MINNESOTA
OWN YOUR FUTURE

Enhanced Home Care Benefit in Medicare Supplemental Plans

Final Report

Prepared for the Minnesota Department of Human Services Own Your Future Initiative

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EXECUTIVE SUMMARY

Currently, Minnesotans lack affordable options that will help them pay for the long-term care that many of them will need in the future. Based on several years of study and analysis, it appears that an enhanced home care benefit embedded in all Medicare supplemental plans sold in Minnesota could provide an option for older adults to help address this gap. (By supplemental plans, we mean all Medicare Advantage plans, cost plans and the Medigap plans that provide supplemental coverage to persons with Original Medicare coverage.)

The Minnesota Department of Human Services through its Own Your Future (OYF) program, has embarked on a multi-year effort to analyze the problem of long-term care financing and recommend solutions. Own Your Future was a joint federal/state initiative begun in 2012 whose purpose was to increase awareness among residents about the growing need to plan for long-term care services as part of their retirement planning. Minnesota added on to the joint effort in order to work on the development of affordable products that would encourage households with incomes between $50,000 and $125,000 to purchase and utilize private insurance and financial products. The hope is that the products would be affordably priced, actuarially sound, appealing to consumers and acceptable from a risk and market perspective to insurers and insurance companies. By increasing the take-up of private market solutions we hope to reduce or prevent dependence on Medicaid at a time when demand for health and long-term care services is expected to grow dramatically and compete with other components of the state budget.

The Minnesota add-on also included evaluation of ways that Medicaid could be redesigned to incent greater use of private financing options. Two private financing products were identified as having the most potential for being purchased and utilized by individuals: 1) a term life insurance policy that provides breadwinner protection during working years and then converts into long-term care insurance when a worker retires; and 2) embedding a package of home and community services and supports in all Medicare health plans sold in Minnesota. This package would add nonmedical supports to Medicare services and provide help for older adults on Medicare who need additional help after hospital stays or other health episodes in order to stay safely in their home. (See the Report on LifeStage Protection Insurance at the following linkXXXXX.)

<u>Background</u>

Minnesota has been working on Medicaid long-term care financing reform for several years. As part of this work in 2015, Minnesota created a new 100% state-funded benefit that provided eight services and supports to older adults who were no longer eligible for Medicaid benefits because Minnesota increased the level of care required for eligibility for Medicaid long-term care services. This change left a group of older adults without access to services they needed to remain independent in the community. In response to this issue, the state created a new program called Essential Community Services (ECS) that provided a package of eight home and community-based services that helped these individuals remain in their own homes and their communities.

When OYF began work on an enhanced home care package within Medicare supplemental plans, we turned to the package of nonmedical support services included in the Essential Community Services package. This benefit would add access to a package of nonmedical services and supports to all supplemental plans sold in the state. The services included in the benefit focused on helping seniors remain in their own homes as long as possible and as safely as possible. This benefit would be funded through premiums paid by the beneficiaries, thus it was seen as a private financing option, bringing more private financing into the mix. Providing these services within the Medicare supplemental plans also provides an opportunity to test and evaluate the cost effectiveness of these services and the efficiency of using the Medicare supplemental plans as an affordable vehicle for nonmedical services that focus on keeping people in their homes longer.

Currently, the home care services covered by Medicare are limited to medical services approved by Medicare, i.e., therapy, home nursing, home health aide services. Examples of the nonmedical services that would now be available through health plans include home delivered meals, home maintenance, homemaker, chore services, adult day care, caregiver training and education, care coordination, community living assistance and personal emergency response systems. Right now, there is little coordination among these services and because of the fragmentation, these services are hard to find and often are not reliably available. Especially for older adults who are alone without family nearby, the lack of services to help them with daily tasks in the home after hospital stays could lead to new injuries or aggravation of existing conditions and possible readmission to the hospital.

OYF completed a full analysis of the enhanced home care concept, which included development of actuarial premium estimates, consumer testing to gauge interest within the Medicare market, and analysis of the potential savings that might accrue by using this option. The cost analysis was completed through the use of a projection model created by the State Health Access Data Assistance Center (SHADAC) program at the University of Minnesota.

<u>Actuarial Analysis of Enhanced Home Care Benefit</u>

The Department of Human Services (DHS) contracted with United Health Actuarial Services, Inc. (UHAS) to estimate premiums and determine the feasibility of offering nonmedical home care services through Medicare plans. The estimated monthly premiums developed were quite affordable compared to other premium estimates researched for home care services. For Medicare Advantage and cost plans, the premium increase for the base package of eight services (without PCA)* added $7.52/month to the current premiums. For the Medigap plans these services added $8.49/month. With the PCA portion added, the estimated premiums went up significantly – $18.92 for MA and cost plans, and $21.38 for Medigap policies. The actuarial estimates assumed that the package of services would be mandated services, which addresses the issue of adverse selection. In other words, these services would be embedded in all plans sold in Minnesota and be available as needed by the beneficiaries.

Consumer Focus Groups

DHS also contracted with the University of Minnesota/Office of Measurement Services to hold six focus groups with Medicare beneficiaries throughout Minnesota in the fall of 2017. The results indicated that participants in all the focus groups thought the services would be helpful for them or their friends and neighbors, especially those who live alone. They expected these services would be more expensive than they were when the prices were unveiled, so to them the cost was affordable and a real value. Most thought the services should be part of all the plans so as to keep the overall cost down, once they understood the concept of adverse selection.

Using Projection Model to Analyze Home Care Benefit

OYF contracted with the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota to create a Minnesota-specific model for analyzing financing options for long-term care. The goal was to create a demographic and economic model for use in testing a variety of long-term care financing options to determine the costs, impacts on other funding sources and overall cost savings that could be identified.

When the projection model was used to evaluate Medicare and the enhanced home care benefit within Medicare, SHADAC found there would significant cost savings through the use of the additional benefit. The cost of home care within Minnesota Medicare would be $990 million in 2015. With no change in state policy, SHADAC projected total Medicaid spending on long-term services and supports would grow by more than 70 percent to $1.714 billion from 2015 to 2030 (assuming an expected annual inflation rate of 2 percent). Their preliminary analysis projected that adopting the enhance home care benefit as a supplemental benefit in all Minnesota Medicare Advantage and Medigap policies would save the state $268 million in Medicaid expenditures between 2015 and 2030, with projected Medicaid 2030 spending of $1.338 billion (assuming and expected annual inflation rate of 2 percent).

Federal and Market Developments

Because Medicare is a federal program, the ability of Minnesota to make any changes in coverage within all the Medicare Advantage and Medigap plans depends on how the federal Centers for Medicare and Medicaid (CMS) react to our ideas.

On February 1, 2018, CMS put out advance notice of changes to the 2019 Medicare Advantage (MA) plans. CMS followed this with its April 2018 Call Letter. CMS confirmed that MA plans may offer non-medical benefits and stated the following points about the offering of nonmedical benefits: "…these additional supplemental benefits will be qualitatively different than the supplemental health care benefits that MA plans may currently offer and may continue to offer to enrollees who are not chronically ill. In addition, it provides authority for the waiver of uniformity requirements only with respect to supplemental benefits provided to a chronically ill enrollee.'' (NOTE: CMS and others sometimes use the terminology "social determinants of health," meaning non-clinical matters such as housing, income and education that impact health care often as much as the actual health status of the individual.) Allowing and encouraging health plans to offer this new set of nonmedical services after years of holding

the line and not permitting Medicare plans to provide these types of services surprised experts and CMS watchers alike. It was particularly critical for OYF in Minnesota because, as a result of the bulletins allowing these services to be offered, we no longer needed to approach CMS for its approval to offer new nonmedical supports to Medicare enrollees in Minnesota.

Next Steps

While everyone expects the 2020 plan year to be the time when health plans really step up to the plate and begin to offer more of the nonmedical services, there has been a surprising amount of activity in 2019. Estimates for the 2019 plan year are that about 1.5 million people (7.5 percent of those in MA plans) will have access to some of these new product features during CY 2019. For Minnesota, the issue may not be whether the DHS effort is supported by our nonprofit or private health plans, but rather how quickly health plans move on their own to add these new home care and other supportive services. If the market is indeed going in that direction it might mean state efforts should be focused on making certain that all MA enrollees have access to these kinds of supports, not just some plans or some plan offerings. OYF continues its dialogue with the plans active in the state, proposing some creative system delivery changes that could better coordinate the medical and nonmedical services so that these newer services would be more easily obtained and authorized to help older adults remain in their homes and communities.

INTRODUCTION

Currently, Minnesotans lack affordable options that will help them pay for the long-term care that many of them will need in the future. Long-term care is defined as personal care and household services and supports that many older adults and younger persons with disabilities need. Based on several years of study and analysis, it appears that a newly created enhanced home care benefit embedded in all Medicare supplemental plans sold in Minnesota could provide an option to help address the availability of these services. (We are including all Medicare Advantage plans and cost plans as well as the supplemental Medigap plans sold to persons with Original Medicare coverage in our definition of supplemental plans.)

As we look out to 2030 and beyond, half of all Minnesota's older adults, at some point, will need enough long-term care help that they will require paid care. Research done by the Urban Institute (O'Leary and Chow, Benefits, Quarterly, 2016) shows that most of these adults will not plan or put aside funds to pay for that eventuality. At the same time that senior care needs are increasing, the ways to pay for it appear to be decreasing. And the impact will be felt most by those in the middle class who have income and assets too high to qualify for Medicaid, but too low to self-fund their care. Private long-term care insurance, once thought to be the answer, has been in a dramatic downward spiral of late, as products have proven to be too expensive and too risky for both consumers and insurance companies. Many insurance companies have increased premiums significantly, have exited the market, or both. As a result, products that are still available are not affordable for middle-income Minnesotans.

WHY THIS IS IMPORTANT TO MINNESOTA

The demographic realities that face Minnesota and other states present significant challenges related to the cost of long-term care for a growing aging population.

- Medicaid long-term care expenditures for older adults in Minnesota are forecasted to increase 8 percent each year going forward until the baby boom generation is gone (Medicaid spent $1.2 billion in FY2016 and will spend $1.7 billion in FY2021).
- "Caregiver ratios" are expected to continue to increase as older adults live longer and the younger population shrinks. This ratio measures the availability of women ages 45 – 64 (the typical age and gender of most caregivers for older adults) and compared to the population 85+). In 2010, there were 15 older adults 85+ for every 100 females ages 45 – 64 in Minnesota. This ratio will grow exponentially and by 2050 there will be 40 older adults for every 100 females 45 – 64. http://www.mnaging.netadvisor/SurveyOlderMN.aspx
- 50 percent of all older adults are living with at least two or more chronic conditions such as hypertension, arthritis and diabetes, and the presence of these conditions increase the risk of long-term care need. https://cvshealth.com/thought-leadership/by-the-numbers-the-impact-of-chronic-disease-on-aging-americans

Demographic Imperative

We need to redesign the way we pay for long term care so that middle income households can afford to pay for more of their care. Traditional long-term care insurance is nearly dead. Since its peak in the early 2000's, there have been large declines in the take-up of traditional policies. While there has been growing interest in alternative products, this is speculative at this point and not attractive even among higher income individuals. Even if they eventually find success, we can't wait for these new products to become reality, if they ever do.

The Minnesota Department of Human Services through its Own Your Future (OYF) program, has embarked on a multi-year effort to analyze the problem of long-term care financing and recommend solutions. Minnesota's goal has been to encourage affordable long-term care solutions for middle-income households with annual incomes between $50,000 and $125,000. The state's approach has been to encourage private market solutions that are affordably priced, actuarially sound, appealing to consumers and acceptable from a risk and market perspective to insurers and insurance companies.

Own Your Future (OYF) is an initiative begun by the Governor Mark Dayton Administration as a federal/state joint effort in 2012. The purpose was to urge individuals to plan for their long-term care, including how to pay for it. Minnesota was the last state to join this campaign, and unlike other states, Minnesota expanded the scope of its OYF initiative and used the initiative to do major work on the issue of long-term care financing in the future.

The other states focused their OYF efforts on public awareness activities, but Minnesota expanded the activities beyond this to include product development and possible redesign of Medicaid long-term care policies. OYF wanted to develop more affordable private financing products and make them available to middle-income households in Minnesota. OYF was thought the appropriate vehicle to evaluate approaches that would redesign Medicaid to incent the purchase and use of more insurance and financial products to bring more private financing dollars into the long-term care financing picture. OYF originally identified 15 different product ideas that had some potential for providing more affordable options to middle income individuals; eventually this process focused in on two products that seemed to have more potential than others:

- A term life insurance product that converts into a long-term care insurance policy when the policyholder retires. It is a "LifeStage protection" product that covers family members during working years, but then converts to long-term care insurance (LTCI) to offer protection from long-term care costs as individuals age. [See separate report on LifeStage Protection Product, December 2018, available at XXXXXXX]

- Embedding an enhanced home care benefit in all Medicare Advantage and Medicare Supplemental health plans sold in Minnesota. This benefit would be paid through a slight increase in the premium charged those who purchase supplemental plans or via plan savings as a result of lower overall costs, and would offer a set of services that would help older adults remain in their homes longer.

In 2016, DHS received federal funding through a federal State Innovation Model (SIM) grant made to the Minnesota Medicaid Office to complete a number of studies of the Medicare enhanced home care concept identified through the Own Your Future initiative. As a result, DHS was able to contract for actuarial analysis to obtain estimated premiums of the enhanced home care benefit. OYF also contracted with the University of Minnesota for consumer testing of the products through focus groups, and for the creation of a projection model through a contract with State Health Access Data Assistance Center (SHADAC), which is part of the University of Minnesota School of Public Health. The projection model developed was a tool that the State could use to determine the potential cost savings through the use of new insurance or financial products.

The advantages of the approach taken by Minnesota is that these can move forward more easily than some of the other potential solutions, e.g., social insurance options. One reason is that these are paid for by the individual through premiums, and thus are attractive to bipartisan support. In addition, the premiums are affordable for middle income beneficiaries or sponsorship.

It should also be noted that the trend in the service delivery world is in this direction. Home health care and home care companies are blurring the lines in terms of what they deliver. Insurers, including Medicare Advantage plans, are considering how to better integrate medical home care and nonmedical home care into their service packages.

Amy Baxter, Top Home Care Trends for 2018 (Home Health Care News Trends for 2018, January 2, 2018), at https://homehealthcarenews.com/2018/01/top-home-care-trends-for-2018/

THE MEDICARE MARKET

Historically home care for older adults has been limited to medical services approved by Medicare. This has included home nursing, home health aide service, therapies of various kinds and homemaker services. This emphasis on medical care has left Medicare beneficiaries at risk for additional injuries or new disabilities that require help with household tasks and personal care needs. And this can lead to an increased risk of new injuries and even readmission to a hospital.

To put the need in context, of the approximately one million people on Medicare in Minnesota, about 60,000 Medicare beneficiaries will use the existing (and somewhat restricted) Medicare home health benefit in any one year for rehabilitation after a hospital stay. As older adults

reaffirm their preference for staying in their homes as long as possible, it is also clear that there is not a clear pathway or service package that provides the types of nonmedical services needed by older adults to support continued living independently in their own home and community. These services each have their own delivery and funding mechanisms that make it difficult for older adults and their families to piece together the types of nonmedical supports that older adults may need to remain safely in their homes.

Medicare provides a number of options for additional coverage of medical costs for its beneficiaries. There are slightly over 1 million Medicare beneficiaries in Minnesota as of the 2018 plan year. In the past, the so-called "cost plans" had the highest enrolment at 400,000. They were slated for elimination a number of years ago but the plans have lobbied to allow them to remain. They are very popular because the plans allow enrollees to use medical providers that are outside the more limited network at very little additional cost to the enrollee. This year, however, they are being eliminated except for those counties in Minnesota that do not have another health plan to provide service. Thus, Medicare enrollees had to migrate to other non-cost plans, and as a result of that, for the 2019 year, Minnesota now has 70,000 enrollees in cost plans, and 393,000 in other types of Medicare Advantage plans. Another result of these movements was that there was significant migration from Advantage plans to Medigap plans, although final figures will not be available until late in 2019. Around 75-80 percent of Minnesota Medicare beneficiaries have supplemental protection of some sort through supplemental plans. The remainder most likely obtain coverage through a working spouse.

Because of the huge market represented by individuals on Medicare (15 percent of the state's population) and the large amounts of public and private monies expended (billions of dollars), the "supplemental market" involves many insurance companies and scores of medical providers. There is wide variety and a broad range of plans that older adults on Medicare can choose from during the annual open enrollment periods. The three key types of plans are described below. For more information DHS makes a document called a "Snapshot of Minnesota Medicare Population" (undated 2018) that can be found at https://www.medicareresources.org/minnesota/

Medicare Advantage (MA) Policies

A Medicare Advantage policy is offered by a private company that contracts with CMS to provide all Part A and B benefits; regulation of these plans is at the federal level. Additional benefits may be provided and may, or may not, include Part D benefits. The health plan is paid a monthly capitation amount from CMS. An MA plan is considered a Medicare replacement plan and benefits are not paid for under Original Medicare.

MA plans include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) and other variants. Enrollment is available on a guarantee issue basis during the annual open enrollment period and other specified occurrences.

Historically Minnesota health plans and beneficiaries have been challenged by the federal payment methodologies that overpay certain regions of the country while underpaying lower cost/high quality states like Minnesota. MA plans are scheduled for additional significant cuts in payments over the next 10 years in order to assist in financing the ACA. Because Minnesota has been generally successful in plans receiving maximum reimbursement from CMS, any funding cuts to MA will have greater impact here than in other parts of the country. But it is not clear what impact the additional payment cuts will have on future enrollment.

Medicare Cost Contract Policies

The Medicare cost plan provides the full Original Medicare benefit package and is subject to many, but not all, of the Medicare Advantage plan requirements. There is a contract between CMS and the health plan offering the product. CMS pays the health plan offering the product based on the reasonable cost of providing the services. Reconciliation between the health plan and CMS occurs on an annual basis based on the submitted, and agreed upon, budget.

Unique to the cost plans, beneficiaries are not restricted to the health plan network. If they receive services from a non-participating provider, payment is made by the fiscal intermediary or carrier to the provider. Pharmacy benefits may be included but are not mandated. While this policy involves a contract between the health plan and CMS, there is some dual regulation from the state involving review of the policy contract.

Until its elimination (in most counties in Minnesota) the state had the largest cost plan enrollment in the country. Nationally, there are less than 500,000 individuals owning these policies; in Minnesota nearly 350,000 seniors were enrolled in these plans. Because of the higher cost of these plans to CMS, there has been legislation to eliminate these plans for many years but strong lobbying efforts have successfully stopped this action. For a variety of reasons, the cost plans were eliminated for 2019, except for those counties in Minnesota where no other plan was available for enrollment. All other enrollees had to find another option for their supplemental plans.

Medigap Policies

Medigap policies supplement Original Medicare benefits by providing coverage for all or a portion of Part A and B co-pays and deductibles. In addition, they provide coverage for some non-Medicare covered benefits as described in state law. These policies are guarantee issued for a six-month period at the point of Part B eligibility. Thereafter, health underwriting is allowed.

The policy contract is between the individual and the Medigap carrier. The premium reflects the cost of the supplemental benefits. There is no additional payment from CMS to the Medigap carrier. The product is guaranteed renewable and regulation is, essentially, at the state level.

The Medicare Modernization Act specifically prohibits new Medigap policies from providing prescription drug benefits that are covered by Part D. This means that an individual purchasing a new Medigap policy needs to purchase a separate Part D product.

Nationally, enrollment in Medigap policies has at best been flat, if not decreasing, as Medicare Advantage enrollment has been increasing. In Minnesota, the results of open enrollment indicate a large increase in seniors who chose Medigap plans, but final figures will not be available until later in 2019.

Minnesota is one of three "waiver states" for the health plans that must be made available, along with Massachusetts and Wisconsin. This means that the standardized plan offerings otherwise required by CMS do not have to be offered in Minnesota or the other two waiver states. Minnesota state law (Minn. Stat. 62A.421) provides for Medigap regulation.

There is continuing discussion regarding the implications of federal legislation that cuts back on first dollar Medigap coverage of co-pays and deductibles. The new standardized plans for Medigap reflect this change in law and are not providing full first dollar coverage. While less expensive than the more generous products, it is too early to judge market success. Eliminating first dollar coverage is frequently described as a cost-saving measure for the Medicare program.

Medicaid and Related Options in Minnesota

Looking at insurance offered in Minnesota, the Medicaid program provides significant coverage.

Essential Community Services (ECS)

Minnesota currently has a 100% state funded program that provides a package of nonmedical services and supports for older adults who no longer meet the Medicaid level of care criteria for long-term care and therefore are not eligible for Minnesota Medicaid long-term care services. Called the Essential Community Services (ECS) program, it is intended for older adults who are functionally ineligible for Medicaid, i.e., do not require the level of care provided by nursing home facilities, but do require some assistance to remain living at home. Usually this means they require assistance with their Instrumental Activities of Daily Living (ADL) such as cooking and cleaning and no more than one of their ADLs such as eating, grooming and dressing. To be eligible for this program – which offers a service package worth about $400 per month – an individual's combined income and assets must be less than $33,546 (this amount is the projected cost of 135 days of nursing home care plus the asset limit for Medicaid which is $3,000). Currently, about 300 older adults are served by this program, much smaller number than originally estimated.

Minnesota Senior Health Options (MSHO)

Minnesota Medicaid also has a program called Minnesota Senior Health Options (MSHO) to serve its dual eligible population. That program serves about 50,000 older adults per year, and DHS maintains contracts with the nonprofit health plans for provision of the services to these individuals. That service package includes both Medicare and Medicaid long-term care benefits including a strong care coordination component required to be provided by the sponsoring health plans.

Alternative Care Program (AC)

Another program that is tied to Medicaid in Minnesota is the Alternative Care (AC) program. Originally established at the same time as Minnesota's Elderly Waiver program (1983), this program provided the same service menu for older adults as the EW program; the difference being that the asset level that the older adult could keep was higher in the AC program than the EW program ($3,000 vs $10,000). Currently, about 30,000 older adults are served in the AC program. More recent changes have eliminated customized living (Medicaid name for assisted living services in Minnesota) from the AC program, with the rationale that the AC program should be focused on helping older adults remain in their home as long as possible, but should not be used to move older adults to assisted living unless their needs are at the level of EW clients.

CONSUMER TESTING – QUALITATIVE ANALYSIS

Own Your Future contracted with the Office of Measurement Services (OMS) at the University of Minnesota to schedule and lead six focus groups with Medicare beneficiaries throughout Minnesota in the fall of 2017. They were located in the following cities and held on the dates listed:

- Austin, September 26, 2017
- Fergus Falls, September 28, 2017
- North Saint Paul, October 10, 2017
- Maple Grove, October 25, 2017
- Minnetonka, October 31, 2017
- Saint Cloud, November 1, 2017

The focus group discussion outline included Medicare Supplemental coverage, in-home health care experiences and expectations, pricing for the Enhanced Home Care Program, and interest in having a benefit added to existing Medicare Supplemental plans.

OMS found that all the focus groups thought the enhanced home care services would be helpful for them or their friends and neighbors, especially those who live alone. Many of them believed these services would be quite expensive, so they were surprised at the affordable premium cost and saw that as a real value. Most participants thought the services should be part of all the plans so as to keep the cost down. Some wanted the ability to opt out, but as the group discussion continued, participants realized the impact of adverse selection and altered their opinion.

Based on the analysis of the overall results, the enhanced home care idea was well-received by participants in all groups. Participants seemed generally enthusiastic about the services it provided as well as how it would help them recover at home. One major theme that emerged was participant's feeling that the EHC filled an existing gap or need in coverage. Participants also reported that these gaps could often be addressed through services provided in the home and by family members, if available.

The most common concerns were related to the cost of the premium, with equal numbers concerned about the current cost as were concerned about the future cost. Some also expressed skepticism about whether the cost would truly cover the actual costs of these services. There were concerns that both the daily ($100) and lifetime ($50,000) benefit limits were too small. Participants seemed to believe that their $100 daily limit would not get them everything they might need. This raised several questions and concerns about what would happen to them if they needed to exceed the daily $100 limit. In other words, while overall the focus group participants liked the concept and recognized how beneficial it would be, it seemed likely to many of the participants that the individual service prices combined with concerns over the benefit amounts and fine print would limit the actual services and that led participants to lower their scores.

On the other hand, a number of participants disliked the idea of the program being mandatory with the majority of these participants disliking the "automatically enrolled" language in particular. Despite these concerns, participants in all groups gave the concept relatively high marks. In part that was due to a recognition by many of the participants that a voluntary benefit would cost more due to adverse selection. Several focus groups also recognized that these services would cost more if bought retail, instead of through an insurance mechanism.

In related public opinion research, the Associate Press in conjunction with the NORC Center for Public Affairs Research found in May 2018 that the most popular long-term care policy proposal to help finance long-term care was giving people the ability to obtain some long-term care coverage through a Medicare Advantage or supplemental insurance plan. This was favored by 81 percent of older adults. See https://www.longtermcarepoll.org/many-older-americans-open-to-using-technology-to-increase-access-to-care/

COST ANALYSIS OF ENHANCED HOME CARE BENEFIT

Quantitative analysis was completed to determine impacts of this new benefit on the state and its Medicaid budget including any cost savings found. The State of Minnesota contracted with the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota to create a Minnesota-specific model for analyzing all financing options for long-term care. The goal was to create a demographic and economic model for use in testing a variety of long-term care financing options to determine the costs, impacts on other funding sources and overall cost savings of various financing options. This model has been used to analyze both products included in the OYF product development work.

When the SHADAC model was used to analyze the enhanced home care benefit within Medicare, it found provided the following information:

- The cost of home care within Minnesota Medicare, benefits paid would be $990 million in 2015
- With no change in state policy, SHADAC projected total Medicaid spending on long-term services and supports would grow by more than 70 percent to $1.714 billion from 2015 to 2030 (assuming an expected annual inflation rate of 2%)
- The preliminary analysis projected that adopting the enhanced home care benefit as a supplemental benefit in all Minnesota Medicare Advantage and Medigap plans would save the state $268 million in Medicaid expenditures with projected Medicaid 2030 spending of $1.338 billion (assuming an expected annual inflation rate of 2%).

ACTUARIAL ANALYSIS FOR THE ENHANCED HOME CARE BENEFIT

The Minnesota Department of Human Services contracted with United Health Actuarial Services Inc. (UHAS) to estimate premiums for embedding a home care benefit in all Medicare supplemental plans, i.e., Medicare Advantage, Medicare Cost and Medigap plans. The leader of this project was Constance D. Rogers, FSA, MAAA, a UHAS consulting actuary with more than 25

years' experience with Medicare-related insurance. UHAS Senior Consulting Actuary Clark Heitkamp, FSA, MAAA, LTCP, contributed his expertise from more than 15 years' experience with long-term care insurance and also served as peer reviewer.

The State contracted with UHAS to estimate the premium for the proposed embedded home care benefit, referred to as the Enhanced Home Care package of benefits. The benefit would be available to Medicare beneficiaries who have a supplemental plan. For the most part, the EHC package is based on the current Minnesota Essential Community Services program, i.e., the service package mirrors that of the Essential Community Services program.

Because of the desire to increase long-term personal care available, the State also tested a variation of the benefit that would add Personal Care Assistance (PCA). This service would be authorized on an assessed need directly related to the condition for which the individual is receiving Medicare-approved home health care. It would provide short-term assistance with dressing, grooming, bathing, eating, transferring, positioning, toileting, all of which are known as Activities of Daily Living, or ADLs. The cost to cover PCA services is high, so the benefit design was reviewed with and without this coverage, but not as an option. Making this sort of benefit an elective dramatically raised the cost since relative healthy individuals typically underestimate their risk for needing long term care. Conversely, those most at risk would tend to opt for such coverage. This imbalance of those at risk versus those not at risk means utilization increases. Higher utilization means higher premiums. Individuals who do not perceive themselves as needing such services then either pass on purchasing the product or, if they do purchase, elect to drop out of the product instead of renewing.

Services are authorized for home care when Medicare approves home-based medical care and/or therapies. The same authorization would apply to the enhanced home care package as currently exists for Medicare home-based care. To meet this standard of Medicare-approved home medical care, the requirements are:

- The Medicare beneficiary must be under a doctor's care and have a plan of care.
- Doctor-certified need for certain kinds of care.
- Must be expected to improve in a reasonable period of time (which may have been eroded by recent federal case law) or employ a skilled therapist to prevent deterioration of condition.
- Doctor-certified to be homebound, likewise now reduced as a burden by case law.

The maximum benefit tested was up to $100 per day and up to a one-year benefit period, in other words, a maximum of $36,500. Since money can be viewed as a pool of benefits, if it is tapped at less than $100/day for 365 days, it will last longer. And, in fact the UHAS review of current programs operating in Minnesota suggests that the average utilization rate is much lower than this (more like $5 to $15/day). If the beneficiary changes plans, the lifetime maximum is portable. Once met, coverage does not reset even on a new policy or with a new carrier.

As discussed in more detail below, the estimated monthly premiums were quite low compared to other premium estimates researched for home care services, even including the more expansive Personal Care Assistance benefit. For Medigap the premium increase for the base case for the Essential Community Service package (without PCA) added $8.49/month more to the premiums. For Medicare Advantage without PCA, it was $6.79/month more. Adding PCA raised Medigap premiums by $21.38/month and MA premiums by $17.09/month. (See Appendix A for more premium information.)

Given other research done on home care premiums, these premium estimates are very attractive (see the working papers created by UHAS on current premiums for various home care options). A number of reasons might explain why premiums were lower than expected, e.g., the fact that a Medicare benefit trigger was used and not a long-term care trigger, the product is community age-rated, which spreads the cost, and there is substantial broad coverage in all Medigap and MA plans. Finally, since the benefit would be embedded in Medicare supplemental coverage, this limits members' opportunity to select against the benefit.

We have based the enhanced home care package on the ECS program that serves low need elderly who no longer are eligible for the full MA menu. This gives us some sense of how the benefit would be utilized or is currently utilized. As a matter of equity, it also gives Medicare beneficiaries access to the same sort of benefit available to some on Medicaid.

The enhanced home care services would need to be approved by a licensed provider (typically the lead physician), so these would be controlled as other Medicare services. They would be for low need seniors who are temporarily in need of help with household tasks but will most likely be able to do those once they recuperate from surgery or other conditions.

We have also designed this benefit so it mostly avoids overlap with those who own long-term care insurance policies. While small (somewhere in the 10% range), we did not want to duplicate that insurance. It should be noted that those with LTC insurance policies do not become eligible for help from their policy until they are really unable to handle 2+ ADLs and pass a waiting period (usually 90 days, but could be longer), so there is also less overlap even if someone could trigger both.

The actuarial analysis of packages tested both ECS alone as well as ECS plus PCA services. We also tested different dollar amounts, caps and other restrictions or limitations. While not wanting to erode the value of the product, we had to make every effort to assure affordability.

Under the contract with the State, UHAS conducted the actuarial analysis and produced the report: *Minnesota DHS Actuarial Analysis of New Home Care Benefit Embedded in Medicare Supplement Plans in Minnesota* (October 2017).

UHAS was the second actuarial firm to examine the general concept of adding long-term care services to Medicare supplemental plans. In 2014 the actuarial firm of Milliman performed a

review of a more extensive benefit that would have provided long-term care services (similar to long-term care insurance benefits) to Medicare supplemental products, on a voluntary basis.

The prototype that UHAS reviewed would instead embed an enhanced nonmedical home care benefit in all Medicare Advantage and Medicare Supplement plans sold in Minnesota. It would not be voluntary, but rather be a mandated benefit. This benefit would be paid through a slight increase in the premium charged anyone purchasing supplemental plans.

Enrollment is automatic in that the benefit would be imbedded in all Medicare Advantage plans and Medigap policies sold in Minnesota. Individuals who are dually eligible for Medicare and Medicaid would not be included (partly because the core ECS benefit is already available to them as part of the Elderly Waiver services for which they are eligible). Persons on Medicare by reason of disability or ESRD are included if they purchase a supplemental policy (UHAS found little price impact by including persons under age 65). No provision for an opt-out would be offered unless it is required by state/federal approvers.

Table 1. ENHANCED HOME CARE BENEFIT DETAILS

ELEMENT	BENEFIT SPECIFICATIONS FOR BASE PLAN
Eligibility	• Benefit would be embedded in all: ○ Medicare Advantage (MA) plans ○ Advantage Cost plans (as long as they are available) ○ Medicare supplement (Medigap policies) This would include all the policies sold in Minnesota by carriers whether domiciled inside or outside Minnesota
Overall Benefit design	• Main elements of the benefit are the services included in the Minnesota "Essential Community Services" package: • personal emergency response system • homemaker services • chore services • training and education of family caregivers • home delivered meals • adult day services • service coordination (aka care coordination) • community living assistance (help in coordinating and using a package of services in order to stay at home). • some level of personal care services, the kind provided by PCAs or similar universal workers who may be recruited from an individual's natural helping network (Note, this benefit is not included in the ECS package.)

NOTE: The "Essential Community Services" Program is one that the state now funds and offers to seniors who are no longer eligible for Medicaid because of low need, but who need some support in order to stay in their homes. For more, see Essential Community Services Bulletin, DHS (2014), at http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_176053

Other Benefit Design. The benefit period would be no more than 365 days if the benefit is used at the full rate.

- The period would be cumulative (not consecutive).
- Daily coverage would either be up to $100/day, and this would create a benefit pool of $36,500 (which is also the lifetime cap). Another variant that tested well was $50,000 lifetime cap and we may well explore a higher amount (e.g., $100,000) given how well these tested.
- Benefit has no vesting period, i.e., period when coverage is not available until enrollee has been member for specified period of time.
- There would be a 90-day elimination period in the current design, i.e., an enrollee has to be eligible for 90 days before the benefit can be accessed.
- The Personal Care Assistance services include the following:
    - Activities of daily living (e.g., eating, toileting, dressing, bathing, transferring, mobility, and positioning);
    - Complex health-related functions;
    - Instrumental activities of daily living (such as meal preparation, managing finances, shopping for essential items, performing essential household chores);
    - Observation and redirection of behavior.

It is not intended that PCA services will be covered to support members with chronic, ongoing deficiencies with ADLs. Such coverage is beyond the scope of the proposed EHC package and was not included because it would be expected to increase the cost of providing the EHC package of services. Instead, such coverage is also available through long-term care insurance.

UHAS was very conservative about the PCA addition. Their report states: "We have some concerns that coverage for PCA services will create induced demand for such services, as this is a common dynamic related to insurance coverages." Without PCA coverage, a family member may have been quite willing to assist a beneficiary at home but once it is added they may let insurance cover it." Thus, PCA services may be used more often and more intensely than usage or experience previously reported in existing MN government programs.

Pricing. Estimated premiums were calculated on a monthly basis. This was done with and without persons under age 65. To address over-utilization, there were scenarios where the plan paid only 50 percent or 75 percent of claims involving the personal care services. (That would mean the individual had either a 50 percent or 25 percent co-insurance amount to cover.)

Premiums were developed based on a target lifetime loss ratio of 75.0% for Medicare Supplement and 80.0% for Medicare Advantage plans (both regular MA as well as the cost variant of MA).

Estimated monthly premiums are shown in Attachment 1 in greater detail. Premiums are shown separately for Medigap and MA (including Cost) plans due to anticipated claim cost differences in the two product types.

The "Base" case called for coverage with no elimination period, $100/day benefit (that is to say, it is capped at $100), $36,500 portable lifetime maximum, and no vesting required. This was applied to the EHC package both with and without coverage for PCA services. In addition, UHAS was asked to produce premiums for several alternatives: with one-year vesting required; with three years vesting required; with elimination periods of 90, 120, and 180 days; and with a $50,000 portable lifetime maximum. The actuarial team looked at monthly premiums for all Medicare eligible ages. What is covered below therefore reflects the premiums that assume coverage for those under 65 are included. UHAS found the cost differential when those on Medicare under age 65 were included was negligible.

For Medigap plans, the base case ($36,500 a year) was that monthly premiums would be $8.49 for the ECS package. With PCA added it would be $21.38/month. With a $50,000 cap it was $8.54/month for ECS only and $23/month for ECS plus PCA.

For MA plans the base case was $6.79/month for ECS and $17.09 for both ECS and PCA. With a $50,000 cap it was $6.83/month for ECS only and $18.38/month for ECS plus PCA. Administrative costs were not included as they are so variable between carriers.

Because of cost concerns two variations of vesting periods were tested; that is the amount of time someone would have to be insured before they could access the benefit. A one year and a three year time period were modeled. It should be noted that vesting periods do not exist in Medicare (you are eligible on day 1) or in long-term care insurance. However, other products have this feature, for example vision and dental insurance.

More details on the various iterations can be found in the chart in Appendix A but are discussed below in some detail.

Vesting. UHAS considered whether requiring an individual to have been continuously enrolled in the same Medicare supplement plan for a 1-year or 3-year period would help reduce anti-selection. UHAS believed that it would. Vesting would also allow the Medicare supplement plan to collect premiums for the EHC coverage for a period of time before claims would begin to incur. However, the actuaries recognized that continuous enrollment in a given MA plan may be complicated by the more transient nature of those plans (particularly the Medicare Cost Plans).

For Medigap, there was some price value to adding a vesting period. Looking at the more extreme option, a 3-year vesting period, dropped the ECS about $2/month, to $6.58 (from $8.49). For ECS plus PCA the drop was greater. A 3-year vesting period dropped the monthly premium to $16.73 (from $21.38).

For MA, it was similar. With a 3-year vest it dropped it about $1.50 a month for ECS ($5.21 instead of $6.79). For ECS plus PCA it dropped to $13.26 (from $17.09).

The other potential control mechanism was to add an elimination period. Three variants were examined: 90 days, 120 days and 180 days. It should be noted that elimination periods are typical in long-term care insurance, but not Medigap (or Medicare).

Elimination Periods. UHAS did find that benefit elimination periods would help control anti-selection. However, it is their opinion that long elimination periods are contrary to the stated purpose of the EHC coverage: keeping people healthy at home. If an individual, for example, would be advantaged by receiving home-delivered meals, but chose to forgo such services for the first 90, 120, or 180 days, the individual's health may be comprised. In such a case, the elimination period would actually subvert the overarching goal of the EHC coverage.

The more extreme at 6 months (180 days) functioned similarly to a 3-year vesting period. Adding a 180-day elimination period to Medigap dropped the ESC package about $1.50/month, similar to a 3-year vesting period. The package with ECS and PCA dropped more, down to $17.51/month (it was $21.38 in the base case). For MA adding a 180-day elimination period also functions similarly to a 3-year vesting period for the ECS only package. For the combined ECS/PCA package, a 180-day elimination period dropped it to about $14/month instead of the base case around $17/month.

UHAS did not examine a scenario where both a vesting period and an elimination period were included. Since vesting periods and elimination periods require tracking and are not part of how Medicare operates, it is probably better to avoid these approaches to cost control. But they are options, particularly if the relatively richer package that combines both ECS and PCA is the one moving forward.

Lifetime Maximum. A fixed lifetime maximum is key to mitigating anti-selection in the opinion of UHAS. Without this coverage element, for example, a member who exhausts his/her lifetime maximum benefit in one health plan could easily enroll in a different MA plan at the next annual open enrollment window, thereby gaining access to an additional $36,500 (or $50,000) of benefit. Naturally, members making such a move would be those most likely to use the full maximum benefit. Therefore, although they recognized administrative challenges presented by this requirement, UHAS believed that it is essential to maintain reasonable pricing for the EHC package.

It should be noted that the difference between a $36,500 maximum and $50,000 is minimal. The reason the higher figure was tested was some thought that a fixed dollar amount might be easier to explain than one created by multiplying the daily cap ($100) by 365 days. In other portions of the research it was clear that many people would get nowhere near to using $100/day. Thus, the "pool of money" that was available to them would last much longer than a year. When all was said and done, the ECS option only added 6 cents/month to Medigap plans and 4 cents to MA for a $50,000 pool. When looking at both ECS and PCA, both MA and

Medigap went up more like a dollar and a half. This is due to the expectation that the services found in the PCA package are more extensively used and for a longer period of time than ECS alone.

Member cost-sharing (co-insurance). We considered a coverage option in which the member would pay 25 percent or 50 percent coinsurance for PCA services (only). Premiums for all considered options are included in the final UHAS actuarial report. UHAS considered whether requiring members to be responsible for some portion of covered charges, either by way of a dollar-value copay or a percentage of charges, would control over-utilization. In general, UHAS thought that cost-sharing for most EHC services would feel like "nickel-and-diming" the member. However, the idea of an initial deductible has some appeal, as does the idea of a percentage cost-share for PCA services, for which UHAS believes to be at the greatest risk for anti-selection.

Coverage for Members Over and Under Age 65. Individuals who are disabled or have End Stage Renal Disease ("ESRD") are eligible to enroll in Medicare. The state of Minnesota requires that all Medigap carriers issue coverage to disabled/ESRD beneficiaries on an open enrollment basis within 6 months of their enrollment in Medicare, but outside of that window Medigap carriers may decline to issue coverage to disabled/ESRD beneficiaries. Medicare Advantage plans are also required to enroll disabled/ESRD beneficiaries during the annual open enrollment period. So, although such individuals come with higher morbidity risks in general, extending the EHC coverage to disabled/ESRD beneficiaries enrolled in a Medicare supplement plan would be consistent with how Medicare operates in Minnesota. The limited one-time open enrollment window limits anti-selection risk for Medigap plans; and the annual open enrollment window limits anti-selection risk for MA plans.

As one can see in greater detail in Appendix A when adding controls such as vesting or elimination periods, the difference when including persons under 65 was sometimes only literally pennies per month particularly when looking at ECS only. When PCA was added it was higher but never more than a dollar more a month.

For the base case Medigap coverage for ages 65+ (only) for the ECS benefit (meaning without PCA) was $8.20/month compared to a price of $8.49 for coverage for all Medicare ages (meaning both over and under age 65). With PCA added coverage for ages 65+ was $20.60/month versus $21.38 for all ages.

For MA it was $6.57 for ages 65+ for ECS only compared to $6.79 when both under and over age 65 were covered. With PCA added, it was $16.48/month for 65+ versus $17.09 for both over and under age 65.

POTENTIAL SAVINGS AND BETTER OUTCOMES

In addition to Medicaid savings, which will be discussed in the section on SHADAC/Quantitative Analysis, the enhanced home care benefit is intended to provide savings across the entire payment system. The actuarial review by UHAS included only minimal efforts to identify savings to Medicare and/or the supplemental plans. From previous research (see below), it appears there are cost savings by providing these sorts of services to beneficiaries while still in their own home, mostly by diverting them from using more expensive services they would utilize if they were admitted to the hospital or nursing home. (As an aside, we know CMS is interested in savings across the health care continuum so it is not just Medicare savings that are relevant.)

It was beyond the scope of the actuarial contract to test for potential savings across all potential funding sources. However, it is the theory that if Medicare beneficiaries avoid more expensive care, they would be less likely to spend down and become eligible for Medicaid.

In terms of reduction in other claims (i.e., savings), UHAS stated:

> … It feels intuitive that the available of home supports services may reduce medical claims. Access to home-delivered meals, for example, may keep members generally healthier during recovery by virtue of receiving more consistent and more nutritive meals. Similarly, having an assistant to perform household chores or even to provide an informed review of the household layout, e.g., presence of tripping hazards, may prevent falls or other injuries and thereby avoid ambulance and/or emergency room claims and hospital admissions. There has been some research on the related topic of home-care services delaying admission to LTC facilities (assisted-living facilities and/or nursing homes). But we were unable to find any research that supported or quantified a reduction in medical claims resulting from members having access to home support services. Therefore, our pricing assumes no offset for this, and we suggest that this is an area for future study.
>
> ….."It has been posited that the availability of home support services may help Medicare beneficiaries remain healthier and in their own homes longer, thereby reducing claims for inpatient hospital services, skilled nursing services, and LTC facility/assisted living services. While we agree that this is a plausible hypothesis, we believe it would be unreasonably optimistic to ascribe firmly quantified assumed savings absent relevant data."

Having said that, OYF staff found two reports of note on this point.

In 2013, the consulting firm Univita (now known as the LTCG) conducted a study of the impact of long-term personal care on end-of-life medical care costs. Holland, et al, *Long term Care Benefits May Reduce End-of-Life Medical Care Costs* (Population Health Management, 2014), at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4273189/ . The study was conducted in the context of a large public employee benefits program which included both LTC coverage and

retiree medical coverage. The study found that, in the last year of life, access to personal care benefits reduced medical costs by 14 percent, reduced pharmacy costs by 13 percent, and reduced inpatient A-5 hospital admission costs by 34 percent. Somewhat offsetting these savings, skilled nursing costs increased by 16 percent.

The personal care benefits in the study referenced above would have been in the context of more intensive medical care than is likely to be the context of the Minnesota EHC benefits. Therefore, UHAS believes that the Minnesota EHC benefits may have a positive effect on medical and skilled nursing costs, but UHAS is not certain the effect would be as large as was demonstrated in the Univita study (the benefit provided in Minnesota would be smaller).

In addition, UHAS assumed that any reduction in inpatient hospital or skilled nursing facility claims would be proportionately much greater for MA plans than for Medigap plans, given the relative nature of those coverages. MA plans pay claims in place of original Medicare, so they would be expected to realize cost savings equal to roughly 80 percent of the forgone hospital or SNF charges. Medigap, however, pays only supplementary to original Medicare, so Medigap plans would be expected to realize cost savings equal to only about 20 percent of the forgone hospital or SNF services. In summary, any assumed hospital or SNF claim reduction is more significant for MA plans than for Medigap plans.

Another study by JEN Associates, Inc. (Cambridge, MA), *Massachusetts SCO Evaluation Nursing Facility Residency and Mortality Summary Report*, in 2015 is relevant. They examined Senior Care Options (SCO), an integrated Medicare-Medicaid managed care program offered to elderly dually eligible Massachusetts residents since 2004. MassHealth and the federal Centers for Medicare & Medicaid Services (CMS) contracted with qualified managed care plans to provide SCO enrollees with a unified benefits package that includes the full range of Medicaid and Medicare services plus additional, program determined, care support.

The study population consisted of community-dwelling Massachusetts residents enrolling in a SCO plan from 2004 through 2011… [N]ew SCO enrollees exhibit reduced nursing facility entry (12 percent reduction in NF residency months) and mortality (17 percent risk reduction in death rate) compared to non-enrollees, possibly due to the care improvements brought about by integrating Medicare and Medicaid services and adding special service types based on enrollee need.

Not reflected in the UHAS report, because information on this came later, was another study on savings found by intervening with LTSS. This is research on “CAPABLE” (Community Aging in Place – Advancing Better Living for Elders) at Johns Hopkins. Their pilot ran from 2012 to 2015 in Baltimore, Maryland. By coordinating care and adding a handyman who could fix all the little things at home that are needed to stay there, Medicare beneficiaries needing help at a 4 ADL deficiency level showed improvement to 2 ADLs. Costs were reasonable; 5 months in the program was about what a week in a nursing home would have cost. “Community Aging in

Place–Advancing Better Living for Elders, Johns Hopkins School of Nursing, accessed at https://nursing.jhu.edu/faculty_research/research/projects/capable/index.html

See also "The Case for a New Medicare Benefit Covering Home- and Community-Based Services," Commonwealth Foundation (June 27, 2018). Also the research article in Health Affairs here…https://www.ncbi.nlm.nih.gov/pubmed/27605633

Yet another study from the Medicaid Program's Money Follows the Person pilots is instructive. Results from the national evaluation of the Money Follows the Person (MFP) demonstration suggested that some Medicaid beneficiaries who used community-based long-term services and supports subsequently had shorter stays when they experienced a period of institutional care. Findings are relevant to how Minnesota is proceeding include the fact that early intervention with home and community-based services leads to better (and less institutionalized) outcomes:

- Very few beneficiaries who initiated their LTSS use in a community setting experienced a long institutional stay. In contrast, one-half to two-thirds of beneficiaries who initiated their LTSS in an institutional setting had a long stay.
- Early use of community-based services also appears to increase the likelihood beneficiaries will receive community-based LTSS when they transition back to the community. Beneficiaries who initiated their LTSS in a community setting and subsequently had a long institutional stay were three times more likely to transition to community-based LTSS compared to those who started their LTSS in an institution.
- Among older adults, beneficiaries who had started their LTSS in a community setting were significantly less likely to be reinstitutionalized after a long institutional stay compared to beneficiaries who started care in an institution.
- Stewart, Kate and Irvin, Carol, "Does Early Use of Community-Based Long-Term Care Services and Supports Lead to Less Use of Institutional Care?" National Evaluation of the MFP Demonstration by Mathematica Policy Research (2017) accessed at https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/hcbsasadiversiontoiltc.pdf

Finally, while not directly analogous, there was a study done examining savings to Medicare – including home health care – by those accessing private long-term care insurance for the Office of the Assistant Secretary for Planning and Evaluation (ASPE) within HHS. The study compared similar samples of Medicare beneficiaries with and without LTC insurance. although it is several years old, there is no reason to think the findings are any less valid, especially given more recent long-term care insurance products are more robust in proving a range of home care services (earlier polices inclined more toward only supplying home health care, which is what this study examined). Among their findings: "After accounting for the differences in the health and socio-demographic characteristics of the two samples, individuals who are receiving private long-term care insurance payments:

- are less likely to access Medicare financed home health aide services;
- have fewer visits and lower expenditures (i.e. $2,400 lower) for home health aide services;
- are just as likely to use Medicare skilled nursing services and have roughly similar expenditures; and
- use similar levels of facility-based skilled nursing services and inpatient hospital care.

Given the EHC product covers many of the same kinds of services (though not to the degree or intensity of LTC insurance), it seems fair to say that the use of and expenditures on the Medicare home health benefit should decline. Miller, J., Dimitrova, M.A., and Cohen, Marc, "The Impact of Private Long-Term Care Insurance Benefits on Selected Medicare Services," For the US Department of Health and Human Services (March 12, 2002). Accessed at https://aspe.hhs.gov/basic-report/impact-private-long-term-care-insurance-benefits-selected-medicare-services

SHADAC PROJECTION MODEL AND QUANTITATIVE ANALYSIS

As stated above, DHS contracted with State Health Access Data Assistance Center (SHADAC) at the University of Minnesota to create a Minnesota-specific model for analyzing all financing options for long-term care to determine their cost and their effect on other financing programs, e.g., Medicare, Medicaid, out-of-pocket expenditures and private insurance.

SHADAC, under a contract and in collaboration with the Minnesota Department of Human Services, developed a long-term services and supports (LTSS) projection model to assist the state with projecting the older population in Minnesota, their characteristics, their use of LTSS, and state spending on these services into 2020 and 2030.

The LTSS Projection Model has three main outcomes. The first is the projection of older Minnesotans who will require LTSS in 2020 and 2030. The second and third are the average and total costs to Medicaid to meet this demand.

The Minnesota LTSS Projection Model was used to estimate the effect of adding an enhanced home care benefit onto future LTSS costs incurred by Medicaid. The model allows users to choose from different levels of implementation (and take-up) of these policies. In particular, users will be able to choose whether the inclusion of a home care benefit in all Medicare supplemental plans is implemented or not. The scenario of status quo, i.e., no policy implemented, requires a projection of how many individuals would have a long-term care insurance policy. In addition, the model allows users to define different levels of Medicaid eligibility as changing economic conditions affect individuals' income, but also affect their medical expenses. Thus, the model allows for three scenarios of eligibility as well as projecting how many individuals will purchase Medicare supplemental plans.

Key modeling assumptions in the SHADAC baseline imputation of who currently has a Medicare supplemental product was based on data from the 2015 Minnesota Health Access Survey (MNHA). SHADAC then imputed probabilities for respondents who report having Medicare coverage and assigned Medicare supplemental coverage using these probabilities and control totals. In addition, SHADAC used 2015 baseline data on Minnesota residents from the American Community Survey (ACS) and data on state Medicaid expenditures on LTCSS from Minnesota's Medicaid Management Information System (MMIS). Other data sources used in the model include the national Health and Retirement Study and the Survey of Older Minnesotans.

SHADAC estimated that in 2015, approximately 679,788 older Minnesotans had Medicare supplemental plans, which represents 84.4% of the older population 65+. Nearly 90 percent of those aged 65+ have Medicare coverage.

SHADAC found that 54,773 Minnesotans made claims for LTSS they received at home or in nursing facilities from Medicaid in 2015 (their baseline year for determining utilization and costs). Approximately two-thirds of the population used HCBS services versus being in a

nursing facility (37,831 to 16,942) but two-thirds of the spending was nursing facilities and one-third was HCBS ($620 million to $371 million). In total they found that Medicaid spending on LTSS in 2015 was about $990 million.

SHADAC projects that if no policy changes are implemented by 2030, the number of Medicaid enrollees who are in nursing facilities will grow 12 percent to 19,000, whereas the number of Minnesotans using Home and Community-based Services (HCBS) will double – 104 percent growth – to 75,000. That means an estimated 94,000 citizens will receive Medicaid in 2030 compared to about 55,000 today. In dollar terms SHADAC projects that by 2030 Medicaid expenditures on LTSS will grow by 73 percent.

The 2015 baseline costs of Minnesota Medicaid LTSS for individuals 65 and older is $990 million. With no change in state policy, SHADAC projects total Medicaid spending on LTSS in 2030 to grow by more than 70 percent to $1.714 billion (assuming an expected annual inflation rate of 2 percent). Their preliminary analysis projects that adopting the Enhanced Home Care Benefit as a supplemental benefit to all Minnesota Medicare Advantage and Medigap policyholders would save the state $376 million with a projected 2030 spending of $1.338 billion (assuming an expected annual inflation rate of 2 percent). See Appendix B for the graphic on this data.

FEDERAL ACTIVITY AFFECTS MINNESOTA OPTIONS

Because Medicare is a Federal program, the ability of Minnesota to make any changes in coverage depend heavily on how the Federal government responds to our ideas. This is especially true pertaining to the Centers for Medicare and Medicaid (CMS). Moreover, separate legislation along similar lines has also been enacted that impacts our efforts.

Center for Medicare Medicaid Innovation (CMMI)

The Minnesota Department of Human Services submitted comments on a CMMI Request for Information (RFI) put out on September 20, 2017. Our comments related to Minnesota's efforts to expand coverage of services to Medicare, while others in the State submitted suggestions related to Medicaid.

We believed our proposal fit well with the fourth and sixth guiding principles enunciated by CMMI, namely:

- The fourth principle focuses on "Benefit design and price transparency – Use data-driven insights to ensure cost-effective care that also leads to improvements in beneficiary outcomes." We believe that our proposal will deliver better care at a modest cost (and could save money within Medicare).
- The sixth guiding principle "Small Scale Testing" is also applicable since we envision our concept as a state-wide test in Minnesota. While at first blush, that might seem larger than tests with specific carriers or health plans, this proposal really works best when offered to ALL beneficiaries with supplemental coverage of some sort within the State.

We also addressed their language around potential models. While we are testing both types of Medicare supplement insurance (Medigap and MA), the fifth potential model -- Medicare Advantage (MA) Innovation Models – is relevant here. We know CMS is currently implementing the MA Value-Based Insurance Design (VBID) model. That model provides benefit design flexibility by providing beneficiaries with high-value services. We also know they are interested in reaching into more states with that. We believe the VBID could be modified so it provides the flexibility for Minnesota MA plans to include our benefit design.

Then, on February 1, 2018, CMS put out advance notice of changes to 2019 Medicare Advantage plans. Of interest to Minnesota were provisions related to Health Related Supplemental Benefits. See https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-02-01.html

Pages 182-183 contain the pertinent language. As noted by CMS, until now they have "not previously allowed an item or service to be eligible as a supplemental benefit if the primary purpose is daily maintenance." As Minnesota and other parties have established, there are services of non-medical benefits so closely related to medical care that excluding them is perverse, especially since they save health care dollars. (The lead example used by CMS was fall prevention devices.)

Of importance, CMS intends to expand the scope of the primarily health-related supplemental benefit standard. Section 1852(a)(3) permits the offering of "healthcare benefits" as supplemental benefits but does not define the term. We therefore have authority to interpret the term more broadly than we have in the past, to permit MA plans to offer additional benefits as "supplemental benefits" so long as they are health care benefits. Under our new interpretation, in order for a service or item to be "primarily health related," it must diagnose, prevent, or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization. Any supplemental health benefit proposed by an MA organization must be reasonably and rationally encompassed by this standard. This will allow MA plans more flexibility in offering supplemental benefits that can enhance beneficiaries' quality of life and improve health outcomes.

CMS further articulated that whether an item or service qualifies would be determined by "national typical usages…and by community patterns of care." They further state that the benefit or service must be medically appropriate and ordered by a licensed provider as part of a care plan. The Minnesota benefits also are triggered by providers certifying medical appropriateness. Thus, in terms of the Minnesota proposal, there should be no problem with how the benefits are accessed.

CMS followed this up in their April 2018 Call Letter. They confirmed that MA plans may offer such non-medical benefits: "These additional supplemental benefits will be qualitatively different than the supplemental health care benefits that MA plans may currently offer and may continue to offer to enrollees who are not chronically ill. In addition, it provides authority for the waiver of uniformity

requirements "only with respect to supplemental benefits provided to a chronically ill enrollee.''

The 2019 plan year Call Letter may be accessed at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html (April 2, 2018). See also the Federal Register notice at https://www.gpo.gov/fdsys/pkg/FR-2018-04-16/html/2018-07179.htm (page 16480). NOTE: CMS and others sometimes use the terminology "social determinants of health," meaning non-clinical matters such as housing, income and education that impact health care, often as much as the actual health status of the individual.

Examples used by CMS for what a Medicare Advantage plan could pay for include:

- In-home support services performed by a personal care attendant or by another individual that is providing these services consistent with state requirements in order to assist individuals with disabilities and/or medical conditions with performing ADLs and IADLs as necessary to compensate for physical impairments, ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization. Services must be performed by individuals licensed by the state to provide personal care services….

    - Adult day care and other services provided outside the home, such as assistance with ADLs/IADLs. Provided by staff whose qualifications and/or supervision meet state licensing requirements.
    - Transportation to obtain Medicare authorized and supplemental benefit items and services. The transportation offered must be used exclusively to accommodate the enrollee's health care needs. Transportation for non-medical services, such as groceries and banking, is not permitted. (Note: plans can already pay for some transportation needs, for instance, ambulance services for emergencies.)
    - Making specific, non-structural, non-Medicare-covered safety devices to prevent injuries in the home and/or bathroom. In addition to providing and installing appropriate safety devices, the benefit may include a home and/or bathroom safety inspection conducted by a qualified health professional, … to identify the need for safety devices and/or modifications, as well as the applicability to the specific enrollee's needs and home.

See Kilbourne and Alston, "Medicare Advantage Benefit Flexibility," CMS (May 2018), accessed at https://images.thinkadvisor.com/contrib/content/uploads/documents/415/2018-5-9-medicare-flex.pdf

For our purposes, it will be important to know what the benefits/services will look like as health plans roll them out. On the one hand, the Minnesota EHC proposal would seem to qualify since the suggested package of benefits and services – respite care for example -- have been established to aid individuals in a way appropriate to how CMS would view the matter. (CMS explicitly decided not to offer an explicit definition of supplemental benefits. That means Minnesota -- and MA plans in Minnesota -- may do so themselves.)

On the other hand, the Minnesota proposal has a set list of benefits that might not contain ideas the health plans want to add. It is also a lot longer list of benefits than what health plans may want to deal with in rolling out new benefits. In the section below on national MA plan activity one can see both issues crop up: Some benefits are benefits Minnesota has not added. While at the same time the number of new benefits added by plans is two or three per plan, not the eight found in the Minnesota proposal.

Chronic Care Act

The CHRONIC Act (S. 870) is legislation aimed at improving the delivery of Medicare to those with the most critical health needs, often chronic illness. CHRONIC is of importance here because of two sections. Section 301 provides authority for CMMI to test some ideas via their Value-Based Insurance Design Model. One can read that language as allowing MA plans to supply additional benefits to the chronically needy. Section (h) (2) lists states where the model may be tested and Minnesota is not one of them, though it is not clear that this would prohibit the State from being included as a pilot via the VBID or some other model. The legislation was moved over and included in the Bipartisan Budget Act of 2018 (H.R. 1892), which was signed into law February 9, 2018. https://www.scribd.com/document/371051819/Bipartisan-Budget-Act-of-2018#from_embed

As of this writing, CMS has not released information on how they will reconcile CHRONIC with their own Call Letter approach to adding such benefits. To some extent it might not be important for Minnesota's approach since CHRONIC is aimed at a much frailer population. The theory behind Minnesota's proposal is intervention at an earlier stage, before frailty becomes severe. Thus, the approaches taken by health plans operating under the Call Letters will likely be of more interest to the State. CHRONIC coverage options start for the plan year 2020.

Original Medicare/Medigap

Medicare supplemental plans are not addressed but Minnesota has independent authority to make plan changes pertaining to them. This market has been declining in all states and is at a very low penetration rate in Minnesota (about 13 percent). Just as with MA plans, there are legislative changes coming. MACRA -- the Medicare Access and CHIP Reauthorization Act of 2015 – eliminates first dollar coverage of Part B deductibles for newly eligible beneficiaries starting January 2020. While this should make Medigap less expensive (because the costs are shifted to the beneficiary), it is not clear what the price impact will be, whether this will erode consumer interest, or just the mere fact the products are changing will create market confusion.

For purposes of the EHC benefit issue, we need to remember that in order to get home care or other non-medical benefits into these policies it would be necessary to change Medicare supplemental plan laws. Minnesota is one of three waiver states that allows us to do this rather than follow the NAIC model. Minnesota is committed to changing its Medicare supplement laws if it concurrently can have leeway through Medicare Advantage (MA) and CMS

to make those same changes in those plans. Having CMS as a partner in talking to the health plans would be of immense value. DHS believes we need to get CMS to work with the State to develop a coordinated effort to bring this concept simultaneously to both the Medigap and the MA plan customers.

National Medicare Advantage Plan Activity

How Minnesota approaches adding EHC to health plans in the state is important because that impacts how the health plans will approach the new environment opened up to them by CMS last year.

While everyone expects the 2020 plan year to be the time when plans really step up to the plate, there has been a surprising amount of activity in the works for 2019. Estimates for the 2019 plan year are that about 1.5 million people nationwide (7.5 percent of those in MA plans) will have access to some of these new product features.

Avalere Health, a health care consulting firm, recently analyzed plan submissions to CMS and determined that the four most common new MA plan offerings under the new authority were:

- Caregiver support services (429 plans)
- In-home support and personal care services (107 plans)
- Social worker phone line (80 plans)
- Adult day care (26 plans)

Their analysis found that close to 10 percent of plans (429 plans) will offer caregiver support services, e.g., counseling and training courses for caregivers. Other supplemental benefits offered for the first time include in-home support and personal care services, social worker phone line, adult day care, among others. They also found significant increase in supportive services already allowed to some extent, including home modification and transportation. Sean Creighton and Joanna Young, "Beneficiaries Will See a Jump in New Supplemental Benefit Offerings in 2019," Avalere (October 19, 2018), at http://avalere.com/expertise/managed-care/insights/medicare-advantage-beneficiaries-will-see-a-jump-in-new-supplemental-benefi

An analysis by Howard Gleckman of the Urban Institute found there were two different benefit styles or models. Anthem, for instance, will offer consumers in six southern or Midwest states a plan called Essential Extras. In some cases, the major part of the added benefits will be available only to enrollees in a Special Needs Plan (SNP) managed care arrangement. In other states, members can choose one of the following additional annual benefits at no extra cost:

- Up to 16 home delivered "healthy' meals per health event, or no more than 64 meals per year. A qualifying health event may be a hospital discharge, or if a member is very overweight or has severe uncontrolled diabetes. Up to 60 one-way trips per year to health-related appointments or other covered services.
- Up to 124 hours of support from a home health aide or similar assistance.

- A $500 allowance for safety devices such as shower stools, reaching devices, or temporary wheelchair ramps.
- Up to 1 visit per week for adult day services.
- Up to 24 acupuncture and/or therapeutic massage visits.

A different model is in play in other states such as SCAN in California where members will be able to access a limited number of home delivered meals, in-home support, respite care, adult day services, transportation, a fitness program, acupuncture and/or therapeutic massage for pain management, and an outreach program aimed at addressing isolation and loneliness. Howard Gleckman, "What A Medicare Advantage Personal Care Benefit Looks Like," Forbes October 5, 2018, assessed at https://www.forbes.com/sites/howardgleckman/2018/10/05/what-a-medicare-advantage-personal-services-benefit-looks-like/#700f00696066

These plan benefits are deliberately narrow in scope. As was true in the report for Minnesota back in 2014 when the State was looking at adding a true long-term care benefit, it is costly to do more. Adding true LTC would be expensive so it could drive some consumers away. The ones that would NOT be driven away would be ones expecting to use those services. This introduces adverse selection. Traditional tools like underwriting or rating classes cannot be employed in MA. A possible tool that might be used would be waiting periods. CMS traditionally has not favored this. An additional wrinkle is confusion with true LTC insurance. See Chris Giese and Allen Schmitz, "Are Medicare Advantage plans ready for the high costs of long-term care?" Milliman (June 12, 2018). http://us.milliman.com/insight/2018/Are-Medicare-Advantage-plans-ready-for-the-high-costs-of-long-term-care

For more on the operational steps health plans must consider see Silvers, Fields, Kytonen and Meier, "Medicare Advantage Flexibility, Improving Care for Seriously Ill Beneficiaries," Health Affairs (July 6, 2018).

One thing should be added here. It is not just the health plans that are active in discussing whether and how to add non-medical services to MA plans. For instance, the Bipartisan Policy Center suggested that CMS partner with the Administration for Community Living to bring in the Triple AAA organizations and other community groups currently funding these sorts of services to existing populations:

- Establishing a CMS-approved model contract between plans and community-based organizations can help facilitate referral and reimbursement by sending a signal that CMS encourages these arrangements. Contracting could accelerate and promote community organizations as critical partners in the delivery of care.

"Improving Care for Patients with Serious Illness: Part One" Bipartisan Policy Center (October 2018) at page 12. See https://bipartisanpolicy.org/wp-content/uploads/2018/10/Improving-Care-for-Patients-with-Serious-Illness-Part-One.pdf See also the earlier BPC report, "Improving Care and Lowering Costs for Chronic Care Beneficiaries: Implementing the Bipartisan Budget

Act, Bipartisan Policy Center (August 2018). Another organization – the Coalition to Transform Advanced Care – that has been involved with these issues has similar ideas.

LTQA Research – Plan Views and Responses to MA New Supplemental Benefit for 2019

The Long-Term Quality Alliance (LTQA) surveyed a selection of MA organizations regarding their response to the opportunity in the 2019 Call Letter to offer a "flexible" supplemental benefit. The intent of the project was to identify challenges MA organizations faced in developing a bid and recommend improvements for CMS in the 2020 bid cycle. See LTQA, "Medicare Advantage's New Supplemental Benefit for 2019: Plan Views and Responses" (November 14, 2018), at http://www.ltqa.org/ma-new-supplemental-benefit/

The plans interviewed were "generally enthusiastic about the opportunity to add benefits that could provide greater non-medical supports and services for their members with complex care needs. They welcomed the idea of greater flexibility to tailor benefits to individual needs." Whether they submitted in 2019 or not, ALL were planning to do so in their 2020 bid response. The major reason half the plans did not submit anything for 2019 was the lack of time to develop the benefit. Those that did add benefits for 2019 viewed this as a pilot.

The MA plans that are offering benefits appear to be focusing on attracting and managing members with complex care needs and in testing benefits that could have the greatest impact on their outcomes and costs. MA plans also believe there will be a competitive advantage by offering the supplemental benefit this coming plan year (or at least avoiding a competitive disadvantage). For a variety of reasons plans also felt they could do something because they had a greater financial margin going into 2019.

For those plans not going forward, one issue that cropped up was that CMS rejected some of the proposed benefits either in preliminary discussions or in bid reconciliation. Another reason was the uncertainty about how to communicate to their members the details of supplemental benefits that were not universally available. Additionally, some plans worried about how the benefits might vary year to year, thus affecting members who come to rely on that benefit.

For plans that did go forward, the benefits that were included were generally limited and considered by the plans to be "proof of concept" especially since the plans often had no data to design and price these new benefits. Examples include: limited personal care and homemaker services, meal delivery for members transitioning from institutions, adult day services, and non-emergency transportation.

Selected issues for future consideration from the LTQA report:

- MA plans have two choices in how they view these benefits. They could offer them in a way that is tailored to meet individual needs for specific conditions versus setting up the benefit so it is provided to all who qualify. MA plans that are participating in the value-based insurance design (VBID) demonstration "see this as an alternative for providing

non-medical benefits for enrollees with specific conditions. … The plans can include Part D drug benefits in VBID benefits that are targeted to specific diseases and conditions.

- Adverse selection is a risk for plans that are trying out benefit designs that manage care for people with complex care needs. Attracting too many members with high health care costs without sufficient risk adjustment will be problematic in the long run.
- Related to this is the fact that many MA plans lack the necessary data for their actuaries to link any savings to the cost of the benefits. This is true not just in the abstract (the benefit yields savings), but also when one has to factor in the possibility there will be a greater population in their plan who are attracted by these benefits thus leading to lower overall market profitability.
- "MA plans do not typically maintain networks of non-medical service providers or have relationships or experience with community-based organizations (CBOs) that would provide these services. In deciding on which benefits to offer, plans had to ensure service providers were available in the relevant markets to serve their members throughout the service area. Plans also had to ensure they were selecting CBOs able to meet their contracting requirements and provide high-quality services. Plans leveraged relationships with service providers in their organization's SNPs and MLTSS plans. They also relied on internal personnel who specialized in vendor contracting, or engaged experienced third parties to ensure the capacity and quality of potential providers.
- "For MA plans, targeting particular benefits to a specific subgroup of members is novel. The plans have to put a process in place to determine when a member meets the criteria for receiving the benefit. The plans referenced a variety of approaches for determining eligibility, such as adapting an existing algorithm currently used to identify members in need of care management or relying on primary care providers to identify members who would benefit from services. Plans expect members to self-identify a need for the benefits once information on the supplemental benefits is communicated.
- "Several of the plans noted that there were substantial marketing and communication challenges with a supplemental benefit that is not universally available and may not have value for a large proportion of plan enrollees.
- "Plans were unclear about the outcomes CMS expected to achieve or the measures that would be used to evaluate the success of this new type of supplemental benefit…. Plans mentioned tracking metrics on hospital readmissions, member satisfaction, and self-reported improvement, and initiating longer-term studies to gauge the effect of specific benefits on cost of care and outcomes."
- There was also interest in focusing beyond members with chronic conditions: "Focusing on medical diagnoses as a condition for receiving non-medical services leaves out a population with functional limitations for whom services and supports could prevent medical events. CMS should see if there is a better way to incorporate functional limitations (defined in terms of need for assistance with activities of daily living (ADLs))

to get beyond diagnoses and medical conditions and broaden the population that can be served."

CONCLUSIONS AND NEXT STEPS

This effort has identified the estimated individual premium cost and current consumer interest in the proposed enhanced home care benefit to be added to Medicare supplemental plans.

- Approximately 80 percent of Minnesota Medicare beneficiaries would be reached through the embedding of these home care services (when eligibility requirements are met).
- Only if the benefit was added to Medicare itself would it reach 100% of the State's Medicare population.
- The premium estimates developed by UHAS for these home care services were seen as affordable by many of Minnesota's Medicare beneficiaries, as represented in the medicare focus groups. Obviously, there are lower income older adults for whom any premium increase is a concern.
- A majority of the Medicare beneficiaries who attended the focus groups saw themselves or their friends (especially those who were alone) using the services included in the package.
- A majority of the older adults in the focus groups were surprised at the affordable premiums and the value of the services to help them remain in their homes.
- The add-on of home care services to the supplemental plans increases the private spending for long term care services, and does not add to the state or federal spending.
- We will need to monitor changes for the 2020 plan year. At that time the CHRONIC Care Act expands the MA-VBID program to all 50 states and federal law (MACRA) bans the sale of new first-dollar coverage in Medigap plans.

Next steps include more detailed discussions about how and when the enhanced home care benefit could be made available to beneficiaries. Other next steps involve the different changes needed at the state and federal level. Minnesota as a waiver state could proceed on its own to implement this for the Medigap program. Indeed, there are four existing benefits that have been added through the years to Medigap in Minnesota. However, CMS must approve any plan for the changes Minnesota would require to implement this new benefit in MA plans. Even if there is agreement to move forward by all parties the timing to do so together may prove daunting.

For the MA plans the issue may well be how extensively health plans move on their own to add these home care and other supportive services. If the market is indeed going in that direction it might mean state efforts are not needed. Or, if needed, the best strategy might be to make certain all MA enrollees have access to these kinds of benefits and not just a limited set of plans or plan offerings.

It goes without saying that another challenge is buy-in from various parties. Any changes made to insurance programs are highly sensitive. This is one reason for moving forward with both Medigap and MA. If we only went with one or the other it might raise competitive and anti-selection issues.

Related to this, Minnesota is not alone in identifying the shortfall in the CMS (and Congressional) action that is limited only to MA plans. Witnesses at a congressional hearing earlier this year pointed out that Original Medicare should have similar benefits or the playing field would be uneven. "Hearing on the Medicare Advantage Program," Ways & Means Health Subcommittee (May 8, 2018), accessed at https://waysandmeans.house.gov/event/hearing-on-the-medicare-advantage-program/ See also Allison Bell, "Maybe Traditional Medicare Should Cover Chronic Care: Hearing Witnesses," Think Advisor (May 8, 2018).

In terms of moving forward in the State, issues to consider include:

- Notwithstanding many meetings with plans, it still likely that further meetings are needed to see if there is general support for moving in the direction of implementation of a pilot.
- What do we need to do to gain support of the health plans? See Appendix C for issues brought forward for discussion with the plans.
- How should we move forward to continue engaging the Minnesota Department of Commerce that is essential for dealing with any changes to Medicare supplement insurance.
- We have to be cognizant that MA Cost plans are going away (for reasons unrelated to Minnesota), so timing for our proposal while this is happening needs to be sorted out.
- Likewise, Medigap first dollar coverage rules are changing as of 2019 so another market event needs to be factored in.
- We will follow up on our submission to CMS. It should be noted we had spoken to them a year ago and they were generally supportive. Their main hesitation was an unclear legal path to approving what the State was pursuing.
- We have been contacted by other states and organizations regarding our work. How do we leverage this?

Additional Considerations for Actuarial or Other Review

The following are some considerations listed in the project Request for Proposal as being of interest if the timeframe and budget permitted. They did not fit into the work done by UHAS in the fall of 2017, but we continue to be interested in exploring some or all of these questions. In addition, the change in policy by CMS to allow a new array of services opens up the field.

Some possible research questions that might be addressed:

- What would be the cost impact of the following: Managed Care trigger (at discretion of insurer via care manager), 5-year vesting, and other additional mechanisms to decrease utilization if it proves necessary to reduce the cost impact of these proposals?

- What about other caregiver related benefits or services; in other words, what other supportive services might make sense (for instance transportation)?

- What would be the total and average premium costs of this program if it were offered as a state-sponsored benefit either for all Medicare beneficiaries or all age-65 and older?

- What would be the cost of incorporating the EHC benefits in Medicare versus embedding the benefits in Medicare supplemental plans?

APPENDIX A – Various iterations of premiums by UHAS

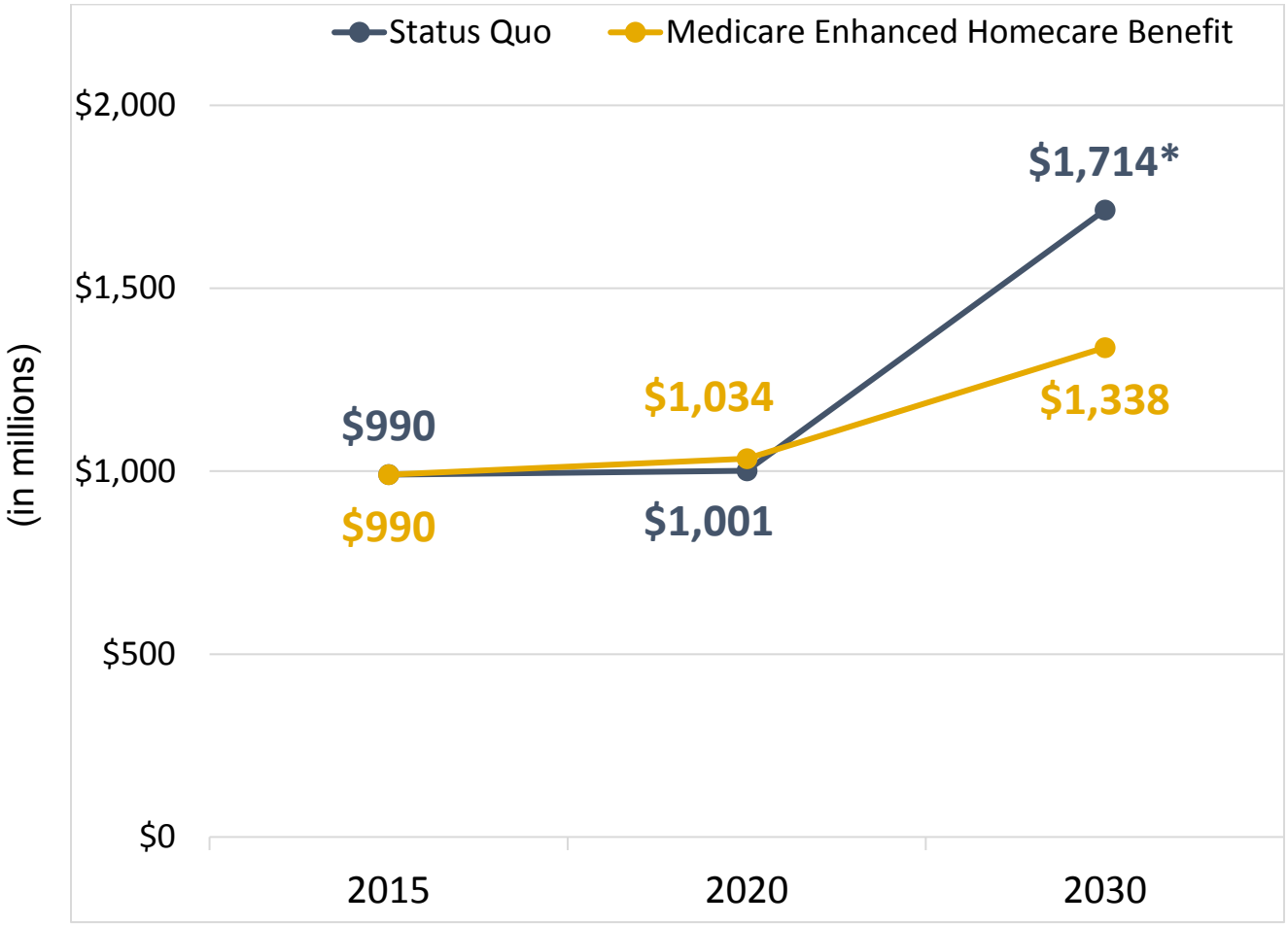
	Monthly Premiums for EHC Benefits							
Scenario	Coverage for All Medicare Eligible Ages				Coverage for Entry Ages 65+ Only			
	Aggregate				Aggregate			
	Without PCA	With PCA	With PCA at 75%	With PCA at 50%	Without PCA	With PCA	With PCA at 75%	With PCA at 50%
Base	$ 7.52	$ 18.92	$ 16.07	$ 13.22	$ 7.26	$ 18.23	$ 15.48	$ 12.74
1-yr Vesting	$ 6.92	$ 17.47	$ 14.83	$ 12.20	$ 6.70	$ 16.87	$ 14.33	$ 11.78
3-yr Vesting	$ 5.82	$ 14.81	$ 12.56	$ 10.32	$ 5.65	$ 14.34	$ 12.17	$ 10.00
90-Day EP	$ 6.78	$ 17.04	$ 14.48	$ 11.91	$ 6.55	$ 16.42	$ 13.95	$ 11.49
120-Day EP	$ 6.56	$ 16.50	$ 14.01	$ 11.53	$ 6.34	$ 15.89	$ 13.51	$ 11.12
180-Day EP	$ 6.16	$ 15.49	$ 13.16	$ 10.83	$ 5.95	$ 14.93	$ 12.68	$ 10.44
$50,000 Pool	$ 7.56	$ 20.35	$ 17.15	$ 13.96	$ 7.30	$ 19.61	$ 16.53	$ 13.46
Scenario	Medigap				Medigap			
	Without PCA	With PCA	With PCA at 75%	With PCA at 50%	Without PCA	With PCA	With PCA at 75%	With PCA at 50%
Base	$ 8.49	$ 21.38	$ 18.16	$ 14.93	$ 8.20	$ 20.60	$ 17.50	$ 14.40
1-yr Vesting	$ 7.82	$ 19.74	$ 16.76	$ 13.78	$ 7.57	$ 19.06	$ 16.19	$ 13.31
3-yr Vesting	$ 6.58	$ 16.73	$ 14.20	$ 11.66	$ 6.38	$ 16.21	$ 13.75	$ 11.30
90-Day EP	$ 7.66	$ 19.26	$ 16.36	$ 13.46	$ 7.40	$ 18.56	$ 15.77	$ 12.98
120-Day EP	$ 7.42	$ 18.64	$ 15.84	$ 13.03	$ 7.17	$ 17.96	$ 15.26	$ 12.56
180-Day EP	$ 6.97	$ 17.51	$ 14.87	$ 12.24	$ 6.73	$ 16.87	$ 14.33	$ 11.80
$50,000 Pool	$ 8.54	$ 23.00	$ 19.38	$ 15.77	$ 8.25	$ 22.16	$ 18.68	$ 15.21

APPENDIX A (CONTINUED)

Scenario	Monthly Premiums for EHC Benefits							
	Coverage for All Medicare Eligible Ages				Coverage for Entry Ages 65+ Only			
	Individual MA				Individual MA			
	Without PCA	With PCA	With PCA at 75%	With PCA at 50%	Without PCA	With PCA	With PCA at 75%	With PCA at 50%
Base	$ 6.61	$ 16.64	$ 14.14	$ 11.63	$ 6.39	$ 16.05	$ 13.63	$ 11.22
1-yr Vesting	$ 6.06	$ 15.30	$ 12.99	$ 10.68	$ 5.86	$ 14.77	$ 12.55	$ 10.32
3-yr Vesting	$ 5.21	$ 13.26	$ 11.25	$ 9.24	$ 5.06	$ 12.84	$ 10.89	$ 8.95
90-Day EP	$ 5.97	$ 14.99	$ 12.74	$ 10.48	$ 5.77	$ 14.46	$ 12.28	$ 10.11
120-Day EP	$ 5.78	$ 14.51	$ 12.33	$ 10.15	$ 5.58	$ 13.99	$ 11.89	$ 9.79
180-Day EP	$ 5.42	$ 13.63	$ 11.58	$ 9.53	$ 5.24	$ 13.14	$ 11.17	$ 9.19
$50,000 Pool	$ 6.65	$ 17.91	$ 15.09	$ 12.28	$ 6.43	$ 17.26	$ 14.56	$ 11.85
Scenario	Group MA				Group MA			
	Without PCA	With PCA	With PCA at 75%	With PCA at 50%	Without PCA	With PCA	With PCA at 75%	With PCA at 50%
Base	$ 6.97	$ 17.54	$ 14.90	12.25	$ 6.74	$ 16.91	$ 14.37	$ 11.82
1-yr Vesting	$ 6.38	$ 16.12	$ 13.68	11.25	$ 6.18	$ 15.57	$ 13.22	$ 10.87
3-yr Vesting	$ 5.49	$ 13.97	$ 11.85	9.73	$ 5.33	$ 13.53	$ 11.48	$ 9.43
90-Day EP	$ 6.29	$ 15.80	$ 13.42	11.04	$ 6.08	$ 15.23	$ 12.94	$ 10.66
120-Day EP	$ 6.09	$ 15.29	$ 12.99	10.69	$ 5.88	$ 14.75	$ 12.53	$ 10.32
180-Day EP	$ 5.72	$ 14.36	$ 12.20	10.04	$ 5.53	$ 13.85	$ 11.77	$ 9.69
$50,000 Pool	$ 7.01	$ 18.87	$ 15.90	12.94	$ 6.78	$ 18.19	$ 15.34	$ 12.49

APPENDIX B

SHADAC Medicaid Savings for the Medicare Enhanced Home Care Option



* Estimated 22% savings of baseline projection or $376 million (in 2030 dollars). The $1,714 million is the status quo and the $1,338 million is with the addition of the EHC benefit in place. From Slide 25 of December 7, 2018 SHADAC presentation to Minnesota OYF meeting.

Appendix C
Issues to be Discussed and Resolved with Health Plans
(From Discussions In the Summer of 2018)

Embed in both Medigap and MA? Yes.

Start Date? January 2020 or 2021.

Go with ECS only or ECS/PCA benefit? DHS is tentatively thinking of going with ECS to start and phasing in PCA at a later date.

Lifetime maximum pool of money at $36,500 or $50,000? DHS is tentatively thinking the higher amount.

Keep the decision as to having no vesting period? UHAS suggested this and DHS agrees.

Keep the decision as to a 90-day elimination period? UHAS found there were savings because adverse selection was reduced. DHS wonders if administrative concerns might not outweigh the benefits of such an elimination period.

Review variant (120 and 180 day) elimination periods? UHAS suggests longer periods may defeat the purpose of proving home care so people stay out of the SNF or hospital. DHS agrees.

Keep/Alter the ECS benefit? No modeling was done on this and DHS finds merit in keeping what was adopted from the Medicaid program.

Keep/Alter the PCA benefit? UHAS modeled a particular PCA design and DHS is reluctant to alter this unless there is strong reason to do so.

Keep/alter benefit (eligibility) trigger? DHS believes in keeping this as it is the Medicare-approved mechanism for receipt of home health services.

Inclusion of beneficiaries under age 65? UHAS found the cost differential when those on Medicare under age 65 were included was negligible. DHS strongly supports inclusion.

Add member cost-sharing (c**o-insurance)?** UHAS considered a coverage option in which the member would pay 25% or 50% coinsurance for PCA services (only) and concluded that cost-sharing for most EHC services would feel like “nickel-and-diming” the member. However, the idea of an initial deductible has some appeal, as does the idea of a percentage cost-share for PCA services (for which UHAS believes to be at the greatest risk for anti-selection). DHS wonders if administrative concerns might outweigh something like this.