



# **The Own Your Future LTSS Funding and Services Initiative**

Options to Increase Access to Long-  
Term Care Financing, Services, and  
Supports in Minnesota

October 2023

Prepared by FTI Consulting, Inc, Actuarial Research  
Corporation, and the Altarum Institute, for the Minnesota  
Department of Human Services Aging and Disability Services  
Administration

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## Summary

Like the nation as a whole, Minnesota is becoming older. With an older population comes an increase in the need for Long-Term Services and Supports (LTSS). The burdens of providing and paying for care are too often personally and profoundly felt by Minnesota's older adults and their families. Increasingly, state Medicaid programs, local area agencies on aging, and community-based programs are relied upon to fund and deliver care.

A recent study performed for the Minnesota Department of Human Services, projects Medicaid expenditures for LTSS needs in 2035 will near an annual amount of 3.4 billion dollars, a 70% increase over the next 12 years<sup>1</sup>. This increase is not unexpected as the older adult population is growing in total, and particularly in the older age segments, which are more likely to need LTSS services into their advanced years. This demographic shift provides an opportunity for Minnesota to realize the benefit of improving access to long-term care services and supports if they are initiated early, are focused on prevention, and are home and community based. Improving accessibility to large segments of Minnesota's older adults and their families can significantly reduce the currently projected increases.

In partnership with Own Your Future, a DHS Adult and Aging Services Division (AASD) initiative, FTI Consulting, Altarum Institute, and Actuarial Research Corporation, facilitated a stakeholder engagement process to solicit recommendations to transform LTSS access and identify funding options. Stakeholder engagement is a core element of this work through gathering, understanding, and synthesizing the needs of individuals, families, caregivers, government programs, insurance programs, and others. The stakeholder component of this project was grounded in the shared goal of addressing the needs of older adults across the state and offering funding approaches that may transform the way care is financed. This report identifies three specific recommendations to alleviate the demand on Minnesota's older adult families and their finances, as well as state Medicaid resources. The discussions by stakeholders and the recommendations offered provide approaches to increase access, expand supports, and innovate with alternative funding approaches. The recommendations and analysis within are intended to provide direction to expand care options and bolster LTSS funding to reduce the strain on Minnesotans and supporting programs<sup>2</sup>.

The DHS staff and project team selected stakeholders, the advisory panel, and expert panelists for their breadth of industry knowledge and experience. All stakeholders and advisory panel members were residents of Minnesota. Expert panelists were engaged from all aspects of the LTSS system and included national and cross-industry experts. As many as 60 individuals and organizations were engaged bringing an understanding of the needs of individuals, families,

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<sup>1</sup> Long-Term Services and Supports for Minnesota's Older Population: Current and Future Utilization and Payments; State Health Access Data Assistance Center (*SHADAC*), University of Minnesota School of Public Health; Purdue University School of Nursing

<sup>2</sup> While people with disabilities may also use overlapping services, this study was specifically focused on the older adult population.

caregivers, government programs, insurance programs, employers, advisors, brokers, consumer representatives, and trade organizations.

Stakeholders reviewed details on how current older adults receive and finance care needs by income levels. Minnesota's Medicaid programs that address both acute and LTSS needs are extensive and lead the nation in many ways<sup>3</sup>. However, they are primarily available to household income levels below \$25,000 and through waiver and similar programs for those households with under \$50,000 of annual income. In the meetings, stakeholders quickly focused on the populations that are without supportive solutions where annual incomes are between \$25,000-\$125,000. While participants focused on solutions for middle income populations, the intent is for recommendations to benefit all of Minnesota's older adults.

Through the guided facilitation, stakeholders identified the following "must haves" for the development of new models for early access to LTSS:

- Leverage existing Minnesota LTSS successes.
- Engage with older adults early
- Provide access to care navigation resources
- Develop creative funding streams
- The necessity for public/private collaboration
- Employ technology enabled solutions
- Strong support for informal and family caregivers
- Robust support for demographic and cultural differences

Based on this grounding, the stakeholders developed recommendations that, if implemented, can significantly reduce the increasing trend in Medicaid costs and broaden the supports for all older adult Minnesotans.

Stakeholders also focused on addressing the caregiver and care navigation crisis currently facing a majority of older adults and their families. As care needs arise, families are often left with little means to successfully identify and manage informal and professional care resources. This led to a primary recommendation to provide strong support to families and caregivers with a comprehensive navigation service developed collaboratively by the state, private industry, and county and local organizations.

In addition, two funding approaches are recommended that seek to enable a strong market with varieties of insurance and financing approaches. These proposals seek to provide solutions that can meet the diverse needs of Minnesota's older adults and their families. Each are recommended with options to consider that, if implemented, may increase the feasibility of these programs and the participation of key stakeholders to deliver collaborative, innovative and evolving public/private solutions.

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<sup>3</sup> [AARP - New AARP Scorecard: Minnesota and Washington State Top Rankings for Long-Term Care Services and Supports for Older Americans, Including Family Caregivers](#)

The recommendations developed through the stakeholder process include the following:

**1. Care Navigation & Support Services**

A state initiated and collaborative care navigation and support service for all older adults. The purpose is to leverage existing services, provide strong awareness and education, and support families and informal caregivers during their care journeys through a broad online and telephonic approach.

**2. A Medicare Companion Product**

A new insurance product concept that coordinates and funds care needs emerging in retirement. The program would coordinate care across the acute and LTSS care needs through collaborative Medicare and LTSS supporting products. There are two approaches, a voluntary **Market Option** or an **Obligatory Option**.

**3. A Catastrophic-Lite State Based Program**

An obligatory state insurance program that would provide funds to help pay for long-lasting, long-term care expenses for five years after a two-year elimination period. The focus is on home and community-based services (HCBS) but funds would be available for facility care as well.

Actuarial and financial modeling that supported the recommendations was a key component of the research and allowed for stakeholders to weigh the benefits of the proposals considered. This started with an analysis of state Medicaid utilization and economic data of older adults which led to the defining of middle income older adult Minnesotans and the potential gaps in LTSS funding. Actuarial models also informed stakeholders with indicative pricing of the proposals under consideration using, payroll tax and premium funding approaches, determinations of the likely coverage levels of participants, the likelihood of participants using potential benefits, and a projection of the value of potential LTSS needs of older adults in Minnesota. Many discussions on issues of actuarial relevance provided for productive recommendations and considerations.

The stakeholder team provided pros and cons for each recommendation. Additionally, a ranking of the potential improvement to Minnesota's LTSS system of the individual recommendations was gathered using the essential criteria elements developed during the engagement. Stakeholders strongly favored Recommendation 1 as it provides supports that allowed families and informal caregivers to care for their older adult family members. Additionally, they showed a preference for providing front-end care funding and supports including enabling care coordination across acute care and LTSS needs.

As Minnesota seeks to expand LTSS access and funding opportunities for residents, the recommendations and discussions provided within this report will inform potential options and

challenges. The recommendations provide a framework where further examination can provide additional context and opportunities for policy discussions. The actuarial analysis provides indicative pricing and comparisons to support decisions and their implications. Additional analysis is required as recommendations are further developed and formulated for implementation.

The facilitation team wishes to acknowledge and thank the many participants including stakeholders, panelists, state department leaders, O'Leary Management Associates, the Minnesota Department of Human Services staff, and the advisory panel for their active participation and willingness to engage with one another.

## Definitions

For purposes of these reports, the following definitions are provided for clarity:

### **Activities of Daily Living (ADL)**

The six ADLs defined by HIPAA are eating, bathing, dressing, transferring, toileting, and continence. Severe cognitive impairment is defined as a loss or deterioration in intellectual capacity that is similar to Alzheimer's disease and like forms of irreversible dementia.

### **Care Coordination and Case Management**

Assessment and coordination of the delivery of all health and long-term care services among different health and social service professionals and across settings of care. References to "case management" also include care coordination, when applicable.<sup>4</sup>

### **Home and Community-Based Services (HCBS)**

Home- and Community-Based Services (HCBS) are types of person-centered care delivered in the home and community. A variety of health and human services can be provided. HCBS programs address the needs of people with functional limitations who need assistance with everyday activities, like getting dressed or bathing. HCBS are often designed to enable people to stay in their homes, rather than moving to a facility for care.<sup>5</sup>

### **Long-Term Care**

Long-term care includes medical and non-medical care to meet health and personal care needs. It helps people with daily activities when they are unable to do them for themselves. You may need this kind of help as you grow older or have a chronic illness or disability. Long-term care

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<sup>4</sup>[MN.gov - Status of LTSS in Minnesota](#)

<sup>5</sup> [MN.gov - What is long-term care?](#)

includes help with bathing, dressing and other personal care. It also includes help for people with memory loss such as someone who has Alzheimer's Disease.<sup>6</sup>

## **Long-Term Services and Supports (LTSS)**

Long-term services and supports (LTSS) are a spectrum of services provided to all ages who have functional limitations. LTSS have the primary purpose of supporting the ability of the person to live or work in the setting of their choice. Living or work settings may include a person's home, a worksite, a community-based residential setting, such as assisted living, a nursing facility, or other institutional setting, such as a hospital or rehabilitation facility. LTSS enable people to lead meaningful lives at all stages with opportunities to make meaningful contributions and build upon what is important to them.<sup>7</sup>

## **LTSS Insurance Products**

LTSS insurance products include the variety of private insurance products that address LTSS needs. This includes Long-Term Care insurance, Short-Term Care insurance, Long-Term Care and Life or Annuity Hybrid products, Chronic Illness riders on Life Insurance products, Supplemental Health products, and other similar products and programs.

## **Stakeholders**

The term stakeholders used throughout this report should be interpreted as "interested and knowledgeable parties". Participants within the stakeholder group brought a variety of experiences and responsibilities to the discussions. The group discussed and provided varying viewpoints to address increasing access and funding to LTSS services.

## **Tax Qualified LTSS**

The Health Insurance Portability and Accountability Act (HIPAA)<sup>8</sup> defines Tax Qualified LTSS needs which require assistance with at least two of the six Activities of Daily Living (ADLs) and expected to last at least 90 days, or for Severe Cognitive Impairment.

## **Caveats and Limitations**

This report was created under contract with the Minnesota Department of Human Services (DHS). It contains estimates of the population need for Long Term Services and Supports (LTSS) in Minnesota, descriptions of current Minnesota LTSS program utilization, and an analysis of three recommendations for LTSS program development within the state. The

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<sup>6</sup> [CMS.gov - Home- and Community-Based Services](https://www.cms.gov/medicare/coverage/coverage-determinations/home-and-community-based-services)

<sup>7</sup> [DHS.state.MN.us - Waiver, AC and ECS case management](https://dhs.state.mn.us/dhs/programs/long-term-care/waiver)

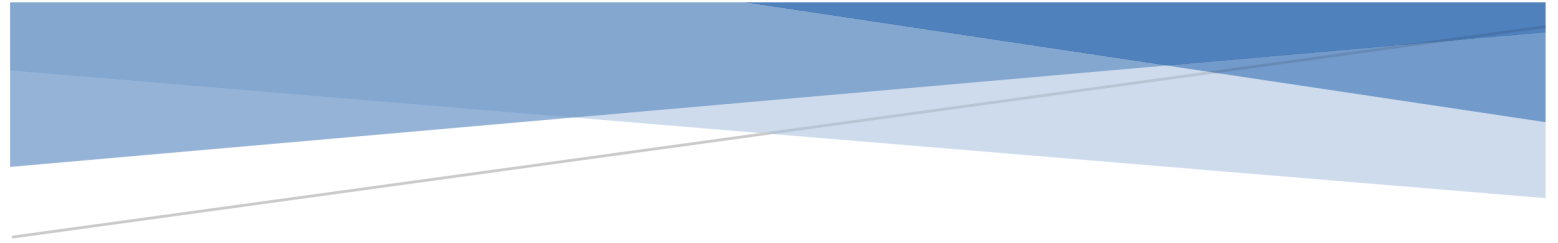
<sup>8</sup> [HHS.gov - Health Information Privacy](https://www.hhs.gov/health-information-privacy)

recommendations were determined through stakeholder engagement with Minnesotans of various backgrounds and areas of expertise.

The analysis of recommendations includes a discussion of program risks and actuarial considerations as well as indicative pricing of the cost of each recommendation under a given set of future assumptions. These cost estimates are meant to illustrate general magnitude of costs and to be used as a basis of comparison for relative costs between the three recommendations. These estimates should not be used to inform program pricing in the event that one of these recommendations is implemented in the future. Program implementation would require a more robust pricing analysis.

This document is intended to be used by DHS and reviewed by other parties interested in LTSS reform initiatives.





# **The Own Your Future LTSS Funding and Services Initiative**

Recommendations and Findings Report

October 2023

Prepared by FTI Consulting, Inc, Actuarial Research Corporation, and the Altarum Institute, for the Minnesota Department of Human Services Aging and Disability Services Administration

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## Report

### Overview

The Aging and Disability Services Administration of the Minnesota Department of Human Services aimed to investigate options for long-term services and supports reform to improve the services available to older adults in Minnesota. In consultation with Own Your Future, a DHS Adult and Aging Services Division (AASD) initiative, FTI Consulting, Altarum Institute, and Actuarial Research Corporation, led a stakeholder engagement process to examine LTSS funding options and provide a policy structure to transform the integration of the existing public-private programs that provide LTSS financing to older adults in Minnesota. Stakeholder engagement was a core component of this work to gather and understand the needs of individuals, families, caregivers, government programs, insurance programs, and other stakeholders. The stakeholder component of this project was grounded in a shared goal of addressing the needs of older adults across the state.

This project leveraged an iterative process for solution development that not only built on strengths and opportunities of the existing LTSS system, but also utilized expertise and priorities identified through stakeholders' industry and personal experiences. Strategic stakeholder engagement activities yielded valuable feedback used to inform the recommended LTSS access and finance solutions. Key themes gathered and resonated through the engagement efforts are detailed in the [Stakeholder report](#) and start with a significant focus on empowering Minnesota's older adults and their families to support informal caregivers and find paid caregiving and supports with readily accessible tools and resources. Furthermore, there was a strong recognition of the caregiver supply crisis that is emerging within Minnesota and nationwide.

Stakeholder input guided refinement of the recommendations and provided the reader with additional areas for consideration. This report documents key discussion points and voiced recommendations culminating from the stakeholder engagement activities conducted between April and September of 2023.

### Goals

This research, under the auspice of The Minnesota Department of Human Services, through its Aging and Disability Services Administration, is examining and evaluating LTSS funding options and care provisions for the State of Minnesota. The goal is to arrive at one or more policy options with the potential to improve access to LTSS services for Minnesotans that typically do not qualify for Medicaid.

A secondary objective is to address structural issues which can help transform the LTSS funding and care system in Minnesota by helping to further integrate the existing public and private programs to offer additional opportunities to provide LTSS financing to Minnesota's older adults.

The emphasis was on arriving at options that will enable older adults to receive care in their homes for as long as possible. Results of this work will be used to inform one or more legislative proposals.

While this work was completed in October 2023, the hope is that the analysis and recommendations will spur additional activity that will enhance access to HCBS for Minnesota's middle income population.

## **Background**

In 2021, the Minnesota legislature provided specific direction to state departments to conduct a research study of public and private financing options for long-term services and supports reform to increase access to long term care services and financing across the state as part of a larger package of strategies to enhance Home and Community-Based Services (Laws of Minnesota 2021 First Special Session, Chapter 7, Article 17, Sec. 17, Subd. 1).<sup>9</sup>

This activity was also formally approved as an American Rescue Plan, section 9817 Home, and Community Based Services Enhanced Federal Medical Assistance Percentage (FMAP) activity by the Centers for Medicare and Medicaid Services and is subject to all reporting requirements specified in that plan.

## **Minnesota's Population is Aging**

This study is largely a result of the demographics. Minnesota, like much of the rest of the United States, is becoming older and the programs and policies that have been in place for decades to help older Minnesotans will not be sustainable on a going-forward basis<sup>10</sup>.

- According to latest Minnesota State Demographic Center projections, there are currently approximately 950,000 Minnesotan older adults (65+)
- The number of older adults is anticipated to continue to grow dramatically to 1,170,000 (+23%) in 2030 and level off close to 1.2 million by 2050.
- According to a report by the Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 7 in 10 of those older adults will need some LTSS and 5 in 10 will need paid LTSS services in their future years.

As the number of older adults has begun to increase dramatically, so have the questions and challenges related to balancing the caregiving responsibilities of families versus the resources provided by local governments, tribal nations, state, and federal governments.

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<sup>9</sup> [Revisor.MN.gov - Minnesota Session Laws - 2021, 1st Special Session](https://revisor.mn.gov/laws/2021/1st-special-session/)

<sup>10</sup> Long-Term Services and Supports for Minnesota's Older Population: Current and Future Utilization and Payments; State Health Access Data Assistance Center (*SHADAC*), University of Minnesota School of Public Health; Purdue University School of Nursing

## Caregiver Supply

A key factor that is now emerging in Minnesota is the number and affordability of caregivers. The Covid-19 pandemic wreaked havoc with the caregiver workforce in both institutional and community settings. There are not enough qualified caregivers, and that shortage of supply is causing the price for those who are available to increase dramatically. The issue is exacerbated in Minnesota's rural areas. More than 20% of Minnesota's population is considered rural<sup>11</sup>.

In the past, a large portion of the LTSS services for older adults in Minnesota was provided by unpaid family members including spouses, partners, and adult children. However, smaller families and households, many with two parents working full-time, have reduced the number of family members available to provide care.

When families and other unpaid caregivers are not available, older adults must look to private providers and facilities for the care they need, who are also facing shortages of qualified staff. The lack of a broad based, reliable, and easily accessible system of resources and private/public funding for LTSS financing in Minnesota is further exacerbating the caregiving situation.

Paying for long term care is expensive. According to a recent cost of care survey, the average annual cost for a semi- private room in a nursing facility care for the state is one hundred and forty thousand dollars (\$140,000), with assisted living costing sixty two thousand dollars (\$62,000) per year and home health aides costing about thirty seven dollars (\$37.00/ hour). Costs vary across the state with some cities as averaging one hundred and fifty-five thousand dollars (\$155,000) per year for nursing home care and forty dollars (\$40.00/hour) for home health supports<sup>12</sup>.

## Own Your Future 3.0

Minnesota's Department of Human Services created a long-term care planning initiative called "Own Your Future" (OYF). The primary focus of the initiative is to raise awareness around the need for long-term care and spur planning efforts within families, particularly middle-income families who will not qualify for long-term care services under Medicaid unless they have spent down many of their resources.

The effort works to promote greater use of existing financing products as well as strategies to encourage new approaches to the financing of long-term care. **The goal is twofold: save families from spending down their assets and income, while also easing the financial burden for government.** Own Your Future and other efforts are designed to help more families make advance planning decisions regarding their long-term care needs. This will be an essential input into managing State budgets for long-term services and supports in the future.

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<sup>11</sup> Sheleen Dumas, "Urban Areas for the 2020 Census-Proposed Criteria," Federal Register, February 16, 2021, [Federal Register - Urban Areas for the 2020 Census-Proposed Criteria](#)

<sup>12</sup> [Genworth Cost of Care Survey](#), November 2021.

For this project, the OYF advisory panel was reconstituted and updated to be included with additional identified stakeholders. The group worked to identify new concepts that will help middle income households find and pay for their LTSS needs.

## Stakeholder and Technical Expert Engagement

A key learning following the efforts of other states who have attempted to implement innovative long-term care funding approaches, is the need for a robust and thorough stakeholder input and engagement process. This is necessary in order to uncover potential issues and barriers prior to implementation of any program, and to develop a broad base of support for positive recommendations coming out of this work.

Therefore, the expanded and updated version of the Own Your Future stakeholders advisory panel was utilized for this project. This research effort together with an intense data study has been termed, **OYF 3.0**. The panel of OYF advisors was a good starting point for this Minnesota specific stakeholder engagement process.

The Stakeholder engagement process proved to be an excellent sounding board for concept modification and evaluation, on-going feedback on concept viability and feasibility, and hopefully will provide on-going support for the furtherance of the recommended solutions.

In addition to Minnesota based stakeholder effort this research used a panel of volunteer experts called the “consultant or expert panel” to both inform and react to the Minnesota stakeholder findings. This panel was convened in two formal sessions and multiple mini-sessions to explore specific topics as they have arisen.

The participating stakeholders and experts who have contributed to these efforts can be found in the [Stakeholder report](#) and number over 60 individuals.

## Data Mining

### The “Red Box”

At the start, a significant focus was on identifying the subsets of older adult populations and how they are served under the existing system supporting LTSS care and financing in Minnesota. Medical Assistance (Medicaid), Elderly Waiver, Older Americans Act programs, Private Insurance, and Personal Funding are the primary ways Minnesota’s older adults receive and fund their care needs. The analysis also showed that a significant portion of Minnesota’s older adults, in particular those within the middle brackets with annual retirement incomes ranging from of \$25,000 to \$125,000, do not have the supports and funding approaches necessary to prevent a dependence on Medical Assistance programs. This became a central focus of the stakeholders’ recommendations. **The goal to help older adults remain in the “red box” as long as possible should they have long-term care needs that create a**

**financial strain.** It should be noted that the recommendations offered are not solely for the “red box” older adults as such programs can support both younger adults and those below and above the box.

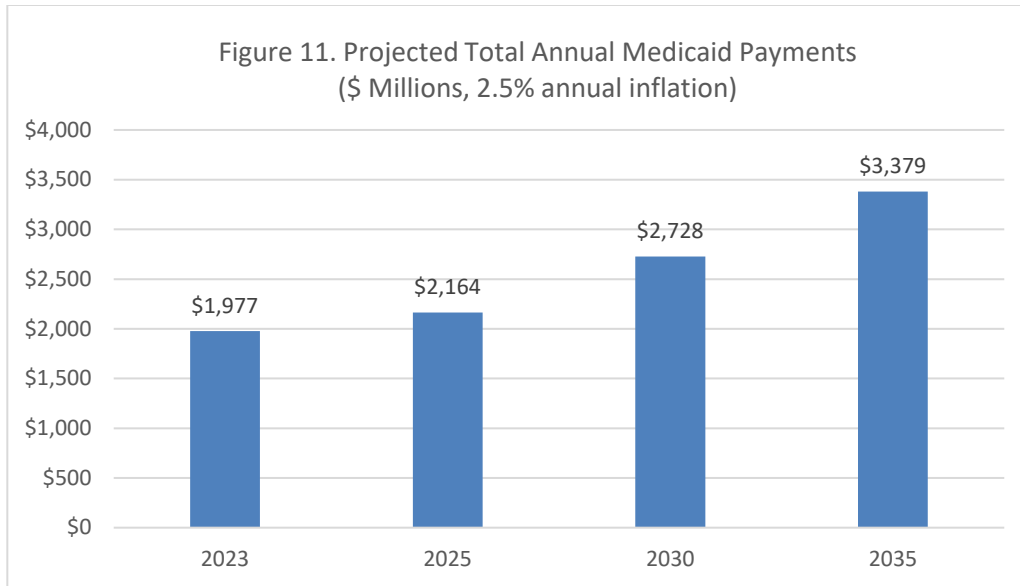
Further study on the transition in and out of the “red box” both during their working years and in retirement is warranted. The options for funding approaches that include a payroll tax, or a premium, can be influenced by the transitions in and out of Medical Assistance programs. For example, if a payroll tax includes a threshold minimum income, the ability of those receiving Medical Assistance to qualify for a proposed compulsory program is limited. Therefore in these cases, Medicaid savings may not be realized to a certain degree.

Family Income	Community Need, All Community	Community Need, % Covered by Medicaid or AC	Nursing Facility Need, All Nursing Facility	Nursing Facility Need, % Covered by Medicaid or AC
<\$10,000	8,600	92%	2,200	94%
\$10,000-24,999	31,000	67%	8,100	77%
\$25,000-49,999	21,100	28%	4,600	61%
\$50,000-74,999	11,500	5%	2,700	48%
\$75,000-99,999	5,900	5%	800	37%
\$100,000-\$124,999	4,500	11%	300	27%
\$125,000-\$149,999	1,200	0%	100	0%
>=\$150,000	2,500	0%	500	0%
Total	86,200	41%	19,300	66%

## A Projection of Medicaid Expenditures

A report titled “Baseline Projections of LTSS Use and Payments: 2023-2035”<sup>13</sup> sites a more than 70% increase in Medicaid LTSS payments from 2023 to 2035. This is based on a 2.5% annual inflation and the projected increase in age 65+ populations in Minnesota. This projection assumes a stable LTSS incidence and continuance assumption. 70% over 12 years is an annual increase of over 4.5% and does not include any increase in service utilization for those in the “red box”. Taken together, these factors contribute to a situation that may not be sustainable compared to annual state budgets and needs.

<sup>13</sup> Long-Term Services and Supports for Minnesota’s Older Population: Current and Future Utilization and Payments; State Health Access Data Assistance Center (SHADAC), University of Minnesota School of Public Health; Purdue University School of Nursing



If nothing changes, the likelihood of a 70% increase (or almost 1.5 billion) in Medicaid LTSS expenditures is anticipated. This increase is not unexpected as the older adult population is growing due to the anticipated population segments aging into their advanced years.

**However, this trend provides an opportunity for Minnesota to significantly realize the financial and supportive benefits of improving access to long-term services and supports that are initiated early in a care situation and are home and community based.** Improving accessibility to LTSS to large segments of Minnesota’s older adults and their families can significantly reduce the currently expected increases.

With this baseline projection, a look at the impact on projected Medicaid LTSS expenditures if specific recommendations are implemented, can be developed based on realistic shifts. The impact on future Medicaid payments can be developed by looking at both the current 65+ population and future 65+ populations under multiple scenarios. Such scenarios would be dependent on the adoptions of the recommendations provided and the ability of the programs to impact future care needs. As the goals of these recommendations are to increase access to LTSS and to keep Minnesota’s older adults “in the red box”, the effectiveness of the programs depends upon participation and specific program provisions.

Examples of the potential scenarios might include: the use of informal caregiving supports that reduces or delays the need for Minnesotan’s to spend down to Medicaid eligibility; a reduction in the transition from HCBS to facility care; and the impact of collaborative care coordination approaches between acute care and LTSS needs. These and other scenarios require further study and support as the specific program features and implementation of any improvements to LTSS access are determined.



## Stakeholder Key Findings

Through the discussions and other opportunities to connect, the stakeholder group expressed their understanding of the current LTSS environment in Minnesota and identified a series of key findings. These findings which impacted the recommendations under consideration and ultimately offered in this report are as follows:

### Care Navigation

- A strong need to provide **enhanced care navigation and coordination** for ALL Minnesotans to enable them to remain in the home and help prevent further decline where possible.
- An equally strong need exists for cross-program and product coordination to provide access to existing supportive programs and to provide older adults with care funding navigation.
- Stakeholders further indicated a strong need **for “quarterbacks” to help users navigate** the LTSS system as they enter it and to stay with them as a “person to turn to” when they need help.
- A desire for early education and interventions to enhance the opportunity for **wellness and prevention programs** to help delay, mitigate and even prevent the chronic conditions that lead to LTSS situations.

### Finance

- A desire for developing creative funding streams so that Minnesotans have options based on their needs and their support structure.
- An interest in supporting all options including self-funded, private funded, and program funded approaches.
- A desire for providing supports and potential **tax credits for Minnesotans who provide care.**
- An emphasize on partnerships between public and private entities to quicken implementation and provide for ongoing updating of resources and solutions.
- A need to consider a range of **incentives to purchase protection** with insurance and other funding sources.

### Existing LTSS efforts

- Need to promote, **strengthen, and enhance existing Minnesota LTSS programs** such as the Senior LinkAge Line, Managed Senior Health Options (MSHO), Elderly Waiver, Alternative Care, OAA, and the work of the Area Agencies on Aging.
- Need to leverage the recently passed Paid Family and Medical Leave Act program (PFMLA) as a collaborative approach to support caregivers and those in their care.
- Currently, the system is fragmented and does not holistically support the needs of a majority of older adults and their caregivers.

## Education

- A significant need to engage older adults and caregivers early to enable them to remain in their home if possible.
- A desire to expand education on LTSS options and care plans that support the family.
- A strong need to provide a **single central and trusted location** where educational resources and supports are made available and are readily accessible to Minnesotans.
- Additional approaches to introduce LTSS financing and services earlier through employee assistance initiatives or similar programs so that Minnesotans know the importance of planning for both care and care funding.

## Technology

- An interest in technology solutions and how they may be used to address the caregiver workforce crisis.
- A need to strengthen state, county, and local programs with **improved technology-based care navigation solutions** that are simple and easy to access and encourage more efficient self-directed care.

## Service Specific

- A need to simplify and more clearly define supports and funding approaches so they are more accessible and understandable to consumers.
- A desire for services and financing approaches that are tailored to the individuals and based on their needs and means across urban, rural, tribal, and cultural differences.
- A basic need to **support and grow the LTSS workforce** through recruitment, retention, and sustainable compensation efforts.

## Considerations of the Stakeholder Group

During the course of the Stakeholder discussions, input was gathered and used to refine the recommendations working towards a set of final recommendations to offer. Many discussions also involved considerations that eventually informed and influenced choices. A summary of such considerations is offered here:

### Leverage existing successful programs:

The stakeholder group identified existing programs in Minnesota that are successful. Stakeholders noted that Minnesota has one of the highest Long-Term Care insurance participation rates among states. The Area Agencies on Aging are very active and support residents with care needs. Programs such as the Elderly Waiver, and Alternative Care, as well as programs and services funded by the Older Americans Act are very supportive of many Minnesotans requiring or providing care whether on Medical Assistance or nearing eligibility.

During the last legislative session, a Paid Family Medical Leave Act program was passed. There are also many long-term care insurers domiciled or with a strong presence in Minnesota.

Stakeholders pointed out that building off of what is working is indeed a strong starting point. However, stakeholders further described the current system as largely serving those in the Medicaid and Medicaid related programs. These approaches do have organized care navigation and coordination built in and there doesn't seem to be much, if any, capacity to expand to more people in the existing system and those in the red box.

### **Front end, back end, or other:**

Robust discussions occurred on whether the funding approaches should focus on initial care needs (front-end), or care needs that are extended (back-end). Many stakeholders stated the need for strong care support initially when the conditions arise, since many older adults and their families will spend down to Medicaid even with a short duration claim, and the necessity to coordinate care early to enable care in the home.

### **Funding approaches under consideration:**

Stakeholders were concerned with an additional payroll tax either paid by employees or employers. One reason for this is the recently passed payroll tax of 0.7% (shared by employers and employees) for the Paid Family and Medical Leave Program.

In addition, the concern that a payroll tax and vesting requirement excludes some Minnesotans such as those that leave the state prior to becoming benefit eligible and those that enter without sufficient time to vest in the program. Furthermore, the payroll tax is generally assessed on all workers, including some who may very well rely on Medicaid both currently and in retirement. Such a program would not leverage the robust Medicaid and supporting programs for LTSS that exist in Minnesota.

Finally, a payroll tax for a benefit that is less likely to be used and not for many decades into the future, gave stakeholders a concern over acceptance by participants. They recognized similarly funded approaches such as Social Security, Medicare Part A, PFML programs, and others including those supported by general revenues such as Medicaid are common. Stakeholders noted the differences where either benefits are available while the tax is paid, are earned based on the tax, or like the Medicare program, are generally a combination of payroll tax (part A) and premiums (parts B & D).

Washington state recently enacted program called WA Cares which includes a payroll tax of 0.58% on all W-2 income for a current maximum benefit of \$36,500. Stakeholders observed that under the WA Cares program many will end up paying more in taxes than the total benefits they could possibly use. Whether programs are intended to be based on private insurance principles or social insurance principles, such issues are a concern over both acceptability of the program by participants and program sustainability.

The selected funding approach has a significant impact on whether public and private collaborations can indeed be successful. Two examples of public private collaboration include the Medicare Supplement market and the Medicare Advantage market. The first approach looks to segment the coverages through meeting deductibles and coinsurances and has little opportunity for deep collaboration. The second uses funding approaches that enable a risk adjustment approach to allow for the benefits of private insurance carrier coordination.

Stakeholders also recognized the need for care navigation and coordination for LTSS and the need for the funding approach to encourage and incentivize care coordination and claim prevention and wellness.

Stakeholders encouraged the examination of alternatives to the payroll tax including delaying the start of the tax until a later age, using premiums which begin closer to the age where care needs begin as a method to fund the program, or a combination of each.

### **Population Considerations:**

Stakeholders were very conscious of the difference in needs and opportunities for care across the state. Currently rural populations and other cultural groups may have limited access to caregivers and have few additional supports to enable them to remain in their homes as a care need arises. Also, the ability to provide informal caregiver support and training is limited for many reasons including the continued gaps in broadband connectivity.

Additionally, there are eleven tribal nations across the state that each have their own culturally-specific needs with opportunities to provide additional care and supports. Older adults with care needs and without family or informal care opportunities may also be without proper supports to maintain their residence and receive care. Finally, cultural differences impact the availability of in-home supports and cause adults with significant care needs to quickly spend down to Medicaid levels as care needs begin. Stakeholders recognized the need for the recommendations to acknowledge these differences and provide meaningful supports for all Minnesotans.

### **Public/Private Collaborations:**

Within the discussion on funding considerations, the topic of public/private collaborations that aim to reduce Medicaid reliance and support families was discussed. Stakeholders preferred collaborations such as Minnesota Senior Health Options (MSHO) where insurance carriers and similar entities are delivering care solutions in a coordinated manner. Many studies have shown the positive impact of care coordination on keeping those with LTSS needs out of the facilities with home care supports<sup>14</sup>.

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<sup>14</sup> [CHCS.org - Demonstrating the Value of Medicaid Programs \(PDF\)](#)  
[Health Management.com - Managed LTSS Improves Quality of Care \(PDF\)](#)  
[Home Health Care News.com - Care Coordination Remains A Growth Driver For Help at Home](#)

As discussed above, such collaborations require funding approaches that can keep all stakeholders properly incentivized and maintain sustainable participation. This also includes stakeholders such as Minnesota families, as well as state, federal, and private insurance programs.

### **Obligatory versus Market Based Approaches:**

As soon as the stakeholder meetings began, the discussions pointed towards providing access to care navigation and coordination as the primary goal. Shortly thereafter the discussions turned to financing approaches to pay for such care. Stakeholders supported a gradual approach where market-based approaches can be tested and once stable, could be leveraged for obligatory (often called mandatory) approaches. Reasons for this include the desire to have a collaborative approach to both providing and financing care. Stakeholders envisioned replacing the current default approach where individuals and families navigate and search alone, with tools that enables them to find and choose care that is right for them with the added support in identifying financing resources.

One comment made by stakeholders was “people do not want to divide themselves”, meaning they want to have to one place to go to find the benefits they need. They need a collaborative approach between public and private financing. While the funding source may vary, individuals should not be struggling to search for which entity pays for what. Mandatory based approaches that “layer-on” or segment the funding of care end up creating confusion and increasing the likelihood that care is not provided. **Care navigation is necessary, but it should also include care funding navigation and should be streamlined so that confusion and frustration does not persist.** Alternatively, public programs that leverage private approaches, whether through insurance carriers or provider organizations, can also bridge the care and funding navigation to avoid consumer confusion.

### **Funding and Populations:**

For LTSS funding purposes, older adults can be generally categorized in to four groups. Those relying on Medical Assistance, older adults with higher care needs due to a chronic illness, healthy populations, and those with a private long-term care solution. Considerations of these categories is important to understand the effectiveness of on obligatory program and how the funding may be reasonably structured.

For example, stakeholders discussed whether charging a tax or a premium on those already enrolled in the Medicaid safety net is reasonable. They also discussed how to cover or insure those with an existing chronic illness or in a current care situation. Approaches were discussed that may use Medicaid or pre-Medicaid programs to offset the impact on program premiums and/or payroll taxes. Such approaches may be direct premium offsets or involve a coordination of funding to offset the expected costs of the program. This would be a reasonable approach to leverage existing successful programs instead of replacing them.

## The Caregiver Supply Shortage:

The caregiver supply shortage was often top of mind for stakeholders. A conclusion of a recent Minnesota DHS study<sup>15</sup> opined that the availability of caregivers in Minnesota is a risk to the success of any enhancements to increase access to care and funding care.

Stakeholders discussed how the recommendations may enhance the caregiver supply. The following were their conclusions:

- The LTSS system needs informal caregivers to be a sustainable system. Supporting informal caregivers with education, training, and information is critical to enable family and other informal caregivers to provide supports in the home.
- Incentives to support family and informal caregivers are necessary. The PFML program is a good start and will support those needing care who have family members that are covered and able to provide support. Furthermore, the stakeholders considered enhanced tax incentives for those providing care and noted that within the Medicaid program, Personal Care Assistance (PCA), is a frequently-used benefit where family members (other than parents of minors and spouses) can be paid to provide care for people eligible for Medicaid. The PCA program may help save Medicaid funds and allow for the individual to receive care they would otherwise not have.
- Stakeholders and expert panelists stated that supporting informal caregivers may reduce the demand on professional caregivers. Furthermore, a public/private collaborative approach may provide funding that can pay an appropriate wage for caregivers and encourage an increasing caregiver pool.
- An idea offered by panelists is for a mobile “Care Corps” that would encourage informal caregiving to provide quick response support for the needs of rural older adults where care resources are limited. The approach may allow for lower cost options for chore services and other light needs.
- The availability of clinicians and social workers that assess care needs and support existing programs is limited as well. This poses a concern as a lack of care assessors may reduce access to supports offered by Elderly Waiver programs and other offerings where an assessment is usually required for eligibility. Using technology to support care assessors is a key proposal.

Stakeholders noted that the recommendations should not exacerbate any of these concerns but should provide remedies that help to resolve the concerns.

## Enabling Employer Support:

Panelists also pointed to the opportunity for Minnesota’s employers to support solutions that address LTSS financing needs. This includes employer sponsorship of insurance and funding options as their employees prepare for retirement.

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<sup>15</sup> “Opportunities to Enhance HCBS for Older Adults and Individuals Providing Care” Susan McGeehan, Barry J. Jacobs, Chris Dickerson, Aaron Tripp, Erica Reaves, and Anya Yermishkin

The Own Your Future stakeholder group has historically supported the involvement of employers as a means to increase the awareness of the LTSS risk. The efforts include the development of LifeStage-like<sup>16</sup> insurance products that would encourage employer-based protection for long-term care needs as their employees age and retire.

Stakeholders believed that the role of employers could include education and product sponsorship which may encourage their employees and their families to address the risk of LTSS expenses. This could help reduce the strain of adverse selection risk in a compulsory program as well as develop a market for middle income older adults to prepare LTSS expenses.

Retirement plans also can play a role in financing LTSS care whether an obligatory program is offered or a market approach. Health Savings Accounts can pay for product premiums and/or LTSS expenses and play a significant role in Minnesotan's retirement planning. Employers can support their employees with education as they prepare for retirement.

### **Regulatory Considerations:**

Panelists discussed the insurance market regulatory environment noting that there have been many times where regulations were enhanced to enable innovative product development. For example, the LifeStage product was supported by a change to the Long-Term Care insurance regulations. Stakeholders noted that Minnesota does not have specific regulatory language to approve commonly known Short-Term Care insurance products which may meet the needs of the "red box" populations.

In general, panelists believed that a wide array of solutions should be available that meet the needs and means of Minnesotans as they prepare and plan for their potential LTSS expenses. This includes long-term care insurance, short-term care insurance, life insurance with LTSS riders, annuity products with LTSS features, enhanced benefits within private insurance Medicare products, and health savings accounts that can fund LTSS needs and/or premiums.

### **Evaluation Criteria:**

A requirement of the research was to evaluate access and funding proposals using a robust set of evaluation criteria. Stakeholders took time during the initial discussions to develop a list of criteria elements that are important to them. They leveraged the work done by a prior forum called the "National Conversation on Long-Term Care Financing" which was summarized in subsequent American of Academy of Actuaries<sup>17</sup> work. The evaluation criteria are intended to provide a robust examination of the impact of reform proposals on the totality of the LTSS system. This encourages participants to look beyond the proposal and identify potential positive and adverse impacts of the proposal so that a broad, diverse, and sustainable system of support for Minnesotan's LTSS needs can be built.

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<sup>16</sup> [MN.gov - LifeStage Protection Product Final Report \(PDF\)](#)

<sup>17</sup> [Actuary.org - Long-Term Care Financing Reform Proposals That Involve Public Programs](#)

Some criteria elements were combined for evaluation purposes and the results for each recommendation are provided in the content below and within the [Stakeholder Engagement report](#). Further details of the development of the Evaluation Criteria are also provided in the Stakeholder Engagement Report.

## **The Recommendations**

This stakeholder engagement leveraged an iterative process for solution development that not only built upon what is working well in the state but also identified the needs of Minnesotans who have initial care needs and care needs that increase in intensity. Stakeholders were focused on solutions that encourage providing supports early and enabling older adults to remain in their home and “age-in-place” using community-based supports. Furthermore, they noted disparities in access to care supports by demographic and regional differences. This focus allowed for solution development that sought to meet the goal of increasing access to care for all Minnesotans. Then stakeholders turned to identifying transformational change in current financing approaches so that Minnesotans and their families may be protected from the high cost of care needs.

The focus of stakeholders was on the group of Minnesotans identified within the “red box”. The iterative process was based upon a discussion of potential options, an actuarial analysis of the impact and indicative pricing of each recommendation, a pros and cons analysis, and the use of established essential criteria to evaluate the proposals.

In the subsequent pages, we discuss each recommendation and provide discussion on potential variations.



## **Recommendation 1: Care Navigation and Support Services**

Stakeholders quickly identified the need to provide older adults and their families and caregivers in Minnesota with care navigation and supports as care needs arise. While the need for funding is clear, stakeholders indicated that Minnesotans equally need help identifying how they and their caregivers can adequately and safely provide care for their loved ones. Stakeholders highlighted the lack of resources currently available. Such resources may inform and provide navigation so that care may be provided in the home or appropriate providers may be identified. Furthermore, this includes support for informal or family care providers as the supply of care providers is limited and there is a strong and appropriate reliance on informal and family care.

Today in Minnesota, there exists strong and supportive tools available to populations through information and assistance via the Senior LinkAge Line and MinnesotaHelp.info, as well as other programs such as Elderly Waiver, Alternative Care, and other services funded by the Older Americans Act. These programs help to navigate care delivery, educate and train informal caregivers and family members, coordinate the funding of the costs of care, and provide access to state and county-based programs. Yet, while these valuable programs and tools exist, too many Minnesotans are not aware of these tools or struggle to utilize them.

Providing stronger access to care and supports is the primary objective of this engagement. The stakeholder group strongly focused on achieving this objective within this recommendation:

### **Summary:**

The State will sponsor, support, and provide a resource for residents and their families to increase access for all older adults in Minnesota to support their long-term care services and to identify necessary services and supports. This resource addresses the need for access to care and provides the navigation necessary to enable Minnesotans to seek support when their or their loved ones' needs initially arise. Additionally, it may offer opportunities for care prevention and wellness programs to reduce the incidence of LTSS needs.

Three different approaches should be employed within the service to deliver the needed support through the resource:

1. An older adult specific online portal which provides self-directed opportunities to find local and community care providers. Education on the importance of planning and help creating that plan before the need for LTSS arises may be the primary opportunity for early engagement.
2. In addition, an enhanced telephonic approach for those without reliable access to broadband and those requiring additional assistance is needed. Furthermore, additional technology based solutions may enable a reduced reliance on the telephonic approach either through self-directed resources or text based/Artificial Intelligence generated interactions.

3. Finally, in person support should be made available for those that qualify through a state or county based program, or for a charge for those who can afford to pay. Leveraging local care planning advisors may provide this opportunity.

The design of this resource must meet the needs of residents including those in urban, rural, and tribal nation settings. It should also be capable of addressing the disparate needs of those from different cultures and those both with and without family support. In addition, it is critical to ensure that cultural differences and personal preferences are recognized and considered within the development of the service portal.

The importance of featuring a strong self-directed function cannot be underestimated. The resource must provide a robust marketplace of services and tools to support home and community care settings. This includes access to care providers of all types including meal services, transportation, adult day care, chore services, and home health care providers. One vendor of such a marketplace environment that offers a variety of resources, indicated a four-fold success rate of enabling older adults to age in place for those utilizing self-directed capabilities.

Stakeholders have themselves expressed a desire to pay for these services and supports out of pocket, especially if such supports can enhance the opportunity to safely remain in their home and prevent increases in the intensity of care needs. Such early supports may also prevent a facility need and mitigate the need to spend down their savings and assets to gain access to Medicaid support. The service should also provide support for identifying funding sources including state and federal programs, health plans, paid family medical leave programs or other sources that may not be known to the older adult.

Access to state, county, and local programs was described by stakeholders as inconsistent. It was felt that this is especially true of Minnesotans within the "red box". More than one participant stated they were not initially aware of the Senior LinkAge Line. This approach can provide more awareness.

It is abundantly important that the care support service is well marketed and known by Minnesotans as the "library of all things" care related. Such a library must include educational resources, care training videos and articles, opportunities to connect to community-based services, access to service providers for care and other related needs such as transportation services, meal preparation, and support in determining potential payers of care and to coordinate the payment to care providers and vendors. Finally, when the time comes, access to resources and programs such as Elderly Waiver, Alternative Care, and other programs may be initiated and assisted with this resource.

**Objective:**

The objective of this recommended initiative is to encourage Home and Community Based Services (HCBS) where older adults of all types and their caregivers and families may support

their needs at a site of care they prefer. Stakeholders strongly believe that most Minnesotans prefer to remain in their home, and to, if possible, “age in place”.

The objective may be achieved if Minnesotans can readily identify care resources, which work for them, are encouraged to access them in a timely manner, and can engage them with minimal assistance. Self-directed approaches are increasingly popular and can be more efficient. That said, there also needs to be strong care navigation and care coordination services available by phone and in person so that all older adults have the opportunity for support in the manner in which they prefer.

Panelists spoke very well of the [Senior LinkAge Line](#) as an example of resources and supports currently available and acknowledged that the service is not known as widely as it should be. Other services providing care navigation support are also available but similarly not readily known. Within private industry, whether supporting Medicare products or Long-Term Care policies, technology has played an ever-increasing role to engage participants early in their care journey and helped to delay the onset of more serious and expensive care needs later.

The use of private industry and collaborative efforts across the current Minnesota care system are necessary to achieve the objective to support all of Minnesotan’s older adults regardless of their circumstances.

### **Features:**

To sponsor the development of this resource that becomes the support structure necessary to enable Minnesota’s older adults to have access to care, the resource will need to be well known, heavily marketed, and provide access to timely and innovative approaches for care support. In particular:

- The service should be positioned and branded as the source for “all things relevant” for long-term services and supports. It needs a simple, recognizable and memorable name. Many stakeholders pointed towards the idea of an enhanced Senior LinkAge Line.
- The approach should include multiple ways to provide information and assistance including web based, smart phone and tablet enabled, telephonic, print, and potentially leveraging existing in-person approaches where appropriate.
- As with many technology enabling approaches, self-directed approaches are often a preference by the consumer. This resource should also rely extensively on self-directed navigation to information and educational pieces.
- Features include:
  - Informal and family caregiver training articles and training videos.
  - Up to date directories of care providers and support services.
  - Ancillary services directories like meals, transportation, home modification, chore services, etc.
  - Includes the connection to local Area Agencies on Aging (as with the current Senior LinkAge Line) and other community services,

- A marketplace for aging in place supports that bring both basic needs and technology enabled supports.
- A connection to programs that provide care navigation and funding support especially with programs that include some care coordination support such as EW and AC. As well as initial access to apply for Medicaid programs.
- Information and support for finding sources to fund caregiving needs and supporting the process for identifying potential payers.
- And a link to, or build upon, other established telephonic services such as the Senior LinkAge Line. In addition, there is a strong potential to collaborate with similar programs that require a supportive approach such as the PFML.

### **Funding Options and Considerations:**

Panelists speculated that the funding for the initial development of this resource should be sourced appropriately with use of grants and other resources. The need for collaborating with programs that may potentially be impacted and perhaps benefit from the care coordination service, is suggested to leverage known best practices. Stakeholders stressed that the service may best be developed in collaboration with private vendors and developers.

Initial estimates of the ongoing costs of the service are based off of a conservative estimate with full use of telephonic supports ([Actuarial Report](#)). This may put an upper bound on the ongoing administration costs that can be enhanced as the structure is developed. The use of self-directed approaches is likely and can significantly lower the costs of the telephonic approach. Furthermore, costs may be shared as existing state and federal LTSS and related programs may leverage the service reducing their own administrative expenses.

The actuarial report provides estimates for a fully telephonic care coordination approach with examples of monthly premium based costs and payroll tax approaches to fund the ongoing administration expenses.

### **Benefits:**

The benefits to Minnesota's older adults and their families are significant. The concerns expressed by stakeholders of a lack of guidance and direction as families are faced with care needs is significantly reduced with such a care coordination and support structure. Stakeholders also discussed potential ancillary benefits of the recommendation:

- The opportunity for educating family caregivers of their own LTSS risks as they seek support for their loved ones may encourage them to plan for their own needs.
- Engaging with family members that may not realize their role as caregivers to provide preventative support and reduce the stress of caregiving demands.
- An opportunity for a marketplace for insurance products that addresses LTSS funding needs can increase the protection and provide for a robust market for "red box" Minnesotans.

- Access to supportive informal caregiving resources and supports where family and friends can be empowered to provide care through strong training and educational articles and videos.
- The service can be employed as a resource for hospital discharge planning. Panelists spoke of circumstances where a lack of support for creating a stable home environment following a hospital discharge is common therefore increasing readmission risk.
- Existing state and federal Medicaid programs may benefit from the support for caregivers and families as they seek to age in place.
- As informal caregivers are better prepared to support their family members needing care, the demand on formal caregivers may be reduced to focus on older adults with more complex needs and/or supporting those without family supports.
- Provides a resource for ancillary services, meals, transportation, chore service, and other needs.
- Smart-home communication devices and other technology solutions can be offered and support the caregiver and the care receiver.
- A focus on caregiver health and stress is possible so they may remain in the workforce and are empowered to support their family member safely.
- Support for navigating the funding sources between acute health care insurance products and LTSS programs and products.
- Primary Care Physicians and their staff may reference the resource to support their patients.

Further research on the impact of care coordination and early support services is necessary to project the savings to Medicaid programs. However, if the support services reduced claim incidence by 5%, the projected annual to Medicaid programs would yield approximately \$100mm - \$200 million.

#### **Additional Considerations/Options:**

While stakeholder and other panelists saw value in the recommendation, there was concern that HCBS services may not be readily accessed if the home environment is not conducive to support the needs of the older adult. Support for a modest home modification and support benefit available to all older adults was expressed and is presented here as an additional consideration.

Today, many Medicaid and Medicare programs offer opportunities to modify an individual's home so that they may remain in a less costly care environment. A few examples of such modifications include grab bars for stability, modifications to the shower or bath, chair lifts, smart-home communication devices, and ramps to allow for safe access in and out of the home.

Stakeholders examined the potential to add a benefit that can be accessed as the initial care need is identified. Today in Long-Term Care Insurance policies, such home modification benefits are available, but insureds are generally not able to access the benefit until impaired to the

degree to be eligible for claim due to tax regulations. In addition, Medicare is now able to provide some home modification and supports. Minnesota's HCBS Medicaid programs offer home modification opportunities but after spend down of assets and income. While the proposed care coordination service does offer access to such home modifications, most costs would be funded by the individual. Stakeholders looked to go "upstream" with this and enable the "red box" (i.e. those with an annual retirement income of \$25,000 - \$125,000) similar opportunities for access to a limited, but core in-home modification benefit to all older adults.

Based on panelist discussions, a lifetime benefit of \$10,000 to \$15,000 would cover the needs of the average older adult seeking modifications in order to remain in the home. Other variations may be possible where the benefit could be used for transportation or other chore services in lieu of home modifications if justified. As an example, a modest one-time benefit of \$2,000 for home modifications, given medical evidence of disability, would increase the annual cost of this program by 33% ([Actuarial Report](#)). This is based on the full cost of the program as a telephonic benefit and does not consider the potential for savings due to coordination with Medicaid and other waiver programs that may be available. An increase in the use of self-directed approaches for care navigation may increase the cost of the additional home modification benefit.

A further consideration related to informal caregiver supports extends a caregiver tax credit following the completion of the available Paid Family and Medical Leave benefit, typically 12 weeks. Such a credit may allow the individual to continue to receive care from their established and effective caregivers for potential lengthy care needs.

### **Assessment of Impact, Pros/Cons Analysis:**

Stakeholders developed an assessment of the impact of the Care Navigation and Support Services initiative and had the following verbatim observations:

#### *Pros:*

- Early intervention is key and leads to greater outcomes and saving the state money.
- Delayed entry to Elderly Waiver and eventually Medical Assistance via early intervention.
- Will help delay events for individuals which relieves stress on the current system.
- Helps with the caregiver's first challenge: Navigating the system.
- Reduced stress on lead agencies and smaller human service organizations.
- Provides needed resources to people at critical junctures. Also, scalable and easiest to get going soon.
- Lighter touch change, easier, and achievable.
- Most realistic option to succeed.

#### *Cons:*

- If folks don't know it exists, it won't be used.
- Need to increase resources - not just access.
- Need to fund service infrastructure.

- Will need constant communication/marketing to ensure awareness and adoption.
- Seems like this will only work if supply is available and either affordable or there is a benefit.
- If people cannot find or access providers, no amount of providing lists of providers will help.
- Still requires coordinated HCBS services through some kind of hub concept with information sharing capability.
- State would likely need a private marketing partner over time for success, otherwise may fail.
- Coordination among various stakeholders may be biggest problem.
- Awareness of resource portal will be challenging.

Stakeholders also rated the potential for improvement over the current LTSS access and funding system following the developed list of essential criteria objectives. A zero implies no improvement, +1 through +3 implies modest to significant improvement:

Access/Equity of Access	+2.36
Costs and Efficiency	+2.00
Benefits	+1.71
Sustainable	+2.29
Systemic Change	+1.79
Feasibility	+2.14
Integration	+1.79
Incentivization	+1.57
Adaptable and Supportive	+2.07
Understandable and Marketable	+2.08

## Recommendation 2: Medicare Companion Product

Currently in Minnesota, the Minnesota Senior Health Option (MSHO) is a long-standing and nationally recognized program where health insurance carriers have seen great success in offering integrated acute and long-term care services to Medical Assistance eligible enrollees for the past twenty-five years<sup>18</sup>. Citing the long-term successes and benefits of this model and as something that already exists in Minnesota, stakeholders sought to identify opportunities to bring this concept “upstream,” into the “red box<sup>19</sup>,” and making it available before those needing care would have to spend down to Medical Assistance (Medicaid) levels.

### Summary:

Building upon the successful Managed LTSS program called Managed Senior Health Options (MSHO), the second recommendation seeks to expand this coordinated care approach to the “red box” older adults in Minnesota. In combination with the support offered in Recommendation 1, stakeholders stated the need for care coordination across the acute care and long-term care needs of Minnesotans. MSHO offers this for Medicaid qualified individuals who enroll.

Bringing MSHO “upstream” may be accomplished by reimagining how to pair the payers for acute health care and long-term care supports and services. MSHO uses both Medicare and Medicaid funding for acute care needs, and primarily Medicaid funding for LTSS needs. The enrollee’s care needs are coordinated across the care continuum and with collaboration with eight insurance carriers and similar entities who take on the risk. Many are non-profit insurers with two county-based purchasing organizations. In a similar way, Recommendation 2 suggests that Minnesotans within the “red box” may receive care through coordination between their Medicare plans and a public or private based plan that funds long-term services and supports.

Stakeholders supported the need for coordination between acute health care needs and long-term care services. Two options were offered that incorporate this “hybrid coordination” approach:

- *Market Driven Approach:* The first approach is to build and enable the structure necessary to expand insurance options that leverage this MSHO-like approach so that older adults in Minnesota have these insurance market options and receive coordinated care solutions. Such a structure may be supported by leveraging the care coordination services of Medicare Advantage plans while linked to a long-term care based insurance product. Such “LTSS Insurance products” may include short-term care, long-term care, hybrid life and LTC, and other supplemental health products that address LTSS needs. Each product approach may have different advantages and may meet a diversity of older adult care and financial needs. Often the products are focused on particular markets including employer, affinity group, individual, and advisor markets.

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<sup>18</sup> [MN.gov - Minnesota Senior Health Options \(MSHO\)](#)

<sup>19</sup> The “red box” refers to Minnesotans with a yearly family income of \$25,000 - \$124,999. This socioeconomic group makes up approximately two-thirds of the Minnesota population over age 65.



- *Compulsory Approach:* The second approach recommended by stakeholders is to develop a state sponsored obligatory or compulsory program. This would require all Minnesotans to have some base level of coverage through a product that funds long-term care services and supports by the time they reach or approach retirement age (for example age 60, 65 or their normal retirement age). The requirement would have a threshold level of necessary coverage, for example a year or a dollar amount, which could be initiated and funded at or prior to retirement age. The key here is to offer a variety of options that meet the needs of Minnesotans as they prepare for the future. Such designs may use private and/or public participating entities where integrated care coordination may be enabled. Minnesota’s older adults that are enrolled in Medicaid would already meet this mandatory or compulsory requirement. Additional funding structures could be employed to reduce the monthly premium for older adults and encourage earlier planning.

This “link” between the acute care and LTSS products may include incentives to use the care coordination services of each and should seek to allow for portability between health insurance products both within Minnesota and other states.

**Objective:**

Consumers need a collaborative approach to managing the chronic illnesses and resulting cognitive and physical impairments in retirement. Similarly, they need a different source that provides a collaborative approach to funding besides a future reliance on Medicaid for their initial and significant care needs. An approach that meets both desires exists today, however, one which is currently limited to only being accessible to supporting the needs of the Medical Assistance (Medicaid) populations in Minnesota. The objective of this recommendation is to provide a similar source while enabling and incentivizing further protections for ALL of Minnesota’s older adults.

Managed Long-Term Services and Supports (MLTSS) programs are used in more than half of the states<sup>20</sup>. In Minnesota there are many insurance carriers and entities who are engaged in the MSHO program. One of the cost-savings benefits of this recommendation is that the infrastructure to support Minnesotans “upstream” from in this manner already exists and that structure can be leveraged beyond MSHO. However, a different financing approach that seeks to retain the incentives for the payor to provide care coordination and support is necessary for success.

**Features:**

In either approach identified above, Minnesotans have the opportunity to have a collaborative LTSS solution as they prepare and plan for their retirement years. Linking the acute and LTSS care coordination efforts are a unique feature of this approach. This can be accomplished in either scenario identified here.

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<sup>20</sup> [AdvancingStates.org](http://AdvancingStates.org) - MLTSS Map

In the **Market Driven approach**, the objective is to enable a market for such products to be developed and provide incentives that encourage participation by all stakeholders, including consumers, insurance carriers, providers and government. Specifically, many existing LTSS insurance products could be leveraged to address LTSS needs including Long-Term Care, Short-Term Care, Supplemental Health insurance, or other products. These private market insurance policies may be issued along with an acute care policy that has care coordination supports. In order to encourage the insured to utilize the care coordination efforts of the acute care programs, the policy would provide incentives. Such incentives could be a reduced elimination period or enhanced benefits if the insured participates in the acute and long-term care coordination programs of each policy. Similar incentives could be leveraged if the insured participates in a wellness or prevention program. Each of these approaches are already employed within products recently available in the LTSS insurance industry.

The Market Driven approach would leverage existing insurance carriers within this market but also encourage new entrants, such as health insurers, who may seek the assistance of reinsurers and/or private LTSS insurance carriers. This leverages already existing care coordination, chronic illness management, and outreach to insureds of the health insurer. This is of significant importance as within the current LTC insurance industry, there is a general lack of pre-claim interventions and support as the tax code does not appear to allow for direct support until the insured is benefit eligible.<sup>21</sup>

One of the benefits within Recommendation 2 of the public/private partnership is the opportunity for the private market to bear the risk. For example, reinsurers or LTC carriers supporting health insurance carriers entering this market may support their care coordination and wellness programs and/or share in the costs with a monthly per policy fee and/or offer risk sharing incentives.

The **Compulsory Approach** can build upon the market driven design with the added necessity for consumers to select a solution prior to a given age, for example their normal retirement age. As discussed above, covering the full population and ensuring that stakeholders are able to participate within a public/private collaborative approach is a necessity, however, a public only option may not offer the cross product care coordination approaches. Stakeholders and expert panelists discussed this and identified potential approaches:

- First, the primary population “above the red box” are Medicaid eligible participants who already have a plan for their needs through Medicaid, including MSHO.
- Second, participants who have purchased a plan prior to normal retirement age, subject to certain minimums, are also covered.
- Finally, it is important to examine the remaining population and the potential funding approaches that can enable a robust approach.

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<sup>21</sup> See prior comments and definitions on HIPAA based eligibility for care.

Within the remaining block of Minnesotans, the potential population could be across the “red box” (or of an upper income level) and will include individuals of a current need for care or those with an existing chronic illness. In addition, those of this group nearing Medicaid eligibility may require a different consideration for the impact of adverse claims and the unaffordability of premiums.

Some approaches that were offered may include:

- Premium subsidies,
- Requiring integration of benefits between acute care, Medicaid and pre-Medicaid programs, and
- Waiting periods or phase-in of coverage levels.

A public option or mechanism may be necessary to fund the adverse claims experience that is anticipated so that participants including insurance carriers who are willing to administer the program, can do so with incentives properly aligned. Stakeholders and experts noted the recognized risk adjustment approaches that enable MSHO and Medicare Advantage programs to continue. Such mechanisms are necessary to enable these public/private collaborations and may be applicable in this approach.

Tax incentives and market opportunities for individuals, employers, and for insurers may be necessary to reduce the burden of adverse claims experience in the Compulsory Approach. Purchasing solutions for LTSS care earlier than the compulsory age brings an opportunity to reduce the impact and need for subsidies for impaired older adults and may result in lower premiums for the buyer. Such incentives could include tax incentives for participants and for employers.

For employers to support this approach, it is imperative to acknowledge the variety of approaches that exist to support the LTSS needs of employees. This includes Health Savings Accounts, group insurance products, multi-life approaches, and the variety of LTC insurance related solutions currently in the market. The stakeholder and expert discussions included employers and employee benefit specialists. Employers are looking to support and incentivize employees to plan for their future LTSS needs. Stakeholders recognized the need for such incentives. Additional analysis of potential design considerations is warranted to determine the benefit of incentivizing the purchase of an eligible LTSS solution over the potential adverse selection issues that arise when participants wait.

Lastly, there may be a need for regulatory changes to enable either approach. For example, the NAIC has a model regulation that contemplates Short-Term Care products<sup>22</sup>. Minnesota would need to draft language that would support this potential market. Second, there may also be an opportunity to further protect Minnesota’s older adults by enhancing the products that may

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<sup>22</sup> [NAIC.org - Limited Long-Term Care Insurance Model Regulation \(PDF\)](#)

qualify under the Long-Term Care Partnership program. Clearly, provisions under the **Compulsory Approach** would require legislative actions.

With **either approach**, there are opportunities to encourage both the consumers to obtain coverage earlier than the normal retirement age and for employers to be encouraged to assist their employees and their families.

One of the main benefits of Recommendation 2 is that it favors both consumers and the market. For consumers, purchasing earlier provides both protection and an opportunity for lower costs as premiums tend to decrease with lower issue ages and better health. In addition, should an early care need arise, the ability to manage the care needs generally improves outcomes for the older adult. Within the obligatory approach, early purchasing reduces the potential for adverse selection at a later age and decreases the need for subsidized premiums described above.

A few key remaining questions are to be consider for the features of either the Market or Compulsory Approaches:

- What is an appropriate minimum amount and type of coverage? Is \$50,000 of pooled benefits a reasonable amount? Is a required inflation component necessary?
- Are there opportunities to enhance their coverage as needs change leading up to the required purchase age and beyond?
- To what extent will participants purchase coverage above the minimum required?
- Is there an opportunity to further protect older adults with LTC Partnership program eligible products?
- How would premiums differ between the market and the compulsory approaches?

#### **Funding Options and Considerations:**

Based on the design of this recommendation and the strong desire for care coordination across the acute and LTSS needs, the funding approach recommended leans towards a premium based approach versus a payroll tax approach. The program design is more similar to existing LTC and Short-Term Care insurance with the need to include incentives for participating in the care coordination efforts of the combined products. The Market Based approach may have increased appeal if all products that provide LTSS funding support are considered for tax incentives and inclusion in partnership eligible treatment.

Within the Compulsory Approach, the estimated monthly premiums for a one-year, \$135 a day benefit at age 65 year-old cohort is \$120 per month, with premiums and benefits increasing both 3% annually. This indicative pricing estimate is without any adjustments for reduced claim incidents and costs due to both care coordination and integrating benefits across funding sources. An initial premium of \$100 per month for similar benefit levels has been a typical target that is marketable for most. The current market for short-term care insurance policies for an age 65 year-old is similarly priced.

Concerns were raised that a compulsory program would be prohibitively expensive due to the impact of a guaranteed issue approach (which includes those currently eligible due to an existing level of impairment). State-based reform approaches have the difficulty of comparing the cost of the program to market based solutions currently available or in nearby states. Stakeholders expressed the need for premiums for an obligatory design to compare reasonably with existing LTC products of a similar level of benefits. This is particularly important with specific state-based reform efforts. As discussed above, premium subsidies and the coordination of claims amongst the Medicaid and Medicare programs may alleviate that concern. Discussions of a premium tax on LTSS products may support the funding of such subsidies and do so at a marginal level.

An alternative approach for the Compulsory Program pricing may be a shared expense that results in a split of a payroll tax and premiums. The payroll tax portion may fund earlier claims and the impact of impaired lives joining the pool at age 65. An alternative could be a waiting period of 5 to 10 years for claim for the impaired risks to offset the impact of early claim. This is further discussed in the Actuarial report.

Another funding structure could mirror the MSHO program for those that purchase at the normal retirement age. Instead of using private insurers to directly write policies issued at retirement, a state program may be the intermediary who then utilizes private insurers writing similar business with risk adjusted payments to provide the care and administer the care coordination programs. The use of the risk adjustment mechanisms similar to the Medicare Advantage program is also an approach that may be examined.

Encouraging Minnesotans to fund their LTSS risks earlier than at retirement may mitigate the need for premium subsidies and risk adjustment provisions. Tax incentives for individuals, employees, and employers should be evaluated and considered.

### **Benefits:**

Panelists viewed the benefits of this recommendation as providing a significant “game changer”. The collaboration between the public/private market products of Recommendation 2 has the following benefits:

- Coordination across the care continuum reduces the duplicative efforts of each product and brings opportunities including reducing both acute and LTSS claim costs and administrative expenses. Hospital re-admission rates may improve when home care is promptly coordinated.
- Care coordination and management programs already employed for acute care needs can bring savings to both the acute and LTSS anticipated costs. Health plans who partner with reinsurers or product carriers can be provided a per member per month cost share for their care prevention and coordination efforts.
- The collaborative approach supports the family and the caregiver to encourage efficient home and community-based care where older adults wish to be. The collaboration may be timely, preventing declines in independence, and address the whole needs of the insured.

- An appeal to consumers who want their care coordinated across the continuum from the physician’s office, to the hospital, to the home for LTSS needs.
- The potential for increased carrier participation within the LTSS market as it leverages existing care coordination programs and services.
- Provides a benefit on the front-end where “red box” Minnesotans need the most support.
- Provides an opportunity to expand participation in the LTC market by middle income consumers, by health and other insurance carriers, and supported by employer and individual distribution partners who work with this population.
- Avoids the issues of a payroll tax approach where participants may lose or reduce their coverage if they leave the state and increases who can participate by removing the employee-based approach.
- Both the Market Based and Obligatory Based approaches allow for portability regardless of whether the individual switches their Medicare plan or leaves Minnesota.
- The approach aligns incentives and enables stakeholders including government entities, providers, insurers, and families to find unique structures not available to segregated product approaches and/or single pay LTSS designs.
- Within the Compulsory Approach, employers, insurers, and distribution partners may sell additional coverage with the same insurer as the base coverage. This removes the supplemental and separate coverages of other potential state-based initiatives.

**Additional Considerations:**

*The LTC Partnership Program*

The LTC Partnership<sup>23</sup> program has historically been limiting and many have stated it failed to meet the objective of increasing middle income participation in the LTC insurance market. However, the reasons are many and include an initial requirement for a 5% annual inflation of benefits which increased premiums beyond affordability. Additionally, the products that have historically qualified for Partnership program status do not include LTC riders on life and annuity products which are the predominant sale today. Encouraging all LTC solutions to be eligible for Partnership status, assuming a minimum level of coverage, may increase the opportunities under Recommendation 2 in either the Market or Compulsory design.

*MSHO Buy-in Option*

As stakeholders seek to leverage what is working in Minnesota, an MSHO buy-in option may be a consideration. An older adult nearing Medicaid eligibility and with a chronic condition may seek support through a coordinated care solution. This option would allow individuals eligible for Medicare and who have a chronic illness or a care need to buy-in to the MSHO program earlier than when Medicaid eligible. This way when the care need intensifies such that Medicaid eligibility is likely, they are already enrolled in a care coordinated solution. This seeks continuity of care and supports the “upstream” effort the stakeholders desired.

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<sup>23</sup> [MN.gov - Long-term Care Partnership](https://www.mn.gov)

The approach has some advantages:

1. It allows for asset and income protection that can be enhanced based on the participation in a care coordination program.
2. It provides an easy transition into MSHO when and if the individual has an LTSS need that would lead to eligibility for Medicaid.
3. Increases the opportunity for those at the top or the "red box" to delay and potentially divert LTSS needs.

This approach may apply in either the Market Option or Obligatory Option and may help reduce the impact of adverse selection on the overall program. The potential to vary the premium and/or co-pays by income or assets may also be an opportunity. Further study is necessary.

### **Assessment of Impact, Pros/Cons Analysis:**

Stakeholders developed an assessment of the impact of the **Companion Product** approach and had the following verbatim observations:

#### *Pros:*

- This is unique, transformational and educates the consumer while encouraging Minnesotans to make a decision on their coverage needs.
- The approach builds awareness for the need and becomes another touch point for the service provided in our Recommendation 1.
- Helps to prevent spend down to Medicaid and loss of assets.
- A market-based approach, with opportunities for additional state support for those with financial need, is generally a good place to start.
- Market option version could offer scalable premiums to a price point that reflects market demand.
- An advantage compared to other funding approaches, e.g. a payroll tax.

#### *Cons:*

- Needs to be done to encourage people to deal with their LTSS needs earlier. Cannot become an insurer (or a program) of last resort.
- A strong need for carrier participation to leverage industry care coordination practices.
- The need for a subsidy for the lower income to achieve 100% buy-in.
- Enrollment specialists or companies will require robust training on how the options work.
- The mandatory option of requires a premium that is not expensive for a small benefit which may be quickly exhausted.

Stakeholders also rated the potential for improvement over the current LTSS access and funding system following the developed list of essential criteria objectives. A zero implies no improvement, +1 through +3 implies modest to significant improvement:

Access/Equity of Access	+1.83
Costs and Efficiency	+1.83
Benefits	+1.92
Sustainable	+2.17
Systemic Change	+2.08
Feasibility	+1.17
Integration	+2.08
Incentivization	+1.42
Adaptable and Supportive	+1.50
Understandable and Marketable	+1.50



### **Recommendation 3: Catastrophic Lite Benefit**

Long-Term Care solutions that address catastrophic long-duration claims have long been proposed in public policy circles. These approaches seek to reduce the impact of long-duration claims on families and offset the need to spend down assets and income levels to qualify for Medical Assistance (Medicaid). The proposed programs are often public social insurance mechanisms either sponsored by the federal government or the states. They seek to reduce the burden of Medicaid expenses that often overwhelm both state and federal budgets. Some designs have waiting or elimination periods based on income levels during the participants' working years before eligible individuals can access benefits.

In Minnesota, eligibility for Medical Assistance requires total asset spend down and poverty-level income limits. Under this recommendation, such state and federal programs would continue along-side this Catastrophic Lite program and coordinate based on the individualized needs of the older adult. Stakeholders have aimed to reduce the need for those in the "red box" to spend down. A Catastrophic Lite program along with the Recommendation 1 approach, can support that goal with claims that are initially less intense and costly.

Stakeholders opined on a "lite" version of a catastrophic design which was identified in the proposal request for this project.

#### **Summary:**

The third recommendation reviewed in detail by stakeholders is a Catastrophic Lite option. This compulsory program is funded by a payroll tax and provides benefits for eligible participants for up to five years of care following satisfaction of a 2-year elimination period. Eligibility would be vested for participants that contribute for at least 10 years with limited gaps allowed. Benefit eligibility would be the tax qualified definition within LTC insurance requiring two of six ADLs or severe cognitive impairment.

The Catastrophic Lite product is intended to cover employees and the self-employed who vest in the program through the payroll tax requirements. An approach to also provide coverage for non-vested spouses is also reviewed.

#### **Objective:**

The Catastrophic Lite product has the objective of reducing the strain of long-duration and intense claims which can have a devastating impact on individuals and their families. Today, when a care need persists for a lengthy period of time, families deplete their savings and the result can financially harm the entire family. More information on expected claim lengths is contained in the [Actuarial Report](#).

Minnesota has supportive Medicaid programs including many programs that aim to defer the need for nursing home care, however, the income restrictions and asset spend down requirements during lengthy claims can have a deep impact on families for generations. Many do not file for Medicaid benefits out of fear of losing their homes or the inheritance for their heirs.

The costs of care, especially in facilities, is significant. The objective of this recommendation is to provide partial relief after two years of care and as care needs intensify and become difficult to provide. Additionally, the approach allows all Minnesotans the opportunity to use a Medicaid like benefit with a similar elimination period but without the need to fully spend down or minimize income.

An additional objective of this program is to encourage the purchase of gap coverage for the two-year elimination period and to enhance the market where insurance carriers may write such policies.

### **Features:**

The Catastrophic Lite product will provide benefits for Tax Qualified LTSS needs which require assistance with at least two of the six Activities of Daily Living (ADLs) and which are expected to last at least 90 days, or for Severe Cognitive Impairment. Coverage will continue for five years after a two-year elimination period. Eligibility requires meeting a vesting requirement and coverage of claims begins at age 65. The benefit has a maximum of \$50,000 per year, \$250,000 over five years, with an annual inflation of 3% per year.

During the elimination period and while benefits are paid, the plan can integrate with other solutions such as Medicare, Medicaid, PFML, Elderly Waiver, and similar programs. Some Minnesotans in “the red box” may be able to rely on Medicaid programs while in the elimination period of this product.

The elimination period is intended to be a 2-year calendar duration so that informal and community caregiving will help satisfy the elimination period. This was encouraged by stakeholders to help preserve the assets and income of “red box” participants.

### **Funding Options and Considerations:**

The payroll tax would be assessed on all W-2 income for those 18 and older. Indicative pricing based on a 70-year projection of demographics yields a range of 0.55% - 1.15% of W-2 income. This estimate reflects a plausible range of funding requirements under multiple eligibility criteria and economic conditions. This assumes that 18 year-olds and above participate and there are no minimums or caps on income that is subject to the tax. This also assumes that initial participants who can become vested are also paying the tax and eligible to become vested. This differs from a new/entry-level population as they would have fewer years to contribute and become eligible. The product design may also cover spouses who are not individually eligible due to their own vesting. Further details are provided in the [Actuarial report](#).

Panelists discussed other considerations that may reduce the cost of the program such as having participants and their non-vested spouses share a benefit pool or using alternative approaches to inflation provisions within the policy.

Potential risks to this state sponsored program include the moral hazard risk as those who purchase supplemental coverage are not incentivized to use informal or other less expensive

care settings as they may essentially have lifetime coverage with few limitations. The LTC industry has seen increased incidence and claim utilization when individuals purchase lifetime coverage or high monthly benefit amounts. This risk of increased claim incidence may be addressed with product design features, care coordination requirements, or potential requirements that encourage reasonable care coordination of claims. Furthermore, the use of Recommendation 1 as a care coordination tool, should be considered as a mitigator for such increased claim incidence.

Administrative expenses may be greater than anticipated as identifying when a potential claimant's elimination period starts may increase costs. These potential risks further support the need for approaches that initiate care coordination and supports at or before the time of initial claim may help reduce the administrative burden and reduce future claim costs.

As this program is designed to begin with a block of Minnesotans across ages 18-65, there is an impact on the likely initial payroll tax rate caused by the initial participants at later ages. For example, a 55 year-old would likely pay the payroll tax for 10 years before being vested in the program while a 45 year-old would pay for 20 years. This disparity is most pronounced initially and would also exist, but to a lesser degree, when individuals move to Minneapolis at a later age. The impact could be material and may reduce the payroll tax to the lower end of the given range. This may also be mitigated with plan design changes such as a grading in of benefits or an opportunity for benefit duration adjustments with such participants.

### **Benefits:**

**The benefits of this approach are many. Stakeholders and panelists provided the following:**

- Stakeholders agreed that the proposal will significantly decrease Medicaid expenditures but at the cost of a payroll tax to Minnesotans.
- Minnesota's older adults may see this as a means to de-risk themselves of the long duration claim and seek protection or pursue a plan for the interim and shorter duration care needs.
- The level of awareness of LTSS needs and costs will go be enhanced from the recognition of the risk to the potential to encourage Minnesotans to plan for the two years they need to cover themselves.
- Opportunities for the market to innovate with creative funding approaches may increase as additional products such as short-term care, life and annuity hybrid products, supplemental health, and personal and tax-advantaged savings, can be used to fill the gap in coverage.

With applicable regulatory changes, the product could be considered eligible for Partnership program protection and allow middle-income Minnesotans to have early access to and supportive in-home benefits without the need to first spend down their savings. This may be of a benefit to those with a care need lasting longer than 7 years or may support the claim when costs exceed the monthly benefit amounts available.

There will be an opportunity to examine approaches to help reduce future claims and sustain a consistent payroll tax and/or benefit levels. This may include:

- Allowing for private collaborations of the risk through cost sharing arrangements with insurers and provider organizations.
- Implementing care coordination and management initiatives that begin as the initial care needs emerge and throughout the elimination period and claim.
- Exploring payroll tax approaches that balance the contributions of initial entrants at older ages with new entrants. For example, the age 55 year old cohort.
- Explore reducing the payroll tax on low-income participants and capping the total tax collected on all participants.
- Developing approaches that give tax credits for those that purchase and retain applicable supplemental products.

### **Additional Considerations/Options:**

Additional considerations and options were offered and fall under the following general topics:

#### Payroll tax considerations

- A payroll tax that is applied to a threshold level of income can reduce the burden on the working poor who may already be Medicaid eligible.
- A cap on the income taxed each year may ensure that vested participants have not paid more in taxes than the lifetime benefits available to them.
- A graded vested benefit may be employed to reduce the burden on the tax rate of individuals who move to Minnesota and are able to qualify in 10 years.

#### Medical Assistance Eligibility:

- As eligibility for care support from Medical Assistance programs differs from the HIPAA Tax Qualified approach in this program, there will be individuals that qualify for benefits under Medical Assistance but not the Catastrophic Lite program.

#### Supplemental or Gap Coverage Considerations:

- Products supporting coverage in the gap years or beyond should include all forms of coverage that address LTSS care needs including worksite and individual products.
- Additional research should be performed to determine whether both the supplemental and the Catastrophic Lite programs should qualify for Partnership Product eligibility.
- For some, 7 years of coverage may not be sufficient to adequately protect them from the cost of extended LTSS needs. Individuals may

also wish to examine impaired longevity products that help support lengthy claims.

- There is a potential to allow the Catastrophic Lite benefits to be administered and coordinated by the same private insurer who may be covering the initial 2 years of care needs. In the same way as MSHO, this approach can leverage the infrastructure for care coordination and claims and also incentivize reduced program and claim costs. Furthermore, the consumer isn't left with the burden of struggling to find who pays for care and when.

### **Assessment of Impact, Pros/Cons Analysis:**

Stakeholders developed an assessment of the impact of the **Catastrophic Lite Program** and had the following verbatim observations:

#### *Pros:*

- This is a more transformative reform proposal.
- This would lead to a reduction in use of Medicaid.
- The approach could allow for incentives for lower income of a premium tax reduction or reduction in payroll tax.
- May help shore up the Medical Assistance program for the "red box".
- Biggest potential for Medicaid savings.
- Coverage of spouses is a positive.
- Higher income populations may buy gap coverage.

#### *Cons:*

- Will take some resources to get through the two years, especially if the trigger is the tax qualified ADL/Severe Cognitive Impairment approach.
- Think this would be more helpful to higher income populations.
- Some would likely pay more in tax than benefits they are likely to receive.
- Doesn't really target the income group just above the Medicaid thresholds.
- This would require the coordinated care component to help avoid spend-down.
- The new tax may be a significant barrier to getting approval for it.
- The benefits will go to a smaller piece of population to those with significant needs for long periods of time versus a "front end" program which would target a broader population.
- Payroll tax would need to start at a higher income and therefore be more regressive.
- The two-year elimination period seems too long for people in the "red box" relative to income and liquid assets.

Stakeholders also rated the potential for improvement over the current LTSS access and funding system following the developed list of essential criteria objectives. A zero implies no improvement, +1 through +3 implies modest to significant improvement:

Access/Equity of Access	+1.67
Costs and Efficiency	+1.56
Benefits	+2.22
Sustainable	+1.89
Systemic Change	+2.22
Feasibility	+1.22
Integration	+1.78
Incentivization	+1.56
Adaptable and Supportive	+1.22
Understandable and Marketable	+1.56

## Implementation Approaches and Potential Constraints

Stakeholders were quick to point out that the three recommendations are not mutually exclusive. While Recommendation 1 (Care Navigation and Support Services) received the strongest interest, there were discussions of how each of Recommendations 2 (Medicare Companion Product) and 3 (Catastrophic Lite) may benefit from the first. Panelists commented that the recommendations may be implemented in order and over a series of years as the programs and their benefits each begin to be realized. Furthermore, they stated that market-based approaches may be a precursor to compulsory programs when implemented to further the opportunities for Minnesota's future older adults.

The sequential approach can also provide broad support. For example, implementing Recommendation 1 may give immediate supports for all older adults regardless of age. Adding the Market Approach of Recommendation 2 allows older adults to participate voluntarily. Then a compulsory approach within either Recommendations 2 or 3 can be implemented for new cohorts and at an entry-age that does not immediately stress the potential sustainability of the programs with "windfall" generations of participants.

Panelists were aware of the degree of willingness of key stakeholders, decision makers, and constituents to pursue the recommendations. This produced a desire for a gradual approach that addressed the root caregiving concerns, helped to alleviate the current caregiver supply crisis, can quickly demonstrate improvement in the overall system, and then build upon successes gradually.

Overwhelmingly, Recommendation 1, with the home modification benefit and a focus on early intervention and informal caregiving support, was highly regarded as a strong approach to implement soonest and address the increasing Medicaid costs and aging of the older adult population through 2035. Early intervention, wellness, ancillary services, and the light-touch pre-claim HCBS initiative were deemed what Minnesotans need soonest. Once established, and with support from other state and federal stakeholders, the other recommendations may be employed.

## Comparing the Recommendations

As the recommendations evolved, stakeholders leaned towards prioritizing caregiver assistance and navigation as a differentiator from the existing system of LTSS supports. As the funding recommendations were developed, panelists sought out an approach where collaboration was a priority and where existing solutions may be readily enhanced. This included options for both market and compulsory solutions.

Stakeholders rated the potential for improvement over the current LTSS access and funding system following the developed list of essential criteria objectives. A zero implies no improvement, +1 through +3 implies modest to significant improvement:

Evaluation Criteria	Rec #1	Rec #2	Rec #3
Access/Equity of Access	<b>+2.36</b>	+1.83	+1.67
Costs and Efficiency	<b>+2.00</b>	+1.83	+1.56
Benefits	+1.71	+1.92	<b>+2.22</b>
Sustainable	<b>+2.29</b>	+2.17	+1.89
Systemic Change	+1.79	+2.08	<b>+2.22</b>
Feasibility	<b>+2.14</b>	+1.17	+1.22
Integration	+1.79	<b>+2.08</b>	+1.78
Incentivization	<b>+1.57</b>	+1.42	+1.56
Adaptable and Supportive	<b>+2.07</b>	+1.50	+1.22
Understandable and Marketable	<b>+2.08</b>	+1.50	+1.56

Comparing the results, it is clear that Stakeholders viewed Recommendation 1, Care Navigation and Support Services, as providing the most improvement on the overall LTSS system.

Additional observations are:

- Generally, scores were lower for the ability of the funding proposals to properly incentivize participation. Panelists did not express strong support that the financing proposals, on their own, would adequately improve take-up rates for LTSS solutions or access to LTSS.
- High improvement scores show that stakeholders believe the recommendations can support older adults by integrating support across the care continuum with significantly improved access to care.
- Stakeholders also viewed these recommendations as improving equity of access to care as the proposed approaches seek to support rural, urban, tribal nation and other demographic differences within the population.
- Both in the ratings and the pros and cons comments, stakeholders were less optimistic about the feasibility of the two proposed funding solutions. However the premium approach gained a stronger acceptance than the payroll tax approaches.





# **The Own Your Future LTSS Funding and Services Initiative**

## Actuarial Considerations Report

October 2023

Prepared by FTI Consulting, Inc, Actuarial Research Corporation, and the Altarum Institute, for the Minnesota Department of Human Services Aging and Disability Services Administration

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## Summary

Actuarial Research Corporation (ARC) performed data analysis and actuarial work in support of the engagement Study Options to Increase Access to Long Term Care Financing, Services and Support in Minnesota. This work consisted of two broad tasks. The first involved data analysis to understand the landscape of the current long-term services and supports need and utilization in Minnesota. This included a particular focus on the middle-income socioeconomic classes – individuals who are not eligible for Medicaid but often would not have assets to support long term care needs. The second consisted of actuarial modeling to estimate costs of the various LTSS programs that stakeholders and the project team considered. This modeling was intended to be indicative, with the goal of setting realistic high-level expectations on the costs and impacts of additional public LTSS benefits.

Table 1 provides an illustration of current sources of LTSS coverage available to Minnesotans age 65 and older in 2019, by family income. The Medicaid and Alternative Care programs provide substantial LTSS benefits to the low-income population and programs funded by the Older Americans Act (OAA) provide limited services to similar populations as well as vulnerable low-middle income populations. Most middle- and high-income individuals finance LTSS care needs through out-of-pocket expenses or private insurance.

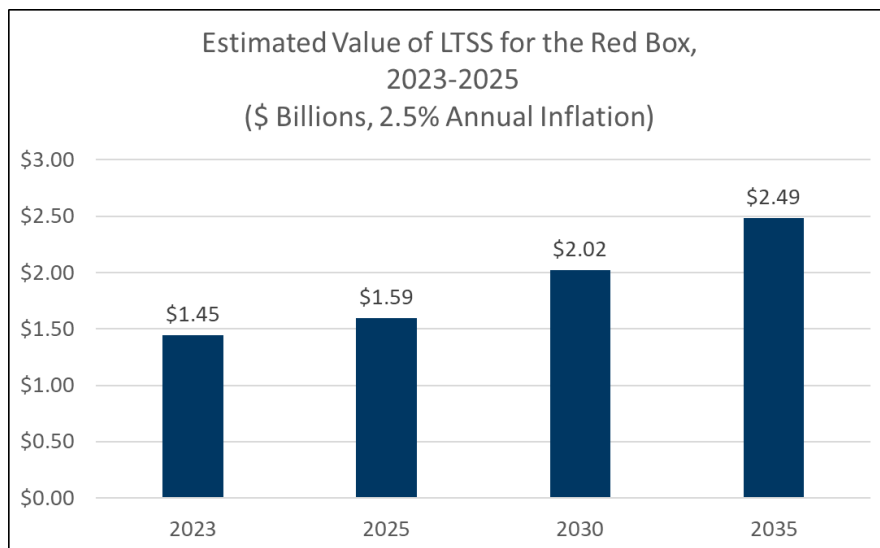
*Table 1: Age 65+ Minnesota LTSS Source of Coverage 2019, by Family Income*

Family Income	Percent of Age 65+ Pop	Medicaid Programs	Alternative Care	OAA	Out-Of-Pocket	Private Insurance
<\$10,000	5%	X				
\$10,000-24,999	20%	X	X			
\$25,000-49,999	25%	X	X	X	X	
\$50,000-74,999	19%		X	X	X	
\$75,000-99,999	11%			X	X	
\$100,000-\$124,999	8%				X	X
\$125,000-\$149,999	3%				X	X
>=\$150,000	9%				X	X

While individuals of all socioeconomic groups rely on informal caregiving, the low-income population is eligible for substantial LTSS benefits provided by Medicaid, and the high-income population has the ability to self-finance care. However, the middle-income population lacks access to substantial LTSS benefits and may struggle to cover the costs of an LTSS need. This socioeconomic group, which the project team named the “red box”, makes up approximately two-thirds of the Minnesota population over age 65. Of those, we estimate 50% do not have assets to cover their LTSS need. This dynamic led the stakeholder discussion to focus on program recommendations that could provide support to the middle-income population, while also considering improvements that could enhance the experience of all LTSS users.

We project that the estimated number of individuals with an LTSS need in the “red box” will increase by 28% between 2023 and 2035. This increase is driven by both an increase in the population aged 65 plus and the fact that these individuals are projected to live longer than previous generations. We estimate that the value of demand for LTSS services needed to support this population could grow from \$1.45 billion in 2023 to \$2.49 billion in 2035.<sup>24</sup> This amount is an attempt to quantify value of services that may be needed to support the projected LTSS need. In practice, a portion of the need will be provided by informal or unpaid caregivers. However, this figure illustrates the growth in LTSS need that will need to be considered going forward.

*Chart 1: Estimated Value of LTSS Demand for the Red Box Population, 2023-2025*



Many recommendations were considered during stakeholder discussions, and this report reflects the costs and impacts of three recommendations selected for evaluation. These include:

- Recommendation 1: Care Navigation and Support Services
- Recommendation 2: Medicare Companion Product
- Recommendation 3: Catastrophic Lite Benefit.

Funding the care navigation services in Recommendation 1 is the least costly of the three programs as it does not directly pay for LTSS care. We assume that this program could be supported by the Minnesota general fund and/or expansion of Medicaid waiver programs and would add between 0.8% and 1.6% to the state general expense budget (\$250-\$500 million in 2025). Recommendation 2 would be supported by a premium starting at age 65. The premium required to support the illustrative one-year, \$135 per day benefit provided under this recommendation is estimated to be \$120 per month, indexed at 3% annually. Recommendation

<sup>24</sup> Estimate assumes community need of 20 hours of care per week at \$27 per hour, \$139,000 per year cost of nursing facility, and 2.5% annual inflation.

3 would provide a five-year, \$135 per day benefit after a two-year waiting period and require a payroll tax ranging from 0.55-1.15%, depending on eligibility and economic assumptions.

Each of the recommendations considered in the actuarial modeling address different issues of those faced with long-term care needs. Recommendation 1 seeks to provide clarity in care options, maximize existing resources, enhance access to care supports, and provide care coordination in order to empower LTSS beneficiaries and their families and improve quality of care and outcomes. Recommendation 2 seeks to provide LTSS care coordination across beneficiaries' acute care and LTSS needs, as well as a benefit that would be used to fund LTSS needs soon after needs arise. Recommendation 3 seeks to provide protection for significant episodes of care which last longer than two years. It is important to note that these recommendations are not mutually exclusive and could be implemented in combination or sequentially over time.

The success of any potential program will hinge upon broad-based support from the population as well as a focus on LTSS education in order to encourage individuals to begin preparing for potential care needs before they arise. The magnitude of incremental taxes or premiums will need to be considered relative to the portion of contributors whose long-term care experiences are meaningfully impacted to ensure that the program is providing meaningful value to the population. This also includes thinking about how one would like to be cared for as well as how care will be funded. In addition, there are many decisions that would need to be made around benefit eligibility and integration with programs that currently provide LTSS, specifically Medicaid. Given the considered LTSS programs are expected to have the greatest impact on the not-yet-Medicaid eligible population, further operational and actuarial research is necessary to optimize the use of existing program budgets to support funding for non-Medicaid beneficiaries.

# Section 1: Quantifying Minnesota LTSS Need

## Prevalence of LTSS Need

Before evaluating potential changes to LTSS delivery in Minnesota, we wanted to understand the current state of LTSS need and available resources.

Our analysis of need focused on the population aged 65 and older. This population would likely not have disability insurance or other employment benefits that would provide support during an episode of care and is more likely to experience a significant LTSS need. However, the recommendations considered are not limited to providing care for this segment of the population and seek to improve care options for all Minnesotans, regardless of age.

There is data available on nursing facility (NF) utilization and home and community-based service (HCBS) utilization within the Medicaid population, but it is not straightforward to identify the community need for those who are not enrolled in Medicaid or those who are cared for by unpaid caregivers, given those needs are served through a variety of formal and informal means. In order to estimate the number of individuals with an LTSS need in the community, we relied on data from the Health and Retirement Survey to estimate the prevalence of individuals with the population who need assistance performing two or more activities of daily living (ADLs) or have severe cognitive impairment. The following table displays an estimate of the Minnesota population, age 65+, with LTSS care need broken out by care setting.

*Table 2: Estimated Minnesota LTSS Need 2020, by Age Group*

Age Group	Minnesota Population	Community Need	Nursing Facility Residents
65-74	566,442	29,000 (5.1%)	3,200 (0.6%)
75-84	269,304	29,700 (11.0%)	5,300 (2.0%)
85+	113,547	27,600 (24.3%)	10,900 (9.6%)
<b>Total</b>	<b>949,293</b>	<b>86,300 (9.1%)</b>	<b>19,300 (2.0%)</b>

Based on these estimates, approximately 10% of Minnesotans over the age of 65 have a significant LTSS need. These counts do not include estimates of individuals who need assistance with 1 ADL, instrumental activities of daily living (IADLs), or any other condition that could be a precursor to more significant disability. Of those with an LTSS need, about 1 in 5 currently reside in a nursing facility.

## Duration of LTSS Need

In order to understand the potential duration and cost of LTSS needs, we examined continuance data derived from the Health and Retirement Survey (HRS). The following table summarizes the distribution of duration of LTSS need by the age of need onset. While the HRS

is not specific to Minnesota, we do not see reason to expect meaningful state variations in continuance by onset age.

*Table 3: Duration of LTSS Need, by Age Group*

Onset Age	Avg Duration (Yrs)	% > 1 Year	% > 2 Years	% > 3 Years	% > 5 Years
55-64	3.2	58%	42%	32%	22%
65-74	2.7	52%	36%	28%	18%
75-84	2.8	62%	43%	33%	20%
85+	2.5	63%	43%	29%	13%
<b>Total</b>	<b>2.8</b>	<b>59%</b>	<b>41%</b>	<b>31%</b>	<b>18%</b>

The average duration of need is at least two and a half years for all age groups. While this is the average, it is important to note that for any individual, the care required can vary significantly. Almost 60% of individuals need care for more than one year, and one in five individuals have a care need for greater than five years. If we assume that the average cost of a semi-private nursing facility bed in Minnesota is \$140,000 per year and the average cost of home health services is \$50,000 per year<sup>25</sup>, the estimated lifetime cost of care for an individual who needs care is approximately \$200,000 in 2022.

This is a burden that many families are not able to afford, which results in the depletion of household assets, the use of informal care through family or other community caregivers, and many unmet care needs.

## Current LTSS Programs in Minnesota

Minnesota currently provides a variety of programs to assist the population with LTSS needs. These programs include:

- Older Americans Act (OAA) Programs
- Essential Community Supports (ECS)
- Alternative Care
- Medicaid LTSS Nursing Home
- Medicaid LTSS HCBS (Elderly Waiver)

OAA and ECS tend to provide limited and targeted support benefits, while Alternative Care and Medicaid provide more comprehensive coverage for residents with low incomes.

<sup>25</sup> [Genworth Cost of Care Survey](#), November 2021.

The following table contains estimates of the count of individuals receiving services through these channels in 2019<sup>26</sup>:

*Table 4: Minnesota LTSS Program Utilization, 2019*

<b>Minnesota Population</b>	<b>Count</b>	<b>% of Age 65+</b>
Age 65+	921,000	100%
OAA Clients <sup>3</sup>	62,900	7%
ECS <sup>4</sup>	300	<1%
Alternative Care <sup>27</sup>	2,400	<1%
Medicaid LTSS <sup>2</sup>	42,700	5%

### **Older Americans Act Programs**

OAA programs provide support to adults age 60 or older. These programs are federally funded so available benefits may be limited in any given year. Benefits are targeted to individuals with the greatest economic and social need.

Many types of benefits are provided by these programs, but they can be grouped into two categories: registered and unregistered services. Registered services require clients to provide significant personal information to receive benefits. Registered services include, chore, homemaker services and home delivered meals. Unregistered services do not require clients to provide personal information and include transportation, legal assistance, and various types of education. OAA also funds the Senior LinkAge Line, which is a resource that anyone can call to receive information and assistance regarding different aspects of LTSS. The following table displays estimates of the number of Minnesotans receiving services through OAA programs in 2019. Note that these numbers do not include those who utilized the Senior LinkAge Line.

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<sup>26</sup> Utilization from 2019 is considered in order to provide a consistent, pre-COVID basis for utilization across programs.



Table 5: OAA Service Utilization, 2019<sup>27</sup>

Persons Served	Total
Registered Services	48,800
Unregistered Services	14,100
Total Estimated Persons Served	62,900

Those receiving benefits from OAA programs tend to be above the income thresholds that would qualify for Medicaid. These clients tend to require assistance with fewer than 2 ADLs, but 54% need assistance with 1 or more IADLs. This is consistent with the idea that these programs primarily provide support to the pre-disabled population who does not qualify for Medicaid and aim to reduce the need to use Medicaid services in the future.

### Essential Community Supports

The ECS program provides limited service and support benefits to individuals 65 and older who live in the community. The population served by this program has a financial need and care needs that are significant but would not meet the threshold for Medicaid eligibility.<sup>28</sup> The value of benefits provided under the program is up to \$466 per month for services and supports in 2023. Services provided under ECS include:

- Adult day services
- Caregiver training and education
- Chore services
- Community living assistance
- Home-delivered meals
- Homemaker services
- Personal emergency response system
- Service coordination / case management

<sup>27</sup> The care threshold that must be met to receive Medicaid LTSS benefits is classified as Nursing Facility Level of Care (NF-LOC). NF-LOC requires that an individual meet one of the following criteria:

1. Would be homeless and:
  - a. Has had a fall resulting in a fracture within the last 12 months
  - b. Has a sensory impairment that impacts functional ability and maintenance of a community residence
  - c. Is at risk of maltreatment or neglect
2. Has a dependency in four or more activities of daily living (ADLs)
3. Has significant difficulty with memory, using information, daily decision-making, or behavioral needs requiring intervention
4. Needs assistance or constant supervision to complete toileting, transferring or positioning, and assistance cannot be scheduled
5. Needs formal clinical monitoring at least once per day

<sup>28</sup> OAA utilization estimates from Title III and VII State Program Reports, provided and reviewed by Minnesota DHS. This estimate includes utilization of registered and unregistered services but does not include utilization of resources such as the Senior LinkAge Line.

ECS funding may be limited and in 2019 it is estimated that a few hundred individuals received benefits through this program.

### **Alternative Care**

The Alternative Care program provides HCBS to individuals age 65 and older who live in the community and meet the Nursing Facility Level of Care (NF-LOC) requirement, have low levels of income and assets, but do not meet the financial qualifications for Medicaid eligibility. Individuals who receive benefits under this program are not Medicaid enrollees although the care is provided through a Medicaid waiver program.

The services provided under the Alternative Care program include those provided under ECS with the addition of:

- Companion services
- Consumer-directed community supports<sup>29</sup>
- Family caregiver support services, including respite
- Home health aides
- Home and vehicle modifications
- Individual community living supports
- Non-medical transportation
- Nutrition services
- Personal care assistance
- Skilled nursing visits

In January 2019, the Alternative Care program provided benefits to 2,427 individuals.<sup>30</sup>

### **Medicaid LTSS**

Medicaid LTSS is provided to individuals who qualify for Medical Assistance and meet the NF-LOC criteria. Income and asset qualifications depend on age, family size, and disability status. Medicaid LTSS benefits are primarily provided through the Elderly Waiver program and direct payments to Nursing Facilities, although some benefits are provided outside of these channels.

The Elderly Waiver program provides HCBS to individuals who have an NF-LOC requirement but choose to live in the community. Benefits provided under the Elderly Waiver are more comprehensive than those provided under the ECS and Alternative Care programs. The services provided under the Elderly Waiver program include those under ECS and AC as well as:

- Case management
- Residential services, such as customized living services, foster care of other type of residential care
- Skilled nursing visits

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<sup>29</sup> Consumer-directed community supports allows an individual to: Choose or design the services and supports that fit assessed needs, decide when to receive services and supports, and hire people (including parents and spouses) to deliver those services and supports ([MN.gov - Consumer-directed community supports](https://www.mn.gov/consumer-directed-community-supports))

<sup>30</sup> Arling, Hass, Blewett, and Woodhouse. *Preliminary Report on Baseline Characteristics and Medicaid Program Participation for Older People in Minnesota with Long-Term Supports and Services (LTSS)*. March 8, 2023

- Specialized equipment and supplies
- Transitional services

In addition to elderly waiver services, Medicaid LTSS provides payment for Nursing Facility residents who meet the NF-LOC criteria, income and asset qualifications, and are not able to live in the community.

The following table summarizes Medicaid age 65+ enrollment by program as of January 2019.

*Table 6: Minnesota Medicaid Program Utilization, January 2019<sup>31</sup>*

Age Group	Elderly Waiver	Personal Care or HCBS without Waiver	Nursing Facility
65-74	9,600	2,700	2,400
75-84	11,500	1,600	3,700
85+	9,600	700	6,700
Total	30,700	5,000	12,900

### **MSC+ and MSHO**

Minnesota offers two types of managed care plans that provide LTSS benefits to those who are age 65 or older and eligible for Medicaid: Minnesota Senior Care Plus (MSC+) and Minnesota Senior Health Options (MSHO). Both of these programs are managed by the Minnesota Department of Human Services and administered by eight health care plans. These plans provide medical, pharmacy, and supplemental benefits through Medicare, and LTSS benefits through Elderly Waiver.

Individuals who receive care through one of these plans are assigned a care coordinator who manages both an individual’s health care and support services. The integration of both medical and LTSS care coordination and management promotes efficiency in care that can reduce cost and improve beneficiary outcomes.

In July of 2019, approximately 17,000 individuals were enrolled in MSC+ and approximately 40,000 individuals were enrolled in MSHO.

### **Income Profile of Minnesotans with an LTSS Need**

While the current Medicaid LTSS and Alternative Care programs available in Minnesota provide comprehensive benefits to a large number of individuals, there are persons with a care need who receive either limited or no services. These individuals either fund care using out-of-pocket funds and/or insurance, or rely on family and community members to provide their care. Table 7 contains estimates of the Minnesota population with a care need broken out by Medicaid or AC coverage and no coverage. These estimates were constructed by estimating the total

<sup>31</sup> Arling, Hass, Blewett, and Woodhouse. *Preliminary Report on Baseline Characteristics and Medicaid Program Participation for Older People in Minnesota with Long-Term Supports and Services (LTSS)*. March 8, 2023

population with a care need in 2020 and removing counts of individuals the proportion expected to receive benefits from Medicaid or AC.

*Table 7: Estimated LTSS Need in 2020, by Primary Source of LTSS Payment, Age and Care Setting*

Age Group	Persons with an LTSS Need	Community - Medicaid or AC	Community – Out of Pocket	Nursing Facility – Medicaid	Nursing Facility – Out of Pocket
65-74	32,100	12,100	16,800	2,400	700
75-84	35,000	13,200	16,500	3,700	1,500
85+	38,400	10,400	17,200	6,700	4,200
Total	105,500	35,700	50,500	12,900	6,400

In order to think about the gaps in coverage of existing programs, we estimated the proportion of the population by income band who received comprehensive LTSS through Medicaid or AC. Table 8 displays estimates of the age 65+ population in 2020 with an LTSS need along with the proportion expected to be covered by Medicaid or AC.

*Table 8: Minnesota LTSS Need and Medicaid Coverage 2020, by Family Income<sup>32</sup>*

Family Income	Community Need, All Community	Community Need, % Covered by Medicaid or AC	Nursing Facility Need, All Nursing Facility	Nursing Facility Need, % Covered by Medicaid or AC
<\$10,000	8,600	92%	2,200	94%
\$10,000-24,999	31,000	67%	8,100	77%
\$25,000-49,999	21,100	28%	4,600	61%
\$50,000-74,999	11,500	5%	2,700	48%
\$75,000-99,999	5,900	5%	800	37%
\$100,000-\$124,999	4,500	11%	300	27%
\$125,000-\$149,999	1,200	0%	100	0%
>=\$150,000	2,500	0%	500	0%
Total	86,200	41%	19,300	66%

Individuals with less than \$25,000 in family income receive significant HCBS support for LTSS needs through currently-provided Medicaid services. There is also significant nursing facility support provided through Medicaid for families with less than \$50,000 in family income. However, for the vast majority of individuals with family incomes between \$25,000 and \$125,000, there is limited Medicaid support for LTSS needs. Those that are eligible for Medicaid support, particularly nursing facility, have likely spent down assets and exhausted other resources to pay for their care. There is essentially no Medicaid support provided to individuals with a family income of greater than \$125,000. This group likely has more significant resources to draw from in the event of a care need, including financial assets and long-term care (LTC) insurance.

<sup>32</sup> The distribution of total, HCBS, and NF populations by family income is based on national HRS data. These distributions have been controlled to align with the family income distribution of Minnesota. These figures are estimates that should be used to understand the general relationship between care need and family income level.

This project focused on developing cost/benefit analysis to providing additional public benefits to help the middle income market, which we have represented with a “red box” on the table above. This box accounts for nearly two thirds of the Minnesota population over age 65. Another representation of this table is found below, which roughly conceptualizes the income groups and the programs that they predominately utilize in the event of a care need.

*Table 9: Minnesota LTSS Program Coverage, by Family Income*

Family Income	Percent of Age 65+ Pop	Medicaid Programs	Alternative Care	OAA	Out-Of-Pocket	Private Insurance
<\$10,000	5%	X				
\$10,000-24,999	20%	X	X			
\$25,000-49,999	25%	X	X	X	X	
\$50,000-74,999	19%		X	X	X	
\$75,000-99,999	11%			X	X	
\$100,000-\$124,999	8%				X	X
\$125,000-\$149,999	3%				X	X
>=\$150,000	9%				X	X

The estimated number of individuals with an LTSS need in the “red box” will increase by 28% between 2023 and 2035. This increase is driven by both an increase in the population aged 65 and older as well as an increase in the average age of the population. This will result in both a larger number of individuals with a need for LTSS services as well as an increase in the intensity of services required. We estimate that the value of LTSS services needed to support this population could grow from \$1.45 billion in 2023 to \$2.49 billion in 2035.<sup>33</sup> This amount is an attempt to quantify value of services needed, and in reality, a portion of the need will be provided by informal or unpaid caregivers. However, this figure illustrates the growth in LTSS need that will need to be considered going forward.

<sup>33</sup> Estimate assumes community need of 20 hours of care per week at \$27 per hour, \$139,000 per year cost of nursing facility, and 2.5% annual inflation.

## Section 2: Policy Design Considerations

This section outlines various policy design considerations that were discussed with stakeholders while seeking input on potential program designs.

### Actuarial Soundness

In the context of funding rates for the policy recommendations considered in this analysis, actuarially sound funding rates are projected to cover all anticipated benefit and administrative costs incurred during program operation over a 75-year projection period.

We estimate the 75-year cost of each policy recommendation as the present value (PV) of outlays for expected benefits and expenses. This rate encompasses the projection period ranging from 2025 to 2100. This is similar in concept to the actuarially sound tax rates estimated for Social Security. The present value represents value in current dollars, assuming a given rate of return.

Where we present program costs as a tax rate, the rate reflects a 75-year tax rate that is expected to cover all benefit payments and expenses under pay-as-you-go financing. A 75-year projection period is used because this encompasses virtually all of the future lifetimes of current participants in the program. Thus, a 75-year planning horizon assures all current premium payers that policy planners have considered all of their future LTSS needs in the design and financing of the program. Given the estimates represent an average rate across a 75-year horizon, it is important to analyze the funds built up from income collected compared with expected payments each year. It may not generate enough income to prevent the trust fund from falling into a deficit position beyond the 75-year window.

We are assuming that under the program recommendations considered in this analysis, the designated administrative entity will have the authority to adjust the level of contributions and benefits to assure actuarial soundness. This is in contrast to the Social Security for which annual adjustments are indexed automatically by methods set in statute. The ability to adjust the income and outgo of the program by administrative action can assure that the program will always be able to pay benefits when due, as long as the administrator acts prudently.

Monitoring the financial progression of any program is essential. When both the income and the outgo of a program are set by statute, the purpose of annual monitoring is to determine the actuarial soundness of the program by projecting both income and outgo to estimate whether income is sufficient to pay benefits and expenses. When the income and outgo are set by administrative action, however, (as they are for the Supplementary Medical Insurance program or Part B of Medicare) actuarial soundness is assured if the administrator takes proper action. In this case, the purpose of monitoring is to determine the actions necessary to maintain the actuarial soundness of the program. A third option is where the income to the program is set by statute but the outgo of the program may be changed through administrative action so that outgo always is less than the income.

For recommendations funded by a payroll tax, it is possible that after the 75-year period, the tax rate would need to increase or program modifications would need to be made, given the portion of utilizing population increases later in the modeling period due to both general population aging and a more stable vested portion of the population (i.e. the initial advantage of several years of the program generating income without benefits has passed).

## **Voluntary vs Obligatory Participation**

The decision about whether to institute a voluntary or obligatory (mandatory) program will impact program costs and funding strategies. A voluntary program would likely be more popular because it allows individuals choice on whether to contribute and receive benefits from the program. Voluntary programs require some sort of underwriting or risk mitigation in order to be stable and avoid adverse selection concerns. This dynamic puts upward pressure on program costs and would require underwriting or premium subsidies to control the cost of contributions borne by enrollees.

A mandatory program may stabilize costs when selection impacts are limited and can make program funding more predictable. However, mandatory plans would likely face political opposition and may be unpopular among voters.

In addition, mandatory plans may use risk selection approaches to mitigate the impact of impaired risks on the premium or tax of the program. Such designs may use risk scores to determine funding subsidies either at the time of enrollment or at claim. This may allow for affordable program designs that can be offered to a larger portion of the population and enhance the equity balance of the program. In such a case, a source of funding for subsidies will need to be identified.

Where the recommendation featured such an approach, we assumed program participation was mandatory. Further assessment is warranted to review the benefits of risk scoring approaches that may reduce the impact of those currently impaired on the pricing of the mandatory programs. Such approaches may both reduce the cost of the program to participants and help address stability concerns.

## **Source of Funding**

We have estimated the funding requirements for each recommendation in aggregate and expressed the amount in terms of:

1. Payroll Tax Base on earnings
2. Premium Rate
3. Portion of Minnesota General Revenue<sup>34</sup>

Earnings subject to the payroll tax considered in this analysis include all wages and self-employment income. Projections of U.S. average earnings for all wages and self-employment

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<sup>34</sup> Minnesota Management and Budget. General Fund Balance Analysis: End of 2023 Legislative Session. July 7, 2023. [MN.gov - General Fund Balance Analysis End of the 2023 Legislative Session \(PDF\)](#)

income from 2025 to 2100 are from the assumptions used in the 2022 OASDI Trustees Report. Average earnings are multiplied by the labor force in a given year to determine the payroll tax base in that year.

Premium contributions are assumed to increase by 3% per year for the duration of the projection period. In this report, monthly premium amounts are displayed in 2025 dollars. Unlike a payroll tax, premium contributions can be made by any segment of the population who chooses or is mandated to enroll in the program.

The Minnesota state General Fund is maintained based on collections from various tax sources. Expenditures from the fund can be made for any program or activity authorized by state legislators. This fund is used to finance various initiatives within the state of Minnesota including but not limited to the Minnesota Departments of Health, Human Services, Education, and Transportation. Tax revenues accruing to the General Fund are estimated to be approximately \$30 billion per year in the period 2024-2025.<sup>35</sup>

## Cost of Care Inflation

Another factor to consider is uncertainty in the increase in the cost of care over time. According to the Genworth Cost of Care Survey, Minnesota has experienced 5-year average cost of care increases higher than the national average from 2014-2020. Table 9 below compares the cost of care increases in Minnesota to the national averages.

Table 10: Cost of Care Inflation, 2022<sup>36</sup>

Care Setting	National	Minnesota
Homemaker Services	3.80%	5.53%
Home Health Aide	3.71%	5.71%
Adult Day Health Care	1.45%	3.23%
ALF - Private One Bedroom	3.62%	4.31%
Nursing Facility – Semi Private	3.00%	9.41%
Nursing Facility - Private	3.01%	8.40%

If the annual cost of care increase in benefits is mandated to increase at market rates, funding for the program could become prohibitively expensive. It may be prudent to institute a maximum annual increase or give program administrators flexibility in setting the annual increase.

Additionally, for recommendations funded by a premium, the relationship between annual premium increases and annual benefit increases has a significant impact on the level of the premium required to fund benefits over the 75-year projection period. If benefit increases

<sup>35</sup> Minnesota Management and Budget. Current Estimates of State Budget. [MN.gov - Current Estimates of State Budget](https://mn.gov/mmb/current-estimates-of-state-budget/)

<sup>36</sup> (2022) Genworth Cost of Care Survey, Ranked State Data Tables. [Genworth - Cost of Care Survey Ranked State Data Tables \(PDF\)](https://www.genworth.com/cost-of-care/survey/ranked-state-data-tables/).



outpace premium increases, the initial premium required to fund the program is much higher than if premiums increase at the same rate as benefit payments.

Throughout the analysis conducted, we have assumed cost of care inflation of 3% per year over the 75-year projection period. This is consistent with the annual premium indexing of 3% and slightly less than the ultimate wage growth assumption of 3.5% per year that underlies the projection of payroll tax income.

## **Vesting/Eligibility**

Depending on the method of funding used to finance a policy, it may be necessary to implement vesting criteria in order to determine eligibility. While this is straightforward in the case of premium funding (an individual is covered as long as they are paying a premium), under a payroll tax framework, individuals will be eligible for benefits after they have finished contributing to the program. In this case, it is necessary to establish a contribution threshold such that an individual who meets this threshold is covered under the program once they are no longer paying taxes.

For context, the Social Security program requires individuals accumulate forty quarters of coverage (approximately ten years of work history and tax payments) in order to be eligible to receive benefits in retirement. The LTSS Trust Act in Washington state (WA Cares) allows for full vesting based on ten years of tax payments over an individual's lifetime or three of the most recent six years of tax payments. In addition, individuals can vest in partial benefits based on the number of years that an individual has worked and contributed to the program through the payroll tax. For those who do not want to participate in the WA Cares program, individuals with qualified LTC insurance coverage are able to opt out. The more ways there are to vest in a program or self-select into or out of a program may increase the cost. Tying eligibility to contributions is an important aspect of social insurance and is a significant consideration when evaluating program financial equity (expected value of benefits compared to contributions for various program cohorts).

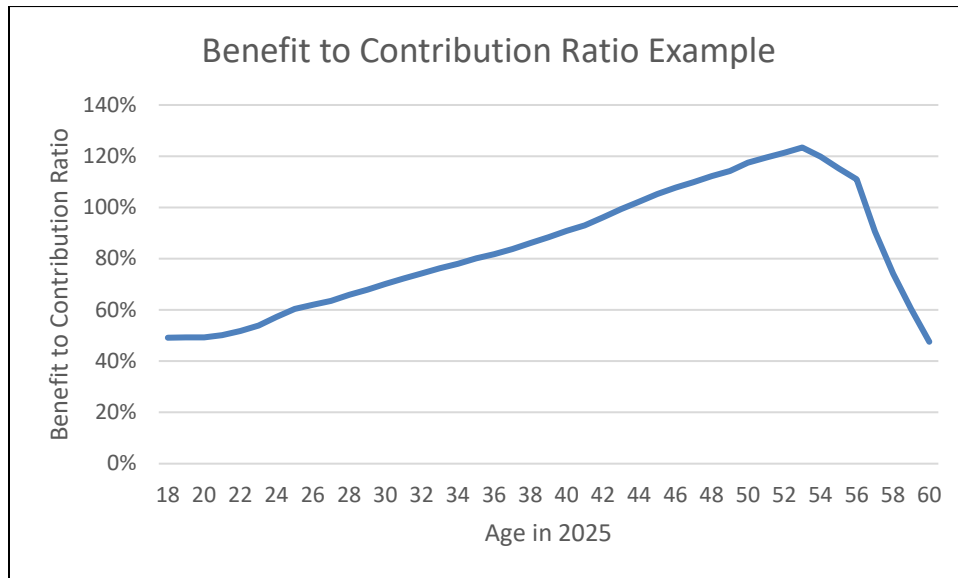
## **Cross Subsidization**

It is important to be aware of potential cross-subsidization of program costs that may occur as a result of a given funding arrangement. Cross-subsidization occurs when contributions from one segment of a population are used to fund benefit payments for other segments of a population.

An example of cross-subsidization would be a program that is funded through a payroll tax and requires 10 years of payroll tax contributions in order to become eligible for benefits. Individuals with ten years of tax contributions would be eligible for the same benefits as someone with thirty years of contributions. In this instance, benefits for these individuals with shorter work histories must be subsidized by those who pay taxes for a longer period of time.

The following chart illustrates how the ratio of expected benefits to expected contributions for a program funded by a payroll tax varies by age at the start of the program. From age 18 until age 53, the expected value of benefits versus contributions increases. This increase occurs because individuals who are older at the start of the program are making fewer years of payroll tax contribution. After age 53, fewer of the individuals who make a contribution continue working long enough to fully vest in the program. This group includes individuals who made contributions but are never eligible for benefits.

*Chart 3: Recommendation 3 Benefit to Contribution Ratio, by Age in 2025*



Cross-subsidization can lead to cohorts that are advantaged and disadvantaged in terms of the expected benefit that they receive relative to their contribution. These scenarios are important to consider as they impact the equity of the program and support that a program could engender.

### **Treatment of Current Medicaid-Eligible**

The Medicaid program is currently the largest source of funding for Minnesota’s LTSS needs. We estimate that approximately 15% of Minnesotans, aged 65 plus with a significant care need, would be immediately eligible to receive benefits through Medicaid. It may make sense to exclude individuals who are eligible for Medicaid benefits from participation in a new LTSS benefits program because these individuals already have coverage for their care needs under an existing program.

Assuming that individuals who are covered by the Medicaid program would not pay taxes or receive program benefits, the payroll tax funding requirements for Recommendations 2 and 3 would decrease. Based on American Community Survey data, we estimate that individuals making less than \$25,000 accounted for approximately 6.5% of the Minnesota tax base in 2021. Assuming that 15% of individuals with a significant care need are eligible to receive Medicaid

benefits at the onset of disability, **we estimate program costs would be reduced by approximately 9% if Medicaid beneficiaries are excluded from program participation or their care is funded directly through Medicaid programs.** If implemented, additional study on the transition on and off of Medicaid, or financial assistance, should be studied in order to determine the impact of excluding Medicaid beneficiaries from program participation.

In the case of premium funding, individuals age 65 plus who are Medicaid eligible would neither pay premiums nor receive benefits. In this situation, premium levels would change to the extent that the incidence of LTSS need differs between the Medicaid-eligible and non-Medicaid eligible populations. While LTSS need is quantifiably higher in the Medicaid-eligible population, it is unclear how much of this difference is driven by population morbidity versus those with a care need spending down to Medicaid eligibility. We would anticipate a slight decrease in premiums if the Medicaid population were excluded from a program funded by premium contributions.

## Financial Equity

It is also important to consider financial equity. In the case of a premium contribution, a flat premium is regressive towards lower wage earners who would be contributing a larger share of their income to the program than higher wage earners. However, if the program benefits are fixed, but funding is through premium contributions which vary by income, or a tax rate such that tax contributions increase by income, the benefits of low earners are subsidized by high earners, and high earners may contribute more than the value of the benefits they are expected to receive.

Alternatively, premium subsidies may address these issues and reduce the financial equity issues by reducing the impact that may be present while allowing for an affordable approach for many participants. A combination of underwriting on the costs borne by policyholders. This could allow more individuals to purchase insurance coverage and increased demand could expand benefit offerings in the private market. premium and payroll taxes may be a potential approach as well.

## Portability

Portability refers to the ability for an individual to receive benefit payments from a program if they are vested in the benefit but move to another state. One potential issue with portable coverage for a state program is the administrative burden that could arise in tracking those who move from the state and distributing benefits, particularly if the benefit is a reimbursement for services.

If benefits are not portable, decisions would need to be made regarding when an individual who moves from the state is no longer eligible for benefit payments. This could be immediate or the benefit could be divested over a period of time.

In this analysis, we have assumed that benefits are portable and anyone who has fully vested in the program is eligible to receive a benefit regardless of residency status.

## Section 3: Summary of Policy Recommendations

While many recommendations were considered, this report examines three which were selected by the project team and developed in light of stakeholder feedback. These policies encompass a range of potential benefits, from services available to all Minnesota residents to substantial benefit payments for those having a significant disability. Table 10 provides a brief description of each recommendation.

*Table 11: Description of Policy Recommendations*

<b>Policy Recommendation</b>	<b>Description</b>
Recommendation 1: Care Navigation and Support Services	State-sponsored LTSS care coordination, and investments in awareness/education. Potentially in partnership with private companies.
Recommendation 2: Medicare Companion Product	A care coordination approach encompassing acute care provided by Medicare as well as LTSS needs. The program would provide insurance options to pay for front-end LTSS needs.
Recommendation 3: Catastrophic-Lite State Based Program	A mandatory state insurance program to help pay for catastrophic long term care expenses. This program would have a fixed waiting period of two years with five years of benefit payments after the waiting period is met.

### Recommendation 1 – Care Navigation and Support Services

Recommendation 1 focuses on providing comprehensive care coordination and limited supports to a broad portion of the population. It does not provide reimbursement for services administered by LTSS providers. This recommendation would focus on care planning and navigation for individuals early in the onset of LTSS need with the goal of improving quality of life and care experience. It would further enable participants to gain access to available community supports and state programs based on their eligibility and need.

The benefits that would be provided under this program are similar to the care coordination and navigation benefits provided by the Minnesota Medicaid program. Care coordination provides people and their families with access to assessment, person-centered planning, referral, linkage, support plan monitoring, coordination and advocacy related to services, resources and informal supports.<sup>37</sup> All seniors with an LTSS need would be eligible.

### Recommendation 2 – Medicare Companion Product

Recommendation 2 seeks to coordinate overall care needs between the acute care delivered by Medicare and LTSS care in retirement via the use of insurance products that provide LTSS coverage. This recommendation will also focus on enabling the private market to provide LTSS insurance options to individuals that will fund services to meet their needs. The approach ties the care coordination approaches of their Medicare plans, if available, to the LTSS provided insurance. This gives the insured the care coordination they desire across their acute care and LTSS needs. The purchase of insurance options could be voluntary or obligatory for the

<sup>37</sup> [Waiver, AC and ECS Case Management](#). Minnesota Department of Human Services. (2020).

Minnesota population. If they are obligated to obtain a minimum level of insurance, the minimum level of coverage will need to be defined and could include Medicaid coverage, private insurance that fund LTSS, or other sources.

In addition to care coordination, this recommendation will seek to ensure that a selection of LTC insurance options are available for individuals to purchase to assist in funding potential LTSS needs. Coverage needs vary across the population, so the program will seek to establish a variety of potential benefits such as short-term care, hybrid products, or traditional front-end benefits.

While this recommendation is focused on care coordination and beneficiary choice that would ideally be voluntary, we have estimated the cost of an obligatory, front-end benefit that could accompany the care coordination component of the program. This analysis will provide a point of reference for the impact of a public, front-end program. The illustrative front-end benefit that we modeled would require a 90-day waiting period and would pay a \$135 per day benefit for one year (\$50,000 total benefit value). The benefit would be indexed at 3% per year. We have assumed that the disability criteria are consistent with the Health Insurance Portability and Accountability Act (HIPAA) requirement of requiring assistance with 2 or more of the six original ADLs or on cognitive impairment.

Additional details of this recommendation are provided in the Recommendations Report.

### **Recommendation 3 – Catastrophic Lite**

Recommendation 3 would provide a five-year benefit of \$135 per day (\$250,000 benefit value), indexed at 3% per year, once an eligible individual meets the definition for disability under the program and completes a two-year waiting period. We have assumed that the disability criteria are consistent with the Health Insurance Portability and Accountability Act (HIPAA) requirement of requiring assistance with 2 or more of the six original ADLs or on cognitive impairment.<sup>38</sup>

It is important to note that this benefit is labeled “catastrophic” due to the two-year elimination period, but “lite” because the \$135 per day benefit is below the full daily cost of a nursing facility and the benefit is not unlimited. Medicaid would remain the ultimate catastrophic coverage for individuals with very high cost needs once this benefit was exhausted.

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<sup>38</sup> The six ADLs defined by HIPAA are eating, bathing, dressing, transferring, toileting, and continence. Severe cognitive impairment is defined as a loss or deterioration in intellectual capacity that is similar to Alzheimer’s disease and like forms of irreversible dementia. See section 7702(B) of the Internal Revenue Code.

## Section 4: Actuarial Analysis

### Analysis Concepts

This section discusses results of actuarial modeling conducted to analyze the policy recommendations. This analysis focuses on estimates of:

- Cost
- Coverage
- Benefit Value, and
- Potential Medicaid Savings

This section discusses considerations made for each of these estimates, and the following sections discuss these considerations in more detail for each of the policy recommendations.

#### Cost

Program cost can be defined in a number of ways. In this analysis, we consider the present value of aggregate cost of projected benefit payments over the 75-year period, 2025 to 2100. This cost can be financed through a variety of strategies, and the analysis examines the cost of these programs in terms of a payroll tax, premium contribution, and a percentage of state general revenues.

Program eligibility is often tied to the financing mechanism. Under a social insurance program funded through a payroll tax, only those who contribute to the program are eligible. This leaves older individuals who have aged out of the workforce without coverage. Under a program financed by a premium, all premium payers are eligible for benefits. However, premiums may need to start early in life to be more affordable to program participants. General revenues is another financing avenue that can be used to fund a program. In order to examine the dynamics of program cost and coverage, we will look at funding for Recommendations 1, 2, and 3 assuming:

- Funding through payroll tax where only vested individuals are eligible for benefits
- Funding through premium payments where all payers are eligible for benefits
- Funding through general revenues where the entire population is eligible for benefits

In generating these estimates, we assume that premiums will be indexed at 3% annually.

In the case of a payroll tax, vesting criteria and the relationship between inflation and wage growth can lead to large changes in the tax rate required to fund a given benefit. Vesting requirements directly impact the number of individuals eligible for benefits. Inflation and wage growth assumptions are uncertain over a 75-year period and also have a large impact on required funding. In the scenarios below, the payroll tax is presented as a range that encompasses reasonably plausible low and high-cost scenarios. The low end of the range represents a 10-year contribution vesting requirement with mid-range interest and wage

growth. The high end of the range represents a more relaxed vesting requirement with early vesting, partial vesting, an opt-out, and lower interest rate and wage growth assumptions.

**All cost estimates displayed in this analysis should be considered indicative pricing performed using broad assumptions regarding population morbidity, selection, and benefit utilization. These estimates should be used to examine the relative magnitude of funding requirements. The implementation of any policy would require more refined modeling with additional details specific to the covered population, program administration, and funding arrangement. We have provided a range around payroll tax estimates that considers a variety of potential scenarios regarding benefit vesting, opt-outs, benefit eligibility, and differentials in interest rates and wage growth.**

**In addition, we have not reduced anticipated claims by the impact of care coordination, care prevention, or the coordination approaches with Medicare or other funding opportunities. While we anticipate that there could be savings related to care coordination, the impact of care coordination initiatives is uncertain and dependent upon various factors including coordination strategy and beneficiary adherence to care coordination practices.**

### **Coverage**

When considering the coverage impact of each policy, it is important to consider the population eligible to receive the benefit as well as those expected to receive a benefit given an LTSS need.

In the case of a program funded through a payroll tax, coverage would extend to individuals who have completed the payroll tax vesting requirement. In the case of premium funding, we assume that all individuals who are making a premium contribution are eligible for benefits.

In practice, there are multiple reasons that an individual could contribute to a program and not be covered by the benefits. These include cases where vesting takes place through income tax contributions and an individual pays into the program but does not complete the vesting schedule or cases where a benefit is not portable and an individual leaves the state after achieving benefit eligibility. For the purposes of this analysis, we do not account for these cases and examine only the scenario in which an individual is vested in the benefit and has an LTSS need. In all cases, we have assumed that benefits are portable if a covered individual moves from the state. If benefits are not portable, the tax or premium necessary to fund benefits would rely on assumptions about individuals leaving the state, similar to a lapse assumption. There is little data to inform how migration behavior could be impacted by eligibility for LTSS program benefits, and this would add additional funding risk to the program.

In terms of quantifying benefit coverage in this analysis, we examine the proportion of those who are eligible for benefits that receive a benefit given an LTSS need.

## **Benefit Value**

Along with the proportion of individuals covered by a policy, it is important to consider the value of the benefits provided. Benefit value can be defined in many ways. There are direct financial benefits in the form of benefit payments as well as indirect financial benefits associated with early intervention, care coordination, and care navigation. These indirect benefits impact the quality of life of the beneficiary and can reduce the overall cost of LTSS need.

In terms of quantifying benefit value in this analysis, we examine the ratio of lifetime financial benefits relative to the anticipated lifetime cost of care.

Lifetime cost of care is estimated using current information about the average cost of HCBS and nursing facility combined with average lifetime length of need estimates, by age. Lifetime cost of care is projected forward consistent with the index used to increase annual benefit payments under the program. Benefit value could increase or decrease over time depending on the relationship between the cost of care and the benefit index applied to a policy. If the annual benefit increase is lower than cost of care increases observed in practice, the real value of the benefit will decline over time.

## **Potential Medicaid Savings**

The Medicaid program could experience savings as a result of fewer individuals spending down to Medicaid eligibility due to the presence of a new policy benefit. We have estimated that up to 10% of those with a significant LTC need may be able to fund their care without spending down to Medicaid due to the implementation of a new benefit.

Due to the costs associated with long-term care, individuals with a care need frequently exhaust their assets and become eligible for Medicaid (often referred to as "spending down" to Medicaid eligibility). The benefits provided by Recommendations 2 and 3 would provide an additional source of care funding and reduce the rate at which an individual needs to spend down their assets during an episode of care. Individuals with fewer assets are more likely to spend down to Medicaid, even with only modest LTSS needs. Individuals with more assets may still spend down if they have extended LTSS needs. As a proxy for the impact on the frequency of spend down, we estimated the portion of individuals with household assets greater than the expected cost of LTSS need gross and net of program benefits Recommendations 2 and 3. We considered both the distribution of LTSS need and the distribution of assets, and considered the portion of time a resident with an LTSS need spends in the community compared to the portion spent in a nursing facility. Assets do not consider primary home equity, as this is typically excluded from Medicaid eligibility requirements.

These estimates are based on national survey data, and further review of Minnesota-specific Medicaid spend-down practices is warranted in order to refine estimates of potential Medicaid savings.



## Actuarial Analysis: Summary

Table 12 –Modeling Parameters: Summary of Recommendations

Benefits	Recommendation 1: Care Coordination /Navigation	Recommendation 2: Medicare/MLTSS Hybrid	Recommendation 3: Catastrophic Lite
Recommendation Name	Care Coordination	Medicare/MLTSS	Catastrophic Lite
Covered Services	Care Coordination	HCBS, Nursing Facility	HCBS, Nursing Facility
Minimum Age for Benefits	65+, Pre-Disabled	65	65
Benefit Trigger	1 ADL, CI <sup>39</sup>	2+ ADLs, CI	2+ ADLs, CI
Daily Benefit Amount	NA	\$135 <sup>40</sup>	\$135
Daily Benefit Index	NA	3%	3%
Lifetime Maximum Benefit	None	\$50,000 in 2025	\$250,000 (5 Years)
Benefit Structure	Care Coord. Services	Reimbursement	Reimbursement
Elimination Period	NA	90	730
Administrative Expense	7%	7%	7%

<sup>39</sup> Everyone is eligible, but we assume the benefit would not be used until an ADL need arises. Caregivers of any age would be eligible for support when caring for an eligible older adult.

<sup>40</sup> While Recommendation 2 is intended to give individuals choices in purchasing a range of private LTC plans, we have modeled a front-end one-year benefit to be indicative of the cost/benefits of this program.

Table 13 – Key Metrics: Summary of Recommendations

<b>Payroll Tax Eligibility</b>	<b>Rec 1 Cost</b>	<b>Rec 2 Cost</b>	<b>Rec 3 Cost</b>
Present Value of 75-Year Aggregate Cost (\$B) <sup>41</sup>	NA	\$70-\$74	\$97-\$104
Payroll Tax <sup>42</sup>	NA	0.45%- 0.85%	0.55%- 1.15%
Monthly Premium Equivalent	NA	\$25-\$45	\$30-\$60
<b>Premium Eligibility</b>	<b>Rec 1 Cost</b>	<b>Rec 2 Cost</b>	<b>Rec 3 Cost</b>
Present Value of 75-Year Aggregate Cost (\$B)	NA	\$65	\$90
Monthly Premium - Starting Age 45, Indexed at 3%/yr	NA	\$50	\$65
Monthly Premium - Starting Age 55, Indexed at 3%/yr	NA	\$70	\$90
Monthly Premium - Starting Age 65, Indexed at 3%/yr	NA	\$120	\$155
<b>General Revenues, All Age 65+ Eligible</b>	<b>Rec 1 Cost</b>	<b>Rec 2 Cost</b>	<b>Rec 3 Cost</b>
Present Value of 75-Year Aggregate Cost (\$B)	\$33	\$90	\$112
General Revenues - % of 2025 General Revenues	0.8%-1.6%	2.5% - 5%	3% - 7%
<b>Coverage</b>	<b>Rec 1 Cost</b>	<b>Rec 2 Cost</b>	<b>Rec 3 Cost</b>
What percent of those with an LTSS need will receive benefits, given eligibility?	All 65+ Eligible	90%	41%
<b>Benefit Value</b>	<b>Rec 1 Cost</b>	<b>Rec 2 Cost</b>	<b>Rec 3 Cost</b>
Expected benefit as a percent of the average cost of care	NA	15%	27%
<b>Potential Medicaid Savings</b>	<b>Rec 1 Cost</b>	<b>Rec 2 Cost</b>	<b>Rec 3 Cost</b>
Potential annual reduction in individuals who exhaust assets and become Medicaid eligible <sup>43</sup>	NA	7,500	1,900
Potential ultimate annual savings as a % of Minnesota Medicaid LTSS expenditures	NA	Up to 0.5%	Up to 0.1%

<sup>41</sup> For the Payroll Tax scenario, aggregate cost represents benefits and expenses associated with individuals who have vested and received benefits during the 75-year period 2025-2100. For the Premium scenario, aggregate cost represents the cost of benefits assuming anyone age 65 or younger in 2025 pays premiums and receives benefits during the 75-year period. For the general revenues scenario, all individuals age 65 or older are assumed to be eligible for benefits beginning in 2025.

<sup>42</sup> The low end of the range represents a 10-year contribution vesting requirement with mid-range interest (4.7%) and wage growth (3.5%). The high end of the range represents a more relaxed vesting requirement with early vesting, partial vesting, an opt-out, and lower interest rate (3.6%) and wage growth (2.3%) assumptions.

<sup>43</sup> We currently estimate that approximately 70,000 out of 115,000 individuals with an LTSS need spend down to Medicaid eligibility as a result of their care expenses. This is on 2024 population basis.

## Recommendation 1 – Care Navigation & Support Services

Table 14 –Benefit Parameters: Recommendation 1

Benefit Parameters	Recommendation 1: Care Navigation & Support Services
Recommendation Name	Care Coordination/Navigation
Covered Services	Care Coordination
Min. Age for Benefits	65+, Pre-Disabled
Benefit Trigger	1 ADL, CI
Daily Benefit Amount	NA
Daily Benefit Index	NA
Lifetime Maximum	None
Benefit Structure	Care Coord. Services
Elimination Period	NA
Administrative Expense	7%

Table 15 – Key Metrics: Recommendation 1

<b>Payroll Tax Eligibility</b>	<b>Cost</b>
Present Value of 75-Year Aggregate Cost (\$B)	NA
Payroll Tax	NA
Monthly Premium Equivalent	NA
<b>Premium Eligibility</b>	<b>Cost</b>
Present Value of 75-Year Aggregate Cost (\$B)	NA
Monthly Premium - Starting Age 45	NA
Monthly Premium - Starting Age 55	NA
Monthly Premium - Starting Age 65	NA
<b>General Revenues, All Age 65+ Eligible</b>	<b>Cost</b>
Present Value of 75-Year Aggregate Cost (\$B)	\$33
General Revenues - % of 2025 General Revenues	0.8%-1.6%
<b>Coverage</b>	<b>Cost</b>
What percent of those with an LTSS need will receive benefits, given eligibility?	All 65+ Eligible
<b>Benefit Value</b>	<b>Cost</b>
Expected benefit as a percent of the average cost of care	NA
<b>Potential Medicaid Savings</b>	<b>Cost</b>
Potential reduction in individuals who exhaust assets	NA
Potential Medicaid savings as a % of 2025 Minnesota Medicaid LTSS expenditures	NA

### Funding Considerations

Recommendation 1 has financing requirements that would be realistic to fund from general revenues. This present value of projected program cost over the entire 75-year period is \$33

billion. **We estimate that annual expenditures associated with this program would make up between 0.8% and 1.6% of general revenues in 2025 dollars (\$250 to \$500 million per year).** However, funding from general revenues would need periodic legislative approval when the state budget is being set. Given the expected growth in the Minnesota seniors population, the needed incremental general revenues gradually increase over time.

Because all seniors are eligible for the benefit, there are no requirements regarding paying taxes or living in Minnesota for any period prior to claiming. While this directionally provides an incentive to move into Minnesota after working age, we believe the magnitude of the benefit and potential incremental cost is not material enough to noticeably drive migration behaviors or impact cost.

Our modeling assumes an average case load of 50 beneficiaries per care manager. This would allow approximately 40 hours per year of care coordination support per beneficiary, which is intended to approximate the relatively robust level of management that managed care organizations provide to members with LTSS needs. We assume the cost of case management to be \$60 per hour (including overhead, in 2020 dollars), which supports a nurse-level manager<sup>44</sup>.

Our annual estimate of case management expense is \$2,340 per person. Analysis conducted on Medicaid services utilization and payment from 2018 to 2021 estimates annualized Minnesota Medicaid case management costs of \$1,823 per beneficiary.<sup>45</sup> This figure likely understates the full cost of case management given some of the cost is borne by Medicare. This data is in line with the estimate used to model the cost of case management.

This estimate can be considered a high-end estimate given the projection of significant telephonic and personal care coordination. However, if the program focused on self-directed opportunities, costs would be less. The costs for implementing a website, software application, or automated telephonic services would be fixed and realized in the start-up phase of the program.

## Coverage

A common theme throughout discussions with stakeholders was that seniors with LTSS needs already have many programs from which to get support, but the impact of these programs is limited due to a lack of awareness of all options and a lack of coordination across programs. The Care Coordination/Navigation recommendation is intended to address this by providing coordination support at the very beginning of LTSS need. This benefit would help beneficiaries navigate the various programs which can provide support. The impact would be a more

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<sup>44</sup> [payscale.com. Average Nurse Case Manager Salary. Pulled on 9/29/2023. Payscale.com - Average Nurse Case Manager Salary.](https://www.payscale.com/research/2023/09/Average-Nurse-Case-Manager-Salary) Loaded for benefits and overhead.

<sup>45</sup> Arling, G., Hass, Z., Blewett, L., & Woodhouse, M. (n.d.). (rep.). *Trends in Demographics, Functional Status, Mortality, Service Use and Medicaid Payments for Older People in Minnesota Who Met Nursing Facility Level of Care from March 2018-March 2021.*

cohesive experience with programs for beneficiaries and, as a potential result, the ability for more individuals with an LTSS need to remain in the community longer and more affordably.

The Recommendation 1 benefit would be available to all seniors. Instead of triggering based off an LTSS-eligibility test, the utilization of this benefit will be initiated by the resident. As a proxy for resident selection, we assume that 50% of residents will utilize the benefit once they need for help with at least 1 ADL or have a cognitive impairment. This is a lower threshold than the eligibility requirements of other recommendations.

### **Benefit Value**

Recommendation 1 is not anticipated to cover substantial costs associated with HCBS or nursing facility care. Instead, the benefits provided on care coordination and limited supports. While these care coordination benefits do have a cost, they do not provide funding towards LTSS that would be required for an individual with a significant care need.

### **Potential Medicaid Savings**

While Recommendation 1 does not include an insurance benefit which directly covers LTSS expenses, to the extent the case management helps beneficiaries utilize less expensive LTSS options, this recommendation also has the potential to reduce spend-down to Medicaid (ex: more care in community relative to nursing facilities). We did not explicitly model this, however, and expect the impacts would be significantly smaller than those shown for Recommendations 2 and 3.

### **Interaction with Existing Programs**

The care coordination provided under Recommendation 1 could be duplicative of care coordination benefits offered by Medicaid and the MSHO and MSC+ programs. The interaction of this care coordination benefit with current care coordination benefits would need to be established in order to maximize the effectiveness of the program and maintain the efficiency of current state programs.

Increasing LTSS utilization of existing programs could also result in beneficial impacts to Medicare spending. The presence of long-term care benefits has shown the potential to reduce end of life costs by reducing emergency and inpatient events. Increased care coordination and care navigation could increase the proportion of the population utilizing LTSS benefits and could reduce end of life, per capita medical expenditures for those with an LTC Need. However, we anticipate that these impacts would be limited under Recommendation 1, given that there is not an increase in funding for the delivery of HCBS or Nursing Facility benefits.

### **Program Variations**

- Offering care navigation through online or telephonic options only
- Including a \$2,000 one-time benefit to cover home modifications could increase the length of time that individuals are able to remain in their home while receiving care and could improve quality of life. **We estimate that adding a one-time \$2,000 benefit**

**for home modifications, given medical evidence of a disability, would increase costs by 33%.**

- Including an ongoing respite support benefit would reduce the burden on unpaid caregivers. **We estimate that a respite support benefit of 200 hours per year, given 25% utilization by those with a significant need, would increase program costs by 130%.**
- Including a transportation benefit of 24 trips per year (non-medically assisted) could assist beneficiaries in attending doctor appointments, obtaining food and medication, and performing other activities that could improve quality of care. **We estimate that adding a transportation benefit would increase program costs by 10%.**

## Recommendation 2 – Medicare Companion Product

Table 16 –Benefit Parameters: Recommendation 2 (Compulsory Example)

Benefit Parameters		Recommendation 2: Medicare Companion
Recommendation Name	Medicare/MLTSS	
Covered Services	HCBS, Nursing Facility	
Min. Age for Benefits	65	
Benefit Trigger	2+ ADLs, CI	
Daily Benefit Amount	\$135 <sup>46</sup>	
Daily Benefit Index	3%	
Lifetime Maximum	\$50,000 in 2025	
Benefit Structure	Reimbursement	
Elimination Period	90	
Administrative Expense	7%	

Table 17 – Key Metrics: Recommendation 2

<b>Payroll Tax Eligibility</b>	<b>Cost</b>
Present Value of 75-Year Aggregate Cost (\$B)	\$70-\$74
Payroll Tax <sup>47</sup>	0.45%-0.85%
Monthly Premium Equivalent	\$25-\$45
<b>Premium Eligibility</b>	<b>Cost</b>
Present Value of 75-Year Aggregate Cost (\$B)	\$65
Monthly Premium - Starting Age 45	\$50
Monthly Premium - Starting Age 55	\$70
Monthly Premium - Starting Age 65	\$120
<b>General Revenues, All Age 65+ Eligible</b>	<b>Cost</b>
Present Value of 75-Year Aggregate Cost (\$B)	\$90
General Revenues - % of 2025 General Revenues	2.5% - 5%
<b>Coverage</b>	<b>Cost</b>
What percent of those with an LTSS need will receive benefits, given eligibility?	90%
<b>Benefit Value</b>	<b>Cost</b>
Expected benefit as a percent of the average cost of care	15%
<b>Potential Medicaid Savings</b>	<b>Cost</b>
Potential annual reduction in individuals who exhaust assets	7,500
Potential Medicaid savings as a % of 2025 Minnesota Medicaid LTSS expenditures	Up to 0.5%

<sup>46</sup> While Recommendation 2 is intended to give individuals choices in purchasing a range of private LTC plans, we have modeled a front-end one-year benefit to be indicative of the cost/benefits of this program.

<sup>47</sup> The low end of the range represents a 10-year contribution vesting requirement with mid-range interest (4.7%) and wage growth (3.5%). The high end of the range represents a more relaxed vesting requirement with early vesting, partial vesting, an opt-out, and lower interest rate (3.6%) and wage growth (2.3%) assumptions.

## Funding Considerations

**We assume the cost of the LTSS care coordination system would be similar to that modeled under Recommendation 1 and could be funded through general revenues, while the cost of a public long-term care insurance plan would be funded by another source such as a payroll tax or premium. The estimates displayed for Recommendation 2 represent the cost of an obligatory, front-end benefit only.**

The estimated payroll tax necessary to fund the illustrative one-year benefit is 0.45%-0.85%, which would be \$25-\$45 per month for a worker earning an average wage in Minnesota in 2025 (projected to be \$68,500). This range accounts for a variety of vesting and economic scenarios. While this is the average monthly contribution, the contribution for each individual would vary depending on their earnings. Minnesota recently passed a bill that will provide paid family medical leave. This program is funded by a 0.7% payroll tax on taxable wages, shared by employers and employees. Given this recent legislative action, there may not be an appetite to fund an additional social insurance program through a payroll tax of the magnitude that Recommendation 2 benefit would require.

The premium for an individual joining the program at age 65 is estimated to be \$120 per month, indexed at 3% per year. This is the premium estimated for the entire population, including those currently enrolled in Medicaid. This premium rate would be substantial for much of the population and may require subsidies or underwriting in order to make contributions manageable.

While Recommendation 2 has been modeled as a mandatory program for the purposes of illustrating the potential cost of front-end coverage, this policy could be operationalized in a number of ways. The program could be voluntary, with insurance coverage purchased on the private market. Alternatively, the program could require that individuals have coverage through one of: the private market, a public option that is underwritten/subsidized, and Medicaid. This approach would ensure that all individuals have some minimum coverage to fund LTSS needs and would be implemented around the options that already exist.

The choice available to consumers either in the form of insurance options or public benefits should allow for a variety of approaches to finance potential LTSS needs. Preferences in care delivery and care setting vary across the population, and having access to benefits that fit individual preferences will encourage more people to purchase products that can fund their potential care needs.

When considering the purchase of an LTC insurance policy, the age at which beneficiaries begin paying premiums has a significant impact on the affordability of a monthly premium. While the care coordination portion of Recommendation 2 is targeted at the Medicare-eligible population, purchasing LTC insurance at age 65 will result in premiums that are much more expensive than if coverage were purchased earlier in life. An emphasis on education regarding LTC insurance options should be provided and initial purchase should be encouraged well before reaching retirement age.



In the case of a mandatory benefit, it is possible to split funding between a payroll tax and a premium for the age 65 plus population. This could reduce the premium contributions necessary for the aged population while covering existing LTSS needs. Table 13 displays an example of funding requirements for the Recommendation 2 – MLTSS Hybrid benefit, assuming that the cost of the program is split between a payroll tax and a premium beginning at age 65. The payroll tax necessary to fund the program is dependent on the premium charged to the age 65+ population. As this premium increases, the required payroll tax decreases.

*Table 18: Recommendation 2 Funding -  
Combination of Payroll Tax and Monthly Premium Starting at Age 65*

<b>Monthly Premium Starting at Age 65, indexed at 3% annually</b>	<b>Payroll Tax<sup>48</sup></b>
\$0	0.65%
\$50	0.37%
\$75	0.23%
\$100	0.08%

### **Coverage**

Beneficiary care patterns, and therefore projected costs, could change as a result of Recommendation 2's increased care coordination between acute care and long-term care. The goal of this intervention is to provide individuals the care and support services that they need before a significant LTSS need arises. This could lead to additional utilization of existing services and increase the reach of current LTSS programs.

In terms of a front-end benefit, approximately 50% of individuals who begin contributing at age 65 would be expected to have a HIPAA-trigger LTSS need during their lifetime. Of those with an LTSS need, 90% would be expected to exceed the 90-day waiting period and receive benefits from the program.

### **Benefit Value**

The average benefit paid under Recommendation 2 is expected to cover approximately 15% of the average lifetime cost of care. While this is the projected coverage of the average LTSS need, almost 40% of LTSS needs last less than one year. This benefit is one year in length, and the annual benefit is \$50,000. This amount would cover a significant portion of HCBS needs and approximately 30%-40% of the annual cost of a nursing facility stay over a one-year period.

Given the recommendation of premium funding starting at age 65, Recommendation 2 benefit payments are projected to steadily increase before peaking in 2055 at \$1.1 billion (in 2025 dollars). This funding could provide incentive for existing care providers to expand and draw new care providers into the market.

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<sup>48</sup> Payroll tax rate needed in combination with age 65 premium to fund projected benefits over the period 2025-2100.

## Interaction with Existing Programs

Various aspects of Recommendation 2's care coordination would need to be defined if this program were to be implemented. For instance, is the LTSS care coordination privatized and implemented by the MA plan that is providing acute care? If not, what are the responsibilities of the MA plan and the LTSS care coordination entity, and how will these programs communicate with one another? Alternatively, would the LTSS insurance product carrier provide the care coordination or would they leverage the MA plan? These details will be critical to ensure proper communication and realize any reduction in anticipated program costs.

Additionally, the program's interaction with The Long Term Care Partnership Program should be evaluated. The Partnership Program promotes the purchase of LTCI policies by allowing policyholder of qualified plans to exclude assets when determining eligibility for Medicaid LTSS benefits. The amount of the exclusion is equivalent to benefits paid by qualified insurance coverage. Ensuring that options offered under this policy are qualified under the partnership program could maximize the financial protection of those who experience an LTSS need.

Increasing LTSS coverage could also result in beneficial impacts to Medicare spending. The presence of long-term care benefits has shown the potential to reduce end of life costs by reducing emergency and inpatient events. The presence of LTSS care coordination and care navigation along with benefit payments could increase the proportion of the population receiving LTSS care and could reduce per capita medical expenditures for those with an LTC Need.

A study performed by Holland, Evered, and Center<sup>49</sup>, examined the impact of LTC benefits provided by private insurance impacted end-of-life medical costs. **The study found that claimants using LTC benefits experienced significantly lower health care costs at end of life, including 14% lower total medical costs.**

## Potential Medicaid Savings

The combination of increased care coordination and increased optionality and take-up of LTC insurance and education lead individuals to purchase long-term care insurance or make care choices that will delay or reduce asset exhaustion. This could lead to a reduction in the reliance of Medicaid to pay for long-term care services.

Recommendation 2, which provides front-end coverage, may prevent more spend-down than the catastrophic Recommendation 3 because it has a greater impact on those individuals with a shorter care need. Thus, those with lower levels of assets and shorter duration of care need benefit more from a front-end program than a catastrophic program.

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<sup>49</sup> Holland, S. K., Evered, S. R., & Center, B. A. (2014). Long-term care benefits may reduce end-of-life medical care costs. *Population Health Management*, 17(6), 332–339. [doi.org/10.1089/pop.2013.0116](https://doi.org/10.1089/pop.2013.0116).

Projected 2025 Minnesota LTSS Medicaid expenditures are approximately \$7.8 billion dollars.<sup>50</sup> We estimate that the front-end benefit modeled under Recommendation 2 has the potential to reduce annual Medicaid LTSS expenditures by up to 0.5% (\$39 million) due to reductions in the number of individuals who spend down to Medicaid due to an LTSS need.

### Program Variations

- Benefit payments could be made to informal caregivers as opposed to reimbursement for formal HCBS care. This benefit would require a certification process to ensure that an informal caregiver is present and would be similar to consumer-directed community supports that is currently available under the Minnesota Medicaid program. The cost of this benefit would depend on personal preferences and eligible beneficiary choice, but **may increase the cost of the program** as it would increase benefit options available.
- As an upper limit, funding requirements would change proportionately to any changes in daily/maximum benefit paid under Recommendation 2. For instance, if the benefit were changed from \$135 per day for five years to \$150 per day for five years, the anticipated increase in required funding would be  $(\$150/\$135-100\%) = 11\%$ .
- Medicaid currently pays for the majority of nursing facility care. **If Recommendation 2 were to be focused on providing benefits only for those in community settings, we would anticipate a decrease in required funding of 35%**
- Recommendation 2 pays benefits as reimbursement for formal services. HCBS benefits are not always utilized on a daily basis, and the rate of utilization varies across the population due to severity of need, availability of resources, and personal preferences. **If Recommendation 2 benefits were paid in the form of daily cash payments as opposed to reimbursement for services, we would anticipate an increase in required funding of 5%.**
- Programs such as Social Security offer spousal benefits to individuals who have fully vested in the program, regardless of the spouse's own eligibility. **If a provision were made to offer spousal coverage so that a spouse of a fully vested individual would be eligible for benefits, we anticipate an increase in required funding of 10%.**

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<sup>50</sup> *Long Term Services and Supports Annual Expenditures*. Medicaid Reports and Evaluations. (n.d.). [Medicaid.gov - Reports & Evaluations Long Term Services and Supports Annual Expenditures](#). Projected using 2019 Medicaid LTSS Expenditures with 3.8% annual growth.

## Recommendation 3 – Catastrophic-Lite State Based Program

Table 19 –Benefit Parameters: Recommendation 3

Benefit Parameters	Recommendation 3: Catastrophic-Lite
Recommendation Name	Catastrophic Lite
Covered Services	HCBS, Nursing Facility
Min. Age for Benefits	65
Benefit Trigger	2+ ADLs, CI
Daily Benefit Amount	\$135
Daily Benefit Index	3%
Lifetime Maximum	\$250,000 (5 Years) in 2025
Benefit Structure	Reimbursement
Elimination Period	730
Administrative Expense	7%

Table 20 – Key Metrics: Recommendation 3

<b>Payroll Tax Eligibility</b>	<b>Cost</b>
Present Value of 75-Year Aggregate Cost (\$Billions of Dollars)	\$97-\$104
Payroll Tax <sup>51</sup>	0.55%-1.15%
Monthly Premium Equivalent	\$30-\$60
<b>Premium Eligibility</b>	<b>Cost</b>
Present Value of 75-Year Aggregate Cost (\$Billions of Dollars)	\$62
Monthly Premium - Starting Age 45	\$65
Monthly Premium - Starting Age 55	\$90
Monthly Premium - Starting Age 65	\$155
<b>General Revenues, All Age 65+ Eligible</b>	<b>Cost</b>
Present Value of 75-Year Aggregate Cost (\$B)	\$112
General Revenues - % of 2025 General Revenues	3% - 7%
<b>Coverage</b>	<b>Cost</b>
What percent of those with an LTSS need will receive benefits, given eligibility?	41%
<b>Benefit Value</b>	<b>Cost</b>
Expected benefit as a percent of the average cost of care	27%
<b>Potential Medicaid Savings</b>	<b>Cost</b>
Potential reduction in individuals who exhaust assets	1,900
Potential savings as a % of projected 2025 Minnesota Medicaid LTSS expenditures	Up to 0.1%

<sup>51</sup> The low end of the range represents a 10-year contribution vesting requirement with mid-range interest (4.7%) and wage growth (3.5%). The high end of the range represents a more relaxed vesting requirement with early vesting, partial vesting, an opt-out, and lower interest rate (3.6%) and wage growth (2.3%) assumptions.

## Funding Considerations

The estimated payroll tax necessary to fund this benefit is 0.55%-1.15%, which would be \$30-\$60 per month for a worker earning an average wage in Minnesota in 2025 (projected to be \$68,500). This range accounts for a variety of vesting and economic scenarios. While this is the average monthly contribution, the contribution for each individual would vary depending on their earnings. Similar to Recommendation 2, there may not be an appetite to fund an additional social insurance program through a payroll tax given the recent implementation of the payroll tax to fund a paid family medical leave benefit. Under a premium approach starting at age 65, the cost of this benefit would potentially be substantial for much of the population and may require subsidies in order to make contributions manageable.

## Coverage

The catastrophic benefits paid by Recommendation 3 aim to reduce the financial impact of long-lasting LTC episodes on family finances. Over 40% of LTC episodes are anticipated to last longer than two years, with almost 20% lasting five or more years. This program provides benefits to a portion of LTSS beneficiaries with longer, more expensive care needs. Many may qualify for Medicaid within the two year elimination period depending on their care needs.

## Benefit Value

Recommendation 3 covers approximately 27% of the average lifetime cost of care. The costs associated with long stays are significant. The following table outlines the annual median cost of care in Minnesota for various services in 2021.

Table 21: Median Annual Cost of LTSS, 2022<sup>52,53</sup>

Service	Median Annual Cost
Adult Day Health Care <sup>54</sup>	\$26,000
Homemaker Services	\$80,080
Home Health Aide <sup>55</sup>	\$82,940
Assisted Living Facility <sup>56</sup>	\$54,090
Nursing Home Facility (Semi-Private/Private) <sup>57</sup>	\$139,211 / \$156,859

A \$135 per day provided under Recommendation 3 is equivalent to \$50,000 in annual benefit. This is enough to cover the median cost of Adult Day Health Care or Assisted Living Facility, and

<sup>52</sup> [Genworth Cost of Care Survey](#), November 2021

<sup>53</sup> Assumes 44 hours per week for in-home services

<sup>54</sup> Provides social and support services in a community-based, protective setting. Various models are designed to offer socialization, supervision and structured activities. Some programs may provide personal care, transportation, medical management and meals. (cite Genworth)

<sup>55</sup> Home health aides offer services to people who need more extensive care. It is "hands-on" personal care, but not medical care. The rate listed here is the rate charged by a non-Medicare certified, licensed agency.

<sup>56</sup> Residential arrangements providing personal care and health services. The level of care may not be as extensive as that of a nursing home. Assisted living is often an alternative to a nursing home, or an intermediate level of long term care. Assisted Living Facilities are referred to as Residential Care Facilities in California.

<sup>57</sup> These facilities often provide a higher level of supervision and care than Assisted Living Facilities. They offer residents personal care assistance, room and board, supervision, medication, therapies and rehabilitation, and on-site nursing care 24 hours a day.

about 60% of the cost of Homemaker or Home Health Aide Services. It would cover less than 33% of the median annual nursing home cost.

The catastrophic benefit structure results in potentially large benefits being paid out to those who have a need of over two years, but almost 60% of individuals with a care need would not be expected to receive any benefit under the program. These individuals would need to find another source of funding for LTSS despite having paid a tax or premium for many years. Those who do meet the two-year waiting requirement will need to fund a significant cost during the two years. This dynamic will limit the impact of the program on reducing the number of individuals who spend down assets and become eligible for Medicaid to those who have enough resources to cover the initial two-year period.

Given the recommendation of payroll tax contributions for funding and vesting in the program, Recommendation 3 benefit payments steadily increase over time and plateau around \$800 million per year (in 2025 dollars) in 2065. This funding could provide incentive for existing care providers to expand and draw new care providers into the market.

### **Interaction with Existing Programs**

A catastrophic program such as Recommendation 3 could have significant overlap with coverage provided by the Medicaid program. This benefit begins after a two-year period, and the cost of providing care during this elimination period could be prohibitive to many individuals. It is likely that many individuals would spend down their assets during this two-year period before benefit payments begin. Individuals in this situation could also qualify for Medicaid benefits. Issues such as coordination of benefits and Medicaid eligibility for individuals covered by Recommendation 3 would need to be addressed.

### **Potential Medicaid Savings**

Recommendation 3 provides substantial benefits to those who have a care need lasting longer than two years. For those individuals who can afford coverage during the waiting period, this benefit could reduce reliance of Medicaid to pay for long-term care services.

Projected 2025 Minnesota LTSS Medicaid expenditures are approximately \$7.8 billion dollars. We estimate that the catastrophic benefit modeled under Recommendation 3 has the potential to reduce annual Medicaid LTSS expenditures by up to 0.1% (\$8 million) due to reductions in the number of individuals who spend down to Medicaid due to an LTSS need.

### **Program Variations**

- Elimination Period: The EP could be adjusted to be longer or shorter than two years.
  - **If the elimination period were one year, we would anticipate an increase in required funding of 45%**
  - **If the elimination period were three years, we would anticipate a decrease in required funding of 25%**
- Income-dependent elimination period: An income-dependent elimination period would require shorter elimination periods for individuals with lower incomes than those with

higher incomes based on the idea that catastrophic expenses are relative to individual financial situations. This concept has been proposed in the WISH Act, a bill that was put forth in Congress which would provide funding for catastrophic episodes of LTSS care.

**We would anticipate an increase in required funding of 10%** given a waiting period of:

- 1 Year for household incomes of less than \$50,000
- 2 Years for household incomes of \$50,000 to \$80,000
- 3 Years for household incomes of \$80,000 to \$120,000
- 4 Years for household incomes of greater than or equal to \$120,000

## Conclusions

Each of the recommendations considered in the actuarial modeling address different issues of those faced with long-term care needs. As such, the cost of each recommendation, and the portion of beneficiaries impacted, varies significantly.

Recommendation 1 seeks to provide clarity in care options, maximize existing resources, and enhance care coordination in order to empower LTSS beneficiaries and their families and improve quality of care. Because care is not directly funded, Recommendation 1 is significantly less expensive than the other options. At the same time, we have not projected Recommendation 1 to meaningfully impact the number of Minnesota Seniors who can afford LTSS, nor therefore, the number of Minnesota Seniors with LTC needs who will ultimately end up on Medicaid. This requires further study and is dependent on the structure and usage of the care coordination and navigation service. That said, we agree that this recommendation could realistically be funded through general revenues given political support. Further, we agree this recommendation could be implemented quickly and help a broad portion of the population navigate the difficult landscape of LTSS options.

Recommendation 2 would provide both care coordination as well as a front-end (one-year) benefit that could be used to pay for LTSS. For a disabled senior living in the community, the benefit value of \$50,000 would cover all or a significant portion of their first year HCBS needs. For seniors who enter a nursing facility shortly after their LTC need arises, \$50,000 would provide meaningful help, though with an average annual cost of approximately \$140,000, seniors who end up with extended stays would need another source of funding and often may spend-down to Medicaid. With this recommendation, we estimate 90% of residents with an LTC need would receive some benefit, and the benefit would avoid Medicaid spend-down for 10% of disabled residents who would otherwise have exhausted their assets. The age 65 premium needed to fund this benefit is expected to be \$120 per month, indexed at 3% annually.

Recommendation 3 provides support for longer episodes of care, by providing \$50,000 annually after a two-year waiting period. This recommendation would be especially helpful for disabled residents with a long-term need that can be met through HCBS. However, by only addressing longer episodes, 41% of disabled seniors would receive some benefit. Further, even though the benefit is larger, because those receiving a benefit will tend to have the costliest episodes, Medicaid spend-down would be avoided for only 2.5% of disabled residents who would otherwise have exhausted their assets. The payroll tax needed to fund this benefit is expected to be between 0.55%-1.15%; this is similar magnitude as Recommendation 2, with the impact of the larger benefit offset by lower expected utilization.

It is important to note that these recommendations are not mutually exclusive and could be implemented in combination and perhaps over time. In all cases, the benefit only fully funds LTSS costs for a minority of seniors with an LTC need. Therefore, a focus on LTSS education is important in order to encourage individuals to begin preparing for their potential care needs early. This includes thinking about how one would like to be cared for as well as how care would be funded.



## Appendix A: Assumptions and Methods

This appendix describes the assumptions and methods that underlie the actuarial estimates presented in this report. The assumptions and methods can be classified into three categories: demographic, economic, and long-term care utilization. This appendix describes the data and assumptions used to produce the estimates contained in this report.

### Demographic Assumptions

The demographic assumptions relate to the projection of the national population of United States. For a pay-as-you-go social insurance program, the covered population is of fundamental importance in the estimation of costs. The income to the program depends on the number of contributors. Estimates of the number of contributors and of the number of beneficiaries are based on the population projection. The model projects the United States population by estimating the number of births, deaths, and net migrants for each future year.

#### Fertility

The number of births in Minnesota are estimated using the total fertility rate for the state as reported by the Center for Disease Control, National Vital Statistics Report (NVSr). We use the distribution of fertility by the age of the mother as used in the 2022 OASDI Trustees Report. In addition, we trend in the total fertility rates to roughly approximate the trend implied by the Minnesota Demographers Office long-range population projection.<sup>58</sup>

#### Mortality

Current and projected US mortality rates by age and sex are based on the 2022 OASDI Trustees Report, Alternative II assumptions. The Trustees Report mortality rates are projected through 2100. US and Minnesota-specific mortality differentials, by sex, were obtained from the Center for Disease Control National Vital Statistics System's CDC Wonder online database. The US mortality projection from the 2022 OASDI Trustees Report is adjusted by the differentials found in the CDC database to estimate Minnesota mortality throughout the projection period.

#### Migration

Minnesota immigration and emigration are tabulated from the American Community Survey 5-Year Data Release files (ACS). The data files are used to calculate the distribution of immigration and emigration by age and sex. Yearly totals of immigrants and emigrants are based on the 5-year ACS tabulations, and are assumed to be constant throughout the projection period. Individuals who emigrate are kept track of separately in the model. Such individuals who contributed to the program could be eligible for benefits outside of Minnesota.

### Economic Assumptions

Economic parameters concerning trends in the labor force, wages, and LTSS prices are of primary importance for the projection of the income and expenditures of the considered LTSS

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<sup>58</sup> Department of Administration, Dayton, M. and Lee, M. (2020) Long-Term Population Projections for Minnesota.

programs. When it is assumed that an option is financed by a payroll tax, the labor force participation and wage level will directly affect annual program income. The index used to trend the daily benefit amount is important because it affects program liabilities in the future. The interest rate assumption affects the interest income earned by the LTSS fund (and the present value of the future benefit stream).

### **Labor Force Participation and Unemployment**

US labor force participation rates (LFPR) and unemployment rates (UR) by age and sex are from the 2022 OASDI Trustees Report. These rates are adjusted to Minnesota-specific levels using the ratio of state LFPR to US LFPR and state UR to US UR. State and US employment data for this adjustment comes from the Bureau of Labor Statistics (BLS) Local Area Unemployment Statistics. This data is used to project the labor force and unemployment rate in each year of the projection period. The labor force is calculated in order to estimate the tax base in each year.

### **Wages**

Projections of US average taxable earnings from 2022-2096 are found in the 2022 OASDI Trustees Report. Covered earnings are the amount of covered earnings subject to the Medicare payroll tax.<sup>59</sup> Covered earnings for years after 2096 are projected using the 10-year trend from 2087-2096. In order to estimate the Minnesota tax base, we adjust the average US earnings to Minnesota-specific earnings by the ratio of the average wage in Minnesota over the average wage in the US. Wage data for this adjustment comes from BLS Occupational Employment Statistics. Average covered earnings are multiplied by the labor force in a given year to determine the payroll tax base in that year.

### **Vesting**

In order to become eligible for benefits, a worker must become vested (or in other words, become insured). Under payroll tax funding for Recommendations 2 and 3, a range of payroll tax funding with both a 10-year payroll tax contribution requirement as well as a more relaxed vesting requirement with partial vesting, early vesting, and an opt-out were modeled. In order to determine the percentage of the population that vests by age and sex, tabulations were produced using the 2006 Earnings Public Use Microdata File. This data provides annual earnings information (i.e., a lifetime earnings profile) for a 1% random sample of all Social Security numbers issued before January 1, 2007.

To find the percentage of the working population that has worked ten total years by age and sex, we isolated individuals with complete work histories (those who turn 65 before 2006). For each age, the percentage of individuals who have worked at least ten years over their entire lifetime is tabulated.

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<sup>59</sup> The 2016 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds, The Board of Trustees, p.144

## Benefit Trend

If the level of benefits is fixed in dollar terms by the legislation, the actual cost of covered LTSS would not affect the funding needs. However, the actual cost of services will be important to the overall success of the program. If benefit increases are indexed in such a way as to increase faster than the increase in the funding (which will grow as wages increase), then the financial stability of the program could be jeopardized. In order to provide financial stability to the program, the increases in the daily benefit amount could be tied to the financial status of the program. The baseline modeling assumption is that ultimate average increase in wages is 3.6% as assumed in the OASDI Trustees Report. Benefit inflation is assumed to be indexed at 3% per year.

The financial status of the program should be reviewed frequently with the goal of making needed adjustments to benefits and/or taxes. If these rates can change independently, an actuarial evaluation of the program will be required at regular intervals to monitor the projected financial status of the program.

## Interest Rates

The ultimate interest rates used in modeling come from the 2022 OASDI Trustees Report. However, short-term interest rates were modified to reflect current federal funds rates. The current July 2023 effective federal funds rate of 5.08% was trended to the ultimate interest rate assumption of 4.7% in 2028. The following table summarizes the interest rate by year. While the Federal Reserve is currently scheduling rate increases, it is difficult to project this activity into the future considering there have been multiple periods in recent history of extended low-interest environments. The relationship between the interest assumption and benefit inflation is critical to the cost estimates, and the inability to obtain investments that yield a long-range return in line with benefit inflation will cause the estimated tax rate required for financing to increase.

*Table A1.1: Interest Rate Assumptions*

Year	Interest Rate
2025	4.85%
2026	4.80%
2027	4.75%
2028	4.70%
2029	4.70%
2030-2100	4.70%

## Morbidity Assumptions

Key to the projection of benefit payments under the long-term care program is the projection of the portion of the covered population that meets the requirements to receive benefits. For the purpose of our modeling, we used three related variables to define morbidity:

- Prevalence – The portion of a population in need of long-term services and supports (LTSS) at a given point in time. Our prevalence assumption varied by sex and age.

- Incidence – The portion of the population that requires LTSS for the first time. We defined incidence on an annual basis. Similar to prevalence, our incidence assumption varied by sex and age.
- Continuance – The distribution of the length of LTSS need. We varied continuance by sex and age of LTSS incidence, and define the metric as the percent of those with LTSS incidence who still need LTSS after an increasing array of lengths. A lack of continuance indicates either death or recovery.

Morbidity in the context of LTSS has traditionally been measured by a person’s ability to perform activities of daily living (ADLs). As originally conceived by Katz in his paper "A Measure of Primary Sociobiological Functions,"<sup>1</sup> there are six ADLs: bathing, dressing, transferring, continence, toileting, and eating. Later, some researchers proposed mobility (i.e., the ability to get about inside of a house), and others the taking of medication, as additional ADLs. This original measure has been expanded to include cognitive ability in addition to physical abilities as an indication of the need for long-term care services. Therefore, for most scenarios, we defined LTSS need as requiring help with two or more ADLs or having a cognitive impairment.

We developed three sets of morbidity assumptions:

- General LTSS – The prevalence, incidence, and continuance of LTSS need, agnostic to whether the need must be fulfilled in a nursing facility (NF) or can be met through home and community-based services (HCBS).
- NF-only LTSS – The prevalence, incidence, and continuance of LTSS need that has historically been fulfilled in a NF.
- HCBS-only LTSS – The prevalence, incidence, and continuance of LTSS need that has historically not been fulfilled in a NF.

The primary source for morbidity data is the RAND Health and Retirement Study (HRS) Longitudinal File.<sup>60</sup> The HRS is a longitudinal panel study that surveys a representative sample of approximately 20,000 people in America, administered by the University of Michigan and supported by the National Institute on Aging and the Social Security Administration. The HRS asks participants questions a wide range of questions, which include those needed to identify LTSS need, NF residency, and, through its longitudinal nature, patterns of continuance. Participants are interviewed every two years through death, including capturing end-of-life information through proxy interviews after participants’ deaths. The RAND HRS Longitudinal File is a cleaned, easy-to-use, and streamlined data product containing information (including imputed and derived variables) from the HRS to support researchers.

Because the HRS focuses on older Americans, we relied on the National Health Interview Survey (NHIS) data for morbidity estimates in the under age 50 population. The NHIS is administered by the CDC and is a cross-sectional household interview survey. The NHIS includes the non-

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<sup>60</sup> *The Health and Retirement Study*. HRS. (n.d.). RAND HRS Products. [RAND HRS Products](#)

institutionalized population only, and therefore can be relied upon only for measuring LTSS need outside of NFs. Further, because it is not a longitudinal study, it can only be used to determine prevalence (and not incidence nor continuance). We used the HCBS LTSS need prevalence as an important data point in adjusting, smoothing, and extrapolating data from HRS.

## **Participation and Adverse Selection**

The programs modeled were specified as mandatory programs for the payment of payroll and income taxes. Universal mandatory programs can be assured that the experience of the group will be average because everyone will be in the program; therefore, there will be no adverse selection. If a program were to be administered on a voluntary basis, underwriting or subsidies would be necessary to control selection risk and stabilize the costs of the program.

## **Administrative Expenses**

In addition to the cost of benefits, any program must pay the costs incurred in administering the program. In general, public insurance programs have been able to return a high portion of income in benefits, with very little required for administration. In 2016, for example, the administrative expenses as a percent of benefit payments for the various Social Security and Medicare programs (as shown in the Trustees Reports) were 0.5 percent for the Old-Age and Survivor Insurance program, 2.9 percent for the Disability Insurance program, 1.7% for Medicare Part A, and 1.3% for Medicare Part B. A long-term care program would likely cost more than any of these programs, because it would entail the high cost of determining eligibility (as in the Disability Insurance program) and the high cost of paying claims (as in the Supplementary Medical Insurance program). In addition, the administrative costs as a percent of contributions for Social Security and Medicare programs were several times greater than the 2016 figures for the first several years of the programs, because of start-up costs.

An administrative load of 7% was assumed for the purpose of modeling the recommendations in this report. This expense was split as 3.5% of taxes and 3.5% of benefit payments.

## Appendix B: Actuarial Modeling Parameters

Recommendation	Recommendation 1	Recommendation 2	Recommendation 3
<b>Name</b>	<b>Care Navigation &amp; Support Services</b>	<b>Medicare Companion Product</b>	<b>Catastrophic-Lite State Based Program</b>
<b>WHO IS ELIGIBLE?</b>	65+ Pre-Disabled	Vested Population, Age 65+	Vested Population, Age 65+
<b>QUALIFYING FOR BENEFITS</b>	1 ADL or Cognitive Impairment	2 ADLs or Cognitive Impairment	2 ADLs or Cognitive Impairment
<b>WAITING PERIOD</b>	None	90 Days	2 Years
<b>DAILY BENEFIT AMOUNT</b>	NA	\$135 per day, indexed at 3% per year	\$135 per day, indexed at 3% per year
<b>BENEFIT MAXIMUM</b>	NA	\$50,000	\$250,000
<b>PORTABLE</b>	NA	Yes	Yes
<b>SPOUSAL COVERAGE</b>	NA	No	No
<b>ADMINISTRATIVE EXPENSE</b>	NA	3.5% of program income, 3.5% of program benefits	3.5% of program income, 3.5% of program benefits



# **The Own Your Future LTSS Funding and Services Initiative**

## Stakeholder Engagement Report

October 2023

Prepared by FTI Consulting, Inc, Actuarial Research Corporation, and the Altarum Institute, for the Minnesota Department of Human Services Aging and Disability Services Administration

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## Overview

The Aging and Disability Services Administration of the Minnesota Department of Human Services (DHS) aimed to investigate options for long-term services and supports (LTSS) reform to improve access to necessary support and services available to older adults in Minnesota (MN).<sup>61</sup> In lieu of federally funded insurance options (Medical Assistance Medicare), state-funded options (Medicaid), or private insurance, the financial impact on Minnesotans for necessary long-term services and supports can be costly. For instance, annual costs for in-home care are approximately \$60,000 for in-home care, \$48,000 for assisted living facilities and \$90,000 for nursing homes<sup>62</sup>. Options for alternative funding solutions are sparse and often unaffordable. The gap requires older adults to pay out of pocket, spend down assets so they become eligible for Medicaid, or remain medically vulnerable.

In partnership with Own Your Future (OYF), a DHS Adult and Aging Services Division (AASD) initiative, FTI Consulting, Altarum Institute, and Actuarial Research Corporation (ARC) worked together as a “team” to conduct a stakeholder engagement to examine and define alternative LTSS funding options. In order to gather and understand the needs of individual Minnesotans, their families, caregivers, government programs, insurance programs, and others; the Team engaged stakeholders<sup>63</sup> as a core component. An iterative process for solution development was utilized. This approach built upon the numerous strengths of Minnesota’s existing LTSS system and documented key priority areas identified. Key themes identified include:

1. Enhanced and continuous long-term service, support, and funding education for the general public, providers, and aging communities;
2. Reiteration of the importance of comprehensive care coordination and care navigation across programs, services, and supports. Stakeholders also discussed the ideal pathways and appropriate funding for required resources;
3. Utilization of various technologies to support, engage, and monitor older adults in lieu of direct supports;
4. Improved accessibility to quality supports and services for all, regardless of location, race, ethnicity, language, or other factors that can reduce access;
5. Understanding and addressing the root cause(s) for the limitations on the current workforce shortage; and
6. A focus on enhanced caregiver support and education.

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<sup>61</sup> While people with disabilities may also use overlapping services, this study was specifically focused on the older adult population.

<sup>62</sup> Minnesota Department of Human Services, How much will my care cost?, 2019.

<sup>63</sup> The stakeholders who participated were from a variety of experiences and responsibilities across the state. The group, which could be better described as “interested and knowledgeable parties”, discussed and provided varying viewpoints to address access and funding inequities to LTSS services.

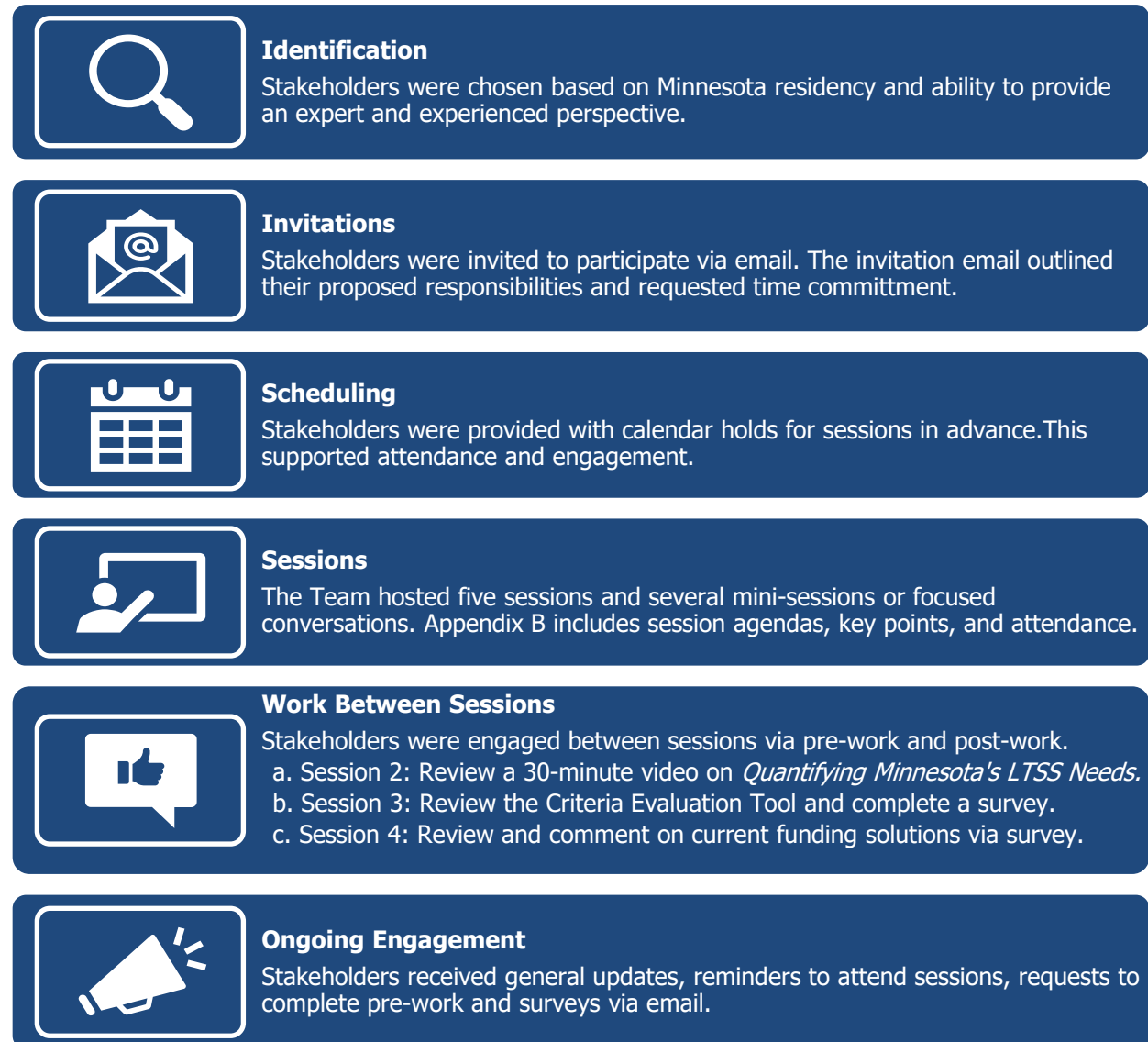
Stakeholder activities yielded valuable feedback which informed the final recommendations outlined in this report and the final LTSS finance solutions. This report documents key discussion points culminating from activities conducted between April and September 2023.

## Stakeholder Identification and Engagement Processes

The Team's stakeholder identification and engagement approach ensured stakeholders were Minnesota-based, informed, and ready to dissect, react, expand upon, and refine the proposed recommendations. **Figure 1** outlines the approach to identify, invite, and engage stakeholders. Stakeholders were requested to:

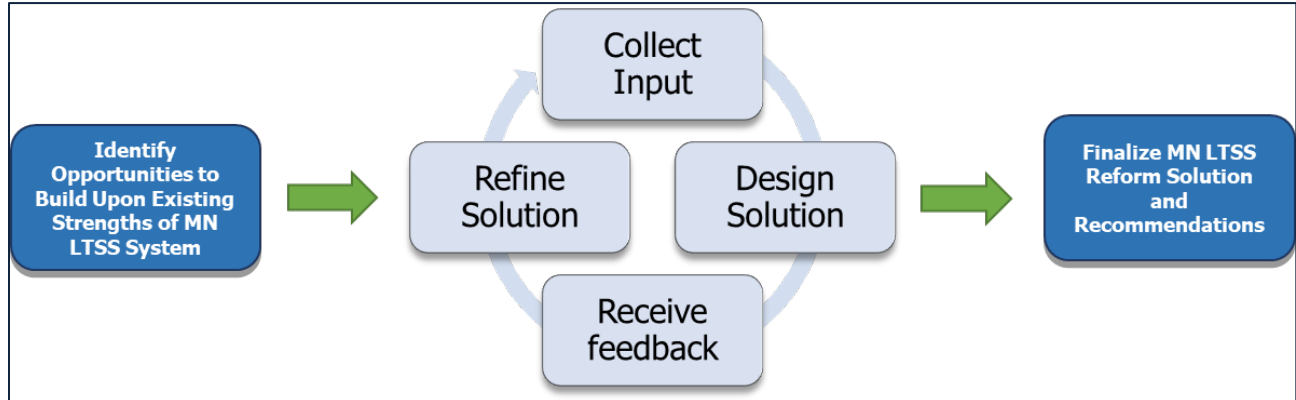
- **Focus on Community:** Expand thinking beyond professional roles to incorporate the views of their fellow Minnesotans.
- **Leverage Data:** Utilize presented data to ground the conversation.
- **Think about Outcomes:** Establish criteria to evaluate proposed recommendations.

## Figure 1: Approach to Effectively and Meaningfully Engage Stakeholders



The Team leveraged a phased approach (**Figure 2**) to optimize stakeholder time and focus engagement efforts on defined milestones.

**Figure 2. Stakeholder Engagement Process:**



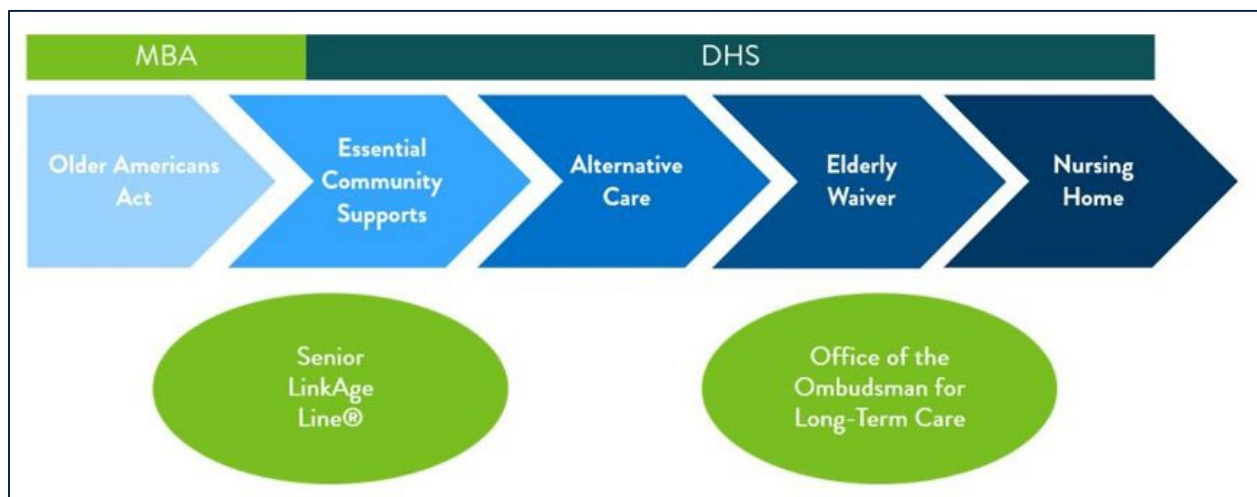
## Stakeholder Feedback

Stakeholders were encouraged to actively engage and discuss team findings, refine proposed solutions, focus their expertise and experiences, and build towards a consensus for Minnesota LTSS funding recommendations. Feedback was solicited through our tiered engagement approach and is described in the following section.

## Current State Strengths and Opportunities

Understanding the strengths and opportunities for improvement of the current Minnesota LTSS system in which to build upon was an essential component of this engagement. In early stakeholder sessions, the Team provided an overview of the current state of LTSS for older adults in Minnesota, focusing on the services and programs utilized by individuals across the spectrum of level of care need (**Figure 3**).

**Figure 3. Minnesota LTSS Continuum**



Additionally, stakeholders discussed opportunities to refine and continue to improve the LTSS system for Minnesotans with too high of an income to qualify for Medicaid, but too low of an income likely to be able to pay out of pocket for LTSS services remain. The population of most interest for this research project was coined as the “red box.” The “red box”, seen below in **Figure 4**, constitutes over 610,000 people. Recommendations for improvement areas were guided by the needs and current access capabilities of those in the “red box.”

**Figure 4. The Red Box**

Family Income	Community Need, All Community	Community Need, % Covered by Medicaid or AC	Nursing Facility Need, All Nursing Facility	Nursing Facility Need, % Covered by Medicaid or AC
<\$10,000	8,600	92%	2,200	94%
\$10,000-24,999	31,000	67%	8,100	77%
\$25,000-49,999	21,100	28%	4,600	61%
\$50,000-74,999	11,500	5%	2,700	48%
\$75,000-99,999	5,900	5%	800	37%
\$100,000-\$124,999	4,500	11%	300	27%
\$125,000-\$149,999	1,200	0%	100	0%
>=\$150,000	2,500	0%	500	0%
Total	86,200	41%	19,300	66%

Key points for both strengths and opportunities are summarized below.

### Strengths

The Minnesota LTSS system is strong. With Medical Assistance (Medicaid), contracts with local Managed Care Organizations (MCOs) and statewide service options: 1) Minnesota Senior Care Plus (MSC+) and 2) Minnesota Senior Health Options (MSHO), the state is well-positioned to work to support broader access.

Minnesota exemplifies many characteristics of an effective and well-functioning LTSS system. For example, the state is fourth in the nation on life expectancy<sup>64</sup>, shows higher financial and insurance literacy levels than other states<sup>65</sup>, and administers a provider capacity grant that provides Home and Community-Based Services (HCBS) to older adults. AARP also recently ranked Minnesota #1 in the country for long-term care services and supports for Older Americans, including Family Caregivers.<sup>66</sup> The community provider base is passionate about LTSS and has demonstrated the desire (and efforts) to support and work with the community to enhance the supports for those they serve. Another strength is that Minnesota has two large LTSS insurers, Thrivent and Securian, and is among the states with the highest per capita

<sup>64</sup> CDC, Life Expectancy at Birth by State, 2020.

<sup>65</sup> WalletHub, 2023's Most & Least Financially Literate States, 2023.

<sup>66</sup> AARP, Innovation and Opportunity: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers, 2023.

uptake of LTSS insurance.<sup>67</sup> Further, the state shows a healthy environment for strong corporate-based employers to implement broader employer-based LTSS finance options.

State legislators recognize the need for and support of formal or informal caregiver support, as demonstrated through the passing of the Paid Family Medical Leave Act (MN-PFML) in 2023. The robust “no wrong door approach” in Minnesota allows for this desired focus on caregivers. The Senior LinkAge Line (SLL), Office of Ombudsman for Long-Term Care (OOLTC), and Minnesota Adult Abuse Reporting Center (MAARC) all demonstrate the state’s priority in supporting older adults in meaningful ways and provide further foundation in which to offer support for all older Minnesotans.

Further, the state runs successful waiver programs to support older adults, including the Elderly Waiver (EW) and Alternative Care (AC). An existing network of partners, including Area Agencies on Aging (AAA) dispersed throughout the state, also works with counties, tribal nations, managed care organizations, and those requiring services to offer federally funded services and support using Older Americans Act funds. While Minnesota shows strength in supports for individuals in the upper- and lower-income spectrum, there are opportunities for growth in LTSS for those in the middle-income bracket.

## **Opportunities**

Stakeholder discussions revealed several key considerations around access to LTSS in Minnesota. Identified opportunities include:

- ***Increase the supply of care providers, care navigators and caregivers.*** There currently are not enough service providers or funding for care infrastructure to expand and update the current system
- ***Consolidation and curation of resources.*** There is not a central location for materials or resources to understand LTSS options better. Existing materials, such as the SLL or MinnesotaHelp.info, could benefit from further marketing so all Minnesotans know about these resources.
- ***Greater education on LTSS options.*** Providers can and should share LTSS options with those they serve to provide supports to keep individuals out of facilities as long as possible. It is imperative that the individuals served be involved in the conversation and receive information about the options available to them.
  - The Minnesota Department of Education recently passed legislation requiring finance classes in high school, which could be leveraged on a larger scale to provide financial literacy classes, with emphasis on LTSS financing to employers and employees throughout the state.
  - While Minnesota is home to skilled LTSS providers, few have the capacity to provide the full array of needed services, especially to individuals in rural communities. There is an opportunity for a creative funding stream to include provider focused LTSS education.

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<sup>67</sup> American Association for Long-Term Care Insurance, Top States for Long-Term Care Insurance, 2020

- Further evaluate and plan for LTSS education needs for those living in rural or tribal areas, individuals who are Black, Indigenous, People of Color (BIPOC), or other historically underserved populations in need.
- ***Growth around technology, accessibility, and the workforce.*** With broadband and the increasing use of telehealth comes flexibility and mobility in service provision. There is an evolving opportunity around leveraging technology and exploring remote options to improve service provision if there is sufficient access to technology throughout the state.
- ***Support existing research efforts.*** Currently there are many efforts led by the Department of Human Services. Examples of work include Caregiver and HCBS Reform Evaluation, Vulnerable Adult Act Redesign, and efforts by the Governor’s Council for Age-Friendly Minnesota.

## Stakeholder Priorities for an LTSS Funding Solution

Stakeholders embraced an iterative process for solution development that built upon strengths, focused on identified opportunities, and prioritized voiced needs. The following sections summarize key stakeholder priorities.

### Stakeholder Feedback on the Recommendations

Stakeholders reviewed proposed funding recommendations. Key themes from stakeholders recommended that solutions should:

- ***Promote and enhance the existing Minnesota LTSS system infrastructure and related programs.*** The ideal solution must continue the current approaches which are flexible and provide equity in access. This allows individuals to select services and supports that work best for them, and offers supports to all individuals, regardless of race, gender, primary language, education level, and geographic location within the state.
- ***Expand upon available caregiver supports and care navigation***
- ***Advance upstream interventions and expand services to better align with early supports***
- ***Clearly define the available supports,*** including considerations around coordination, services, supports, quality of care, caregiver structure, and life stages for different diseases.
- ***Remain portable***
- ***Have services be available more promptly, particularly in transition periods***
- ***Incorporate end-of-life care***
- ***Emphasize partnership between public and private entities***
- ***Have the option to self-fund*** or be funded through other programs.



- ***Provide alternatives to a compulsory option***, such as caregiver credits, options for employer coverage and wellness incentives.

Regarding moving upstream, stakeholders also recommended that ***interventions should occur as early as possible in an individual's care journey***, reducing the financial impact that LTSS would potentially have on them. These interventions would include family and other caregiver supports, which are needed to empower individuals whether they are in a home care or institutional setting. Stakeholders consistently shared their desire for a focus on caregiver support within the proposed recommendations, also recognizing that some individuals may not view themselves as caregivers and, therefore, may not seek out services. Solutions to achieve the desired level of supports and navigation for caregivers include to:

- ***Provide benefits and potential tax credits for caregivers***
- ***Leverage the recently passed Minnesota-Paid Family Medical Leave Program***
- ***Expand the definition of caregiver*** to include individuals who are not directly related to the person receiving care.
- ***Engage caregivers early*** through engagement efforts, especially in skills development and diagnosis or condition-focused education. Implementing strategies to decrease the administrative burden on the individual and the caregiver to better coordinate their supports, services, and address needs is essential.

While certain elements and programs for supporting caregivers are already in place, the needs of caregivers are varied and connecting them to appropriate solutions for their individual situations can be difficult to do efficiently. Examples of services and programs already in place in Minnesota include caregiver education, respite services and caregiver consultations. Solutions should continue to ***leverage SLL*** and target an ***additional level of support for caregivers with the highest risk***. One strategy to bolster existing programs and services available could be to allow broad access for all individuals to an online platform that provides caregivers with new information or skills needed to manage care for one in the home, through Area Agencies on Aging (AAA) and other organizations providing services.

Stakeholders also suggested leveraging county assessor results ***to risk stratify and provide services tailored to the direct needs*** of caregivers. In considering the focus of returning to the community, stakeholders noted opportunities to form partnerships with medical entities when care transitions occur or when individuals experience a change in diagnosis to ensure caregivers are supported.

There is a continued need for ***long term service, support, and financial education***, including a ***central location for educational resources and care support opportunities***. Stakeholder feedback revealed that LTSS solution(s) must incorporate education about the available services and programs, eligibility criteria considerations, and how to access available supports. Such resources should also include tools to find area providers, training opportunities

for informal and family caregivers, as well as access to state and community programs. Both self-directed and assisted approaches should be enabled.

***Education should be offered at the point of care with healthcare entities***, who should feel empowered to initiate LTSS conversations early in a patient's care continuum to ensure awareness and understanding of options on the front end. Further, education should be provided consistently, at varying levels, including online resources and through direct provider conversations. Employers should be encouraged to ***introduce LTSS finance and services earlier through employee assistance programs (EAP) or similar programs***. LTSS system education must also recognize and acknowledge that historically underserved and vulnerable populations need specific supports. Overall, education must support individuals in understanding not only what programs and coverage are available, but also what supports they qualify for and how to access them.

Other key areas stakeholders highlighted included ***technology, accessibility, and the caregiver workforce as core focus areas for LTSS solutions***, which were also identified as areas that need improvement in the opportunities section. Stakeholders broadly emphasized strengthening existing state, county, and local-based programs with technology-based programs. Technology use should be leveraged to support the workforce and be woven into support system reform solutions; however, it is crucial to recognize the challenges this may bring to older adults and those within the "red box". Utilizing technology could support keeping costs lower, reducing some burden on caregivers, and better supporting older adults in their independence. Stakeholders highlighted the importance for LTSS finance solutions to consider developing and having available systems to better ***support LTSS workforce members, including recruitment and retention efforts***. This point was important when the viability of the Care Navigation and Support Services (Recommendation 1) was discussed. While this option was favored, it was emphasized that supplemental efforts would need to be taken to provide financial incentive to the LTSS sector, encourage innovation, and support the caregiver workforce.

### **Pros/Cons Analysis**

In the final stakeholder session, attendees shared final thoughts on the three funding recommendations by analyzing the pros and cons of each. This exercise revealed a desire for a program that leads to ***delayed entry into the system*** via early interventions. Early intervention would relieve stress on the system and conserve resources. There was some support for an ***obligatory program with a significant risk pool***, preventing Medicaid spenddown and loss of wealth and assets. However, some stakeholders expressed concern that this would be met with backlash. If the final recommendation is compulsory, ***the benefit offered needs to match the pay-in amount***. There were also some ***concerns that a lack of proper supply of resources, whether workforce staffing or monetary, could lead to issues down the road***. There was also a note that ***constant and consistent marketing*** and communication would be required for people to know where supports and services may be found and what services were available. This was a noted concern with the current system.

Finally, there was an emphasis on ensuring the solution *targets as much of the "red box" as possible*. Stakeholders' feedback explicitly noted that the Catastrophic-Lite option seemed more geared toward providing support for higher-income individuals earlier than existing Medicaid supports.

### **Additional Stakeholder Feedback**

The Team also solicited feedback from individuals included in the consultant panel and advisory panel, as well as Minnesota Senior Health Options (MSHO) representatives, agencies focused on long-term care and supports, and industry experts to bolster solution design.

Consultant panel members reviewed and identified key issues within the sample designs that arose through previous stakeholder sessions. Feedback revealed several key themes highlighted below.

- ***Cross-program coordination is essential*** to not only cover the needs of Minnesota older adults, but to ensure available services are offered.
- ***Coordination needs to build upon, not overtake, information and referral (I&R)*** through Older Americans Act (OAA) funded programs and the Senior LinkAge Line. Staff training is essential for collaboration across the wide variety of state programs, and consistent with stakeholder session feedback, consultant panelists emphasized the need to address the workforce crisis. It is important that whatever solution is chosen strengthens current efforts instead of just replacing them.
- ***Care coordinators working with individuals would be beneficial to support cross-program navigation*** and advocate for individuals and their formal or informal care providers.
- ***Establish an office of care coordination*** at the state level that would coordinate all efforts and programs across Medicare, Medicaid, MSHO, OAA-funded services, and the state's Medicaid contracts. This office could report directly to DHS and have broad authority to propose program service and eligibility design changes to avoid duplicative efforts and address gaps, as well as offer training and support to care coordinators 'on the ground'.
- ***The evident need for experienced coordination*** for chronic conditions across various programs and specialists, not just referrals, is a persistent challenge for effective and proactive coordination. There is a ***need for education***, or an informational resource which is focused on Minnesota LTSS planning and options to provide a comprehensive orientation to available resources. Physicians were explicitly noted as a target for education, as they are not currently being funded to be knowledgeable on this topic.
- ***A credit approach for caregivers*** should be considered and premiums should be proportionate to income. Discussion on how such credits would be enabled and ways to subsidize premiums provided some integrated design considerations.

- **Technology utilization** was also emphasized, with feedback highlighting how it could supplement care. It was noted that a well-tooled website alone would not be beneficial for many within the older population. A supplemental telephone option staffed by workers familiar with the community and caregiving options was recommended. All technological options should be multilingual to improve accessibility.
- **Risk adjustment** was raised, but it was noted that while it could save members money, it would also increase the cost to taxpayers. Regarding LTSS insurance, the panelists noted that this may be difficult to foster public buy-in, and people may end up paying money into a service they may not have to use.
- **Proper funding processes** would involve the program being privately funded first, and then shift to public, or vice versa. Identifying approaches that leveraged public/private collaboration was a strong desire. Going along with this, inflation protection was noted as being extremely important. Not having this protection could lead to individuals having to spend down sooner.

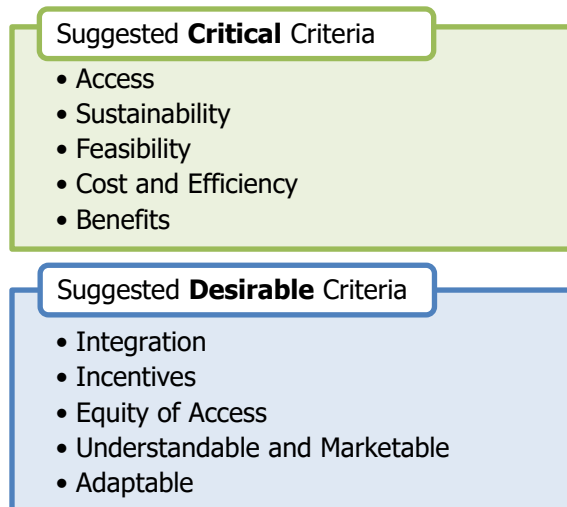
Other critical areas of focus in additional stakeholder feedback offered suggestions to define expected outcomes clearly and include key metrics that should be met through financing reform. It is essential to measure progress for the recommendations put forth and to be flexible enough to allow people to continue to make changes and enhancements based on outcomes.

## LTSS Finance Solution Scorecard

A LTSS Financing System is the collection of the approaches which fund all public, private, and informal means to address the long-term care needs of the population. While this research primarily focused on the financing of care for Minnesotans, acknowledging the availability of caregivers and how the financing approach could enhance that availability was paramount. The research also required establishing an essential criteria framework for which to evaluate proposals. Therefore, early in the solution design phase, the Team sought to develop a comprehensive scorecard to evaluate the potential impact on the entirety of the LTSS system, which a proposed financing approach may produce.

To initiate the development of a potential scorecard, the stakeholders viewed an example provided by a Society of Actuaries and American Academy of Actuaries roundtable hosted in 2012 called, "A National Conversation on Long-Term Care Financing". These criteria were further leveraged by the Academy's LTSS Criteria Work Group for later issue briefs.

**Stakeholders developed a set of considerations to be included in the LTSS Finance Solution Scorecard. The group also suggested a *weighting of evaluation criteria* to prioritize goals and metrics for the state around LTSS, separating out those criteria that are critical or essential for an LTSS reform solution versus desirable, but not required. Among the critical criteria elements for consideration in solution design are: 1) access; 2) sustainability; 3) feasibility; 4) cost and efficiency; and 5) benefits. (Figure 5). Figure 5. Scorecard Criteria**



Under this engagement, and in collaboration with stakeholders, the Team refined the criteria to evaluate proposed recommendations to ensure support for all Minnesotans. This was done through the Scorecard, which intended to collect feedback on essential criteria elements for Minnesota LTSS funding proposals. Key criteria elements assessed in Minnesota’s Scorecard are outlined in [Table C1](#).

Stakeholders provided input and comments on two occasions and feedback was incorporated into the final tool. Stakeholders were first asked to rank the Scorecard criteria elements by importance (1 being the most important, and 10 being the least). The highest ranked choice was “equity of access/access,” with 39% (n=7) of the 18 respondents indicating highest importance. “Health equity” was followed by “Feasibility,” which 22% (n=3) of respondents marked as most important. “Incentivization” received the lowest ranking. Full rankings are in [Figure C1](#).

Next, stakeholders completed an exercise in which they assessed the current state of each element using the scorecard. The Team walked through the criteria, and stakeholders “graded” each element. The scale ranged from 1 (no improvement) to 4 (substantial improvement). Stakeholder rankings of the current state of LTSS system components in Minnesota reveal low averages across all elements ranging from 1 (understandable and marketable) to 2 (benefits). The overall average for all elements was 1.3. This feedback demonstrates perceived gaps and opportunities for focus in proposed LTSS funding recommendations. Results are documented in [Table C2](#) and the final Scorecard is available in [Table C1](#). Stakeholder feedback collected during the Scorecard development phase is captured in the “Additional Clarifications” section.

## Recommendations

Stakeholder feedback support key recommendations for the proposed Minnesota LTSS solution(s). Recommendations are detailed below.

- **Improve Care Coordination and Care Navigation:** Strengthen coordination efforts across LTSS services, organizations, and partners to help ensure gaps are covered and managed, and there are no duplicative efforts for individuals and their caregivers across payers. Provide caregivers with tax credits, leveraging Minnesota’s Paid Family and Medical Leave Program. Engage caregivers early and provide them with the proper resources to deliver quality care. Care coordination efforts would be beneficial in supporting cross-program navigation between Medicare and Medicaid.
- **Optimize Current Services:** Integrate the solution into LTSS services already in place. The SLL should be leveraged and enhanced to target those at higher risk for LTSS needs. Developing a resource library can also better educate and upskill caregivers. Services should be made available in multiple modalities for those with different technological capabilities, languages, abilities, and resources to outreach and connect.
- **Emphasize Education:** Enhance educational supports for the public on LTSS service and support availability by having providers deliver LTSS education directly at the point of care for individuals and their caregivers. Infusing education within visits themselves can support individuals in better understanding their options at the beginning of the care continuum. The education system should recognize historically underserved or vulnerable populations and their unique needs.
- **Leverage Medicaid:** Utilize the state’s Medicaid contracts to require more coordination and caregiver supports to those receiving LTSS services and supports. Require comprehensive caregiver programs that are aligned with OAA-funded programs and other state programs, as opposed to allowing them to be value adds with current providers.
- **Tailor Services:** Utilize available data to best meet the needs of the state population, including individuals, caregivers, and providers. Leverage caregiver risk assessment results and their level of care needs to tailor services and the amount of funding for services or supports provided through enhanced programs (e.g., possible utilization of 1115 Medicaid demonstration waiver, possible expansion of OAA-funded programs, and MSHO value-add programs). It is important to make sure that any solution is best targeting the “red box” population that was the subject of this engagement.
- **Engage Private Industry:** Engage employers as a part of the education process of LTSS funding, services, needs, and supports. Leverage employer-based EAP programs to better support individuals and their caregivers with necessary supports (e.g., caregiver counseling, LTSS needs and funding counseling, guidance on accessing services, in-home modification lists, and (limited) funding). Coordinate and integrate Paid Family and Medical Leave Program into LTSS needs and assign a care coordinator. Technology can be a big help in enhancing the LTSS workforce, aiding in both recruitment and retention.

- **Funding and Implementation:** Services should be available as soon as possible and should be portable across time and states. A self-funded solution would be the most appealing to the target population, but a compulsory option would ensure more uptake. Other options such as caregiver credits, employer coverage and wellness incentives would also be beneficial.

The above recommendations will require a robust implementation roadmap to ensure success and serve as a foundation for alternative LTSS funding solutions.

## Appendices

### Appendix A: Stakeholder Member Identification

The Team worked closely with the State to identify potential stakeholders to engage. Names were initially taken from past OYF efforts, then existing relationships with other individuals and organizations were leveraged. From there, gaps were identified, and the Team determined how to best have all necessary sectors represented. The subsequent list included over 118 individuals, most of whom were Minnesota residents who brought a breadth of experience and expertise in various focus areas.

Together, the Team decided to divide the comprehensive list into three audience types:

- **Stakeholders:** The LTSS Funding Transformation stakeholders were selected to be a body of varying viewpoints from representatives across the state to address health inequities to LTSS services. Their input was vital in the funding solution selection process. Stakeholders were selected based on specific criteria, including the requirement that they have some connection to Minnesota (such as living or working there) and the ability to provide valuable insights on finance, Medicare, Medicaid, policy, consumers, and providers. We identified 25 stakeholders.
- **Advisory Panel:** The LTSS Funding Transformation Advisory Panel consists mostly of members of the Minnesota State Government. The Advisory Panel's role was to offer state-specific expertise and support. We identified five Advisory Panel members. While the Advisory Panel was typically expected to attend stakeholder sessions and provide input in that avenue, there was also a separate session held with members on June 9th, 2023, with the following goals:
  - Discuss the project extension plan and report timeline.
  - Review the upcoming consultant panels and additional outreach.
  - Outline the proposed funding solutions as well as highlight what the stakeholders are leaning towards.
- **Consultant Panel:** The LTSS Funding Transformation consultant panel was developed to supplement the views of the LTSS Funding Transformation stakeholders. The consultant panel consists of representatives from various state-based organizations, internally and externally, to Minnesota. We identified 39 consultant panelists.

The stakeholder and consultant panel roles were divided based on their projected contribution to the project.

- Stakeholders were expected to take on a more significant role and were seen as the ultimate decision-makers, so selected individuals had to be able to participate accordingly.



- Consultants provided a smaller, more supportive role, but were still important in the decision-making process.

## Appendix B: Member Lists and Session Summaries

### Stakeholders

LTSS Funding Transformation stakeholders represented a forum of varying viewpoints from representatives across the state to address health inequities to LTSS services. Stakeholders and their organizations are listed below in **Table B1**.

**Table B1: Stakeholder Names and Organizations**

Name	Organization
Bentley Graves	Minnesota Chamber of Commerce
Chelsea Georgeson	Minnesota Health Plans
Cheryl Hennen	Minnesota Office of the Ombudsman for LTC
Craig Roers	Newman LTC
Dan Pollock	Fairview Southdale Hospitals
Dawn Simonson	Minnesota Association of Area Agencies on Aging
Emily Raspante	Le Clair Group
Greg Arling/ Zach Haas	Purdue University
Kari Benson	Minnesota Area Board on Aging, Minnesota Department of Human Services
Kari Thurlow/ Jeff Bostic	Leading Age Minnesota
Kathy Messerli/ Andrea Young	Minnesota Home Care Association
Kristi Kane	Minnesota Association of Area Agencies on Aging
Kyle Wilson	Securian
Lucas Nesse	Minnesota Council of Health Plans
Lynn Blewett	State Health Access Data Assistance Center
Mary Jo George/ Zoe Bentacourt	AARP Minnesota
Mimi Stender	Age-Friendly Minnesota Council
Patti Cullen	Care Providers of Minnesota
Rachel Shands	Minnesota Department of Human Services
Sam Smith	Minnesota Alzheimer's Association
Sara Hower/ Matt Johnson	Blue Cross/Blue Shield Minnesota
Steve Sperka	Thrivent
Sue Kvendru	Minnesota Department of Human Services
Tom Devine	Horizon Agency

Stakeholders met for five sessions. The date, goals, total attendance, discussion points, and discussion summary are summarized by session below.

## Session 1: April 27<sup>th</sup> with 19 attendees

Session goals include:

- Understand the stakeholder's role in this necessary research.
- Develop a baseline understanding of the current state of LTSS services, supports, and the ability of Minnesotans to access supports consistently and without undue burden (emotionally or financially)
- Establish criteria for evaluating LTSS finance reform proposals.

The session focused on getting the stakeholders acclimated with the project via an overview of OYF initiatives and explaining their role. Stakeholders also received an explanation of the current state of LTSS in Minnesota. John O'Leary provided the history of the OYF initiative and informed the stakeholders of the current phase's goals. Kari Benson of the Minnesota Board on Aging and Department of Human Services then offered a brief overview of the current state of LTSS for older adults in Minnesota. The focus was on the services provided along the spectrum, Older Americans Act programs, and discussing the strengths and opportunities of the LTSS system. Finally, criteria elements to evaluate proposed solutions, or "the scorecard" ([Table C1](#)), were shared. Stakeholders were asked to watch a [30-minute video](#) from Edward Armentrout on the current state of Minnesota's financial system as pre-work. Stakeholders were asked in breakout sessions to assess the strengths and opportunities of the current LTSS system. A detailed breakdown can be found in a [previous section](#).

## Session 2: May 10<sup>th</sup> with 18 attendees

Session goals include:

- Stakeholders will understand Medicaid, Medicare, LTSS, and MLTSS across the country in general, and in Minnesota specifically.
- Stakeholders will better understand current healthcare funding avenues in Minnesota.
- Stakeholders will start to identify current funding gaps and potential solutions.

This session emphasized outlining LTSS funding in Minnesota for Medicare and Medicaid, reviewing the current ability of Minnesotans to receive and fund their healthcare, and discussing the scorecard criteria. Sue Kvendru of Minnesota's Department of Human Services provided a thorough overview of Medicaid and the role of MCOs in Minnesota. Kari Benson then offered a brief comparison of the different programs and services offered in Minnesota, including OAA, Essential Community Supports (ECS), AC, and EW. During the comparison, Kari highlighted that as an individual's needs increase, the program services required (and costs) increase. Some programs support the full spectrum of "just enough services" to keep someone in the community through the Elderly Waiver. Claire Jensen of LTQA and Matt Johnson of Blue Cross Blue Shield Minnesota supplemented this by highlighting alternative ways of payment, including an insurer's perspective. Next, stakeholders were introduced to the "red box" population, which was referenced previously.

Finally, Steve Schoonveld shared with the stakeholders the draft of the scorecard that was being created to evaluate the proposed funding solutions. As pre-work, stakeholders were asked to evaluate the scorecard ([Table C1](#)) and provide feedback on how it could be improved.

### **Session 3: May 25<sup>th</sup> with 16 attendees**

Session goals include:

- Summarize everything we have discussed so far.
- Use the criteria evaluation tool to evaluate the 3-5 proposed funding solutions.
- Discuss and refine key metrics.

This feedback-driven session focused on fine-tuning the scorecard and practicing using it. It also involved stakeholder-led discussions on the proposed five funding solutions, allowing time to brainstorm alternative solutions as well. First, the feedback from the pre-work, where stakeholders were asked to evaluate the scorecard, was shared. The stakeholders were then asked to weigh in by completing a ranking poll where they were asked to rank the scorecard criteria elements by importance (with 1 being the most important, and 10 being the least). The highest ranked choice was "equity of access/access," with 39% of the 18 respondents indicating that this was most important. This was followed by "feasibility," which 22% of respondents marked as being most important. The remainder of the rankings can be seen below, with "incentivization" receiving the lowest ranking. The five proposed funding solutions were then shared and explained to the stakeholders. Keeping what they were shown in mind, they were asked to:

1. Provide feedback on the five proposed solutions.
2. Brainstorm their own alternative solution.

Immediately following the breakout group discussion, stakeholders were asked: *In one word, describe what is most important to you within the funding solutions?* The most popular word mentioned was "affordable." The stakeholders were instructed to complete a survey to provide feedback on the funding solutions for pre-work.

Stakeholders were asked to rank the criteria elements by importance, use the scorecard to evaluate the current state of LTSS in Minnesota, provide feedback on the five proposed funding solutions and brainstorm an alternative solution, and describe what was most important to them within the funding solutions. Results were discussed in a [previous section](#).

### **Session 4: June 20<sup>th</sup> and 28<sup>th</sup> with 19 attendees**

Session goals include:

- Understand what the proposed models for LTSS funding are, and why they may be effective as well as the key metrics.
- Solidify project goals.

This session focused on LTSS funding in Minnesota, including the data and demographics surrounding the current ability of Minnesotans to fund their long-term care healthcare needs. It was held in two parts to get the opinions of the full stakeholder panel. The session started with the stakeholders taking time to give their views on the proposed funding solutions via survey if they had not done so already. Edward Armentrout then provided an overview of the financing

for each of the solutions, highlighting the impact that each option would have on the individual or taxpayers at large. The proposed funding solutions were then reviewed again, and stakeholders were asked to build their own solutions using elements of the ones that had been proposed. Taking what they were shown with the five proposed funding solutions, stakeholders were asked to brainstorm their ideal solution. We were considering these “alternative” funding solutions. Comments made can be found in a [previous section](#).

**Session 5: September 14<sup>th</sup>, 19<sup>th</sup>, and 20<sup>th</sup> with 24 attendees**

Session goals include:

- Stakeholders will get a final understanding of key findings and the proposed funding options.
- Stakeholders will provide their feedback and overall ratings on recommended options and sub-options.
- Stakeholders will provide additional feedback on implementation considerations.

This session focused on getting final feedback from the stakeholders based on the proposed recommendations. Being the final meeting, it was held in three parts in order to get input from as many stakeholders as possible. The first part of the session was focused on relaying feedback from the previous sessions, including non-stakeholder sessions like the consultant and advisory panels. (Figure B2).

**Figure B2. Key Findings from Stakeholders**

Care Navigation	Finance	Existing Efforts	Education	Technology	Service Specific
<ul style="list-style-type: none"> <li>• Care navigation and coordination for Minnesotans is essential</li> <li>• Cross-program coordination is essential to provide access to existing supportive programs</li> <li>• Early interventions enhances the opportunity for wellness &amp; prevention</li> </ul>	<ul style="list-style-type: none"> <li>• Establish creative funding streams</li> <li>• Support self-funded or program funded approaches</li> <li>• Provide supports and potential tax credits for Minnesotans and their caregivers</li> <li>• Emphasize partnership between public and private entities</li> <li>• Private industry incentives</li> </ul>	<ul style="list-style-type: none"> <li>• Promote, strengthen and enhance existing MN LTSS programs such as; the Senior Linkage Line, MSHO, Elderly Waiver, and the work of the Area Agencies on Aging</li> <li>• Leverage the recently passed paid family and medical leave act (PFMLA)</li> <li>• Currently, a highly fragmented system that does not meet the needs of a majority of older adults.</li> </ul>	<ul style="list-style-type: none"> <li>• Engage older adults and caregivers early</li> <li>• Expand education on LTSS options</li> <li>• Provide a central location where educational resources and supports are made available</li> <li>• Introduce LTSS finance and services earlier through employee assistance or similar programs.</li> </ul>	<ul style="list-style-type: none"> <li>• Focus on technology, accessibility, and how it may be used to address the workforce crisis</li> <li>• Strengthen state, county, and local based programs with technology-based solutions</li> </ul>	<ul style="list-style-type: none"> <li>• Supports and funding approaches are clearly defined, accessible, and understandable</li> <li>• Tailor the services and financing approaches based on individual needs and means across urban, rural, tribal, and cultural differences</li> <li>• Support the LTSS workforce, including recruitment, retention, and sustainable compensation efforts</li> </ul>

Stakeholders were then given an overview of the three recommendations and asked to provide pros and cons for each.

Additionally, they were asked to give their rankings on how each recommendation showed improvement from the current state, using the scorecard. Results are shown below in

**Table C3.** Finally, stakeholders were asked to share any final thoughts, which were added to this report.

### *Advisory Panel*

The LTSS Funding Transformation Advisory Panel consists of members involved in or work with different areas of State Government on LTSS issues. The Advisory Panel’s role was to offer state-specific expertise and support. While the Advisory Panel was typically expected to attend stakeholder sessions and provide input in that avenue, there was also a separate session held with members to gain specific insight.

**Table B2: Advisory Panel Names and Organizations**

Name	Organization
Fred Anderson	Minnesota Department of Commerce
Mary Olsen Baker	Minnesota Department of Human Services, Minnesota Board on Aging
Nicole Stockert	Minnesota Department of Human Services
Robyn Rowen	Minnesota Insurance and Financial Services Council
Todd Stump	Minnesota Department of Human Services, Minnesota Board on Aging

In addition to attending stakeholder sessions, Advisory Panel members met for one additional session. The date, goals, total attendance, discussion points, and summary of the discussion are summarized below.

#### **Session 1: June 9<sup>th</sup> with 4 attendees**

Session goals include:

- Discuss the project extension plan and report timeline.
- Review the upcoming consultant panels and additional outreach.
- Outline the proposed funding solutions as well as highlighting what the stakeholders are leaning towards.

This session was held to allow the Advisory Panel members to expand upon what they observed in the stakeholder sessions. It also gave the project team the chance to lay out the project's potential next steps, as well as explain the reports timeline. The panel members were also given the opportunity to provide feedback on the proposed funding solutions, considering the stakeholders’ opinions.

*Consultant Panel*

The LTSS Funding Transformation consultant panel was developed to supplement the views of the LTSS Funding Transformation stakeholders. The consultant panel consists of representatives from various state-based organizations, both internal and external, to Minnesota.

**Table B3: Consultant Panel Organizations Represented**

Organization
Minnesota Business Partnership
John Hancock
Cares Plan Washington
Genworth
Reverse Mortgages SIDAC
CA Healthcare Advisors
Federal Life Insurance Company
The Carolyn Olson Group
NAIFA
Ameriprise / RiverSource
UHAS
Minnesota Department of Revenue
Thrivent Financial Services
ET Consulting
Colorado Area Agency on Aging
New York Life
RBC Wealth Management
National Academy of Elder Law
ACLI
Previous State Representative
Industry Consultant
Securian
Minnesota Department of Human Services, Minnesota Board on Aging
Compliance Expert
Colorado State Representative
Independent Living Systems
CT
Illumifin
Ice Floe Consulting
PA Department of Insurance
LTCi Partners
Long-Term Care Associates
America’s Health Insurance Plans

The consultant panel met twice. The date, goals, total attendance, discussion points, and summary of the discussion are summarized by session, below.

## **Session 1: July 12<sup>th</sup> with 39 attendees**

Session goals include:

- Provide panel with background on the research and process related to the project.
- Express the importance of reaching the “red box” population.
- Revisit what is currently working in Minnesota and introduce the scorecard.
- Present the current proposed funding solutions.

In this session, consultants were given an overview of the project and told how they fit into everything. Much like the stakeholders, they got an overview of why our “red box” population is being targeted, as well as a summary of what had been discussed in the stakeholder groups. They were additionally presented with the five proposed funding solutions, which they were asked to comment on after the session. A formal discussion was not held for this session, as consultants were placed in a listening position. Comments were collected via survey, the results of which were mentioned in a [previous section](#).

## **Session 2: September 7<sup>th</sup> with 20 attendees**

Session goals include:

- Summarize progress to date since Session 1.
- Recap key stakeholder, consultant panel, and mini-session feedback and insights on proposed options.
- Review updated proposed options and provide additional comments.
- Present implementation considerations.

In this session, consultants were given a recap of the project, including a reminder of the engagement’s purpose, the “red box”, the essential criteria, and feedback to date. The session's emphasis was getting concluding thoughts from consultants so they could be shared at Stakeholder Session 5. Extensive time was taken to get feedback on each of the three remaining approaches: Care Navigation and Support Services, Medicare Companion Product, and a Catastrophic-Lite State Sponsored Program

### *Mini Sessions*

“Mini-Sessions” were held for additional context and obtain reaction to the direction of stakeholder discussions. A majority of mini-sessions were topic specific and brought experts from across industries nationwide.

## **Caregiver Supports with Health Management Associates (HMA) and Minnesota Department of Human Services**

In this meeting, the group discussed current structures around caregiver supports, challenges in this space, and ways to improve the existing infrastructure. There was also discussion surrounding the HMA Caregiver Report, which had been recently released. The group examined how preliminary information gathering and aid can come through SLL, but individuals need to be referred to a caregiver for deeper assessment. There are many existing tools for caregivers;

however, there is a need to build out caregiver consultations further. Creating partnerships with hospital associations could be beneficial for caregivers in instances when care transitions occur. These types of partnerships can also support efforts to keep people at home and in the community. Opportunities exist for training to occur directly in a hospital or transitional care unit setting. For example, training around respite education support tools (e.g., transporting someone, handling challenging situations, etc.) and other training topics could occur while caregivers are waiting. While there are restrictions and pressures on care management under current systems, there are ways for hospitals, AAAs, and even health plans to potentially engage in offering caregiver supports. Specific to Minnesota, the group discussed services available through TCare and Trualta, two prominent platforms designed to support caregivers, noting the importance of building on the work already being done but considering ways to support caregivers more comprehensively across the state.

**Table B4: Caregiver Supports Organizations Represented**

Organization
Minnesota Department of Human Services, Minnesota Board on Aging
FTI
O’Leary Consulting
Altarum
Health Management Associates

**Senior LinkAge Line (SLL)**

In this discussion, members of the Minnesota State Government explained how the SLL is currently being used. They expressed the need for expanded funding to supplement MinnesotaHelp.info, which is a central “hub” where caregivers and older adults can learn where and how to access services. There was also a desire to reach people earlier or “upstream” before they need services. This would help the population be more well-informed about LTSS.

**Table B5: SLL Discussion Organizations Represented**

Organization
Minnesota Department of Human Services, Minnesota Board on Aging
FTI
O’Leary Consulting
Altarum

**Waiver Discussion**

During a group discussion, staff from both FTI and Altarum engaged in an in-depth exploration of the present and prospective waivers, while also taking a close look at the strategies and approaches being adopted by other states in this regard. Emphasis was placed on the 1915(i) and 1915(k) waivers, which are currently in a reviewal process with the Centers for Medicare



and Medicaid Services (CMS). If approved, these waivers will expand HCBS to cover more Minnesotans in and out of the home.

**Table B6: Waiver Discussion Organizations Represented**

Organization
FTI
Altarum

**LTSS Health Equity Discussion**

This meeting aimed to discuss Advancing States’ [Advancing Equity through MLTSS Programs](#) paper. The intention was to integrate findings and suggestions into the proposed funding solutions.

**Table B7: MLTSS Health Equity Organizations Represented**

Organization
Altarum
Minnesota Department of Human Services, Minnesota Board on Aging
O’Leary Consulting
FTI
ADvancing States
Impact 180

**Expert Panels**

A series of mini expert panel sessions were held with existing members of the stakeholder panel, Advisory Panel, and consultant panel to get insights into industry specifics. A total of 6 sessions were held between May 19<sup>th</sup> and May 24<sup>th</sup>, focusing on the following industries: Insurance, Employer/Employee Benefits, Advisory and Broker, and Legislative and Regulatory. Attendees were primarily asked to provide feedback on the proposed funding solutions.

**Table B8: Expert Panelist Organizations Represented**

Organization
Thrivent
Securian
New York Life
Ameriprise
LTCI Partners
LeClair Group
Horizon Agency
Minnesota Business Partnership
Newman LTC
LTC Associates
RBC Wealth Management

The Carolyn Olson
Minnesota Chamber of Commerce
Fairview Southdale Hospitals
Minnesota Department of Human Services, Minnesota Board on Aging
Minnesota Department of Commerce
Previous State Representative
Minnesota Insurance and Financial Services Council

**MSHO**

In this discussion, we engaged a number of Minnesota insurers to understand support systems that were available to those 65+ receiving MA, through MSHO. In addition to discussing the MSHO program, attendees also discussed additional opportunities for upstream interventions identified throughout the course of the engagement.

**Table B9: MSHO Discussion Organizations Represented**

Organization
FTI Consulting
Altarum
Medica
HealthPartners
Minnesota Department of Human Services
United Healthcare
Primewest
UCare
OPGMedia

**Rural Technology**

In this discussion, we engaged a number of National experts to understand the support systems with a strong technology base that are available in the market. This helped determine the opportunities for rural supports where access may be limited.

**Table B10: MSHO Discussion Organizations Represented**

Organization
FTI Consulting
O’Leary Management Associates
Scenscio
T-Care
Trualta
The Helper Bees
ARM
Minnesota Department of Human Services

## Appendix C. Scorecard of the Essential Criteria Elements – Minnesota LTSS Funding Proposals

The intent of the Scorecard was to collect feedback on essential criteria elements for Minnesota LTSS funding proposals. This was presented to stakeholders on two separate occasions so they could a.) assess the current state of LTSS in Minnesota and b.) utilize the scorecard to evaluate the proposed funding solutions. On the left-hand side is each quantitative, qualitative, or supportive element that is used as an analysis tool to decide if there was no improvement, limited improvement, significant improvement, or substantial improvement.

**Table C1. Essential Criteria Elements Scorecard**

Assessment of a Proposed System Change	Description	Comments:	No Improvement	Limited Improvement	Significant Improvement	Substantial Improvement
<b>Quantitative: Access</b>	Improves access to and usage of Long-Term Care (LTC) by Minnesota’s older adult population.					
<b>Quantitative: Costs and Efficiency</b>	The system improves efficiency and generates savings for public programs, consumers and their families/caregivers.					
<b>Quantitative: Benefits</b>	Total benefits are reasonable in relation to the total costs borne by the consumers across the system of public/private/ personal approaches.					
<b>Quantitative: Sustainable</b>	The funding mechanism is sustainable and adjusts to changing economics, demographic eras, changes in family composition, and care support conditions. Sustainability applies across all stakeholder groups including consumers (out of pocket costs), public and private programs (solvency), and care providers (reasonable reimbursement).					

Assessment of a Proposed System Change	Description	Comments:	No Improvement	Limited Improvement	Significant Improvement	Substantial Improvement
<b>Qualitative: Systemic Change</b>	Provides fundamental positive changes to the way LTC funding and service delivery is coordinated in MN.					
<b>Qualitative: Feasibility</b>	Implementation of the financing program is feasible and with limited obstacles and limited administrative costs to implement.					
<b>Qualitative: Integration</b>	The care and supports, financing, and care coordination/management between private, public and other sources should be part of an integrated system.					
<b>Qualitative: Incentivization</b>	The financing approach encourages support for care, prevention, and wellness initiatives. The approach aligns stakeholder needs. The system promotes consumer responsibility.					
<b>Supportive: Adaptable and Supportive</b>	The system is flexible and adaptable related to market conditions, demographic shifts, and availability of care providers and resources. The system is responsive to cultural needs and embraces caregiving approaches of different cultures and family composition.					
<b>Supportive: Understandable and Marketable</b>	Eligibility for LTC benefits, the financing approach, and the processes are simpler, clearer, and more understandable to consumers and their families/caregivers, providers, employers, and other stakeholders.					
<b>Supportive: Equity of Access</b>	Equity of access applies across urban and rural areas and across demographic and ethnic groups.					
<b>Total Weighted Score:</b>						

Additional Clarifications of terms used in the scorecard, as defined by stakeholders.

**Equity of Access/Access:** Expand access to quality HCBS for “pre-Medicaid eligible” individuals. Reduce health disparities in access to quality Nursing Home and Assisted Living Facilities. Prevent or postpone extending the spend-down period for those “pre-Medicaid eligible.” Level the playing field by eliminating policies and practices that reinforce differential treatment of groups of people who have been marginalized. Make equity a strategic priority. Build an infrastructure including the collection of race/ethnicity, Sexual Orientation and Gender Identity (SOGI), disability, and urban-rural data to support and monitor equity in access to needed LTSS.

**Integration:** Coordination of acute and LTSS, including behavioral and mental health services. New financing mechanisms should build on the strengths of existing Minnesota-integrated LTSS programs—coordination and integration with new state policies, including newly passed Minnesota Paid Family Medical Leave legislation.

**Marketable:** Any new program should be accompanied by a marketing and information dissemination strategy.

**Efficiency:** New financing mechanisms should maximize/leverage Federal financial participation through Medicare coverage policy and existing waivers and State Plan Amendments (SPA) authorities.

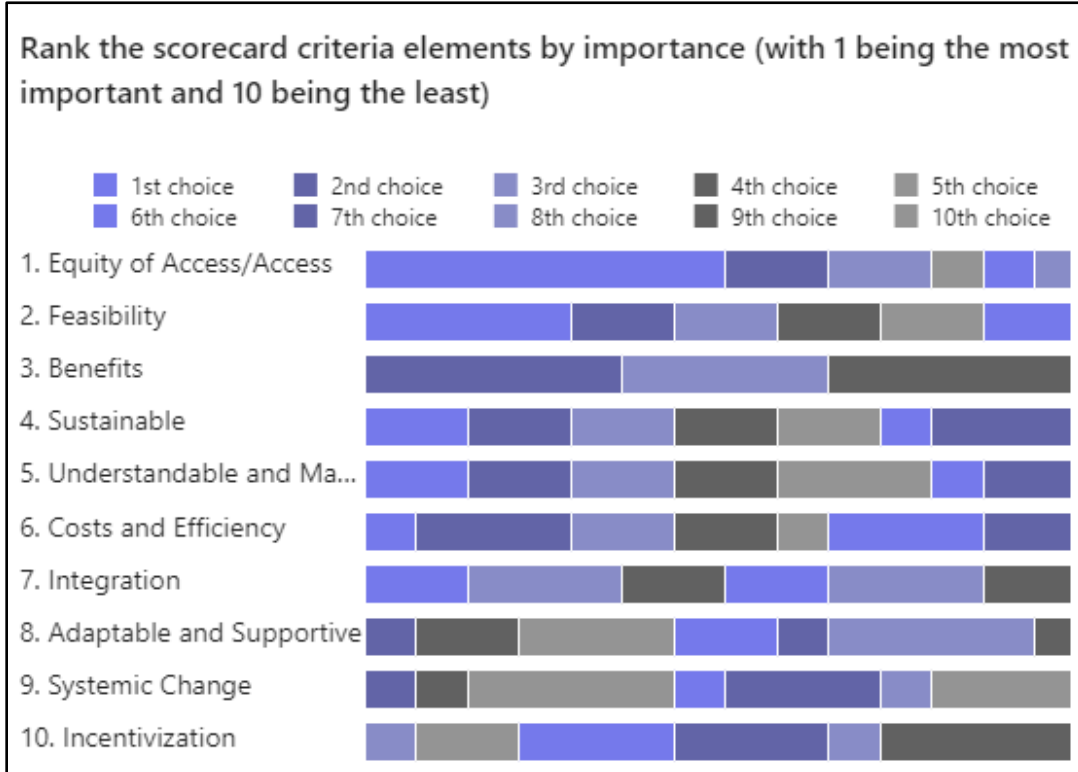
**Financial Equity:** Limit exposure for catastrophic LTSS costs and Medicaid spend-down for modest and middle-income people who could manage with some public/private financial support. Develop financing innovation that helps reduce disparities in access to NH and Assisted Living services.

**Adaptable Culturally Supportive:** The strategy must include a transparent process to include input from users of Medicaid LTSS and their families/advocates in the design of any new system of financing and care – those with “lived experiences”—targeted outreach strategies to communities of color, ethnicity, and rural and urban areas.

**Sustainability:** Works to moderate state spending growth for Medicaid LTSS expenditures.

**Incentivization:** Incentives to prevent or delay spend-down. Incentives to address those with low incomes and the highest LTSS needs – possibly through a social determinants risk adjustment mechanism. Incentivization to take personal responsibility for care needs and financing.

**Figure C1. Essential Criteria Elements Ranking**



**Table C2. Stakeholder assessment of the current LTSS system status, using the scorecard components. Scores were provided via group chat during the session and averaged among those who responded.**

Element	Average Score
Access/Equity of Access	1.4
Costs and Efficiency	1.3
Benefits	2.0
Sustainable	1.2
Systemic Change	1.2
Feasibility	1.8
Integration	1.1
Incentivization	1.1
Adaptable and Supportive	1.2
Understandable and Marketable	1.0

**Table C3. Stakeholder assessment of the improvement between the current LTSS system and each of the three recommendations. The scoring was a scale between 0 (no improvement) and +3 (significant improvement).**

<b>Element</b>	<b>Recommendation 1</b>	<b>Recommendation 2</b>	<b>Recommendation 3</b>
Access/Equity of Access	2.36	1.83	1.67
Costs and Efficiency	2.00	1.83	1.56
Benefits	1.71	1.92	2.22
Sustainable	2.29	2.17	1.89
Systemic Change	1.79	2.08	2.22
Feasibility	2.14	1.17	1.22
Integration	1.79	2.08	1.78
Incentivization	1.57	1.42	1.56
Adaptable and Supportive	2.07	1.50	1.22
Understandable and Marketable	2.08	1.50	1.56