4 Medical Insurance and Long-term Care Insurance

Medical Insurance: Within Japan's medical insurance there is association-managed health insurance for employees (and their families) of workplaces of five or more workers, Japan Health Insurance Association-administered health insurance for employees (and their families) of workplaces with fewer than five workers, national health insurance for the self-employed, etc., and medical insurance provided by mutual aid associations for national government employees and local government employees (see upper row of Table VI-11). Subscribers in medical insurance programs pay the insurance premium themselves, but the subscribers themselves and their families may receive medical services at the medical institution of their choice by paying only a portion of the medical expense. Furthermore, with regard to people aged 65 or over requiring long-term care and all older people aged 70 or over, there is a system of medical aid for older people (see lower row of Table VI-11) that is funded by insurance premiums paid by older people, contributions borne by health insurance societies and the national health insurance scheme. Under this system, the insurance premiums of older people on low incomes are reduced and, in the event that the local authority cannot sustain the finances alone, it is possible for a number of local authorities to form an extended association to provide medical and healthcare services to older people.

Table VI-11 Medical Insurance System

Plan			Insurer (As of 31 March, 2009)	Subscribers (As of March 31, 2008) and (subscriber's dependents) (Unit:1,000 persons)	Insurance Benefits	
					Medical Benefits	
					Payment in part	High-Cost Medical Care Benefits, and the High-Cost Medical Care & Nursing Care Benefits Combination System
Health insurance	Ordinary employees	Kyokai Kenpo	Japan Health Insurance Association	34,705 (19,496 15,210)	After the commencement of compulsory education to those 69 years of age: 30% Prior to the commencement of compulsory education: 20% 70 to 74 years old: 20% (*) (Persons with income comparable with those of an active worker: 30%) (*) For those 70 to 74 years of age, the rate will be kept at 10% from April 2008 to March 2010.	High-Cost Medical Care Benefits • Maximum amount paid by the patient Under 70 years of age: High income persons: 150,000 yen＋（medical costs-500,000 yen）×1% Average income persons: 80,100 yen＋（medical costs-267,000 yen）×1% Low income persons: 35,400 yen From 70 to 74 years of age: With income comparative with those of an active worker: 80,100 yen + (medical costs-267,000 yen)×1% , Outpatient Treatment (for each patient): 44,400 yen Average income persons(*): 62,100 yen, Outpatient treatment (for each patient) 24,600 yen Low-income persons: 24,600 yen, Outpatient treatment (for each patient) 8,000 yen Low-income persons with especially low income: 15,000 yen. Outpatient treatment (for each patient) 8,000 yen • Standard amount for aggregation of households: For those under 70 years of age, if there are multiple payments of more than 21,000 yen in the same month, reimbursement is calculated on the basis of their sum. • Burden reduction for those with multiple cases: If a household has been eligible for reimbursement three times or more within a 12-month period, the amount of payment in part from the fourth time will be: Under 70 years of age: High-income persons: 83,400 yen Standard-income persons: 44,400 yen Low-income persons: 24,600 yen 70 years of age or older with income comparative with those of an active worker and standard income (*): 44,400 yen • Burden reduction for patients suffering from long-term and high-cost illness Self-pay limit for the patients suffering from hemophilia or chronic renal failure requiring artificial dialysis: 10,000 yen Self-pay limit for high-income persons receiving artificial dialysis: 20,000 yen (*) Burden reduction for multiple cases is not applicable to persons from 70 to 74 years of age classified as standard income class as the self-pay limit will be kept unchanged at 44,000 yen (12,000 yen for outpatient treatment) from April 2008 through March 2010. High-cost medical care and high-cost nursing care benefits combination system: Burden reduction system applicable in the instances where the total of the self-pay burden under the medical insurance and nursing care insurance paid in a year (from August to July next year) become extremely high. Self-pay limits will be fixed in high details according to the income and age of the patients.
		Associationmanaged	Health insurance associations 1,497	30,337 (15,906 14,431)		
	Insured parties, as stipulated in Article 3, Par.2, Health Insurance Law		Japan Health Insurance Association	17 (11 6)		
Seamen's insurance			National government	144 (62 82)		
Mutual aid insurance	National government employees		Mutual aid associations (21)	9,023 (4,394 4,629)		
	Local government employees		Mutual aid associations (55)			
	Private school instructors		Mutual aid associations (1)			
National health insurance	Farmers, self-employed etc.		Municipalities 1,788	39,492 Municipalities 46,881 Health insurance associations 3,522		
			Health insurance associations 165			
	Retired workers eligible for employees insurance benefits		Municipalities 1,788			
Long life medical care system （Medical care system for the latter-stage elderly people)			Management body: Extended associations for medical care for the latter-stage elderly people (47)	13,458	10% (Persons with income comparative with those of an active worker 30%)	Maximum amount of payment in part / Outpatient care (per person) (Persons with income comparable to that of an active worker) 80,100 yen＋(medical cost-267,000 yen)×1% / 44,400 yen (Incase of frequent reimbursement) 44,400 yen (Average income persons) 44,400 yen / 12,000 yen (Low income persons) 24,600 yen / 8,000 yen (Very low income among low income persons) 15,000 yen / 8,000 yen

Plan			Insurance Benefits			Financial resources	
			Medical Benefits		Cash Benefits	Insurance premiums	Government subsidies
			Hospital Meal Charge Benefits	Hospitalized living expenses benefits			
Health insurance	Ordinary employees	Kyokai Kenpo	Standard payment amounts for dietary therapy: • Standard-income persons 260 yen per meal • Low-income persons Up to the first 90th day 210 yen per meal From the 91st day 160 yen per meal • Low-income person with especially low income 100 yen per meal	(Standard payment amounts for those living in hospitals) • Standard income persons (I) 460 yen per meal and 320 yen per day • Standard income persons (II) 420 yen per meal and 320 yen per day • Low income persons 210 yen per meal and 320 yen per day • Low income persons with specially low income 130 yen per meal and 320 yen per day • Applicable to persons 65 years of age or older hospitalized in the convalescent ward * For patients with greater needs for inhospital treatment due to being obstinate or other diseases, the payment amount will be same as the standard payment amounts for dietary therapy.	• Sickness benefits • Lump-sum payment for childbirth, child care etc.	9.34% (National average)	13.0% of benefits (contribution for latter-stage elderly people 16.4 %)
		Associationman-aged			Same as above (including additional Benefits)	Rates vary from one kind of health insurance to another.	Fixed amount (Budgetary aid)
	Insured parties, as stipulated in Article 3, Par.2, Health Insurance Law				• Sickness benefits • Lump-sum payment for childbirth, child care etc.	Daily rate (class 1) 360 yen (class 11) 3,020 yen	13.0 % of benefits (contribution for the latter-stage elderly people 16.4 %)
Seamen's insurance					Same as above	9.25% (Sickness insurance rate)	Fixed amount
Mutual aid insurance	National government employees				Same as above (including additional benefits)	—	None
	Local government employees					—	
	Private school instructors					—	
National health insurance	Farmers, self-employed etc.				• Lump-sum payment for childbirth, child care • Funeral services expenses	Each household is assessed a fixed amount and amount based on ability to pay Calculations vary somewhat according to insurer	43% of benefits etc.
							32-55% of benefits etc.
	Retired workers eligible for employees insurance benefits						None
Long life medical care system (Medical care system for the latter-stage elderly people)			Same as above	Same as above. • Persons on senior welfare pensions 100 yen per meal	Funeral services expenses etc.	Rates are fixed based on the equal amount per insured and the percentage of their income determined by the respective extended associations.	• Insurance premium 10% • Contribution Approximately 40% • Public Approximately 50% (Breakdown of public expenses) National : Prefectures : Municipals 4 : 1 : 1

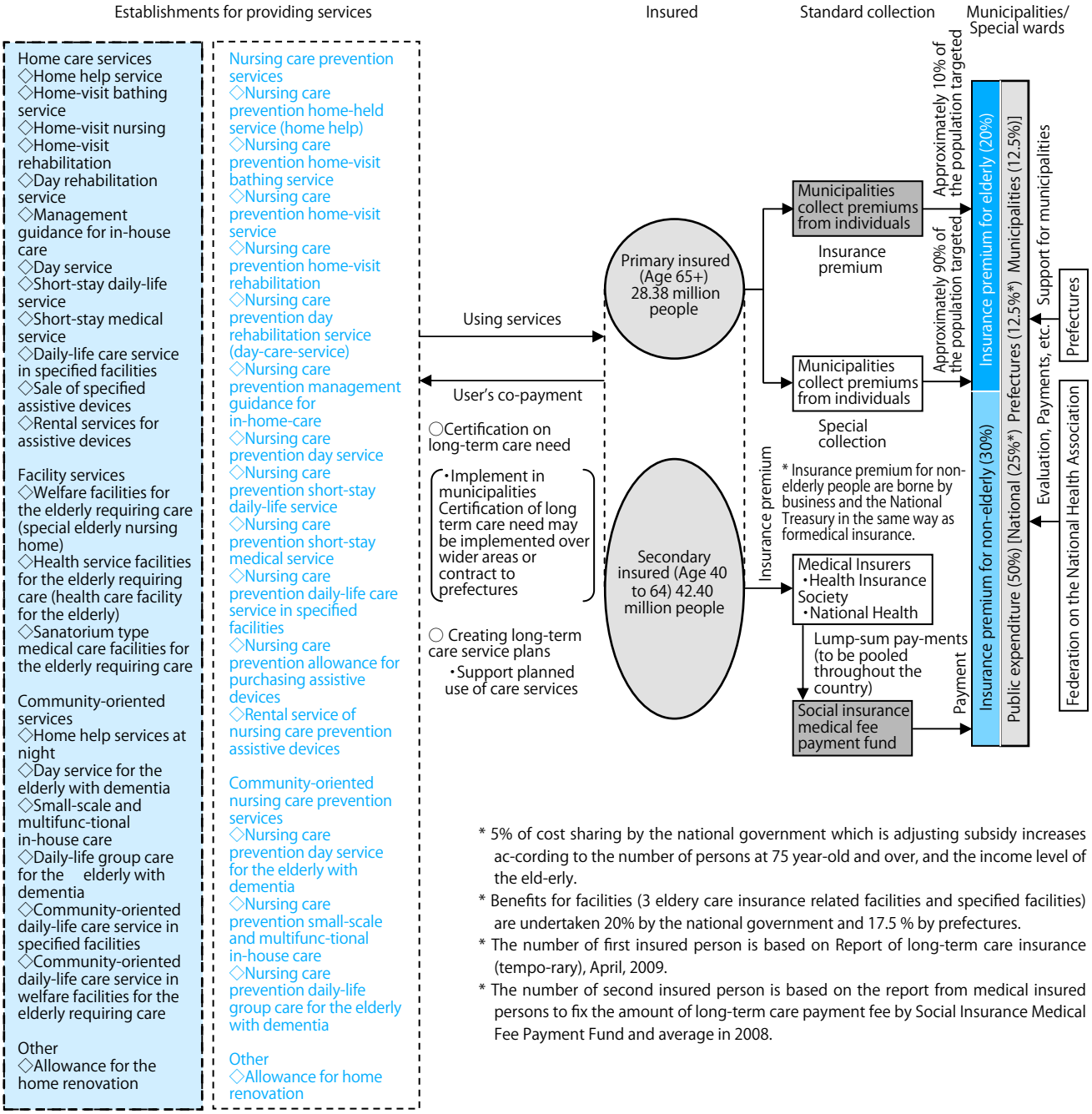
Source: "2012 Annual Health, Labour and Welfare Report", References, 2 Health and Medical Services, (1) Health Care Insurance, Outline of Healthcare Insurance System (as of June 2012)

Notes: 1) Those insured by the long-life medical care system (medical care system for the latter-stage elderly people) comprises persons of 75 years of age or older, and the persons from 65 to 74 years of age certified by an extended association to have a certain degree of handicap.
2) Persons with income comparative with those of an active worker mean their taxable income is 1.45 million yen (0.28 million yen for monthly income) and annual income is more than 5.2 million yen [family including elderly person(s)] or 3.83 million yen (single-elderly person household).
3) For new subscribers and their families who are exempt from health insurance eligibility and subscribe from September 1, 1997, the fixed-rate state subsidy to NHI Associations will be at the same level as that paid to the Japan Health Insurance Association
4) Numbers of subscribers are preliminary estimates in the case of health insurance. Sums in the breakdowns may not add up to the totals due to rounding.
5) Between July 2010 and FY2012, the state subsidy rate for the Japan Health Insurance Association (general employees and persons insured under Article 3 para. 2 of the National Health Insurance Act) is 16.4% of the benefit cost.

National health expenditure, combining the cost of medical benefits from public health insurance with that from public assistance, topped 30 trillion yen (6.1% of GDP) in 1999, creating a need for appropriate controls on the growth of healthcare expenditure. When long-term nursing insurance was introduced in 2000, growth in healthcare expenditure temporarily decreased. It subsequently turned back to an increase, however, and expenditure remains in an upward trend. In FY2010, national health expenditure reached 37.4 trillion yen, and the ratio of expenditure to GDP had risen to 7.8%. By age group, national health expenditure was 2.4 trillion yen (6.5%) for ages 0-14, 5 trillion yen (13.4%) for ages 15-44 5, 9.3 trillion yen (24.8%) for ages 45-64, and 20.7 trillion yen (55.4%) for ages 65 and over. Expenditure on the elderly accounted for the highest proportion of all national health expenditure. If this continues to be supported by a combination of public spending with contributions from national health insurance and health insurance associations, problems will arise due to a slowdown in growth of insurance premium income accompanying the reduced rate of growth in the Japanese economy. In view of this and the need to ensure intergenerational fairness between current working generations and the elderly, a revision of the system was necessary, and a reform of the elderly healthcare system was introduced in 2008. In the previous system (the system of elderly healthcare), elderly patients were only liable for copayment of costs incurred by health examinations or hospital stays (with reduced burdens for low earners), and they paid no insurance premiums. By contrast, the "longevity healthcare system" (the late-stage medical care system for the elderly) introduced in 2008, covering the over 75s and disabled elderly persons between ages 65 and 73, is a public healthcare system in which 50% of medical benefit costs are paid from the public purse (specifically, by the central government, prefectures and municipalities in proportions of 4:1:1). Besides this, 40% is borne by health insurance contributions from working generations up to age 64, and the remaining 10% is funded by insurance premiums from the elderly themselves. However, those on low incomes are exempt from paying premiums and also have lower copayment costs.

Long-term care insurance: Long-term care insurance has been in operation since April 2000 to provide public assistance to lighten the care burden for long-term care recipients' families. This assistance makes it easier for bedridden older people and other older people requiring long-term care to receive this care at home, and for others to receive long-term care at a facility outside of home. Under the long-term care insurance system, in exchange for citizens aged 40 and above paying long-term care insurance premiums, it is possible to receive specific types of long-term care service if required after reaching the age of 65, such as the dispatch of a home-helper; in order to receive these services, the older person concerned must submit an application and have it approved by the municipality's long-term care approval committee. Whereas the insurance premiums and the standards for certifying the necessity of receiving long-term care are set in a uniform manner nationwide, the task of issuing approvals based on those standards is undertaken by municipal long-term care approval committees. In addition, long-term care services are provided on the basis of care plans drawn up by care managers, by a service provider selected by the person requiring long-term care from among the long-term care service providers approved by the municipality, respecting the choice of the individual requiring long-term care (Figure VI-12). Those using long-term care services bear 10% of the cost, as a general rule. However, a maximum limit is set in order to ensure that the cost burden on the user is not too high, with the municipality paying any high-cost long-term care service fees in excess of that maximum limit.

Figure VI-12 Long-term Care Insurance System



* 5% of cost sharing by the national government which is adjusting subsidy increases ac-cording to the number of persons at 75 year-old and over, and the income level of the eld-erly.

* Benefits for facilities (3 eldery care insurance related facilities and specified facilities) are undertaken 20% by the national government and 17.5 % by prefectures.

* The number of first insured person is based on Report of long-term care insurance (tempo-rary), April, 2009.

* The number of second insured person is based on the report from medical insured persons to fix the amount of long-term care payment fee by Social Insurance Medical Fee Payment Fund and average in 2008.

Source: "2012 Annual Health, Labour and Welfare Report", References, 10 Health and Welfare Services for the Elderly, Outline of Long-Term Care Insurance System

With regard to the number of people enrolled in long-term care insurance, as of 2011, there were 29.78 million people insured aged 65 or above (primary insured persons) and 42.70 million people insured aged between 40 and 64 (secondary insured persons). As of 2011, 1.40 million persons requiring support and 3.91 million persons requiring long-term care were certified eligible to receive long-term care insurance services. The number of long-term care workers (the total of full-time and part-time) providing long-term care services to elderly persons certified as requiring support or long-term care was 177,000 for home visit type long-term care, 330,000 for daycare type long-term care, 44,000 for in-home type long-term care, and 322,000 for long-term care insurance facilities, etc. (Ministry of Health, Labour and Welfare, FY2008 Survey of Institutions and Establishments for Long-term Care).

Given these circumstances in which many older people have been certified as requiring support or long-term care and are receiving long-term care insurance services, in municipalities that have a particularly high population aging rate, a situation has arisen in which the rise in the cost of providing long-term care insurance benefits is continuing and a deterioration in the state of public finances for long-term care insurance has become unavoidable. In order to deal with this problem, an amendment to the Long-term Care Insurance Act was made in 2005. Through this, initiatives such as those focused on the prevention of illness so that people do not end up in a state in which they require long-term care and the establishment of regional comprehensive support centers to provide more cohesive services in the community were incorporated into the long-term care insurance framework. Besides this, a Community-Based Care Improvement Initiative that would make use of diverse networks connected with long-term care (such as monitoring by NPOs and others as well as by local authorities and healthcare facilities) was proposed in 2008. The aim of this was to enable the elderly to receive long-term care services while remaining in the familiar surroundings of their home communities. With this, Comprehensive Regional Support Centers were to be established as facilities where comprehensive efforts would be made to improve the health, welfare and healthcare of local residents, prevent abuse, provide management to prevent long-term care, and others in the local community. The centers would be established by local authorities, but the day-to-day running could be outsourced. In future, meanwhile, elderly residents are expected to increase in urban areas while increasing more gradually in provincial areas. To address this, a comprehensive regional care system that would guarantee five aspects in cross-linkage (securing homes for the elderly in line with local circumstances, supporting their lives, preventing long-term care, providing long-term care services, and medical care) was proposed (Elderly Healthcare and Health Promotion Project, Comprehensive Regional Care Research Group Report). Based on new ideas like this, the 2011 revision of long-term care insurance incorporated a provision to the effect that the central government and local authorities should endeavor to create comprehensive regional care systems. Today, initiatives enabling the elderly to receive long-term in-home care while living in the familiar surroundings of their home communities are being promoted in forms appropriate to the circumstances of each locality.