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Policy Studies

The German Long-Term Care Insurance Program: Evolution and Recent Developments

Pamela Nadash, BPhil, PhD,[1,*] Pamela Doty, PhD,[2] and Matthias von Schwanenflügel, LLM Eur[3]

[1]Associate Professor of Gerontology, and Fellow, Gerontology Institute, University of Massachusetts Boston. [2]Senior Policy Analyst, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Washington, District of Columbia. [3]Director, Aging Divison, Bundesministerium für Familie, Senioren, Frauen und Jugend, Berlin, Germany.

*Address correspondence to Pamela Nadash, Associate Professor of Gerontology, and Fellow, Gerontology Institute, University of Massachusetts Boston, 100 Morrissey Blvd., Boston, MA 02125. E-mail: pamela.nadash@umb.edu

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Abstract

Background and Objectives: Since 1995, Germany has operated one of the longest-running public programs providing universal support for the cost of long term services and supports (LTSS). Its self-funding, social insurance approach provides basic supports to nearly all Germans. We discuss its design and development, including recent reforms expanding the program and ensuring its ongoing sustainability.

Research Design and Methods: The study reviews legislative and programmatic changes, using program data, as well as legislative documents and program reports.

Results: The program is widely accepted among citizens and has achieved many of its original goals: ensuring access to LTSS and reducing reliance on the locally-funded safety-net social assistance program, which can be used to cover nursing home costs. It also strengthened the LTSS provider infrastructure and expanded access to home care. Recent reforms have addressed some of the program's key issues: the benefit's decreasing value, the eligibility and benefit structure that largely excluded cognitive impairment, and the program's longer-term financial sustainability—particularly its ability to sustain newly expanded benefits, which provide stronger protections to caregivers, index-link benefits, and more systematically incorporate cognitive impairment via a new assessment system. It has addressed financing issues by increasing premiums, introducing subsidies for the purchase of private insurance, and creating a "demographic reserve fund."

Discussion and Implications: The reforms constitute a significant strengthening of the program, remarkable in an era of retrenchment. Overall, the program provides evidence for the financial viability of a social insurance model, although longer-term challenges may yet arise.

Keywords: Social care, Long-term services and supports, Comparative welfare policy, Policy, Germany

Introduction

Since 1995, Germany has operated one of the longest-running public programs providing universal support for the cost of long-term services and supports (LTSS) in the world. Its model of social insurance for LTSS has been an example to other nations, such as Japan and Taiwan (Campbell & Ikegami, 2000; Chen, 2005). Meanwhile, the United States remains one of the few developed countries lacking some form of universal LTSS coverage for the elderly. And yet, despite the fact that the proportion of the German population that is elderly (21%, as of 2013) matches the proportion that some fear will bankrupt the United States by 2050,

Germany has been successful in maintaining a fiscally solvent, self-funding program of universal coverage for LTSS. This paper discusses its design and evolution, including recent reforms designed to ensure the program's ongoing sustainability, as well as the tradeoffs necessary to maintain solvency while keeping individual contributions affordable.

Background

The Long-Term Care Insurance (LTCI) program (Pflege-Versicherungsgesetz) is an integral part of Germany's comprehensive social safety net, which balances universal public entitlements and means-tested social assistance with personal and family responsibility, and rests on a profound consensus about the importance of social solidarity. The approach originated with Bismarck's establishment of the world's first large-scale social security system in the 19th century and has endured throughout Germany's tumultuous history and regime changes. The LTCI Act of 1994 joined the health insurance laws of 1883, the accident insurance laws of 1884, the invalidity and old age provisions of 1889, and the unemployment insurance laws of 1927 to become the "fifth pillar" of the system; it aims to reduce the physical, psychological, and financial burdens that result from frailty and dependency, and secure "basic" provision for individuals at various levels of assessed need. The program currently covers 89% of the German population; the remaining 11% are required to purchase private LTCI (to supplement their private health insurance), ensuring coverage for all (Verband der Privaten Krankenversicherung, 2015). Largely unaltered since its beginning, the program underwent major legislative reforms in 2008 (Pflege-Weiterentwicklungsgesetz), 2014 (Erste Pflegestärkungsgesetz), 2015 (Zweite Pflegestärkungsgesetz) and 2017 (Dritte Pflegestärkungsgesetz).

The LTCI program was shaped by political and cultural factors, particularly Germany's history as a conservative welfare state; in such states, government, labor, and business collaborate closely to maintain social structures (Esping-Andersen, 1990). A key goal of the program, however, was to address the growing burden on the 16 German states (Länder), which operate means-tested social assistance programs (Cuellar & Wiener, 2000; Götze & Rothgang, 2015b). Unlike means-tested coverage of long-term care under the U.S. Medicaid program, which is jointly financed by the federal government and states, with federal financial participation being greater to states whose residents have lower per capita incomes, German states were solely responsible for paying for long-term care for the poor prior to the establishment of the social insurance program. These costs were growing at the same time that the Länder were experiencing fiscal pressures due to reunification (Heilemann & Rappen, 1997). Due to this political pressure from the German Länder (Campbell & Morgan, 2005), as well as from other groups, such as the nonprofit provider organizations, a social insurance program for LTSS became a perennial topic for political debate, with various proposals going back and forth among the political parties for roughly 20 years, with 17 bills proposed over that time (Gotze & Rothgang, 2015a).

Demographic pressures were critical, too: the program aimed to address the growing need for LTSS resulting from the aging of the German population as well as the reduced availability of family caregivers, due to the changing role of women and lower fertility rates. Indeed, the proportion of Germans 65 or older is projected to rise to nearly 23 million (32%) by 2050, up from 21% in 2014 and 16% in 1995, when the program was launched (Statistisches Bundesamt, 2015a). This dramatic increase in the number of older people means an increase in the number of persons needing LTSS. Although the precise relationship between aging and care needs can only be estimated (Maisonneuve & Martins, 2013), it is projected that the number qualifying for LTCI will rise from 2.6 million in 2013 to about 4.5 million by the year 2050 (Statistisches Bundesamt, 2015a).

The LTCI program was also designed to be consistent with German cultural values: most importantly, assumptions about family responsibility, women's roles, intergenerational connectedness, and the appropriate relationship between the state and the market (Theobald, 2012b). Traditionally, family plays a strong role in German social policies; the program was a form of recognition that families were increasingly under stress. Moreover, the risk of dependency and need for LTSS was accepted as affecting all ages, even if the risk is far greater for older individuals than for younger ones (Cuellar and Wiener, 2000).

Also important to Germany's social insurance model is the concept of "subsidiarity." What this means is that a national regulatory system coexists with a market orientation, in an attempt to balance social equity and consumer choice. Responsibility is delegated to both lower levels of government and private actors (Theobald, 2012a), including the family—in particular, women (Morel, 2007; Tester, 1994). In the context of the LTCI program, the critical institutional players are the roughly 118 "sickness funds" that provide medical care coverage and LTSS coverage for most Germans. In each Land, associations of providers negotiate bilaterally with associations of sickness funds over payment rates and other contract provisions.

However, one of the biggest issues Germans faced in designing their LTCI program was that of solvency and long-term fiscal sustainability. At the time, the model for a LTSS program was the Dutch program, launched in 1968, which was seen as having out-of-control costs (and has since been substantially reformed). Thus, the Germans required their program to be self-financing, setting a premium of 1.7% of income (rising in 2015 to 2.35%, or 2.6% for those without children). This self-financing mandate, combined with the desire to expand eligibility for individuals with cognitive impairments, and the need for quality improvement systems that span informal and formal care delivery systems, led to a series of reforms, culminating in

Table 1. Selected Program Changes—Germany's LTCI Program

Type	Year	Change
Premiums	1995	Established at 1.7% of income
	2002	Retired people contribute full premium
	2005	Added 0.25% for childless adults
	2008	Increase to 1.95%
	2015	Increase to 2.35%
	2017	Increase to 2.55%
Benefit adjustments	2008, 2010, 2012	Incremental increases to benefit levels
	2014	Benefit index-linked
Caregiver benefits	2008	Public pension contributions
	2008	Unemployment insurance contributions
	2008	Subsidies for health insurance and LTCI
	2016	Extension of pension benefit to more caregivers
Benefits for cognitively impaired	2002	Annual payment (€460) for cognitively impaired
	2008	Monthly supplement to benefit, tiered based on basic benefit
	2017	New assessment tool incorporating need for supervision
Counseling	2008	Introduction of community-based care support centers
	2009	Legal right to counseling consultation

Note: LTCI = Long-Term Care Insurance.

major changes in 2014, 2015, and 2017 (see Table 1). This paper discusses these reforms.

Eligibility

One significant change has been the gradual inclusion of a broader range of recipients. Historically, the program aimed to serve people who, owing to a physical, psychological, or mental disease or handicap, required significant help in carrying out daily and recurring activities of everyday life over a prolonged period of time, typically at least 6 months, and needed help with personal care, nutrition, mobility and housekeeping (under Germany's Social Code, Sozialgesetzbuch XI). Although the LTCI program covers all ages, most who qualify are 60 or older: only 17% are under 60, whereas 28% are between 65 and 80 years of age and 55% are 80 or older. Until recently, the program based eligibility on three care levels focusing on physical impairment, with a supplement for people with dementia and related cognitive impairments and a "hardship" benefit for those requiring substantial care. In 2013, a care level 0 was introduced to incorporate people needing "general supervision and care" in the home—typically, individuals with dementia, intellectual disabilities, or mental illness. (See Table 2.) In 2017 eligibility categories are being simplified into five care levels, with a goal of erasing the distinction between cognitive and physical disability (Büscher, Wingenfeld, & Schaeffer, 2011), a distinction that was already fading via the introduction of benefits targeted to people with cognitive impairment; from January 2017, eligibility now focuses not on the amount of time for which care is needed (see Table 2), but on individual ability to manage in the face of sustained physical, cognitive, or psychological impairments or health-related stresses or requirements.

Eligibility assessment will be reformed, as well. Previously based on duration and type of assistance, the new assessments aim to assign categories based on recipients' level of autonomy, awarding points along six parameters: mobility, cognitive and communication skills, behaviors and psychological problems, self-care, ability to manage treatment, and social environment, with differential weighting, such that some categories count more than others. The total points then translate to one of the five care levels. Table 2 shows approximate equivalencies between the new and old systems; transitioning protocols aim to ensure that no beneficiary loses out in the changeover. Assessments will continue to be conducted by professionals (primarily doctors and nurses) on the funds' peer review boards. Historically, benefit determinations, including denials, have generally been accepted as reliable and fair and are rarely overturned, if appealed.

Benefits

Benefits under the German LTCI program are flat-rate and do not vary based on income or assets, but do vary based on level of disability; where care is provided; and whether the beneficiary opts for cash rather than in-kind services. (Beneficiaries may also receive a mix of cash and in-kind services.) Cash benefits are approximately half the value of in-kind services, and are often used to supplement family income rather than to purchase services (Nadash, Doty, Mahoney, & Von Schwanenflugel, 2012). Generally speaking, the program allows broad discretion to recipients in making choices among service providers and using cash benefits as they see fit. The program also includes a "day and evening care" category, similar to adult day services, where people travel to a setting to receive supportive care and

Table 2. Eligibility Criteria, Pre- and Post-Reform

Old system	Disability level	New system
PS 0	No need for ADL assistance, but may benefit from general supervision and preventive/ancillary services.	PG 1
PS 1	Need for assistance with personal hygiene, feeding or mobility for at least two activities at least once a day and additional need help in the household several times during the week for at least 90 minutes a day with 45 minutes accounted for basic care.	PG 2
PS 1 + supplement	As above, plus a need for daily supervision	PG 3
PS 2	Need for assistance in at least two basic ADLs at least three times a day at various times and additional help in IADLs several times a week for at least 3 hours a day with 2 hours accounted for basic care.	PG 3
PS 2 + supplement	As above, plus a need for daily supervision	PG 4
PS 3	Need for assistance in at least two ADLs around the clock and additional help in IADLs several times during the week for at least 5 hours per day with four hours accounted for basic care.	PG 4
PS 3 + supplement	As above, plus a need for daily supervision	PG 5
Hardship	Need assistance at the PS III level for at least 7 hours a day with at least 2 hours during the night or needing basic care that can only be provided by more than one person simultaneously	PG 5

Notes: ADLs = need for assistance with activities of daily living; IADLs = instrumental activities of daily living. The "supplement," or "eingeschränkte Alltagskompetenz" was a payment for the costs of daily living oversight (i.e., IADLs), typically for people with dementia.

Table 3. Monthly Benefit, in Euros (dollars), 2017

Care level	Home care: benefits in kind	Home care: cash benefit	Day and evening care	Nursing home care
PG 1	—	—	—	—
PG 2	689	316	689	770
	(786)	(360)	(786)	(878)
PG 3	1,298	545	1,298	1,262
	(1,480)	(621)	(1,480)	(1,439)
PG 4	1,612	728	1,612	1,775
	(1,838)	(830)	(1,838)	(2,024)
PG 5	1,995	901	1,995	2,005
	(2,274)	(1,027)	(2,274)	(2,286)

Note: "Day and night care" includes services in a facility setting (similar to adult day services). Source: Verband der Ersatzkassen, 2016.

Table 4. Selected Ancillary Benefits, 2017

Benefit	Amount, in Euros (dollars)
Short-term respite (for emergency leave)	125
	(143)
Long-term respite: expenses up to 8 weeks (per year)	1,612
	(1,838)
Support for LTCI recipients in shared living arrangements (monthly)	214
	(244)
Initial funding for the establishment of shared living arrangements (per individual, max of 10,000 euro ($11,400) per home)	2,500 (2,850)
Special supplement to nursing home residents (per year)	266
	(303)
Medical supplies (per item)	40
	(46)
Home modifications (per year, in individual or shared living arrangements)	4,000
	(4,560)

Note: "Shared living arrangement" refers to "Ambulant betreute Wonhgruppen," an arrangement whereby individuals with LTSS needs choose to live together and share services. Source: KV-Media http://www.kv-media.de/pflegereform-2016–2017.php.

supervision. (See Table 3.) Although the lowest benefit level does not pay out monthly benefits, it qualifies the recipient for ancillary benefits, including respite, home modifications, counseling, and pension contributions. (See Table 4.)

The LTCI funds pay statutory pension contributions on behalf of qualifying caregivers; they also pay unemployment insurance, health insurance, and LTCI for qualifying caregivers, who must provide at least 14 (from 2017, 10) hours

a week of care in the care recipient's home, and be limited in their ability to work due to caregiving responsibilities. Caregivers are entitled to 6 months leave, and (as of 2017) up to 24 months of part-time leave. Caregivers can apply for interest-free loans which they then are required to repay after returning to work. Other benefits include "low-threshold care"—community-based services where helpers take care of beneficiaries at home or in groups for limited time periods under the supervision of trained carers, as well as one-time payments to set up group living arrangements. Beneficiaries may also apply for help and subsidies to retrofit dwellings to meet care needs and for free nursing training for caregivers.

Thus, the reforms introduced important benefit expansions, in terms of both populations included (the more systematic inclusion of people with supervision needs), types of benefits (such as specific benefits targeted at caregivers and people with dementia) and increases in the value of the monthly benefit (which included three benefit hikes and then, 2014, the indexation of the benefit—all of which nonetheless failed to restore the benefit to its 1995 value). (See Table 1.)

Benefit Adequacy

As noted, the program was designed to cover only basic, not comprehensive LTSS costs, based on the political compromises that ensured its passage (Gotze & Rothgang, 2015a). Moreover, failure to inflation-adjust benefits from 1995 to 2008 resulted in their decline in value. In 2008, however, legislation increased benefits and introduced automatic indexation, starting in 2015.

Further, although the program covers care both at home and in nursing homes, it explicitly does not cover the cost of room and board. This affects the affordability of nursing home care significantly, because the benefit only partially covers the cost of the care itself and pays nothing toward the remainder. Rothgang (2014) estimated that a resident of a nursing home costing a typical rate of €3,302 per month would face out of pocket costs of €1,792, despite receiving the highest level of benefit. Consequently, dependence on the safety-net social assistance program to help cover the cost of nursing home—one of the factors that motivated the introduction of the LTCI program—has risen, although not to the levels seen before the LTCI program was introduced. Prior to its introduction (in 1992), 8.4 people in a thousand relied on social assistance to fund a nursing home stay, dropping to a low of 3.5 in 1998. Since that time, it has risen to 5.5 (in 2013), an average increase of about 3% a year (Statistisches Bundesamt, 2015b). Alarm about such increases was one factor motivating the recent reforms (Der Spiegel, 2012).

Finally, although LTCI benefit amounts are uniform across Germany, provider charges are not. Beneficiaries who choose higher cost providers or live in areas where providers charge more will need to pay extra to get the same level of service. Additional costs may also arise if beneficiaries choose nursing home care when the LTCI fund deems it unnecessary; in these cases, benefits are limited to the cost of home care. Consequently, families must either pay out of pocket or apply for means-tested social assistance for eligible expenses. Indeed, German law requires family members "in the direct line of descent" to cover the cost of care (Moskowitz, 2001). Many elderly who do not move into nursing homes supplement their LTCI benefits with uncompensated help from family, friends, and neighbors, or hire cheaper, "gray market" labor (sometimes, by using the cash benefit to do so) (Theobald, 2012b). About 4% of Germans have chosen to purchase additional private LTCI to supplement their mandatory public or private coverage if they go into claim (Nadash & Cuellar, 2017).

Service Infrastructure

Consistent with the subsidiarity principle, the system seeks to encourage competition among private sector providers, which is primarily based on quality and reputation and to a lesser extent on price, as prices are heavily regulated. Providers are both for- and nonprofit: few are public sector. (Just 1% of home care providers are public, for example, compared to the 64% of home care providers that are for-profit.) Moreover, the system prioritizes care in the least restrictive environment. Thus, of approximately 2.73 million LTCI beneficiaries in 2016 (the number covered by both public and private insurers), the majority (69%) received care at home (Statistisches Bundesamt, 2015a). However, the higher costs of institutionalized beneficiaries means that spending on residential and home-based LTSS is about equal.

The LTCI program successfully expanded the formal services infrastructure in home and community-based settings, which rose from about 4,000 providers in 1995 to roughly 12,800 in 2013, as well as in residential care, which rose from about 4,300 to about 13,030 facilities, which were particularly needed in the former German Democratic Republic. In addition, the 2008 LTCI reforms introduced so called "Pflegestützpunkte." Comparable to Aging and Disability Resource Centers in the United States, these are organized by the LTCI funds in partnership with local communities to provide information and referral to LTSS recipients and their families.

LTCI sickness funds are legally required to ensure that beneficiaries receive the care they need and that this care meets quality standards. The policy intent is that the sickness funds represent the interests of the insured; funds collectively negotiate service and remuneration contracts as well as performance and quality agreements. Those needing LTSS are thus able to choose among providers; sickness funds do not seek to create narrow provider networks.

Although insurers reimburse authorized service providers, those opting to receive their home care benefit in cash are paid directly. The cash benefit is meant to acknowledge and reward care-giving by relatives, friends or neighbors, rather than to act as a means of developing the formal service delivery infrastructure (as it does in some other

countries). Indeed, a 2010 survey investigating uses of the cash benefit revealed a strong preference for care from family members and an aversion to care from "strangers." Most home care users—78% in 2010—choose cash over formal agency-based care, although this proportion has dropped from 88% in 1995. Expenditures for cash-only benefits have also declined from 82% to 62% of home care expenditures—a steeper decline because more beneficiaries choose a combination of cash and in kind benefits. Cash benefits may also be used to pay stipends to community volunteers, often church-affiliated (Bundesministerium für Gesundheit (BMG), 2011). Moreover, an estimated 120,000 illegal migrant care workers are reimbursed through cash benefits or out-of-pocket (Theobald, 2012c).

This latter point highlights the lack of requirements and accountability mechanisms associated with the cash benefit, in contrast to the oversight insurers wield with respect to direct services. Indeed, the 2010 survey found that 31% of all cash benefit recipients—49% at the highest care level—reported using their cash benefits for basic living expenses (BMG, 2011), which is widely considered a legitimate use of the benefit. Moreover, because the cash benefit does not count as income, it is tax-free. To ensure that cash beneficiaries are receiving necessary care and are not being abused, neglected, or financially exploited, they receive in-home quality monitoring visits from formal services providers every 6 months (every 3 months for the most impaired) (BMG, 2011) or acknowledged counseling centers.

Quality Assurance

A "Medical Advisory Service," sponsored by the sickness funds, monitors all LTSS providers; its job is to check, annually and without advance notice, whether licensed care facilities fulfill performance and quality improvement standards required under regulation. These standards are developed by the Association of LTCI funds, which comprises representatives from service providers and insurance funds; the standards therefore have widespread credibility. Nursing homes are bound by separate standards, set also by the Association of LTCI funds in agreement with provider groups. These specify quality standards, quality assurance requirements, and quality management systems within each facility, which are required under law (Schulz, 2010, 2012). In general, quality in nursing homes is rated highly (Geraedts, Harrington, Schumacher, & Kraska, 2015).

Other initiatives to improve quality include a website (since 2008) that provides publicly available information on nursing home quality, modeled on the United States "Nursing Home Compare" website (http://www.pflegelotse.de), in line with general efforts to increase transparency in LTSS. (See, for example, https://www.vdek.com/vertragspartner/Pflegeversicherung/grundlagen.html.) Another effort, yet to be implemented, focuses on strengthening the link between community-level services—which include nursing, counselling and case management—and formal care financed by the LTCI.

Financing

Maintaining the solvency of the public LTCI program is a challenge: it is financed on a pay-as-you-go basis and is legally required to be self-financing. Thus, as demand grows and benefit levels decrease relative to inflation, administrators must either constrain demand by limiting eligibility or benefits, or increase revenue by raising income from premiums (which depends not only on contribution rates, but also on the age distribution and employment status of the population as a whole). However, such changes require legislative approval, making them difficult to introduce. Thus, until recently, premiums were increased only rarely. (See Table 1.)

Financing was not an issue in the early years of the program, which generated a surplus while claimants were few. However, outgoings exceeded revenues by 2002, creating the impetus for premium increases and prompting discussions about prefunding the program (Rothgang, 2010). Contribution rates were initially set at 1.7 % of gross income (up to a cap, currently €4237.50 per month) and remained unchanged until 2008, when it increased to 1.95%, and then 2013, 2015, when it rose to 2.35%; the last increase was on January 1, 2017 to 2.55%. This is expected to sustain the program until 2022, at minimum, in addition to helping to prefund the program. Employers pay half, but after retirement the insured pays the full premium. Only dependents are exempt; parents or spouses contribute on their behalf. Because the societal expectation is that Germans who have children can expect to receive unpaid LTSS in their old age (thus reducing costs for the LTCI fund), childless persons 23 and older must pay a supplementary contribution of 0.25% (a provision that was introduced in 2005).

The concept of prefunding the program through a demographic reserve fund bore fruit in 2015, with the institution of the Pflegevorsorgefonds. This fund, managed by the federal bank, receives 0.1% of premium income, with a goal of building reserves of about €1.2 m. The fund will become available from 2035 onwards, when up to 1/20 of it can be drawn upon to support the program in a given year; the fund, however, only partially addresses future funding needs (Bowles & Greiner, 2015; Hagen & Rothgang, 2014).

The reforms also aimed to use the private LTCI market to address the gap between the full cost of care and benefits under the LTCI program. They did so by subsidizing the purchase of private supplemental LTCI policies through the "Pflege-Bahr," a program introduced in 2013. This supplemental market is separate from the mandatory private LTCI that covers the 11% of the population with private health insurance; eligibility for and benefits under these mandatory policies match those in the public program, creating the same coverage gaps. However, unlike the public program, premiums for the mandatory private policies are based on the age of the insured upon enrolment and never change (unless the insured lapses coverage and re-enrolls at an older age), and are paid by the insured individual but by

law premiums cannot be more expensive than the public program. Regardless, private supplemental policies may be purchased by anyone, whether they obtain their mandatory coverage from the private or public system.

A separate, supplemental LTCI market has always existed, but has had limited reach, comprising only about 3% of the eligible population (2.3 million of the 77 million Germans covered by the mandatory programs in 2012). To boost this private market, with the Pflege-Bahr, the federal government is offering a subsidy (capped at €5 per month) for the purchase of certain supplemental policies. Applicants must be 18 or older and not receiving statutory benefits. These benefits, which are paid in cash, must meet certain minimums: for disability at level 1, they must be at least 20% of the statutory amount; at level 2 at least 30%; and at level 3, benefits must be at least €600. (These rules will change when the statutory program transitions to five disability levels.) Benefits may not exceed 100% of statutory benefits when the contract is signed, but inflation riders mean that benefits may grow relative to the statutory program. Eligibility is determined via statutory disability criteria and triggers payment; claimants must typically have held their policy for 5 years.

The program expanded private supplemental coverage to over 4% of the population in 2015, with a total of 683,500 subsidized policies sold since its introduction in 2013. These were very popular upon introduction, with 360,000 subsidized policies sold in year 1, but sales growth subsequently slowed. It is important to note that sales of supplemental products were fairly healthy in the years prior to the reform, averaging 12% annually since 1996 (Verband der Privaten Krankenversicherung, 2015). Despite the popularity of the subsidized policies, there are concerns about their longer-term actuarial sustainability. Because underwriting is not allowed for subsidized products (in other words, they must take all comers and cannot adjust premiums based on medical risk), unsubsidized supplemental products, which offer risk-adjusted premiums, are better deals for some people (typically, younger and healthier individuals). Subsidized products therefore provide a marketing opportunity for insurers, who can steer better risks to the unsubsidized products offering more favorable terms. Given the pattern of risk selection between the subsidized and unsubsidized products, the subsidized products may face an adverse selection over the longer term. Interestingly, however, such adverse selection has not materialized; growth in the unsubsidized market has stalled, raising questions about the impact of LCTI program expansions on the private market (Nadash and Cuellar, 2017).

Taking Stock After Over 20 Years

After over 20 years, the German LTCI system has become an integral component of the country's social security system, enjoying a high level of acceptance among citizens. Most importantly, it has achieved many of its original goals, first among them ensuring access to LTSS: about 3% of the insured are currently receiving benefits. One of its major goals was reducing reliance on the safety-net, locally-funded social assistance programs, which supported nursing home residents. Although this goal was largely achieved, erosion of the benefit's value has reversed this trend somewhat.

Other important goals have been achieved: the LTSS provider infrastructure has been strengthened, having added over 250,000 new jobs. Home care has also been bolstered, with more than two-thirds of those needing LTSS receiving services at home. And lastly, the LTCI program exemplifies core German values: it strengthens social solidarity by requiring everyone to pay premiums; it also emphasizes the importance of personal responsibility by only partially covering the cost of care.

The recent reforms therefore constitute a major achievement in tackling some of the program's key issues: the decreasing value of the benefit, the eligibility and benefit structure that excluded adequate coverage for people with cognitive impairment, and the longer-term problem of the program's financial sustainability in the face of an aging population. It is remarkable that the reforms were politically feasible, given cost estimates of 1.4 billion euros ($1.6 billion) (Rothgang et al., 2015). How this plays out over the longer term, however, remains to be seen, given the unpredictability of demographic change and future LTSS needs, and the adequacy (or not) of the financing reforms.

Conclusion

The German LTCI program's most notable feature is its universality: not just seniors but all citizens are covered. Participation is mandatory and occurs either via the public social insurance program, which is financed by a fixed percentage of income and paid to the same sickness funds that provide participants' health insurance or, for a minority (about 11% of the population), is financed by age-rated premiums and paid to the same private insurers that provide participants' private health insurance.

The LTCI program's most notable accomplishment is that it is entirely self-financing. Although the income-related contributions that finance LTCI for most Germans may appear to Americans to be akin to the payroll taxes that finance Social Security and Medicare Part A benefits, they are seen in Germany as mandatory contributions for insurance rather than as a tax supporting a government program. This difference in perception may be because Germans must actively choose a fund (if they are in the public program) or insurer (if they are in the private)—although they must obtain both their health and long-term care insurance from the same one. It may further help explain how self-financing and actuarial soundness can be enforced. If contribution rates and premiums prove insufficient to pay benefits, those amounts must be increased or benefits reduced. The federal government plays a strong

role in monitoring the system's adequacy and solvency because any changes in contribution rates and/or benefits must be legislated. At any given point in time, a contractual entitlement exists, enabling beneficiaries to know what benefits are guaranteed and their monetary value, based on their professionally assessed level of disability-related need.

The challenge of the German LTCI model is that a self-funding mandate can be difficult to sustain in the face of an aging population: revenues vary based on who is in and out of the labor force, as well as the demographic profile of the working population. One of the most remarkable achievements of the German program has been its ability from 1994 through the present day to accurately forecast demand and associated expenditures. Other countries with universal financing for LTSS (most notably, Japan) have not been as successful: although attributed to higher than anticipated demand, reasons for this are poorly understood. An important constraint to such programs is on the revenue-generating side: it can be politically difficult to increase revenue by raising premiums set by legislatures—which is why Germany's most recent reforms, which increase premiums and index-link benefits, are so significant.

Its other notable feature is the program's explicit trade-off regarding affordability and benefits: the program does not aim to cover the full cost of care. Thus Germans trade low benefits—a program that is inexpensive because it is mandatory but also acceptable as mandatory because it is so inexpensive—for comprehensive, high dollar policies affordable only to affluent low-risk individuals—policies that are affordable only because they exclude lower-income, higher risk individuals (as does the U.S. private insurance market).

In contrast, the United States' most recent serious effort to increase access to non-means-tested coverage, the Community Living Assistance Services and Supports (CLASS) Act aimed to offer voluntary LTCI coverage to employed Americans by charging premiums that were age-rated but not otherwise linked to health and disability status. However, lacking a mandate, the program was unable to meet the provision (built into the law) of certification for actuarial soundness over a 75 year span (US Department of Health and Human Services, 2011) Many observers concluded that mandating participation is necessary to avoid the exclusion of those most likely to need long-term care coverage.

Over the years, some American admirers of the German LTCI program have recommended adopting a social insurance model by adding LTSS benefits to Medicare. Currently, the most often discussed proposal is a public/private partnership where universal social insurance would cover "catastrophic" LTSS costs after a waiting period, providing opportunities for private insurance to fill gaps in coverage (Bipartisan Policy Center Long-Term Care Initiative, 2016; Favreault, Gleckman, & Johnson, 2016). Another proposal envisions adding a low-cost, modest, home and community-based personal care Medicare benefit, aimed at beneficiaries with both LTSS needs and high medical care utilization (Davis et al, 2016), financed in part by a small payroll tax increase but also by monthly premiums paid by Medicare enrollees. In addition, a unique feature seldom included in a "social insurance" model would lower program costs by requiring income-adjusted co-payments of up to 50 percent.

Americans will continue to watch the German system closely, particularly some of its latest initiatives. First, it will be interesting to see whether subsidizing the purchase of private insurance has a significant impact on purchasers' levels of financial protection over the longer term, given concerns that the subsidized products will suffer from adverse selection and the slowdown in sales growth in the unsubsidized market. Second, it will be interesting to see whether the demographic reserve fund plays an important role in ensuring longer-term financial sustainability, given scepticism that the fund will be kept inviolate in times of budget crisis, and concerns that it will be depleted when demand is highest (Bowles & Greiner, 2015; Gotze & Rothgang, 2015a). And last, will the program be able to sustain the expanded benefits it is offering, which provide stronger protections to caregivers, index-link benefits, and more systematically incorporate cognitive impairment under its new eligibility assessments?

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References

Bipartisan Policy Center Long-Term Care Initiative. (2016). Initial recommendations to improve the financing of long-term care. Washington, DC: Author. (February), 1–48. Retrieved from https://bipartisanpolicy.org/library/long-term-care-financing-recommendations/

Bowles, D., & Greiner, W. (2015). Kollektiv-ergänzende Kapitaldeckung in der sozialen Pflegeversicherung – Wirkungen des Pflegevorsorgefonds auf die Beitragssatzentwicklung. *Zeitschrift Für Sozialreform*, **61**(2), 199–224. doi: 10.1515/zsr-2015-0205

Bundesministerium für Gesundheit. (2011). *Zahlen und Fakten zur Pflegeversicherung*. Munich, Germany: Author. Retrieved from http://www.bmg.bund.de/fileadmin/dateien/Downloads/Statistiken/Pflegeversicherung/2011_03_Zahlen_und_Fakten_Pflegeversicherung.pdf

Büscher, A., Wingenfeld, K., & Schaeffer, D. (2011). Determining eligibility for long-term care-lessons from Germany. *International Journal of Integrated Care*, **11**, e019. doi: 10.5334/ijic.584

Campbell, J. C., & Ikegami, N. (2000). Long-term care insurance comes to Japan. *Health Affairs*, **19**(3), 26–39. doi: 10.1377/hlthaff.19.3.26

Campbell, A. L., & Morgan, K. J. (2005). Federalism and the politics of old-age care in Germany and the United States. *Comparative Political Studies*, **38**(8), 887–914. doi: 10.1177/0010414005277575

Chen, C. (2005). The Long-term care policies in Germany, Japan and Canada : A lesson for Taiwan. *Taiwanese Journal of Social Welfare*, (December), **5**, 49–69.

Cuellar, A. E., & Wiener, J. M. (2000). Can social insurance for long-term care work? The experience of Germany. *Health Affairs*, **19**(3), 8–25. doi: 10.1377/hlthaff.19.3.8

Davis, K., Willink, A., & Schoen, C. (2016). Medicare Help At Home. *Health Affairs Blog*, April 13, 2016. Retrieved from http://healthaffairs.org/blog/2016/04/13/medicare-help-at-home/

Der Speigel. (2012). 400,000 Senioren können Altenheim nicht mehr zahlen Retrieved from http://www.spiegel.de/wirtschaft/soziales/hunderttausende-senioren-koennen-ihre-altenpflege-nicht-mehr-zahlen-a-863822.html

Esping-Andersen, G. (1990). *The Three Worlds of Welfare Capitalism*. Princeton, NJ: Princeton University Press. Retrieved from http://press.princeton.edu/titles/4558.html

Favreault, M. M., Gleckman, H., & Johnson, R. W. (2016). *Can Catastrophic Insurance Improve Financing for Long-Term Services and Supports?* Washington, DC: The Urban Institute.

Geraedts, M., Harrington, C., Schumacher, D., & Kraska, R. (2015). Trade-off between quality, price, and profit orientation in germany's nursing homes. *Ageing International*, **41**, 89–98. doi: 10.1007/s12126-015-9227-1

Gotze, R., & Rothgang, H. (2015a). Fiscal and social policy: financing long-term care in Germany. In K. P. Companje (Ed.), *Financing high medical risks: Discussions, developments, problems and solutions on the coverage of the risk of long-term care in Norway, Germany and the Netherlands since 1945 in European perspective*. Amsterdamn: Amsterdam University Press.

Götze, R., & Rothgang, H. (2015b). Fiscal and social policy: financing long-term care in Germany. In K. P. Companje (Ed.), *Financing high medical risks: Discussions, developments, problems and solutions on the coverage of the risk of long-term care in Norway, Germany and the Netherlands since 1945 in European perspective*. Chicago: University of Chicago Press.

Hagen, K., & Rothgang, H. (2014). Erfolge und Misserfolge der Pflegeversicherung – Ihre Weiterentwicklung bleibt notwendig. *Vierteljahrshefte Zur Wirtschaftsforschung*, **83**(4), 5–20. doi: 10.3790/vjh.83.4.5

Heilemann, U., & Rappen, H. (1997). *The Seven Year Itch? German Unity from a Fiscal Viewpoint* (Economics Studies Program No. AICGS Research Report No. 6). Washington, DC. Retrieved from http://webdoc.gwdg.de/ebook/lf/2003/aicgs/publications/PDF/sevenyearitch.pdf

Maisonneuve, C. D. La., & Martins, J. O. (2013). *Public spending on health and long-term care: a new set of projections*. OECD Economic Policy Papers, No. 6. Retrieved from http://www.oecd.org/eco/growth/Health FINAL.pdf

Morel, N. (2007). From subsidiarity to "free choice": Child- and elder-care policy reforms in France, Belgium, Germany and the Netherlands. *Social Policy and Administration*, **41**(6), 618–637. doi: 10.1111/j.1467-9515.2007.00575.x

Moskowitz, S. (2001). Adult children and indigent parents: Intergenerational responsibilities in international perspective. *Marquette Law Review*, **86**(3), 402–455. Retrieved from http://scholar.valpo.edu/law_fac_pubs

Nadash, P., & Cuellar, A. E. (2017). The emerging market for supplemental long term care insurance in Germany in the context of the 2013 Pflege-Bahr Reform. *Health Policy, 0*(0). doi:10.1016/j.healthpol.2017.03.006

Nadash, P., Doty, P., Mahoney, K. J., & Von Schwanenflugel, M. (2012). European long-term care programs: Lessons for community living assistance services and supports? *Health Services Research*, **47**(1 PART 1), 309–328. doi: 10.1111/j.1475-6773.2011.01334.x

Rothgang, H. (2010). Social insurance for long-term care: An evaluation of the German model. *Social Policy and Administration*, **44**(4), 436–460. doi: 10.1111/j.1467-9515.2010.00722.x

Rothgang, H. (2014). Financing long-term care in the future : challenges and policy strategies. Paper presented at the biennial meeting of the International Long Term Care Policy Network, London, England. Abstract retrieved from http://ilpnetwork.org/presentations/funding-long-term-care-in-the-future-challenges-and-policy-strategies/

Rothgang, H., Kalwitzki. T., Müller, R., Runte, R., & Unger, R. (2015). BARMER GEK Pflegereport 2015. Retrieved from https://www.barmer.de/blob/36042/73f4ded2ea20652834aeedbb7c2bc16a/data/pdf-barmer-gek-pflegereport-2015.pdf

Schulz, E. (2010). *The long-Term Care System in Germany*. ENEPRI Research Report No. 78. Berlin, Germany: European Network of Economic Policy Research Institutes. Retrieved from http://www.ancien-longtermcare.eu/sites/default/files/ENEPRI%20_ANCIEN_%20RRNo78Germany.pdf

Schulz, E. (2012). *Quality Assurance Policies and Indicators for Long-Term Care in the European Union. Country Report: Germany*. ENEPRI Research Report No. 104. Berlin, Germany: European Network of Economic Policy Research Institutes. Retrieved from http://www.ancien-longtermcare.eu/sites/default/files/RR%20No%20110%20_ANCIEN%20WP5D5.2_%20LTCQualityAssuranceIndicatorsinEuropeanCountries.pdf

Statistisches Bundesamt. (2015a). Pflegestatistik 2013. Pflege im Rahmen der Pflegeversicherung. Deutschlandergebnisse. Retrieved from https://www.destatis.de/DE/Publikationen/Thematisch/Gesundheit/Pflege/PflegeDeutschlandergebnisse5224001159004.pdf?__blob=publicationFile

Statistisches Statistisches Bundesamt. (2015b). Population in Germany:Age structure. Retrieved February 23, 2016, fromhttps://www.destatis.de/EN/Publications/Specialized/Population/GermanyPopulation2060_5124206159004.pdf;jsessionid=F13A68EE4369DE94B01588409355238D.cae2?__blob=publicationFile

Statistisches Bundesamt. (2015c). Statistik der Sozialhilfe: Hilfe zur Pflege 2013. Wiesbaden, Germany. Retrieved from https://www.destatis.de/DE/Publikationen/Thematisch/Soziales/Sozialhilfe/HilfezurPflege5221020137004.pdf?__blob=publicationFile

Tester, S. (1994). Implications of subsidiarity for the care of older people in Germany. *Social Policy & Administration*, **28**(3), 251–262. doi: 10.1111/j.1467–9515.1994.tb00427.x

Theobald, H. (2012a). Combining welfare mix and new public management: The case of long-term care insurance in Germany. *International Journal of Social Welfare*, **21**(Suppl.1), 1–10. doi: 10.1111/j.1468-2397.2011.00865.x

Theobald, H. (2012b). Home-based care provision within the German welfare mix. *Health & Social Care in the Community*, **20**(3), 274–82. doi: 10.1111/j.1365-2524.2012.01057.x

Theobald, H. (2012c). Long-term Care Insurance in Germany Assessments, benefits, care arrangements and funding. Institute for Futures Studies. Retrieved from http://econpapers.repec.org/RePEc:hhs:ifswps:2011_013

US Department of Health and Human Services. (2011). A Report on the actuarial, marketing, and legal analyses of the class program. Washington, DC. Retrieved from https://aspe.hhs.gov/report/report-actuarial-marketing-and-legal-analyses-class-program

Verband der Privaten Krankenversicherung. (2015). Zahlenbericht der Privaten Krankenversicherun, 2014. Retrieved from https://www.pkv.de/service/zahlen-und-fakten/archiv-pkv-zahlenbericht/zahlenbericht-2014.pdf