ATTACHMENT: Overseas Funding Models

Germany's long term care insurance model: Lessons for the United States
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THE evolution and implementation of universal long term care (LTC) insurance in Germany is an important public policy development that will be watched closely by other countries around the world. Although it may be premature to view the German model as a blueprint for universal LTC insurance in the U.S., it is hoped that an understanding of the German approach will contribute to the debate over the feasibility and acceptability of such insurance in the U. S.

Transferability of social programs between countries is often dismissed from the very outset in the U. S., especially by those fundamentally opposed to an expansion of government-mandated programs. Differences in values, culture and customs are frequently cited as rendering foreign prototypes of dubious value. There is, of course, some validity to such objections. But, in general, the similarities of the conditions existing in the industrialized nations are greater than the differences. In fact, the German "free-choice-of-provider health insurance system," comes a great deal closer to the traditional (i.e., pre-managed care) model of U. S. health care than do the systems of many other countries.

ABSTRACT

The implementation of public long term care (LTC) insurance in 1995 in Germany is an important public policy development that offers lessons for the U.S. The German ETC model is comprehensive and mandatory, covering 88 percent of its population, by equal premium contributions on wages from employees and employers. The new German system has uniform eligibility and benefit criteria, covers both institutional and home care, pays for family caregivers, is financially solvent, and is considered a success by the public. In contrast, the U.S. financing of ETC is largely private, with the government serving as the safety net for the majority of the ETC costs after individuals spend down their resources. This paper considers whether a German-type ETC system is feasible and affordable and discusses the issues and complexities of public ETC insurance, including cost containment, home care services, quality control, and administrative structure.

THE GERMAN LONG TERM CARE INSURANCE SYSTEM

The LTC insurance program has denned benefits for all those who are determined to be eligible for services, with maximum payment levels for the different types of care in order to control costs. The cash payments for informal care at home are set at slightly less than half of the formal and institutional payment levels (euro205 per month for Level I, euro409 per month for Level II, and euro665 per month for Level III) (9). The payments for formal

services such as professionals or home care agencies range from euro 3 83 per month for Level I, euro920 for Level II, and euro1432 for Level III. The institutional payments are euro1023, euro1278, euro1432 per month for the respective levels; for special cases, payments may be authorized up to euro 1917 for formal services at home and up to euro 1687 for institutional services per month in 1998 (9). The informal or formal home care services can be provided with a residential care home. The program also has an option for semiinstitutional care (day care or night care) if the home care is not adequate.

An important copayment provision applies to institutional care, with individual beneficiaries expected to pay at least 25 percent, and usually about 50 percent, of the average costs of care. These payments are made out of the beneficiaries' pension funds and other individual income sources. For those who are poor and cannot pay, the social welfare system pays the share of costs that is not covered by the LTC insurance payments.

In addition to the cash benefits, informal caregivers receive payments into their own pension insurance funds if they provide more than 14 hours of care per week, as compensation for those who give up or reduce the number of hours that they work.

Some achievements: The LTC insurance system began operation for home care in 1995 and for institutional benefits in 1996, thus providing a phase-in that created a financial cushion for the LTC insurance funds' first year of operation. By 2,000, 71.4 million individuals were covered by the social (public) LTC insurance program (8.1 million by private LTC funds), and LTC services were provided to 1.92, million beneficiaries (including 97,000 in the private sector) (8). The program has been successful in maintaining individuals in their own homes and limiting funds for institutional care. By 2000, 71 percent of the beneficiaries received care while living at home and only 29 percent received institutional care. In terms of actual 1999 program expenditures, 2,6 percent was for informal home care providers, 13 percent was for formal home care providers, and 45 percent was for institutional care, while 16 percent was for other services (such as respite care, equipment, pension contributions for informal caregivers, and administration) (8). Even for those beneficiaries that received 24-hour care, 55 percent were living at home and 45 percent were in institutions.

Statistics from the first 5 years of operation showed that the program was financially solvent. In 1999, revenues and expenses of the program came close to euro16.36 billion with an accumulated surplus of euro4.95 billion for a reserve (8). It is expected that the program will remain solvent with a reserve fund designated for emergencies. The LTC insurance system expects to gradually increase the combined employer and employee contributions from a total of 1.7 percent to 2.4 percent of gross employee income by 2030, in order to meet the future demand for the program which will result from the progressive aging of the population. Germany expects the percentage of people above 60 years to reach 35 percent by the year 2030 (8).

In addition to these achievements, the new LTC insurance program was able to substantially reduce the financial burden on the communities and states (Laender) previously created by those individuals who were unable to bear the cost of their nursing home care and who received public assistance through a means-tested system. Prior to the new LTC system, 80 percent of individuals in nursing homes were unable to pay the full costs of their care (2,4). This figure has now been reduced by half so that spending on indigent LTC by the local social welfare programs funded by the states (Laender) and communities has decreased for the first time (4).

As would be expected, Germany faces many challenges in the development of its new LTC insurance system, including how to ensure adequate numbers of LTC providers, how to ensure quality of care, and how to contain costs. The two most discussed issues that will be covered by bills expected to be enacted in 2001 are (1) an expansion of coverage of the cost

of LTC for persons suffering from dementia, and (2) a more precise definition of the requirements for quality assurance of LTC providers. In spite of this unfinished agenda, the program has made remarkable progress during its first five years (2,3, 12-14). Most importantly, the public, while acknowledging that there are areas where improvements are needed, considers the new program a success (15).

LONG TERM CARE IN THE UNITED STATES

The Current Financial Burden of LTC

The only segment of the U.S. population whose cost of LTC is fully covered is made up of those below the poverty threshold who are enrolled in the state-run, federally-supported Medicaid plans. In contrast, the non-poor elderly enrolled in Medicare are entitled only to a limited number of skilled nursing care days (up to ioo days) if medically required following hospitalization, and some short-term home health care services (16). With some exceptions, the rest of the population must either pay for care out-of-pocket, or resort to privately purchased LTC insurance.

Many persons of moderate incomes needing LTC are unable to afford the costs of LTC services, which can be as much as $50,000-60,000 per year for nursing home care. If individuals "spend down" to the poverty threshold, they can become Medicaid eligible as a last resort, making LTC a mean-tested program (16,17). The spend-down requirements constitute not only a hardship to the patient and a social stigma, but create dependence on federal and state assistance which would be unnecessary if the entire population were insured. Means-tested programs create financial incentives that encourage individuals to divest their income and assets to qualify for services. The system also creates access barriers to services for those who have low incomes but whose incomes are not low enough to qualify for the Medicaid program. These individuals may not have sufficient funds to pay for LTC directly out-of-pocket (17).

The US government already pays for the majority of all LTC in the U.S. In 1998, national estimates for LTC spending were $117.1 billion (not including hospital-based nursing facility and home care) (18). Of the total expenditures, 25 percent ($29.3 billion) was for home health care and 75 percent was for nursing home care ($87.8 billion) (19). Medicaid and certain other governmental sources paid for 49 percent of all skilled nursing home care, and 17 percent of all home health care, while Medicare paid for 12, percent of nursing home care and 35 percent of home health care (19). Overall, government paid 53 percent of home health costs and 60 percent of nursing home costs (19). Most of the burden for government spending is from general taxes used to pay for Medicaid and a combination of general taxes and payroll taxes that finance the Medicare program.

Private Voluntary LTC Insurance

Most private funds for LTC were paid directly out-of-pocket by those needing LTC (32 percent of nursing home costs and 20 percent of home health costs were paid directly out-of-pocket). Private health insurance only paid for an estimated 5 percent of nursing home care and 13 percent of home health care expenditures in 1998 (19). Other private third party payers spent 2 percent for nursing home care and 13 percent for home health services.

The financially crippling cost of LTC is one of the great fears confronting persons who are otherwise self-supporting. Yet relatively few of them have either the means or motivation to insure themselves privately (20,21). Only about 10-20 percent of the elderly can afford to purchase LTC insurance (20,21). Premiums for two policies purchased at age 65 were estimated to cost an average of $3 500 per year, which would be about 13 percent of a

median elderly couple's income. A 40 year old person and spouse could buy a policy for $600 per year, but few younger people are willing to make this type of long range investment in insurance (21).

Several analysts have pointed out that private, voluntary LTC insurance is not a viable approach to financing LTC (zo). Although private LTC insurance has been available since the late 19808, only 4.5 million LTC insurance policies had been sold by 1994, but not all of these policies were still in effect (22). Sold on an individual basis, private LTC insurance is primarily attractive to persons whose health condition places them at high risk and makes them likely candidates for LTC. Without the spreading of risk of the well and the ill that is inherent in group insurance, the selective enrollment of high health risk persons contributes, in turn, to high premiums of private LTC insurance. It also causes the most vulnerable applicants to be rejected by private insurers because of pre-existing or latent illness (21).

Consumer Reports has shown the intricacies that make purchasing an LTC insurance policy a risky process even for those with adequate knowledge about LTC (23). While this by itself tends to discourage enrollment, the pool of candidates for voluntary insurance is further reduced on the one end of the spectrum by those individuals with sufficient resources to cover four years of nursing home care for whom private LTC insurance may consequently not be a financially wise investment, and on the other end by those who are poor or near-poor who either immediately upon entering the nursing home, or soon thereafter, would qualify for Medicaid (20).

Finally, prospects for a significant enrollment in private, voluntary LTC insurance are diminished because, in contrast to meeting the cost of acute illness, employers have generally refused to provide coverage for LTC as part of their employee or retiree benefit package. Eighty-eight percent of LTC insurance policies were sold to individuals rather than employers (22). Although some organizations such as the California State Public Employee Retirement Systems are now offering a private LTC insurance policy, it continues to be the employee or retiree who is expected to pay for the coverage.

A UNIVERSAL, MANDATORY SOCIAL INSURANCE MODEL

A mandatory social insurance program is likely to offer distinct advantages over the current U.S. approach (20,24). If everyone paid into the system, individuals would have access to coverage when they are chronically ill or disabled without the humiliation of having to become poor to receive services. Similar to Medicare, where members of the workforce commence paying for covered services that generally occur after retirement, the payment of LTC contributions early in a worker's life would "prefund," at relatively affordable rates, LTC services that generally occur late in life. And administrative costs would be freed from the high cost of marketing (24). The program could also reduce the access problems that are currently experienced by those who are in the generally under-reimbursed Medicaid program.

Thus, the financial risk could be spread across the entire population so that individual premium costs or taxes would be relatively manageable, in comparison to the costs of insurance purchased when individuals are older and at high risk of needing LTC. This would be a more palatable approach than the one used when a major federal effort was made to expand Medicare by adding drugs and other benefits in the 1988 Medicare Catastrophic Coverage Act, Part C of Medicare (25). Most sections of this Act were repealed by Congress shortly after enactment before even becoming fully operational. Its demise resulted from strenuous objections voiced by organizations representing retirees to what they saw as a basic conceptual flaw and injustice; Part C was to be progressively income-related and solely

financed by the contributions levied on the self-sufficient elderly (rather than being spread in the customary Medicare fashion over the entire working population).

The German social insurance model provides universal coverage for the entire population needing LTC. If its provisions were replicated in the U.S., children and adults, the aged, the physically or mentally disabled and developmentally disabled would all be covered. Thus, the current narrow definition of Medicaid eligibility groups could be eliminated in favor of a universal eligibility that is based on the need for LTC services.

Paying For A Universal LTC Insurance Program

The required revenues could be derived from employees and employers through the Social security tax system, if payroll taxes were used as they are in Germany, where they are equally levied on both employers and employees, each paying a rate of 0.85 percent of wages up to a defined maximum. Such a level of employee contribution, if it could be replicated in the U.S., is likely to be considered affordable by many Americans. Public opinion has found respondents to be willing to pay additional taxes depending upon their income for an LTC insurance program (26).

A payroll tax-based system, while accepted by the public in the Germany and in the U.S., is far less progressive than an income tax base system since many wealthy individuals are exempt from payroll taxes. When wages fall during recessions or remain stagnant, then the payroll taxes may need to be increased in order to have adequate funding for the program. As a major alternative to the funding through payroll taxes, new revenues could come from a range of other taxes as suggested by Norton and Newhouse (27) and Weiner (28). Elaborating on direct taxation, they argue against solely using payroll taxes as a way to pay for LTC because it apportions too little of the extra burden on the elderly and would give them a windfall in new benefits. A system of financing could be made more equitable than payroll taxes but may be less likely to receive public acceptance.

Employers may resist any mandatory payments for LTC insurance because they are already concerned that the costs of health insurance are too high. This could occur even though some studies have shown that increases in health benefits in the U.S. have resulted in substantial reductions in wages to employees to offset increased benefits (29). At the same time, many employers recognize the link between employee productivity and family LTC demands. Others recognize that employees sometimes leave the labor market to provide LTC to family members. If the costs of the premiums were no more than the .85 percent of wages, perhaps some employers would see the value of the trade-off by having coverage. During periods of low unemployment and competition for workers, LTC insurance could be an attractive benefit, but as the economy goes through recessions, employers may strongly resist any increases in their costs.

Naturally, the German contribution rate of .85% by the employee and .85% by the employer is simply a point of departure for a thorough analysis of factors in the U. S. that would bear on the computation of appropriate U.S. contribution rates. Among the variables to be evaluated would be the likely home care/institutional care ratio that could be achieved under the guidelines and incentives of a new LTC insurance program; the availability of familial (informal) caregivers as an alternative to professional home health personnel; an answer to the question whether and how the familial caregivers should be compensated in the U.S.; and the projected future cost of institutional care if classification of need and cost constraints were to resemble what is now in place in Germany. Such analyses would benefit from an understanding of how the coming together of mandatory coverage, practice guidelines, disability, classification, incentives, cost controls, and quality safeguards in Germany created a program that shows financial stability and community acceptance after five years of operation.

Apart from these determinations, decisions would need to be made whether employers and employees would share the cost of insuring the working population. If so, would a 50/50 sharing between employers and employees prove acceptable as in the German model? (In actuality, the German formula significantly lightens the burden on the employers because one paid, legal holiday was abolished to assuage the employers" concerns.) Alternatively, could the formula be set at 25 for employers, 50 for employees, and 25 percent for government, since government is currently paying 57 percent of the total expenditures and would under a universal LTC insurance plan be relieved of part of this burden? Would U.S. employee contributions be set at a constant percentage of wages (up to a certain maximum), thereby scaling them to the worker's income (resembling the contributions to Social Security), or a percentage of wages without a ceiling (like the Medicare contributions)? A payroll tax would have the advantage of using the Social Security system that is already established.

It is conceivable that at the inception of a universal program in the U.S., the younger population would be opposed to a payroll tax that would give the elderly, who have not spent their working years contributing to the LTC program, a heavily subsidized benefit. The younger population may need education to understand that all age groups are at risk for needing LTC. A recent study showed that 13.2 million adults in the U.S. received assistance with activities of daily living (both formal and informal services). Of this total, 6.9 million (52 percent) were between age 18 and 64 and 6.z million were age 65 and over (30). Moreover, younger individuals would derive some benefits from having formal LTC services available for their parents and grandparents, which could directly reduce their own financial burden for providing care and, if this became applied in the U.S., also compensate familial caregivers. Finally, the majority of the U.S. population would benefit from LTC insurance because the risk for needing services is so high. Of those age 65 and over, 43 percent are expected to use nursing home care before they die, which is a large figure, even if one considers that some of the total is for Medicare beneficiaries using short-term nursing home services (31).

The working poor and the affluent may also object to payroll taxes for LTC insurance. The affluent could be given the option of purchasing private LTC insurance as in Germany to address their concerns, although this undermines the underwriting pool for the insurance program. It would be those of moderate means, who fall between the poor (having Medicaid as a safety net), and the affluent (having the resources to pay for care out-of-pocket), to whom universal LTC insurance would have the greatest appeal. Some Medicare beneficiaries may object to higher premiums because they already consider the Medicare premiums, copayments, and the deductible to be too high.

Would the system be designed as in Germany on a pay-as-you go basis, possibly staning out by delaying the payment of institutional care for a year, or would there be a way to phase in the system with some prepayment? One might consider a variation in the straightforward employer/employee payroll tax where those who are retired might at the program's inception start off with either a reduced benefit or a supplemental premium taken out of their Social Security pensions. The regressive nature of payroll taxes would continue to be a problem for those with low incomes, unless appropriate adjustments are made for those on the margins of poverty (24).

Means of financing of other population segments would have to be considered. Would the self-employed be required to pay the full premium? Who would make contributions for the unemployed? What would be the source of funds to include the poor within a universal LTC

insurance program? As in the German system, government at state and federal levels could pay the premiums for the unemployed and the poor.

Under Medicaid, the current approach uses a combination of federal and state general tax funds (the 50% federal match, rising to a maximum of 83% as a reflection of lower per capita incomes in certain states). A new LTC insurance program could be very attractive to the states if it reduced the 46 percent of the total LTC expenditures currently paid by Medicaid. Medicaid LTC services could be folded into the new universal LTC insurance program so that it would no longer exist as a separate two-tiered program. In any case, a mandatory social LTC insurance system could reduce the current burden on the general fund for financing the Medicaid program, bringing relief to government, as was the case in Germany.

Because there currently exists a small private insurance market, a universal LTC program in the U. S. could follow the German approach in allowing individuals earning in excess of the income limit to opt out of the public program provided they purchase a qualifying private LTC insurance policy. The pros and cons of such an approach would need to be explored.

Organizational Structure

In spite of the fact that LTC is generally seen as a major threat to a family's financial security, any consideration of insurance-be it voluntary or universal-is encumbered in the U.S. by a number of widely held concerns standing in its way. It is a blend of social and medical services whose extent (especially the custodial dimension in nursing homes) seems to be open-ended and without limit; the financial drain of institutional care on the current Medicaid programs is perceived to be an ominous sign of what the country would face if LTC coverage became universal. The rapid aging of the population is seen as accelerating utilization, care in nursing homes has from time to time been plagued by serious problems of staffing and adequacy, and home health services have likewise been the focus of concern. What makes the German model so interesting is that it appears to provide organizational, financial, and quality safeguards that would greatly ameliorate these problems.

Cost Containment

The area of greatest concern for any type of new entitlement program is one of costs (32). The German system has built in a number of interesting features to control costs. For the purposes of this commentary, four are selected here since they would have particular relevance to the U.S.

First, in Germany, eligibility for services is based upon clear and simple need criteria. In the U.S., the Medicaid program has adopted need criteria for eligibility and states have experience in developing screening procedures for services. Most states use some type of minimum standard based on need for assistance with activities of daily living (e.g. eating, transferring or toileting) and/ or the need for supervision. Others include cognitive limitations and limitations in instrumental activities of daily living (e.g., shopping) (33). The approach of setting need standards is well accepted and was proposed by the Pepper Commission and the Clinton LTC insurance plan (34,35). Of course, need criteria must be established to take into account the special needs of children, those with developmental disabilities, and other special groups.

Second, by (1) establishing maximum payment rates, (2.) requiring the patient to bear at least 25 percent of the cost of nursing home care, and (3) excluding from insurance payments the costs of "room and board," the German plan has installed a large cost-sharing feature (altogether, it is estimated that close to 50 percent of cost in the nursing home is currently borne by the patient). The "room and board" institutional reimbursement exclusion resembles one included in certain past U.S. proposals (e.g., Pepper Commission) (34). Such share of costs or copayments for institutional care could be incorporated in a U.S. design in

the expectation that these out-of-pocket payments would generally come out of the patient's social security pension, unemployment benefits, and/or other income. While a level of institutional care cost-sharing as high as in the German plan could well be seen in the U.S. as excessive, it is consistent with the current Medicaid nursing home cost-sharing (spend down) provisions. As a general principle, substantial cost-sharing would make the program more appealing to policy makers understandably concerned with the containment of costs. Nevertheless, in designing a plan for the U.S., great care would have to be taken to make sure that the cost-sharing burden on an institutionalized individual would not become so heavy as to be self-defeating. After all, an unaffordable cost-sharing burden could prove as financially devastating as no coverage at all. Clearly, cost sharing as a deterrent to unnecessary institutional care, and as a cost-saving device for the insurance funds and those who finance them, must not become a barrier to medically necessary care.

Third, the German plan caps the reimbursable cost for an individual patient per month, although special exceptions are allowed. This is certainly a powerful device in controlling costs. To be fair and realistic, such ceilings in the U.S. would have to be adjusted to take into account the special costs of different groups and types of services. For example, the costs of care in intermediate care facilities for the developmentally disabled can be as high as $75,000 per year, a level substantially higher than nursing home care for the elderly (36). Ceilings for individuals may be unpopular with the public but they could provide a further constraint if financially necessary to maintain the program.

Fourth, a per-beneficiary limit on aggregate program-wide institutional expenditures was established in Germany's enabling legislation with the provision that if the ceiling is exceeded, reductions of covered services would be triggered. Again, this constitutes a financial safeguard that could be incorporated in a U. S. model.

Special Features

Perhaps the most attractive aspect of the German plan is its emphasis on home health care. The graduated levels of home care, and their commensurate payment scales, that are established upon the medical and social evaluation of a patient could provide a real alternative to institutional care. Most older people strongly prefer to remain in their own homes rather than to receive institutional care (32.). The initial German experience of providing care to 72 percent of recipients at home, and of allocating 44 percent of LTC expenditures to fulltime institutional care, would be an admirable goal worthy of replication in the U.S. The Medicaid program has been criticized by many researchers and advocates because of its imbalance in services. Only about 12 percent of the Medicaid LTC expenditures were spent on home care in 1998 while the remainder was for institutional care (19). There is much evidence to suggest that the Medicaid program is unnecessarily biased toward nursing home care and lacks adequate program resources for caring for persons with disabilities in the home (36). New legislation has been introduced that would give Medicaid recipients a clear choice between home and community services and institutional services to correct the current institutional bias in the program (38). Starting a new LTC insurance program could give individuals a choice and place the emphasis on home care rather than institutional care.

The enlisting of family caregivers-their training, supervision, and payment-is a particularly striking example of what could be done to avoid institutionalization by replacing it with far less costly, adequately supervised home care. Could the principle of paying the familial caregiver be adopted in the U. S., since it constitutes a major bulwark against needless and costly institutional care? The German approach of recognizing informal caregivers is an eminently humane approach to recognizing the enormously important role of these individuals who, like in the U.S., are probably primarily women spouses and daughters. The

idea of providing pension benefits to those who assume large burdens of care giving would address a serious problem in the U. S. where caregivers not only give up employment, but then are not eligible for pensions. Apart from the direct advantages to the LTC insurance program, this could ameliorate the serious poverty that many older women without pensions in the U.S. face.

Many state Medicaid programs currently allow for the payment of independent care providers to provide personal care (attendant) services in the home (39). Thus, states have experience with this type of approach that allows relatives and friends to provide such services, although in the U.S. parents and spouses are currently prohibited from receiving Medicaid funds. Such an approach to providing services would not only support the existing informal caregivers but it may prevent the use of costly agency-based home health care and institutional care. More recently, three states have demonstration projects (using Robert Wood Johnson funds) to provide cash payments for LTC services to beneficiaries, rather than paying independent providers directly (40). This approach is similar to the relatively new system used in Germany of engaging and paying the family caregiver. Although adopting this approach would be a major policy shift in the U.S., it could be phased in over time or tested with more demonstration programs. Germany has shown that cash payments have been successful in maintaining individuals in their home without undesirable increases in program costs.

Defining LTC services using the German model is compatible with the current U. S. model, which currently separates acute from LTC services. The basic health insurance offered by private insurance and Medicare pays for hospital, physician services, and short-term nursing home, rehabilitation, or home healthcare. Thus, basic health insurance benefits under Medicare and private insurance are already separate from the LTC coverage in the U.S., even though there are demonstration projects that have shown the benefits of coordinating acute and LTC services (41). The disadvantage of separate programs may be cost-shifting disputes between acute and LTC programs as well as incomplete coverage, poor coordination of care, and access or quality problems for individuals needing care. On the other hand, adding a social insurance LTC program to the current private insurance-dominated system for acute and ambulatory care in the U.S. would be even more difficult.

Methods of Administration

Many decisions would have to be made on how to administer such a new program. Should certain guiding principles for the program be adopted at a federal level or regional levels? Would the program be administered on a uniform basis (centralized) such as the Medicare Part A and B programs? There are many benefits associated with a federal system in terms of ensuring defined benefits, uniform eligibility, and uniform services and payment systems, as was established in Germany and under the Medicare program. The Medicare program enjoys broad popularity among its beneficiaries and has low administrative costs (18). If the program were federally administered, would administrative mechanisms that resemble the "fiscal intermediary" system of Medicare be appropriate?

Or would the program be decentralized to the states or local levels such as in the current Medicaid program? Would state agencies set provider rates and pay providers? The states certainly have extensive experience in managing the Medicaid LTC programs, setting reimbursement rates, and paying providers. On the other hand, state Medicaid programs have been criticized for wide variations in access and quality of services across and within states, especially for home and community based services (42,). Moreover, the Medicaid program has been historically stigmatized as being for the poor and paying substandard rates to providers. One must acknowledge, though, that the creation of a new agency could

prove to be cumbersome and costly, so that choosing one of the existing agencies might be the realistic course.

What entity would establish standards of care, provider qualifications, and performance measures? Who would enforce the standards and oversee the program? Currently, Medicare and Medicaid standards are set for LTC providers by the federal government, and monitoring of quality and standards is a joint federal and state agency responsibility. This same approach could be used with a new universal LTC insurance system, broadened perhaps by the rules governing the German method of standard setting which includes all stakeholders, and not simply government agencies, in that process.

SUMMARY

An examination of the German LTC insurance system should stimulate weighing of the pros and cons from a societal perspective, and could lead to a wide-ranging, objective discussion of the organizational and financial choices and options in the U.S. The major contribution of the new German LTC insurance program has been to dispel the myth that public LTC insurance is not affordable. Because LTC is a predictable need for a relatively large segment of the population, it can be covered by insurance for a reasonable cost if the plan is mandatory so that the risk is spread across the population.

The German model offers an opportunity to observe the maturing of a new social LTC insurance system. Given its successful start, it warrants the hope that a similar model might be seriously considered in the U.S., preceded perhaps by demonstration projects testing certain program elements and steering a careful course between the difficult solidarity and intergenerational equity issues, and those relating to quality, delivery, and cost. To date, the major obstacles to change in the U.S. have been the lack of public understanding of the unmet need and the potential for dealing with this need through an adequate insurance system, as well as the financial concerns of policy makers confronting this formidable problem. The German system now demonstrates that public demand and careful planning can bring about a system that promises to continue its initial track record of being conceptually and financially sound, and that thereby will greatly ease the fears that come with old age and disability.

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