Long-term Care Insurance in Japan

Implications for U.S. Long-term Care Policy

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ABSTRACT

The purpose of this article is to review the long-term care insurance program in Japan and the present system of payment of long-term care services in the United States. The long-term care insurance system in Japan was implemented in 2001 for the purpose of promoting independence in older adults with functional disability. It reimburses for both home and institutional care. Several concerns expressed about the Japanese system include increasing applications for nursing home placement, lower use of home care services than anticipated, limited coverage for disabilities for those under 65, regional variations in service, educational preparation for case managers, and access to care for older adults. Revisions to the Japanese system and implications for U.S. long-term care policy are discussed.

Japan has a rapidly growing older adult population that is increasing faster than any other country's older adult population in the world. Like the United States, reforms in pension and health care programs have become important policy issues in Japan (Okamoto, 2003). In 2000, 17% of the population in Japan was older than 65, and by the year 2020, the percentage of older adults is expected to reach 27%. As the population ages, more people are expected to require care with an increase in health care related costs (Murashima, Yokoyama, Nagata, & Asahara, 2003). In Japan, traditionally, the same high level of resources has been used in long-term care that has been used in acute care. In fact, long-term hospitalization of older adults accounted for a third of the cost of health care for this population (Ogura & Suzuki, 2001).

In the United States, where 6.3 million older adults needed long-term care in 2000, resources for long-term care and acute care are considered separately (Rogers &

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Komisar, 2003). Medicaid costs for long-term care in the U.S. account for a third of Medicaid spending. Both institutional and community-based long-term care services are covered by the Medicaid program for those who demonstrate a financial need (Burwell, Sredl, & Eiken, 2004). However, in the U.S. a comprehensive policy for payment of long-term care costs does not exist for those who do not meet the eligibility requirements for Medicaid. The purpose of this article is to review the long-term care insurance system in Japan and the system of payment of long-term care services in the United States. Revisions to the Japanese system and implications for U.S. long-term care policy are discussed.

The choice of institutional care versus community care is left to the individual, except for those who require the lightest level of care.

LONG-TERM CARE INSURANCE IN JAPAN

Long-term care insurance (LTCI) in Japan, referred to as Kaigo Hoken, is a social insurance system that was implemented in April, 2000. The purposes of this insurance are to promote independence in older adults with functional disability and to reimburse for both home care and institutional care, in an attempt to reduce the costs associated with long-term hospitalizations (Murashima et al., 2003; Talcott, 2002). Those who are 65 and older are eligible for benefits if an assessment determines there are physical or mental disabilities. Those ages 40 to 64 may receive benefits if they require care because of aging-related diseases (Ikegami, Yamauchi, & Yamada, 2003). All Japanese people who are older than 40 pay premiums into the system. A premium of 0.9% of monthly income is charged for those ages 40 to 64, and an average of $23 is deducted from pensions of those 65 and older based on individual income and service plan (Ikegami et al., 2003). Benefits are for either institutional or community-based services. The choice of institutional care versus community care is left to the individual, except for those who require the lightest level of care. This group is eligible for home care in the community only.

Services reimbursed in the community may include day care, equipment and home modification, rehabilitation and home health care, visiting nursing care, in-home medical care, respite care, group homes, care management, and physical examinations. When the system was originally developed, coverage for institutional care included nursing homes, long-term medical facilities, and wards for those with dementia. Services are paid for by a 10% co-payment, and the remainder is half paid for by premiums and half by taxes (Shirasawa, 2004).

There were several reasons for the development of the LTCI program in Japan. Reasons included a rapidly growing older adult population, an increase in the number of women working so there are fewer informal caregivers available to provide care, a strain on medical insurance because most of the long-term care in institutions has been provided in hospitals at a high cost, and changing family values where daughters-in-law who traditionally have provided care to older adults are questioning that role and a wider acceptance of help with caregiving is occurring (Campbell & Ikegami, 2003).

Eligibility

Eligibility for services under the LTCI program is determined by the recipient's physical and mental status, irrespective of financial status or family support (Tsutsui & Muramatsu, 2005). When the system was established, there were six levels of care needs defined by the LTCI program in Japan which were based on the total number of estimated care minutes. There are different reimbursement rates allocated for each level and type of long-term care facility used or for the provision of home care (Murashima et al., 2003). The levels of care needs defined range from mostly independent and requiring only partial help to requiring maximal care. Facilities that have higher staffing ratios have been allocated higher rates of reimbursement by the government to offset costs and as a quality incentive (Ikegami et al., 2003).

Japan developed a computerized system of needs certification that was influenced by the U.S. system of Resource Utilization Groups (RUGs) (Tsutsui & Muramatsu, 2005). The assessment system is nationally standardized and is thought to ensure equity and objectivity (Tsutsui & Muramatsu, 2005). The needs certification process in Japan is initiated by either the older adult or the formal or informal caregiver and begins with an assessment by a trained

municipal employee using a questionnaire that addresses physical and mental status and the use of medical procedures. The information is entered into the computer and generates a standardized score in seven categories of physical and psychological status that include: paralysis and limitation of joint movement, movement and balance, complex movement, conditions requiring assistance with activities of daily living and independent activities of daily living, communication and cognition, behavioral problems, and conditions requiring special assistance (Tsutsui & Muramatsu, 2005). A Nursing Care Needs Certification Board reviews the data, including a report from the applicant's primary care physician and notes by the assessor, and assigns one of the levels of care needs. Every 6 months, eligibility is re-evaluated (Ikeda, 2004).

Certified Care Manager Role

Services provided in the community may be coordinated by a certified care manager. Older adults and their families may choose their own services and providers, but many allow a certified care manager to coordinate their care (Asahara, Momose, & Murashima, 2002). The role of the certified care manager is to make a plan of care based on the level of need that is established for the beneficiary. Implementation of the plan, as well as monitoring and evaluation of the care plan, is also part of the certified care manager role (Nakatani & Shimanouchi, 2004). The needs of the older adult are discussed in coordination with family members. The plan is developed with family members, and the certified care manager assesses the ability of the family to provide care and discusses family member concerns (Murashima, Nagata, Magilvy, Fukui, & Kayama, 2002).

The role of the certified care manager was created as a component of the LTCI system. Many of the individuals who took the certification examination were nurses, but care workers, pharmacists, physicians, home helpers, and others also become certified care managers (Murashima et al., 2002). Outcomes of the care management function have been evaluated and show that a care plan based on the necessary quantity of services with a high level of monitoring and evaluation positively affected client outcomes (Nakatani & Shimanouchi, 2004).

JAPANESE LTCI CONCERNS

Nursing Home Issues

One of the purposes of the LTCI system implemented in Japan is to promote the use of home care rather than institutional care. However, the implementation of the system resulted in an increase in applications to nursing homes, which may be due to increased eligibility and a societal increase in the willingness to use institutional care for older adults. Lists for those waiting for beds in nursing homes have increased (Campbell & Ikegami, 2003). It is estimated that waiting lists for nursing home beds became three to five times longer than they were prior to implementation of the LTCI program (Shirasawa, 2004).

With an increase in the availability of nursing homes through new construction, there has been concern that the cost of nursing home care will continue to escalate. Because those who are frail or have dementia pay a fixed amount for care in a long-term care facility and those in the community may have increased out-of-pocket costs due to multiple care needs, there was concern that there may be cost incentives in favor of institutional care rather than community-based care (Shirasawa, 2004; Tsutsui & Muramatsu, 2005).

Other Challenges

The use of home care services by older adults and their families has been less than what was allowed. Co-payments of 10% of the cost, a shortage of home care services, care provided by family caregivers, hesitancy of families to welcome formal caregivers into their homes, and lack of information have been proposed as reasons for the low use of home services (Momose, Asahara, & Murashima, 2003).

Eligibility criteria for the insurance program that provides coverage for those ages 40 to 65 for aging-type disabilities may be problematic for some. For instance, disabilities resulting from accidents under LTCI would not be covered, yet disabilities related to Parkinson's disease would be covered. Some believe a system based on functional disability would be more equitable than the present system for allocating services for those younger than 65 (Campbell & Ikegami, 2003).

Another challenge that exists in the implementation of the LTCI program in Japan is that there continues to be regional variations in service availability and implementation of the needs assessments. A centralized computer system does enable the evaluation of regional differences in these areas, however (Tsutsui & Muramatsu, 2005).

The LTCI program in Japan is heavily dependent on the role of the care manager who is instrumental in the success of the program. Questions were raised about the need for more education for care managers so they could effectively guide more participants in the LTCI system toward community-based care (Shirasawa, 2004). Nurses in Japan have expressed concern that care management is a nursing role and that the new position of certified care manager fulfills a role that overlaps with nursing (Murashima et al., 2002). Care managers

TABLE

COMPARISON OF JAPANESE AND UNITED STATES LONG-TERM CARE INSURANCE SYSTEMS

Japan	United States
Social insurance entitlement program that provides comprehensive services to those 65 and older with physical or mental limitations.	Private insurance companies sell policies to individual consumers resulting in fragmentation with two government programs: • Medicare: pays for acute care home care, and short stay skilled nursing care as ordered by a primary care provider • Medicaid: needs-based and pays for nursing home care.
National standards for eligibility with a computerized system for needs certification.	Private long-term care insurance policies with eligibility that varies from one agency to another.
Assessment, planning, monitoring, and evaluation of services by a certified care manager.	Lack of coordination of services due to the variety of different long-term care policies available.
Premiums are based on individual income and service plan and provide benefits for institutional or community-based services.	Premiums for private long-term care insurance are based on age of consumer, type of coverage chosen, and agency costs. Benefits vary but may include institutional and community-based services.

have also expressed concerns about the lack of a complaint or inspection system, and there was no system of monitoring of care managers built into the original LTCI program (Tompsett, 2001).

Nurses in Japan have expressed concern about issues related to distributive justice including fair access to care for older adults using the Japanese LTCI program. There is concern that older adults with chronic severe conditions may use the majority of resources and those who require some care and are at risk for injury and disease may not be eligible for services (Barnes, Asahara, Davis, & Konishi, 2002). The need to develop programs for older adults who are not eligible for services and the need to promote comprehensive care management for all older adults were also concerns identified by public health nurses in Japan (Barnes et al., 2002).

REVISIONS OF THE JAPANESE LTCI SYSTEM

Revisions Implemented in 2003

Revisions in the LTCI system to address cost containment, and to promote community-based services and independence were implemented in 2003. Reimbursement rates were increased for rehabilitation services, home help, and care management and were reduced for institutional services to promote home care rather than institutionalized care (Murashima et al., 2003; Tsutsui & Muramatsu, 2005). An indicator for dementia was added to the needs assessment because of concern that problem behaviors of those with dementia were not adequately reflected by the original needs assessment (Ikeda, 2004). There is concern that this addition may increase the number of people who are labeled as having dementia to increase reimbursement to institutional facilities (Tsutsui & Muramatsu, 2005).

Revisions implemented in 2006

Another series of revisions in the Japanese LTCI system were implemented in 2006 in an attempt to curb the escalating costs of the system. The number of system beneficiaries have doubled since the system was established in 2000. It is estimated that of the 25 million adults age 65 and older, 4 million are beneficiaries ("Reforms," 2006).

To address the escalating cost, there is an increased focus on preventive services in the latest revisions. A change has been made to the prior categorization of levels of services in that those older adults who previously qualified for services in the highest level of functioning are now categorized as needing support and are eligible for preventive services only. The preventive services introduced in the latest revision include nutritional counseling and exercise training in an attempt to prevent further limitations in functioning and the need for more costly interventions. Municipalities will be expected to develop centers for preventive services by the year 2008 ("Preventive Care," 2005).

The revised insurance plan will no longer reimburse for the cost of accommodations and meals in public nursing homes. There is concern related to the financial burden of this change for older adults with low-income. Another change is that those who are eligible for chore services in the home setting will be expected to live alone and assist with the work in the home. They will also be required to pay 10% of the cost of the assistance ("Preventive Care," 2005).

To address the concern related to educational preparation of care managers, a change was implemented to make it necessary for care managers to receive training

every 5 years with license renewal every 5 years. Future revisions being discussed to control escalating costs in the Japanese LTCI system include requiring adults ages 20 to 40 to contribute financially to the system, and allowing younger disabled persons to receive benefits. If these changes are approved, they are not expected to be implemented until 2009 ("Nursing Premium," 2006).

PAYMENT FOR LONG-TERM CARE SERVICES IN THE UNITED STATES

In the United States, the major payers for long-term care services are Medicaid, out-of-pocket spending, and Medicare (Feder, Komisar, & Niefeld, 2000). Medicare pays for short-term care for rehabilitation in skilled nursing facilities and for home health benefits. Private LTCI pays for approximately 11% of long-term care costs (Kassner, 2004). Unlike the Japanese LTCI system, the United States does not have a national LTCI system that insures against the high costs of long-term care services (see this and other comparisons between the Japanese and U.S. systems in the Table on page 10). Medicare, although it pays for short-term rehabilitation care, does not cover long-term care services after 100 days. There continues to be little interest in the purchase of private LTCI by individuals in the United States (Kassner, 2004). Medicaid does cover long-term care, but only after individual financial resources are spent (Feder et al., 2000).

Medicare Program

The Medicare program is a federal health insurance program that pays for inpatient hospitalizations for up to 90 days for each episode of illness, home health care visits, and up to 100 days of skilled nursing facility care following a 3-day or longer hospital stay, physicians/nurse practitioner services, medical equipment, lab services, hospice care, medications, outpatient physical, speech, occupational therapy, and some preventative care. There is substantial cost-sharing requirements, and many older adults obtain a supplemental insurance policy to help pay for health care costs not covered by Medicare (Caplan, 2005).

Medicaid Program

The Medicaid program is a state and federally funded needs-based health insurance program that covers the majority of nursing home patients in the United States. To receive federal funding for the Medicaid program, states are required to provide reimbursement for the following services for older adults: inpatient and outpatient hospital services, nursing home care, laboratory and x-ray, home health care for those who qualify for nursing home placement, and physician and nurse practitioner services. Optional services that states may cover and receive funding for from the federal government include medical equipment, home- and community-based services, clinic services, hearing aids, eyeglasses, prescription drugs, and dental and optometry services (Flowers, 2005).

Medicare and privately purchased health insurance plans do not cover institutional long-term care services or non-medical home care services that assist functionally impaired older adults to remain in the home setting. Medicaid has emerged as the largest payer for long-term care services. Many older adults receive Medicaid because their life savings have been spent on non-covered long-term care services in nursing homes and the community making them eligible for Medicaid benefits (Gibson, Fox-Grage, & Houser, 2005).

Private LTCI

The costs of long-term care in the United States are unaffordable for most Americans and some purchase private LTCI to help cover unexpected costs. Generally, policies reimburse a fixed daily amount for long-term care expenses if disability criteria are met. Typically rates are reimbursed for a set period of time or until a maximum limit is paid by the insurer. The cost of private long-term care policies increases considerably with the age of the recipient when the policy is purchased. Older adults purchasing policies pay a much higher premium than if purchased when younger (Kassner, 2004).

Other considerations affecting the cost of a policy is whether there is coverage for rising long-term care costs over time and the amount of coverage chosen (Pfuntner & Dietz, 2004). Those older adults who already have disabilities are not eligible to purchase LTCI (Gibson et al., 2005). Concern has been expressed about the appropriate pricing of LTCI premiums. There

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CONSIDERATIONS FOR A COMPREHENSIVE LONG-TERM CARE POLICY SYSTEM BASED ON THE KAIGO HOKEN EXPERIENCE IN JAPAN

- How does one develop a system that promotes community-based care and does not increase the demand for institutional long-term care at a greater cost to society?
- What background and training should be required for care managers and should this be a role that only a nurse performs?
- What should be the eligibility requirements to receive benefits from a long-term care insurance policy that is equitable and does not create a demand for services that is larger than society can afford?
- Should those younger than age 65 be eligible for benefits, and if so, should need be based on functional limitations rather than "aging-type" disabilities?
- How does the government allocate resources so all resources are not expended on those with severe chronic diseases, leaving those at risk or with less severe problems without needed assistance?
- How does one finance a long-term care insurance system that does not place an increased financial burden on those in the work force, who are already experiencing financial difficulty?
- How does one determine eligibility of older adults with dementia that avoids labeling for the purpose of meeting eligibility requirements?
- How does one avoid regional differences in accessibility and availability of needed long-term care services?

is a need to avoid underpricing to ensure adequate funds in the future for insurers to pay claims for long-term care. At the same time, it is important to avoid increases in premiums so beneficiaries can continue to afford monthly premiums. Both of these issues continue to require regulation and monitoring (Lutzky, Alecxih, Foreman, & The Lewin Group, 2002).

The pressure in the United States for an improved long-term care system is expected to grow because older adults and their families currently pay more than 25% of long-term care costs. Also, the current financing system lacks an

> insurance system, public or private, that spreads the financial risk, and in its place [is] a system that protects people only if they are impoverished (Feder et al., 2000, p. 45).

Japan has implemented a comprehensive long-term care policy. The Japanese system of LTCI may serve as a model for comprehensive coordinated long-term care policy in the United States.

IMPLICATIONS FOR U.S. LONG-TERM CARE POLICY

With the increased focus on health policy in gerontological nursing programs in the United States today, nurses are in an excellent position to influence the development of a comprehensive long-term care policy. With background in policy analysis, health care economics, and comprehensive health care of older adults, advanced practice nurses need to become more involved in promoting long-term care policy models. The analysis of existing policy as well as suggesting initiatives to legislators for the purpose of improving the present system of reimbursement of long-term care services are also important roles for the advanced practice gerontological nurse.

Several considerations for a comprehensive long-term care policy system deserve analysis based on the Kaigo Hoken experience in Japan. These considerations are listed in the Sidebar (above).

Gerontological nurses need to become more involved in promoting discussions with legislators that address issues related to LTCI policy. Nurses need to take an active role in defining any future long-term care policy system in the United States, including the role that nurses wish to have in the system. Nurses have the potential of assuming a major role in any future system that provides for long-term care services for older adults and their families.

There is a need for nurses to share experiences of caring for older adults and their families in the community and institutional setting to assist legislators in understanding the issues related to access and reimbursement of services in the United States. It is the experience of nurses, with a rich background providing long-term care and observing the effects of the current long-term care reimbursement system, that can help to influence long-term care policy legislation in the future. This experience, combined with health policy analysis skills and a basic understanding of health economics, can assist nurses to be a major force in promoting a comprehensive, equitable LTCI policy for all Americans.

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