Case study

Republic of Korea

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Abstract

This study aims to provide a case study of the Republic of Korea for the price setting and price regulation for the care of older persons. This case study will first examine the coverage, financing and organization of long-term care (LTC) systems, focusing on long-term care insurance (LTCI) in the Republic of Korea. Then it will examine the pricing and price regulation of various types of LTC or care of older persons provided by different types of providers, such as nursing facilities (LTC facilities), home-based care, and long-term care hospitals in the Republic of Korea.

Contents

1
Population coverage of LTCI

Long-term care insurance (LTCI), introduced in 2008, is the key institution for LTC in the Republic of Korea. As in the case of national health insurance (NHI), pricing and price regulation is a key policy instrument for financial sustainability and affordability in LTCI. LTCI is separate from NHI, although both are administered by the National Health Insurance Service (NHIS) to save administrative costs, i.e. managed by a single agency with two different funding pools.

Different from European countries (e.g. Germany, Netherlands) where LTC systems have been developed for people with disabilities including older people, LTCI in Korea was introduced in the context of population ageing. As a result, people aged 65 years or older are eligible for all types of LTC, but eligibility of those under 65 is restricted to aged-related LTC need, such as individuals with geriatric diseases, e.g. dementia, cerebrovascular disease. The design of LTCI to which younger people pay contribution but their eligibility for benefits is restricted has resulted in a big inter-generational transfer and to some extent contributed to the financial sustainability of LTCI. As of December 2018, LTCI covered 8.4% of older people over 65 (Table 1). For 10 years since the introduction of LTCI, the population coverage in terms of the percentage of the population aged 65 and over has doubled.

Table 1
Long-term care insurance (LTCI)-eligible people in 2008-2018, Republic of Korea

(Unit: thousand persons)

	2008	2010	2012	2014	2016	2018
a. Total population	50 001	50 581	51 169	51 757	52 273	52 557
b. Older population (aged 65+)	5086	5449	5922	6463	6940	7612
c. LTCI eligible population	214	270	342	425	520	671
c-1. aged 65 and over	200	251	318	400	493	640
(% of older people 65+)	(3.9)	(4.6)	(5.4)	(6.2)	(7.1)	(8.4)
c-2. aged under 65	14	19	24	25	27	31

Source: NHIS (various years).

To become eligible for LTCI, individuals who have disability for more than 6 months can apply for needs assessment. Needs assessment examines functional status in physical, cognitive, behavior, and rehabilitative characteristics based on 52 items[1]. The eligible group is classified into six levels/grades. As of 2018, the distribution of severity levels 1-5 are 7%, 13%, 32%, 40%, and 8%, respectively (Table 2). With the increase in the number of severity categories, the proportion of the most severe level (i.e. level 1) has declined.

Table 2
Distribution of LTC grades/levels among LTCI-eligible people in 2008-2018, Republic of Korea

(Unit: thousand persons, %)

	2008	2010	2012	2014	2016	2018
Grade I	57 (26.8)	31 (11.6)	38 (11.2)	38 (8.9)	41 (7.9)	45 (6.7)
Grade II	58 (27.2)	64 (23.6)	71 (20.7)	72 (17.0)	74 (14.3)	85 (12.6)
Grade III	99 (46.0)	175 (64.8)	233 (68.1)	170 (40.1)	186 (35.7)	211 (31.5)
Grade IV	-	-	-	134 (31.6)	189 (36.3)	265 (39.5)
Grade V	-	-	-	10 (2.5)	30 (5.8)	54 (8.0)
Grade for cognitive support	-	-	-	-	-	11 (1.7)
Total	214 (100)	270 (100)	342 (100)	425 (100)	520 (100)	671(100)

Source: NHIS (various years).

1 Need assessment examines physical functions (dressing, face washing, tooth brushing, bathing, dining, changing positions, sitting, moving, control of excrement, shampooing, level of self-reliance), social functions (housing, preparing for meals, laundry, financial management, shopping, using telephones, using transportation, going out for short distances, dressing, taking pills), cognitive functions (recall of stories, dates, places, ages and birthdays, difficulties in understanding directions, lack of judgment, difficulties in communication, difficulties in calculations, difficulties in understanding daily schedules, difficulties in recognizing family or relatives), change of behavior (newly occurred psychological symptoms related to dementia, delusion, anxiety, etc.), nursing necessity, rehabilitation necessity, willingness to use welfare equipment, main source of care, residential environment (evaluating whether environments are harsh or detrimental to health), vision and hearing ability and morbidity. The assessment of each item is based on 2 or 3 scales.

2
Benefits and expenditures of LTCI

LTCI provides in-kind benefits for institutional and home-based care, and cash benefits are available only in exceptional cases, e.g. when no service providers are accessible in the region. Meals are not covered by LTCI, and extra charge is applied for private wards. People with severity levels 1-2 can use all types of care whereas those with lower levels of severity are not eligible for institutional care.

The amount of benefits depends on the eligibility/severity level, and the ceiling on benefit coverage is different by the level. For example, the maximum monthly benefits range from ₩1 007 200 for level 5 to ₩1 498 300 for level 1 in the case of home-based care (Table 3). The benefit ceiling for institutional care is higher than that for home-based care. The ceiling for welfare equipment is ₩1 600 000 (about US$ 1400) per year. In most cases, benefits to the insured/beneficiaries and payment to providers do not depend on individual services because provider payment is based on the visit (e.g. home-based care) or day (e.g. institutional care).

Table 3
Monthly ceilings on the benefits in LTCI, 2020, Republic of Korea

(Unit: Korean won)

Severity Level	Level 1 (most severe)	Level 2	Level 3	Level 4	Level 5	Cognitive
Home-based Care	1 498 300	1 331 800	1 276 300	1 173 200	1 007 200	566 600
LTC facility	2 129 700	1 976 100	1 822 200			

Source: NHIS (2019).

1 US dollar = about 1100 Korean won.

Note: average monthly salary of a nurse is around 4 000 000 won.

The proportion of institutional care in total expenditure for LTCI was 45.5% and for home-based care, it was 54.5% (Table 4). The proportion of institutional care in total LTCI expenditure has been declining slightly over the years. The home-based care consists of visiting care, visiting bathing, visiting nursing, day and night care, short-term care and welfare equipment. Home-visit care and day/night care account for 71% and 21% of home-based care expenditure of LTCI, respectively. The number of users of different types of LTCI benefits is presented in the Appendix.

Table 4
LTCI expenditure by service types, 2012-2018, Republic of Korea

(Unit: billion Korean won, %)

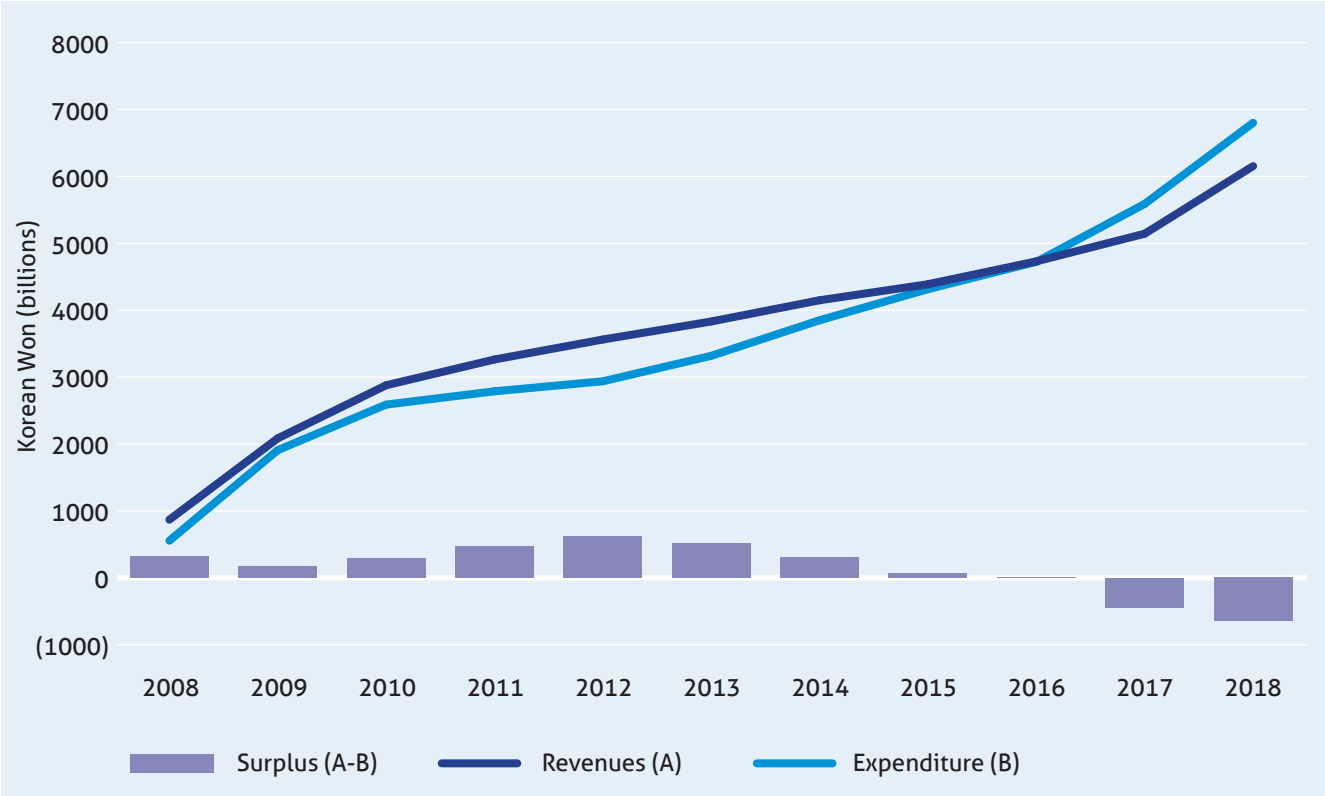
	2012	2013	2014	2015	2016	2017	2018
Total LTCI expenditure	2718	3083	3498	3982	4418	5094	6299
(%)	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Institutional care	51.1	51.8	52.1	51.3	50.7	48.1	45.5
Home-based care	48.9	48.2	47.9	48.7	49.3	51.9	54.5
Within home-based care							
Home-visit care	80.6	79.0	78.3	76.4	73.8	71.6	70.9
Home-visit bathing	5.3	4.9	4.2	3.7	3.5	3.4	2.9
Home-visit nursing	0.5	0.5	0.5	0.5	0.4	0.5	0.5
Day and night care	7.2	8.6	10.4	13.2	16.6	19.4	21.4
Short-term care	0.7	1.0	1.0	0.8	0.6	0.5	0.4
Welfare equipment	5.7	6.0	5.6	5.4	5.2	4.6	3.8

1 US dollar = about 1100 Korean won.

Source: NHIS (2019).

The contribution rate for LTCI is 8.51% of health insurance premiums in 2019 (increased from 7.38% in 2018). In other words, anyone who pays NHI contribution pays LTCI contribution. The contribution is exempted for the poor. Because the NHI contribution is 6.46% of wage, the contribution for LTCI was about 0.55% of wage (6.46 X 8.51) in 2019. The contribution rate started at 4.05% of the health insurance contribution in 2008, increased to 4.78% in 2009, and to 6.55% in 2010-2017. Since 2017, LTCI has experienced an annual increasing deficit (Figure 1). As a result, the financial sustainability of LTCI is a serious concern.

Figure 1
Fiscal status of LTCI, 2008-2018, Republic of Korea



Source: NHIS (various years).

The financing mix of LTCI consists of contributions (60-65%), tax subsidies (20%), and copayment by service users, which is 20% for institutional services, 15% for home-based services, and 15% for welfare equipment. The coinsurance rate for institutional care is higher than that for home-based care in order to promote de-institutionalization and community-based care. There is a 40% copayment discount for those in the 25-50% income quartile and 60% discount for those in the lowest (0-25%) income quartile. Copayment is exempted for the beneficiaries of the Medical Aid program, which is a public assistance program for the poor.

3
LTC provision

After the introduction of LTCI, the number of LTC providers rapidly expanded from 1700 to 5320 facilities/institutions and 6618 to 15 970 home-based care agencies from 2008 to 2018 (Table 5). An over-supply seems to result in severe competition among LTC providers. The number of care workers and nurse aides increased dramatically, as they need a shorter period of education and training than registered nurses.

Table 5
Number of LTC providers, Republic of Korea

Institution (number)	2008	2010	2012	2014	2016	2018
a. Home-based care agency	6618	11 228	10 730	11 672	14 211	15 970
b. Institution/Facility	1700	3751	4326	4871	5187	5320
b-1. Aged Care Facility	1379	2408	2588	2714	3137	3389
b-2. Senior Congregate Housing	321	1343	1739	2157	2050	1931

Source: NHIS (various years).

The increase in quasi-professional staffing seems driven by small-sized institutions, e.g. capacity of less than 30 residents or group homes (less than 10 residents), where the entry to market is relatively easy for private sector providers. About 70-80% of providers are from the private sector, and the majority of home care providers are concentrated in urban areas. To assure the quality of care in the LTC sector, the NHIS has implemented a quality evaluation system since 2009. The number of quality indicators varies by the type of service providers, e.g. 88 items for institutional care and 32-59 items for home-based care, and they are grouped by five domains of quality measurement, namely, management of institutions, environment and safety, rights and responsibilities, process of services and outcome of services (Jeon and Kwon 2017).

The result of the evaluation score (A-E) has been publicly disseminated through an official LTCI website (Table 6 for the results of the year 2018), and high-performance institutions have received incentives of 1-2% additional reimbursement of LTCI. Based on the provider assessment report, the NHIS gives 2% extra payment to the top decile of facilities and 1% extra payment to the next decile. Facilities that employ more human resources than required by law (social worker, nurse, night watch) also receive extra payments.

Table 6
Results of the assessment of LTC facilities, 2018

A (Highest)		B		C		D		E	
%	Score	%	Score	%	Score	%	Score	%	Score
13.5	94.1	21.7	85.3	24.4	76.7	19.8	68.3	20.6	55.7

Note: 4287 facilities were assessed with a mean score of 74.9.

Source: http://news.healthi.kr/news_view.asp?articleid=190424110016&CatrCode=1201

Inadequate collaboration between local governments and the NHIS has been criticized because local governments are not active in controlling the quality of LTC providers even though they have the authority to approve or close the operation of providers (Jung et al. 2014). LTCI is a centralized system with a single pool and has a concern of a lack of coordination between the NHIS and LTC delivery by local governments. The central government, i.e. MoHW (Ministry of Health and Welfare), formulates policy and provides overall guidance on LTC policy implementation but does not have direct control over local governments. Although the centralized single pool has the benefit of equity in financing and efficiency of risk pooling, it has not been so far effective in organizing LTC delivery at the local level. This coordination problem is prominent in the Republic of Korea, as the majority of LTC providers are private, the role of gate-keeping by general practitioners is minimal, and consumers are used to the freedom of choosing their providers.

Informal care is not covered by LTCI, in other words, LTCI covers LTC only when LTC is provided by formal care providers. According to a national survey of community-dwelling older people (65 years and older) by the Korea Institute of Health and Social Affairs (KIHASA) in 2017, about 25% of those surveyed needed some type of care/support when care need was defined as at least one limitation among the 17 items of ADL (Activities of Daily Living) and IADL (Instrumental Activities of Daily Living) (Chung et al. 2017). 71% of those who needed support received care from many sources (multiple sources could be chosen in the survey). Among those who received some care, 19% relied on LTCI and 89% received some support from family members, mainly the spouse.

4
Payment and price setting in LTCI

The payment method varies by severity level and service type, such as pay per visit (service hours) for home-visit care and pay per day for institutional care (Table 7). Payment per visit is higher for visiting nurses and visiting baths than that for visiting homes. In contrast to the collective price negotiation between the provider association and the NHIS in the case of the national health insurance system, there is no price negotiation process in the case of LTCI. This lack of negotiation seems related to the weak professional power of LTC providers relative to health care providers.

Table 7
Per-diem payment for LTC facilities, 2019, Republic of Korea

	Severity Level	Amount (won)
Aged Care Facility	Level 1	69 150
	Level 2	64 170
	Levels 3	59 170
Senior Congregate Housing	Level 1	60 590
	Level 2	58 220
	Levels 3	51 820

Source: NHIS (2019).

1 US dollar = about 1100 Korean won.

The LTC committee plays a key role in the pricing of LTC. It discusses and makes final decisions on various aspects of LTC insurance, such as premium, benefits, pricing for providers, etc. It consists of 21 members, with the Deputy MoHW as the Chair: 7 from payers (employer associations, labour unions, civic groups), 7 from providers (4 associations of LTC facilities and home-care providers, 2 medical associations, nursing association), and 7 representing public interests (MoHW, MoF (Ministry of Finance), NHIS, and 4 experts). Because providers account for only a third of the committee membership, they complain that the annual increase in price is lower than it should be.

The pricing of LTC is based on the costing of a standard practice model. Standard models are based on the operation with the following numbers of older persons being cared: 70 persons for LTC facilities, 9 for senior congregate housing (group homes), 26 for day and night care and 17 for short-term care. Standard models for home-visit providers are based on 6450 visits per year. It is an important issue whether the standard models well represent the real practice or standard of care with optimal

operation. A recent study of cost function estimation of LTC facilities shows that the optimal scale is larger than 100 beds (Kwon et al. 2019). However, the sample size in the study is small, and it is controversial if the study fully controlled the quality of care due to measurement and data issues.

Standard models of each provider type are based on the different number of personnel and include depreciation. The minimum number of care workers is 28, 3, 3.7, and 4.3 for the above four types of providers, and 15 for home-based care, respectively. The minimum number of nurses or nurse aids is 2.8, 1, 1, and 1 for the above four types of providers (facilities), respectively. At least one social worker is required for standard models of LTC facilities, short-term care and day/night care. The estimate of personnel cost depends on various data, such as a survey of LTC providers, the minimum wage and its increase, etc. Payment for each of the five levels of severity is determined by considering resource needs (amount of hours needed to provide care for each severity level), personnel cost for care workers, administrative cost, etc. For the decision on pricing by the LTC committee, NHIS provides information on the costing based on standard models of practice.

In addition to the lower professional bargaining power of LTC providers, there are some differences among NHI and LTCI in terms of costing (Table 8). NHI has fee-for-service (FFS) payment for a large number of medical services, from relatively simple to complicated cases, relying a lot on medicines and technology services. Health services paid by NHI often use heterogeneous resources and inputs provided by various health professionals, and indirect costs to be allocated to services are often very high especially in the case of big hospitals. As a result, how to allocate indirect costs to individual services has a big effect on the price of individual medical services under FFS payment. To the contrary, LTC services rely heavily on the direct labor input of care workers, with a much smaller number and type of simple homogeneous inputs, mostly in a smaller scale of practice.

Table 8
Costing approach in NHI and LTCI, Republic of Korea

	NHI	LTCI
Costing unit	Numerous services	7 Service/provider types
Payment system	Fee for Service	Lump sum per day or visit
Diversity of products	Numerous products	Limited types of products
Role of medicines and technology	High	Low
Role of indirect cost	Relatively high	Relatively low
Complexity/diversity of inputs	Relatively complex/diverse	Relatively simple
Homogeneity of inputs	Heterogeneous	Homogeneous
Operating scale	Big	Small

Since 2016, the NHIS has collected panel data consisting of about 550 LTC providers based on the seven major types of care, size of providers, region and ownership type. Although they are valuable data, the reliability of the data is still controversial, as they are based on self-reporting. Especially when providers are engaged in both LTC and other types of social welfare services, joint cost allocation between LTC and other welfare services can be biased following the strategic motive of providers to maximize reimbursement from LTCI. The NHIS is considering the construction of its own LTC facilities, which can provide reliable data on the costing and standard practice of LTC.

5
Coordination between NHI and LTCI

Medical or nursing care for older persons is provided by long-term care (or geriatric) hospitals, which are paid by NHI, not by LTCI. The minimum requirement for medical doctors and nurses is lower in LTC hospitals than acute care hospitals. The boundary or division of labor between LTC hospitals (reimbursed by NHI) and LTC facilities (reimbursed by LTCI) is a serious concern in the Republic of Korea. The pricing of services provided by LTC hospitals are governed by the NHI system, i.e. through price negotiation between NHI and the Korean Hospital Association (KHA). Although LTC hospitals (LTCH) are somewhat different in nature from acute care hospitals, there is a negotiation between the NHIS and KHA, covering all types of hospitals, including LTCH. LTCH think it is better for them to be included in the bargaining between the NHIS and KHA, rather than separately bargaining with the NHIS.

Policy challenges remain regarding the lack of coordination between health care and LTC. For example, overlapped inpatient services are provided by LTC facilities/institutions (under LTCI) and LTCH (under NHI) for older people with similar

health and functional status. LTCH are required to have physicians, whereas the minimum requirement for medical personnel in LTC institutions/facilities is a nurse aide. Some older people, even without the need for medical treatment, want to stay in LTCH, because they worry that the medical capacity of LTC institutions is very limited and referrals to hospitals are not well arranged (Kim, Jung and Kwon 2015).

The lack of effective coordination between LTC facilities and LTCH resulted in the persistent medically unjustified social admissions of older people with lower medical care needs in LTCH (Jeon, Kim and Kwon 2016). On the other hand, a significant portion of older people with clinical care needs stay in LTC facilities where health care is not provided. Based on a national representative sample of 52 LTCH (1364 patients) and 91 LTC facilities (1472 residents), which are 6% of LTCH and 4.4% of LTC facilities nationwide, Kwon et al. (2013) showed about 35% of patients in LTCH are in the categories of Cognitive Impairment, Behavior Problem, and Physical Function. They do not really need medical care and are better to stay in LTC facilities (Table 9). At the same time, about 35% of residents in LTC facilities need medical care and are better to stay in hospitals.

Table 9
Distribution of resource utilization groups in LTCH and LTC facilities, the Republic of Korea

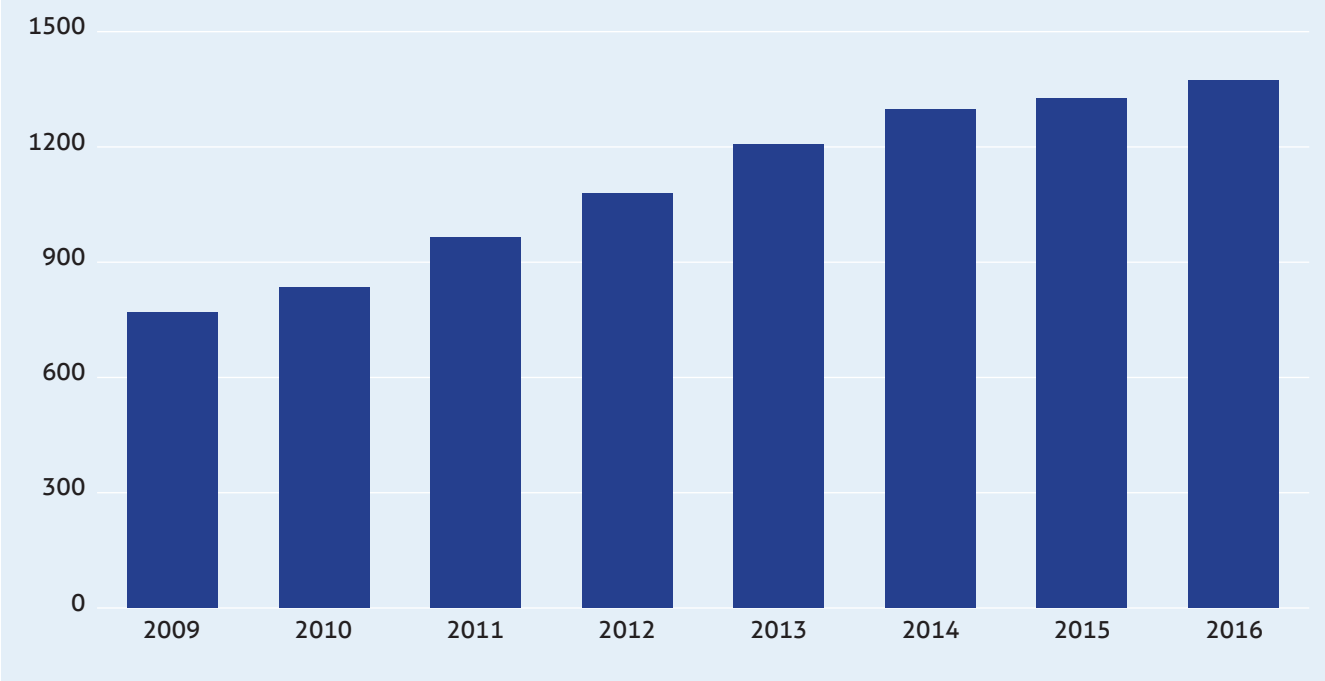
	LTC Hospital (%)	LTC Facility (%)
Rehabilitation	44.20	19.77
Extensive Special Care	5.45	1.36
Special Care	2.68	2.92
Clinical Complex	13.35	11.28
Cognitive Impairment	4.23	9.44
Behavior Problem	1.97	4.62
Physical Function	28.23	50.61

Source: Kwon et al. (2013).

The coordination failure between health insurance and LTCI has to do with the history and path dependency in the development of the LTC system for older people in the Republic of Korea (Jeon and Kwon 2017). With population ageing and the increased need for LTC of older people, the government introduced LTCH with lower requirements for medical personnel than acute care hospitals. LTCH were reimbursed by NHI (there was no LTCI then). When there was no public funding for LTC, many older patients in LTCH were reluctant to be discharged to LTC facilities because they had to pay for LTC facilities while the majority of the cost of LTCH was funded by NHI. As a result, social admissions were prevalent in LTCH

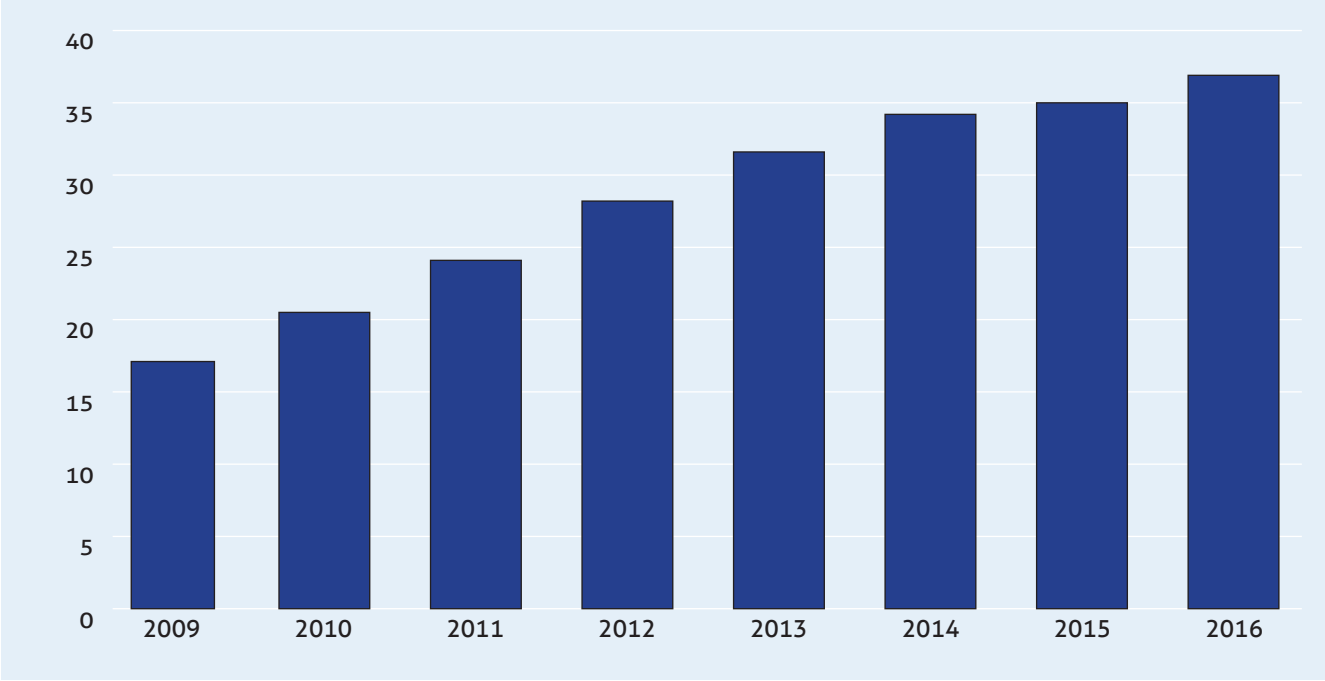
before LCTI was introduced, but inefficient social admissions unfortunately have continued even after the introduction of LTCI. LTCH have mushroomed over the last ten years (Figure 2), and competition to attract patients has been fierce. The number of LTCH beds per 1000 persons aged 65 or older has increased from 5.9 in 2005 to more than 35 in 2016 (Figure 3).

Figure 2
Number of LTCH in the Republic of Korea in 2009-2016



Source: KOSIS (Korean Statistical Information Service) (2020).

Figure 3
Number of LTCH beds per 1000 older people aged 65 and over in 2009-2016



Source: KOSIS (2020).

There are several institutional factors contributing to the persistent social admissions in LTCH. The majority of LTCH and LTC facilities are private, and more patients/residents mean profits for them. The benefits packages of NHI tend to be more generous than LTCI, e.g. the ceiling on cumulative copayment every six months in NHI. As a result, after a few months of stay in LTCH, copayment can be exempted. Then it becomes less costly for patients to stay in LTCH than in LTC facilities. There is a financial penalty, i.e. reduced fees, for LTCH when patients stay for more than 6 months. However, the lower fee (for a given copayment rate for patients) means lower total copayment or OOP (out-of-pocket) pay for patients, resulting in a financial incentive for patients to stay longer in LTCH.

In 2018, 38% of the funds for copayment exemption under NHI were paid to patients in LTCH (NHIS 2019). As of 2018, 64% of patients in LTCH got financial support from the above policy of copayment exemption. Government plans to merge the three patient groups with lower need for medical care in LTCH (Cognitive Impairment, Behavior Problem, and Physical Function) into one category and raise the copayment rate from 20% to 40%. However, the increase in copayment is likely to have a limited impact on the reduction in long-term stay in LTCH, because many patients will get benefits from the copayment exemption. In other words, the increase in copayment rate can result in reaching the ceiling of copayment earlier than present.

Coordination problems between health care and LTC are also associated with weak primary care, dominant private providers, and separate insurance (with separate payment) for health care and LTC, all of which are chronic challenges facing the Republic of Korea. An effective approach would be to change the policy of copayment exemption in the case of LTCH. A policy can consider that copayment is not exempted for long-term stay, e.g. if patients stay for more than 6 months, in LTCH. Government can mandate a strict discharge planning and patient assessment for LTCH, and the above policy of no exemption of copayment can be applied to patients with minor severity or those who can be transferred to LTC facilities. Although the above policies have been discussed, they have not been implemented mainly due to opposition by LTCH and older people, because many older people still tend to prefer LTCH to LTC facilities.

References

Chung K et al. (2017). *2017 National Survey on Health and Welfare of Older People*. Korea Institute of Health and Social Affairs and Ministry of Health and Welfare.

Jeon B, Kim H and Kwon S (2016). Patient and hospital characteristics of long-stay admissions in long-term care hospitals in Korea. *Health Policy Manag* 26(1):39.

Jeon B and Kwon S (2017). Health and long-term care systems for older people in the Republic of Korea: policy challenges and lessons. *Health Systems & Reform* 3(3):214-223.

Jung HY et al. (2014). Quality monitoring of long-term care in the Republic of Korea. In: Mor V, Leone T and Maresso A, editors: *Regulating Long-Term Care Quality: An International Comparison*.

Kim H, Jung YI and Kwon S (2015). Delivery of institutional long-term care under two social insurances: Lessons from the Korean experience. *Health Policy* 119(10):1330-1337.

KOSIS (2020). Number of hospitals and hospital beds [online]. *KOSIS*. [Accessed 4 March 2020]. (http://kosis.kr/) [in Korean]

Kwon S et al. (2013). Survey of LTC Hospitals and Institutions for Care Coordination. *National Health Insurance Service*. [in Korean]

Kwon S et al. (2019). Costing Approach for the Pricing of Long-term Care. *National Health Insurance Service*. [in Korean]

NHIS (2019). *Law and notice on long-term care insurance*. NHIS. [in Korean]

NHIS (various years). *Long-term Care Insurance Statistical Yearbook*. NHIS. [in Korean]

Appendix
LTCI beneficiaries by service type, 2012-2018, Republic of Korea

(Unit: No. of recipients)

	2012	2013	2014	2015	2016	2017	2018
Total LTCI benefit recipients*	**369 587**	**399 591**	**433 779**	**475 382**	**520 043**	**578 867**	**648 792**
Institutional care*	**104 023**	**156 999**	**168 924**	**180 157**	**189 374**	**200 475**	**213 775**
LTC facility	83 538	130 750	142 382	153 840	164 221	176 041	189 615
LTC Congregate housing	20 485	26 249	26 542	26 317	25 153	24 434	24 160
Within Home-based care*	**447 785**	**487 574**	**522 075**	**574 731**	**634 955**	**723 732**	**821 630**
Home-visit care	210 508	224 233	240 392	260 252	284 232	317 195	357 575
Home-visit bathing	67 035	65 509	62 017	60 285	61 812	68 590	74 801
Home-visit nursing	7 866	7634	7660	8613	9 077	11 485	14 270
Day and night care	24 014	28 051	35 089	45 006	57 165	74 081	94 399
Short-term care	4867	7264	7021	6436	5866	5421	4685
Welfare equipment	133 495	154 883	169 896	194 139	216803	246 960	275 900

Source: KOSIS (http://kosis.kr/statisticsList/statisticsListIndex.do?menuId=M_01_01&vwcd=MT_ZTITLE&parmTabId=M_01_01#SelectStatsBoxDiv).

Note: Totals do not always add to 100% because people can use more than one type of benefit.