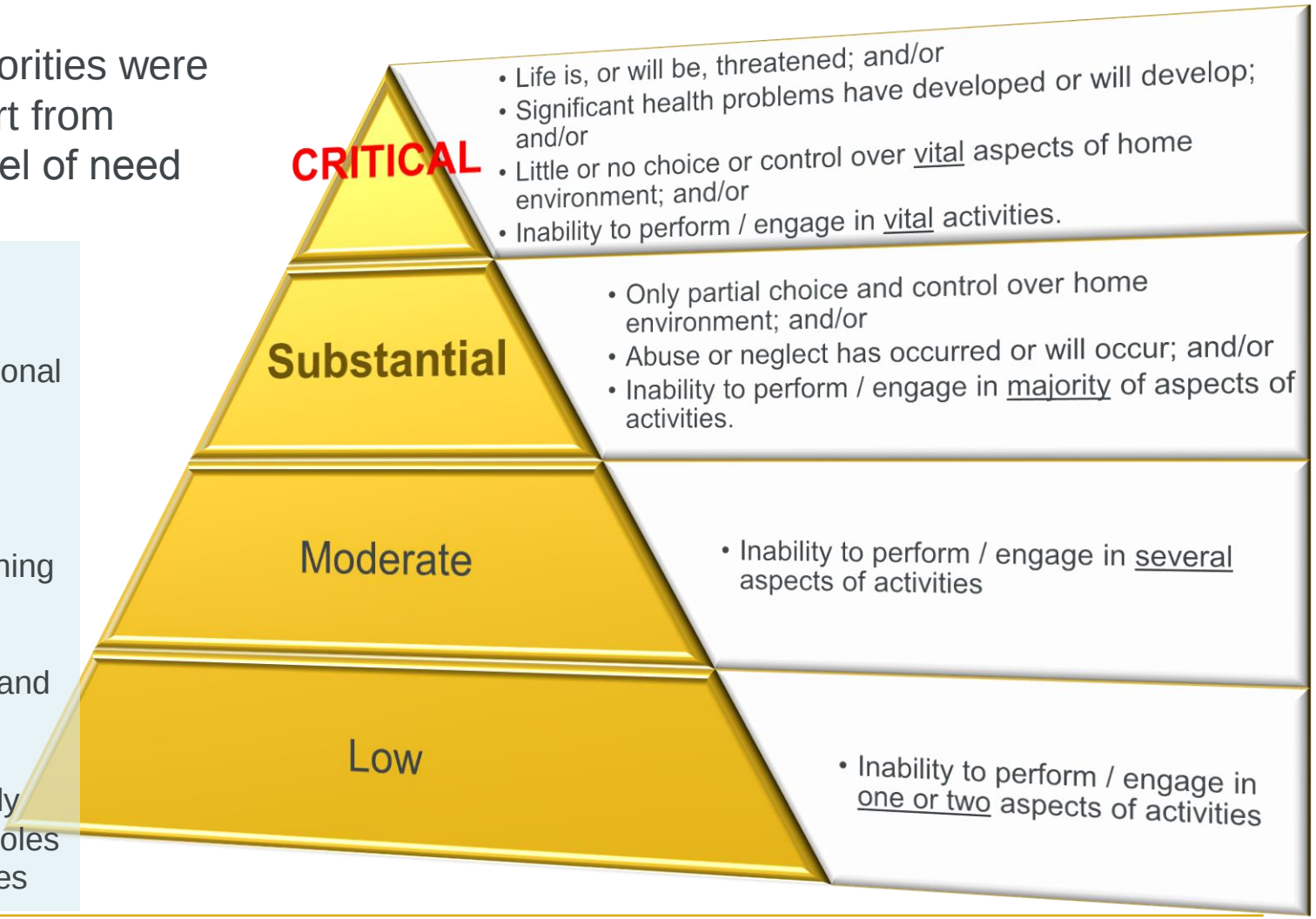
Eligibility criteria before April 2015

Most Local Authorities were providing support from "Substantial" level of need

Activities:

- Carrying out personal care or domestic routines
- Sustaining work, education or learning
- Sustaining social support systems and relationships
- Undertaking family and other social roles and responsibilities



Source: Department of Health Guidance on Eligibility Criteria for Adult Social Care, England 2010
http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113155.pdf

The new national eligibility criteria

Needs are related to a physical or mental impairment or illness which makes adult …

… unable to achieve two or more specified outcomes and as a result …

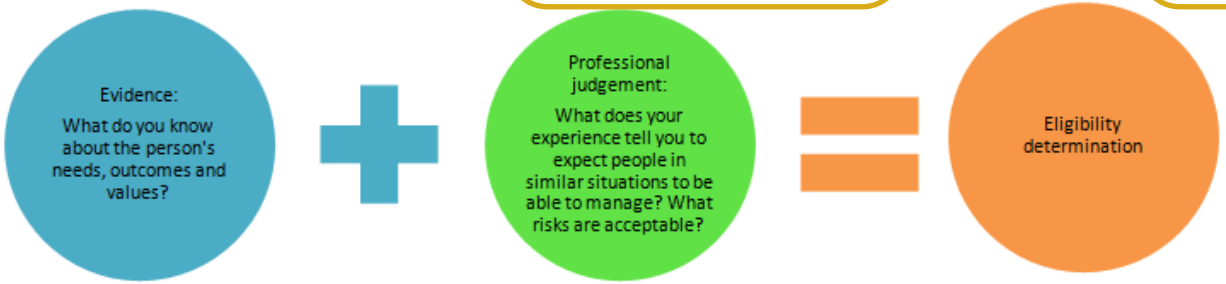
- Nutrition
- Personal hygiene
- Toileting
- Dressing
- Mobility
- Cleanliness and safety of the home
- Maintaining relationships
- Engaging in work or education
- Safe use of necessary local facilities
- Carrying out caring responsibilities

… there is likely to be a significant impact on wellbeing.

- Personal dignity
- Physical and mental health and emotional wellbeing
- Protection from abuse and neglect
- Control over day-to-day life
- Participation in work, education, recreation
- Social and economic wellbeing
- Personal relationships
- Suitable accommodation
- Individual's contribution to society

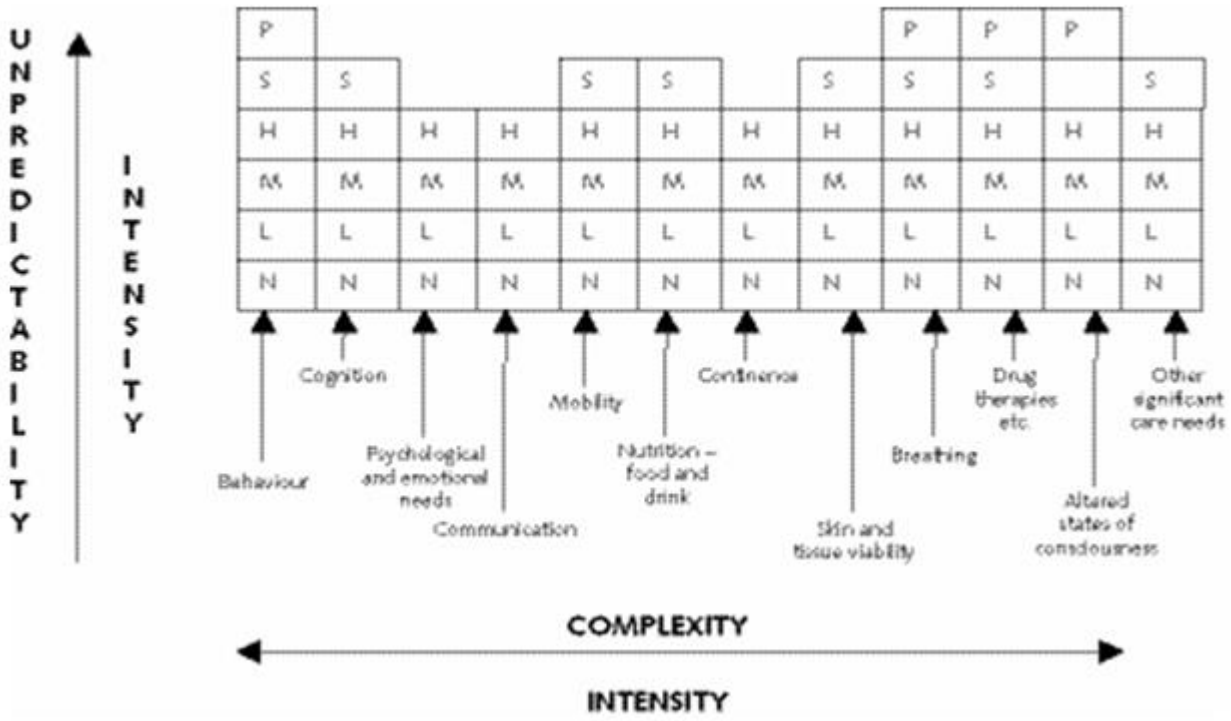
Eligibility determination process

www.scie.org.uk



NHS continuing care eligibility

- "An individual will be eligible for NHS continuing healthcare where it can be said that they have a 'primary health need'" – *Decision Support Tool for NHS Continuing Healthcare*
- Primary care needs are determined across 12 "Care Domains" and divided into levels of need



P – priority
S – severe
H – high
M – moderate
L – low
N – no needs

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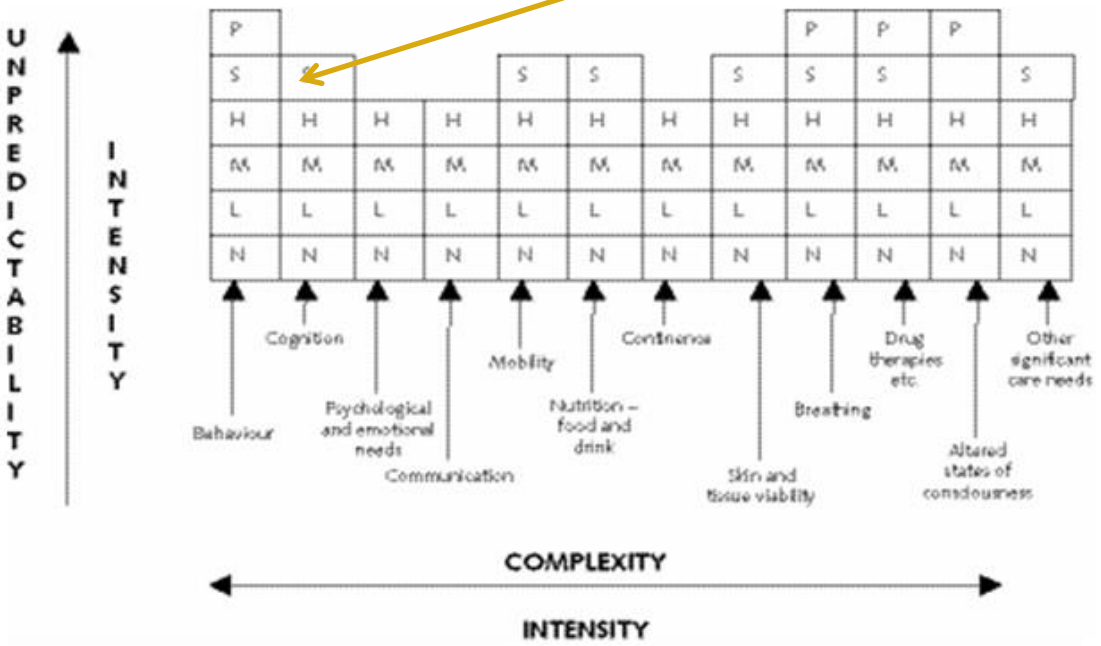
NHS continuing care eligibility examples

- Eligibility for continuing care is clear if
  - Any need is at priority level; or
  - Two or more severe needs are identified.
- There may be eligibility for continuing care if
  - There are needs in a number of domains

Severe disorientation to time, place or person. Unable to assess basic risks even with assistance.



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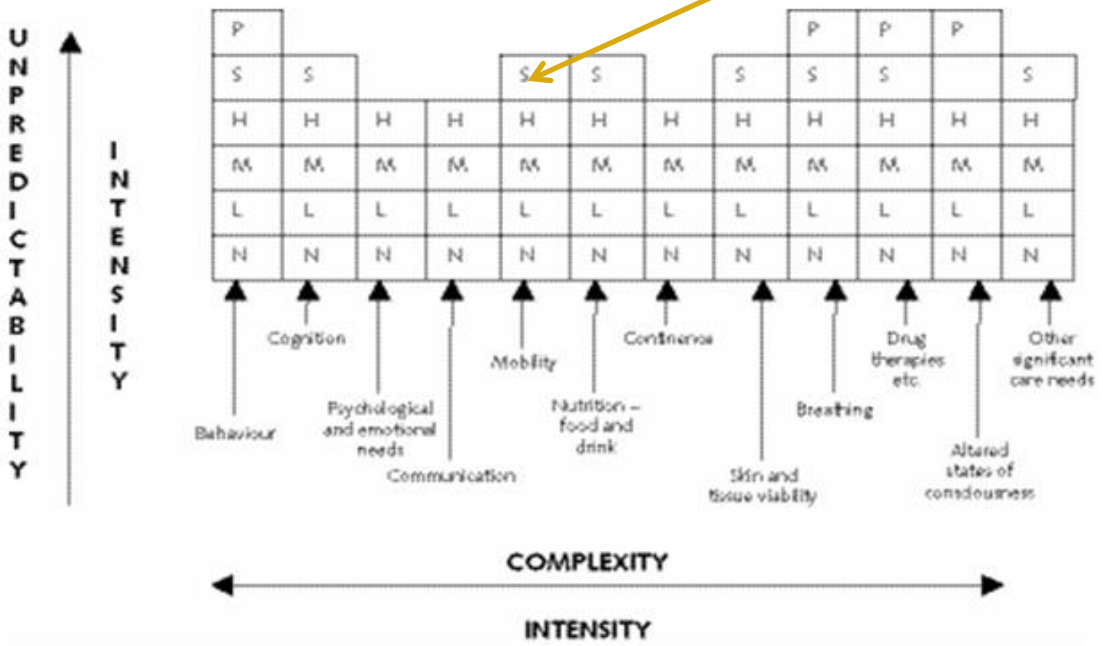
Completely immobile and there is high risk of serious physical harm on movement or transfer.



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NHS continuing care eligibility examples

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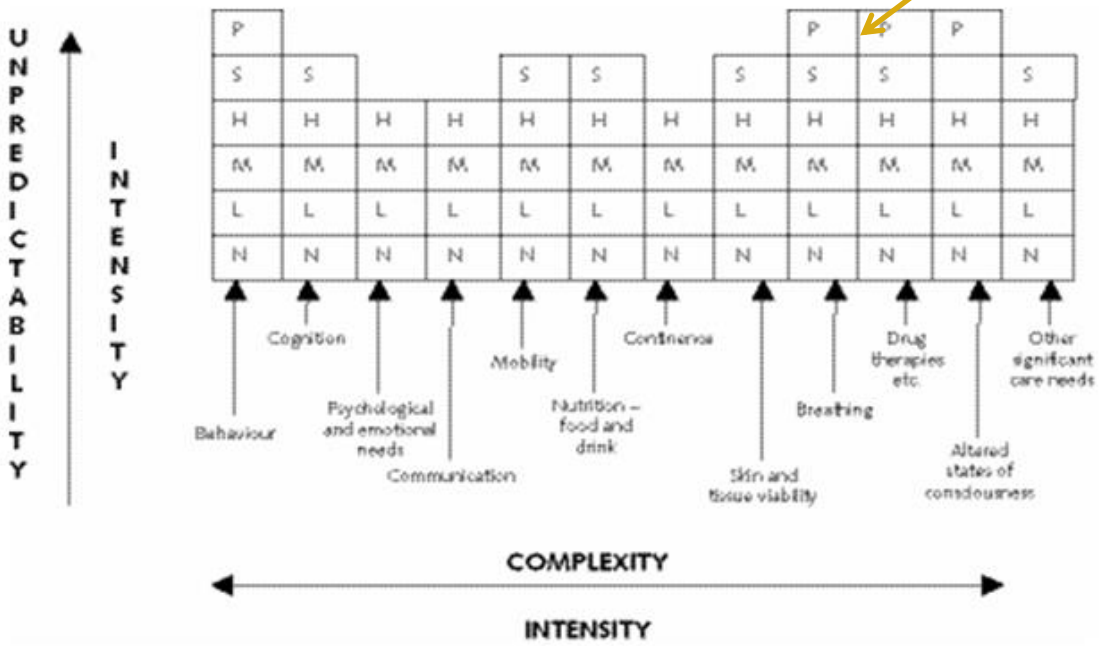
Drug regime that requires daily monitoring by a registered nurse to ensure effective symptom and pain management associated with a rapidly changing and/or deteriorating condition.
OR
Unremitting and overwhelming pain despite all efforts to control pain effectively.



NHS continuing care eligibility examples

- Eligibility for continuing care is clear if
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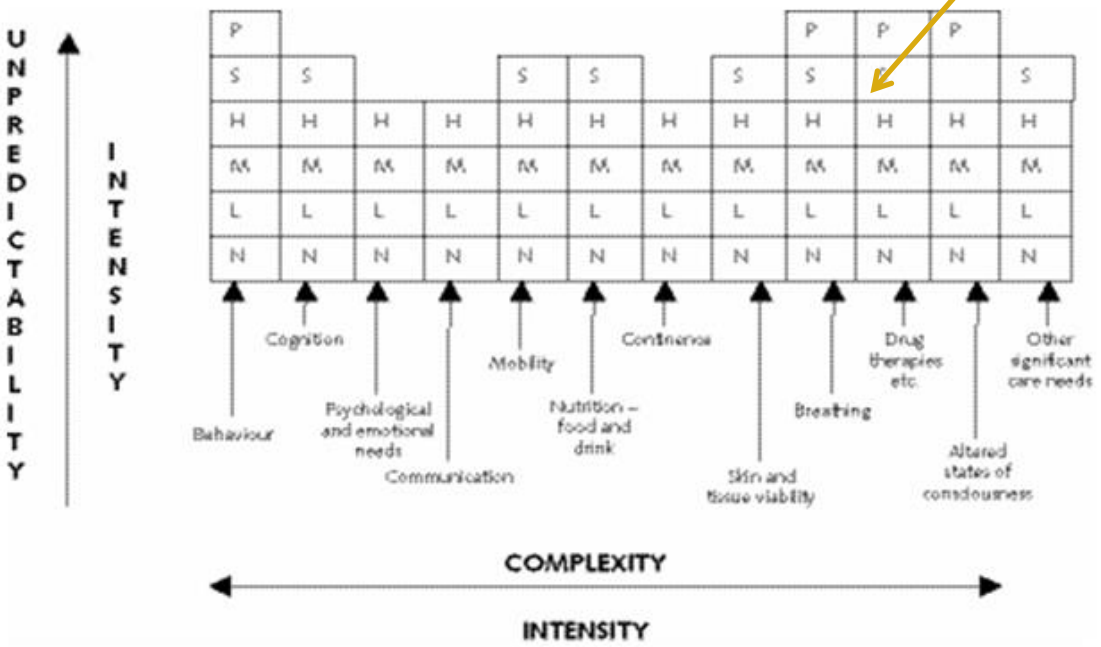
Requires administration by a registered nurse because there are risks associated with potential fluctuation of the medical condition or severity of side-effects
OR
Severe recurrent or constant pain which is not responding to treatment.



Trends in local authority-funded adult social care in England

Financial year	Local authority spending in England in 2017-18 prices	Number of local authority-funded care recipients – all ages	% of local authority-funded care recipients aged 65+	Number of local authority-funded care recipients in residential or nursing care
2000-01	£11.7bn			
2005-06	£17.0bn	1.75m	70%	
2009-10	£18.0bn	1.7m	68%	0.3m
2012-13	£16.5bn	1.3m	69%	0.3m
2015-16	£16.8bn	Reporting change which reduces community-based services count		0.3m

Sources:
Public spending on adult social care in England by Polly Simpson , The Institute for Fiscal Studies for spending figures
Adult social care in England: overview by National Audit Office March 2014 for care recipients
Performance Tracker by Institute for Government Spring 2017 for residential and nursing care finding recipients

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LTC insurance – a tiny contribution

- Number of nursing and elderly home beds in Great Britain unchanged at 550,000 between 2003 and 2015
  - Source: WHO Number of nursing and elderly home beds measures

- Self-funders in England 2010: 339,000
  - 170,000 care home residents (45% of care home residents)
  - 169,000 living in the community
  - £10.2bn spent (vs £14.6bn by local authority + £2.5bn user contribution for local-authority arranged care)
  - Source: Adult social care in England: overview by National Audit Office March 2014 for care recipients

- LTC insurance ABI statistics
  - 1,228 new policies in 2010
  - 34,000 in force end 2010
  - £100m claims in payment (vs £10.2bn self-funder spend)

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Conclusion

- Significant pressures continue in adult social care funding
  - Cutbacks occurring mostly in community-based services
- The eligibility bar is broadly unchanged following the introduction of The Care Act 2014
  - Different mechanics but still requires professional judgement
  - Local authorities now have more obligations around conducting assessments and sourcing care, even for self-funders
- Local authorities are obliged to provide or signpost to information and advice, including financial advice
  - Housing wealth
  - Only 2 providers of Immediate Needs Annuities currently
  - Pre-funding confined to Whole of Life riders

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Questions

Comments

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