



# Long-Term Care Coverage Stakeholder Thoughts on State- Based Catastrophic Insurance

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# Long-Term Care Coverage

## Stakeholder Thoughts on State-Based Catastrophic Insurance

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# Long-Term Care Coverage

## Stakeholder Thoughts on State-Based Catastrophic Insurance

### Executive Summary

Long-term care (LTC) financing in the United States is a mix of public and private components that do not always align well for the American public. The disparate elements of LTC financing, from LTC insurance to informal family caregiving to Medicaid and other governmental programs, are not organized in a manner to keep up with the need to finance and provide care to our expanding aging population. These challenges are being exacerbated by the aging baby boom generation who will soon be coming to the ages when LTC needs are most prominent and affordable LTC solutions are lacking for many.

The terms **Long-Term Care (LTC)** and **Long-Term Services and Supports (LTSS)** are used interchangeably to describe non-medical care provided to people with chronic conditions and functional or cognitive impairments.

The Society of Actuaries Research Institute's Aging and Retirement Strategic Research Program sponsored this exploration of stakeholder views in Minnesota on the efficacy of a public catastrophic LTC insurance program at the state level.

This report examines a potential state-based solution to one aspect of the financing problem, the devastating effects of long duration LTC as both a public policy and insurance problem. Highlights of that survey include:

- Broad support for the concept of—and challenges to—such a public program
- Support for a mandatory program
- Concerns about the viability of a tax increase to finance such a program
- A recognition of the value of properly interfacing a social insurance program with both Medicaid long-term care benefits and private LTC insurance

The report also briefly explores other recent efforts to develop research and policy solutions for financing long-term care. Working off efforts by Marc Cohen, Judy Feder, Melissa Favreault, the Long-Term Care Financing Collaborative and others, this research is the first phase of a study to explore catastrophic (back-end) coverage at the state level. To do this, the authors defined two potential “strawman” designs and then solicited feedback from Minnesota stakeholders.

The two separate potential options would both be mandatory state insurance programs for Minnesota residents to help pay for long-term care expenses. All Minnesota residents aged 65 and older would be eligible for benefits including non-working spouses. There would be a waiting period after a claim is certified, as explained below. Similar to Social Security, there would also be a work requirement of 10 years or 40 quarters of employment before an individual would vest under the program.

In Option 1 (Comprehensive Option) participants would qualify for benefits when they need help performing two or more of the Activities of Daily Living or are Severely Cognitively Impaired (usually referred to as the HIPAA trigger). They would receive up to \$5,000/month (\$165/day), which would track

with inflation in future years, as reimbursement for their long-term care expenses. That would continue for as long as recipients continued to meet the qualification requirements.

There would be a variable waiting period of between one and four years depending on a person's lifetime income. Those with average annual earnings under \$50,000 would wait one year but those with annual earnings over \$120,000 would have a 4-year wait before benefits begin. Individuals would be responsible for their care during the waiting period, and it was believed that communicating this broadly would incentivize individuals to plan for covering that gap, for instance, by purchasing LTC insurance.

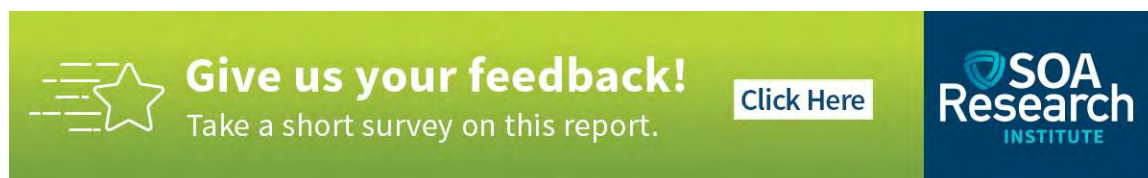
To give stakeholders a sense of potential program costs, a team of actuaries from Milliman who specialize in LTC and collaborated with the authors provided a range of payroll deduction increases of between 0.75% and 2.25%. That would translate to \$30 to \$90 per month for the typical Minnesota worker. To simplify discussions with stakeholders the interviewers often rounded the range to a 1-2% potential increase in payroll deduction.


Option 2 (Condition Specific Option) would provide funds to help pay expenses resulting from certain conditions such as Alzheimer's, Parkinson's, ALS, and MS that typically lead to LTC needs. Since these conditions tend to require earlier service interventions, the waiting period was shortened to one year for those whose annual income is under \$50,000 and two years for those over that. The actuaries estimated that Option 2 would result in a lower payroll deduction increase of between 0.5% and 1.75% for Minnesota workers. That would translate to a \$20 to \$70 per month increase.


Specifics of these designs can be found in Appendix A.

While this research was conducted in the State of Minnesota, it was neither a state sponsored nor state funded activity. Minnesota was chosen by the researchers from among a group of states because of its history in promoting the health and well-being of its senior population. The researchers also had familiarity with state-based stakeholders from previous work each had done in the state. This facilitated knowledge of, and access to individuals to interview. Stakeholders included long-term care experts, policymakers and thought leaders who were knowledgeable about LTC financing and delivery in Minnesota.

The researchers synthesized feedback and input from Stakeholder interviews to determine potential barriers and issues with the "strawmen" designs. That input is important for a possible second phase of this project, covered later in this report.



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## Section 1: Background and Context

### 1.1 THE DYNAMICS OF LTC FINANCING

Private LTC insurance was once thought to potentially provide widespread coverage of long-term care funding, but currently less than 10% of the population has chosen to buy private LTC insurance and to date it is only responsible for about 5% of LTC expenses. Many people are not planners and those that are, have been largely unwilling to voluntarily buy insurance for events that could be far into the future. In addition, potential buyers face challenges of high premiums and rate instability.

Regarding available public programs, despite the public perception, Medicare pays very little for this care, (about 6%). Medicaid does pay for LTC, and in fact finances more than 40% of long-term care expenses. However, restrictions limit Medicaid to people with low income and limited assets. To qualify, Medicaid requires that recipients spend down what assets they have before benefits become available. At the state level, Medicaid programs are already under significant financial pressure and that pressure will likely increase with the projected growth of the aging population.

Today, consumers end up paying about half of all LTC expenses out of their own pocket. This includes substantial amounts of caregiving, usually in the form of informal care by family members. There are a host of problems with this including if a couple's assets are spent for a partner this can then leave the survivor without sufficient assets to fund their own long-term care.

The current long-term care funding challenges have led several groups to seek different approaches to address this risk, including the assumption that a mix of public and private resources and funding might be needed. This research looks at the potential of providing catastrophic long-term care funding through a public state program. While it is based on work by others looking at a national model, the thought is that states can often be innovation leaders for programs like this because they are closer to the problem and likely to feel the financial impacts on their budgets sooner.

### 1.2 THE NEED FOR LTC INSURANCE

Seven in ten Americans aged 65 and over will need some long-term care and half will need paid long-term care services during their lifetimes. They will typically need that care for an average of two years, but about 20% will require long-term care for five years or more. This is considered "catastrophic" care.

By 2050, more than 500,000 Minnesota seniors are expected to need long-term care. In addition, many who will need that are the most vulnerable to spending down to Medicaid and the most likely to exhaust any informal supports they put in play.

### 1.3 WHAT IS CATASTROPHIC LTC INSURANCE?

"Catastrophic LTC insurance" is an insurance program that is specifically designed to address lengthy and typically more expensive long-term care occurrences. With this approach, the individual would be responsible for covering expenses for an initial period or up to a certain dollar amount on their own before the catastrophic coverage comes into play.

"Catastrophic care" is generally more expensive than shorter duration care and it is now, and will increasingly be, a major financial challenge for consumers, government, and private insurance in the decades ahead.

#### 1.4 WHY STATE-BASED CATASTROPHIC LTC INSURANCE

There are several reasons to consider catastrophic insurance on a state basis. First, the financial impact of increases in the Medicaid program will be felt sooner and more strongly at the state level. A state-based catastrophic program would address this problem. Second, states may be able to move faster to implement a program than the federal government. Third, a state-based program can be tailored to the unique aspects of each specific state's needs, versus a one size fits all approach. Lastly, states have often served as models of innovation to be learned from and replicated by other states, and ultimately the federal government.

The goals of state-based catastrophic insurance include:

- Provide an alternative to Medicaid spend-down and impoverishment for residents who experience long duration LTC needs
- Reduce reliance on state Medicaid programs
- Encourage the market for private LTC insurance products to cover more predictable and lower risk "front-end" care
- Keeps program costs affordable by spreading risk across as large a group as possible through a mandatory program
- Improves funding for care providers and choice for consumers by offering complementary private pay and public pay programs



## Section 2: Topline Summary

To give some sense of what stakeholders thought, this section summarizes what they said. Section 4 goes into more detail.

### Overall feasibility

Overall, most stakeholders had a favorable view of the concept of a publicly supported catastrophic insurance program. However, stakeholders also pointed out several challenges, both conceptual and operational, which they believed would have to be addressed for the program to be successful.

A significant challenge that emerged was the perception of the difficulty of “increasing state taxes” via higher payroll deductions. So, in essence, the key obstacle would not necessarily be the details of any program design but rather the difficulty of any program implementation because of the need to raise taxes to fund it.

### Option 1 versus Option 2 (Comprehensive versus Condition Specific)

Stakeholders preferred Option 1 which delivered a broader trigger for more conditions. While there was some positive views of the “condition specific” option (covering, for instance, dementia or Parkinson’s), overall, it was thought as more problematic for stakeholders. For instance, they pointed out the potential problems in determining how to select which conditions would or would not be covered, and whether that would be perceived as unfair by discriminating for or against some conditions. As a result, stakeholders favored the comprehensive option as the better approach.

### Affordability

Many stakeholders felt the amount of the payroll deduction estimated to cover program benefits and costs was too high, especially for lower wage workers. Some stakeholders advised trying to modify the program design to reduce the cost or perhaps alter how to treat low wage workers. Notwithstanding this, stakeholders generally found the program had merit although it was thought employees would perceive the cost as too high.

### Mandatory versus voluntary enrollment

Stakeholders overwhelmingly concurred that the program had to be mandatory in order to succeed, even though they appreciated the challenges of enacting any mandatory program. Based primarily on the experience of other programs, where many individuals opted out of the program during a time-limited initial window, stakeholders were opposed to an approach that allowed people to opt out of the program if they had private LTC insurance coverage.

### Front end versus catastrophic

Overall, most stakeholders supported the idea of catastrophic back-end coverage which would cover those at greater financial risk. That said, some stakeholders indicated that a program with “front end” coverage would cover more people. Hence it would be easier to implement, albeit not necessarily a better idea.

### Education and marketing

Many respondents emphasized, in different ways, the critical need for a well thought out education and marketing program to present this program to key constituencies, including employers, private insurers,

agents, other stakeholders and legislators, as well as the public. Such an education program should be a key feature to pursue in implementation of a program.

### **Trust fund**

The idea of a trust fund in which the revenues collected to support the program are held and invested separately was appreciated though stakeholders emphasized that the fund had to remain dedicated and not used for other purposes. They also were looking for clarification on how the monies in the program can and should be invested, since the program would intend to be pre-funded.

### **Employers and employment issues**

Stakeholders pointed out that it is critical to success to have both employee and employer buy-in. The employers are the front-line for information to their employees and confusion on this can be a significant contributor to implementation problems. Other issues impacting employers were pointed out as well, such as whether they have the capacity to do payroll deductions and their potential concern of being asked to supplement their employee's contributions.

### **Payroll deduction timing**

Some stakeholders liked the notion of better aligning the beginning of deductions with the timing of the benefit. That might call for starting the payroll deductions at an older age (say 50) rather than at age 21, which would likely result in higher premiums. Future actuarial analyses should look at the premium differences of starting the program at older ages compared to age 21 to help understand the trade-off of this and other changes to the program designed to keep premiums down.

### **Benefit amount and delivery situs**

While stakeholders generally reacted positively to both the \$5,000/month (\$165/day) benefit level and the unlimited lifetime maximum in the abstract, they recognized that the higher benefit levels likely meant a less affordable payroll deduction amount. The idea of positioning a program as primarily a home and community-based program was brought up. While not the traditional view of a catastrophic program, some suggested this as a way to overcome the potential issue of the benefit amounts that some perceived as too low for institutional care. In addition, it would better reflect consumer wishes to receive care at home.

### **Benefit trigger**

An example of the barriers mentioned above that came up with stakeholders is the use of the HIPAA benefit trigger versus Medicaid qualification. Some stakeholders felt strongly that the HIPAA benefit triggers were the most suitable because of their reliability and objectivity and widespread use in actuarial insurance modeling. Some felt that a HIPAA trigger also provided a more suitable criteria for a program that may work to complement private LTC insurance coverage. Stakeholders working closely with the State Medicaid program felt that the program's benefit criteria would be more appropriate. This dilemma is a key one that will require attention.

### **Role of Medicaid**

There was strong interest in how this program would work with Medicaid. Some stakeholders even suggested having the program be run by and through the existing Medicaid operation to take advantage of that program's administrative capability as opposed to creating another state bureaucracy.

As indicated by its inclusion in Appendix F, this approach deserves additional study as it has the potential to be a game changer in terms of unifying the LTC funding approach of public and private funding options. It also has significant institutional barriers to overcome, not the least of which is the potential difficulty and cost of using different benefit triggers if insurers were to continue to use HIPAA.

### **Variable waiting period and use of income to determine eligibility**

The concept of a variable waiting period which could range from one to four years depending on income was thought by stakeholders to be overly complex and potentially even unfair. They noted that both low income and higher-income workers could feel penalized by the approach. The idea of a single (universal) waiting period of one or two years was the preferred direction of stakeholders.

### **Relationship to private LTC insurance**

Nearly all stakeholders were favorably disposed to the idea that a program like this could help private LTC insurance carve out a more expansive role in funding long-term care than at present. One reason is that they felt future LTC insurance products could be targeted as one of the solutions to address the waiting period gap before this program kicked in. While stakeholders did not really get into the issue of existing LTC insurance policies, the obvious inference is that coverage provided by them will still function with such a public program.

### **Cash versus reimbursement**

The program could pay a cash benefit when an individual satisfies the benefit trigger or reimburse the expense of covered services when they are used. Reactions to cash versus reimbursement were split, with stakeholders on either side. A number of respondents preferred cash, but others favored reimbursement because they worried that the impact on premium might be too high. The second actuarial phase of this research should look at the cost increase required for adding a cash component to the reimbursement model, along with ways to mitigate the additional costs of including a cash benefit.

### **Portability**

It was clear that the lessons learned include the notion that benefit portability needs to be addressed in the following populations: those working in state but residing elsewhere and those residents who retire out of state. The stakeholder perspective was that people should not be charged for a benefit that they will not be eligible to receive. With that in mind, a range of portability options should be explored to determine both feasibility as well as cost.

### **Coordination**

The purpose of coordination of benefits is to ensure that all available coverages can be used such that there is no duplication (or waste) of benefits paying twice for the same thing. Ensuring the program coordinated with existing public and private insurance was important to many. Stakeholders mentioned Medicaid, Medicare, private insurance and the programs accessed through the Older Americans Act (sometimes referred to as AAA or Triple A, for Area Agencies on Aging).

### **Wellness**

The idea of including some type of a wellness benefit received more of a mixed reception than expected but, overall, it was thought that it could be more desirable if its targets were expanded to include those younger than age 65 and/or before the catastrophic benefit was triggered. That was thought to potentially improve the likelihood of a wellness program's effectiveness and hence its popularity.

**New design (Option 3)**

The report also identified some other approaches, that while beyond the scope of this research, might be interesting to pursue in further research. More critically, there appeared to be a number of areas where the design could be tweaked to better meet the various input received from stakeholders. This appears as Option 3.

## Section 3: Research Project Methodology

### 3.1 RESEARCH DESIGN

The initial thinking for this catastrophic insurance program research study is that it would have two phases. This first phase of the study would identify and solicit feedback from Minnesota stakeholders and analyze that feedback to determine the design parameters of such a program. Phase 2 would then use findings from Phase 1 to better calibrate and price the program and to examine financial sustainability and state impact aspects in greater detail.

Key program design issues to be explored in Phase 1 included:

- Program Eligibility: age, income, and benefit triggers and/or qualifying events
- Program benefit duration and daily/monthly benefit amounts
- Waiting or vesting period prior to the commencement of benefits
- Coordination with other pre-catastrophic funding such as private LTC insurance
- Need for coordination with Minnesota Medicaid programs
- Potential financing approaches including state payroll taxes

The research was composed of the following components:

- Reviewing existing literature on catastrophic plans
- Developing an interview questionnaire and a list of potential stakeholders/interviewees
- Developing “strawman” plan design options to be evaluated by stakeholders
- Scheduling and conducting interviews
- Analyzing results and reporting out findings to the project oversight group (POG) of subject matter experts recruited for this effort

### 3.2 LIMITATIONS

Our research is qualitative, meaning that we sought and received the thoughts of a modestly sized group of experts to help us understand the pluses and minuses of various aspects of a state-based catastrophic insurance program. We believe we obtained high quality interviews and, throughout the process, sought additional interviewees that were thought to add to our learnings and knowledge.

Our plan designs were based on a national model created by Marc Cohen, Judy Feder and Melissa Favreault but were modified for use at the state level. Any deficiency in doing that is solely the responsibility of the authors. In addition, our research started before COVID-19 began and was interrupted for eight months because of COVID-19 related issues. Once it began again in earnest, it was difficult to determine whether stakeholder responses were dramatically impacted by COVID-19. For instance, there was great concern about state budgets during COVID-19 but by the time this report comes out Minnesota will have a multi-billion dollar surplus.

### 3.3 INTERVIEW DESIGN AND PROTOCOLS

Our research design, reviewed and discussed with the POG was that the research would be qualitative in nature, with a series of interviews with Minnesota expert stakeholders. We chose these interviewees using the criteria that they be knowledgeable about and conversant with a wide range of issues pertaining to the design and implementation of a public insurance benefit that would help cover long-term care expenses for Minnesotans. We interviewed 32 stakeholders.

The interviews were scheduled for an hour, although many exceeded that time limit. Interviewees encompassed a wide range of expertise including those in the legislative process, LTC insurance carriers and agents, state health policy and LTC policy experts, state Medicaid experts, LTSS service providers, and representatives of senior advocacy organizations.

We used a discussion or interview guide (see Appendix B) to facilitate dialog around the two “strawman” plan designs. Other materials we used to communicate to stakeholders can be found in Appendix C and D. All interviews were recorded to assist with an accurate portrayal of responses, but we explicitly assured respondents that no comments would be attributed to individuals to encourage an open and frank interchange of their thoughts and ideas.

Our goal in these interviews was to gain an understanding of their overall reaction to the concept of a state-based catastrophic insurance program; to get their reactions to important plan design elements; and to uncover issues and potential barriers in both the program’s design and in its implementation that might impede the program’s success.

### **3.4 HISTORY OF CATASTROPHIC LTC INSURANCE**

For purposes of this report, the salient background leading to its undertaking goes back a few years as several groups looked at the problem and offered directions to take.

Beginning in 2014, the SCAN Foundation, along with LeadingAge, and AARP studied and addressed the LTC funding problem and concluded that the status quo is unsustainable and funded multi-pronged research that included a catastrophic approach.<sup>i</sup>

They were joined conceptually by the Bipartisan Policy Center<sup>ii</sup> and the Long-Term Care Financing Collaborative,<sup>iii</sup> which weighed in with similar approaches.

In addition, there have been several studies and initiatives at the state level: Hawaii, California, Washington, and others have put forth ideas and funded studies of various LTC insurance approaches.<sup>iv</sup> The LTC insurance industry was looking at new ideas as well. One of this report’s authors worked with the Society of Actuaries Research Institute on a Delphi study called “Land this Plane: A Delphi Research Study of Long-Term Care Financing Solutions”.<sup>v</sup>

From a state perspective, the Washington State Program (WA Cares) was the first state to propose use of payroll deduction to fund a state-based program via a dedicated trust fund. Because the program is a limited “front end” program it did not influence our catastrophic design.

The WA Cares program, as enacted, would provide benefits up to a lifetime maximum of \$36,500, funded by a payroll tax on employees of 0.58%. The program is currently on hold while modifications are being made to address issues with supplemental coverage, portability and documentation requirements for those who opted out through the purchase of private LTC insurance. Helpful lessons learned from this experience can be used for future catastrophic program development.

In 2018, Marc Cohen and Judy Feder, working with Melissa Favreault at the Urban Institute, published a paper recommending an approach for a national catastrophic model. Because the Cohen/Feder/Favreault report contained the most developed approach to back-end catastrophic coverage, the authors used that as their basis for developing a state-based approach (see Table 1).

In addition to its influence on our design, another approach based on Cohen/Feder/Favreault can be found in proposed federal legislation, the WISH Act, HR 4289.<sup>vi</sup> This research design and launch pre-dates the entry of the WISH Act. However, as stakeholder interviews showed, the WISH Act is dealing with many of the same issues as encountered in this research.<sup>vii</sup>

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**Table 1**  
**POLICY DESIGN FEATURES OF A NATIONAL CATASTROPHIC PUBLIC LONG-TERM CARE INSURANCE PROGRAM<sup>viii</sup>**

**Description:**

- A public catastrophic insurance program for LTSS costs that takes effect after an income-related waiting period has been met. A package of actions designed to spur development of affordable products and significant growth in the private long-term care insurance market.

**Eligibility, Work Requirement and Benefit Trigger:**

- Eligibility would be phased in over 10 years, with people eligible for benefits once they work 40 quarters after the law’s enactment (assumed as January 1, 2015, for modeling purposes. Current elderly and people with disabilities would not be eligible). Benefits would become available once people incur impairments in two+ ADLs and/or severe cognitive impairment – that is, the HIPAA benefit “trigger” for federally qualified private long-term care insurance.

**Coverage/Benefits:**

- Up to \$110/day cash benefit (2014 dollars) paid out either daily or weekly.
- Unlimited benefit once a qualifying level of disability and an income-related waiting period are met.
- Waiting period of one year for people with lifetime incomes in the lowest two quintiles of the distribution and two, three, and four years for people with incomes in the third, fourth and highest quintiles, respectively.
- Annual benefits increase at the rate that hourly costs increase for home health aide workers.

**Financing:**

- Premium surcharge on Medicare tax
  - Medicaid savings due to substitution of new public benefit plus potential impacts of higher private insurance take-up
-

### 3.5 “STRAWMAN” PLAN DESIGNS

With input from SOA Research Institute staff and the POG we created two options for evaluation. The comprehensive option (Option 1) has a traditional LTC insurance “trigger” based on the inability to perform two or more activities of daily living (ADLs) or being assessed as having severe cognitive impairment. This is called the HIPAA trigger because it is enshrined in federal law (The Health Insurance Portability and Accountability Act of 1996) and the NAIC Model Act for insurers offering federally tax qualified LTC insurance policies.

For the comprehensive approach we chose the HIPAA trigger as opposed to a Medicaid based trigger believing it offered the best possibility for working with insurers to cover the gap period before the catastrophic program began.

With Option 2 we wanted to evaluate reaction to a condition specific approach similar to critical illness insurance for specific conditions that tend to cause the need for long-term care. Examples would include Alzheimer’s and other forms of dementia, Parkinson’s, Multiple Sclerosis (MS), and similar conditions.

Overall, as stated above, the plan designs chosen for this research drew heavily on the national catastrophic insurance model developed by Marc Cohen, Judy Feder and Melissa Favreault, as well as related proposals of the Long-Term Care Financing Collaborative. We incorporated changes to that model to adapt it to a state versus a national approach and made modifications to enhance benefit levels. An example of this adaptation can be seen in the financing approach for this plan. To accomplish this at the state level would necessitate an increase in Minnesota payroll deductions (a new tax) instead of an increase on the existing Medicare tax (a federal program).

Option 2 differed in both the trigger, which was a medical diagnosis of a specific condition, as well as waiting period. This was one or two years (versus one to four years) based on input that a longer waiting period for persons with those conditions wasn’t desirable.



## Section 4: Detailed Findings from Stakeholder Views and Discussion

Key perspectives from the stakeholder interviews are set out below.

### 4.1 OVERALL FEASIBILITY

Overall, most stakeholders had a favorable view of the concept of a publicly supported catastrophic insurance program of the type described. However, stakeholders also pointed out challenges, both conceptual and operational, which they believed would have to be addressed for the program to be successful.

A significant challenge that emerged was the perception of the challenges to increase state taxes via higher payroll deductions. This may be reflective of a larger national trend of opposing any additional funding for social programs on a state or national basis. Comments included:

- To move it forward, it would be good if the premium were lower
- Could alternate funding approach(es) be found?
- The timing doesn't seem right for a new public program right now

Thus, though we did not specifically view this as a design element, it was important to know what stakeholders thought of the prospects both for passage as well as successful implementation.

While stakeholder views varied, the majority raised questions that suggested the key obstacle would not be in the design of the program but challenges for implementation of any program. Some stakeholders worried about the financial risks for running such a program with no caps on the back end or other controls on utilization and inflation.

Others wondered about interaction issues pertaining not just to Medicaid but Medicare and the interaction of this program with them. Some stated that there was no interest now in creating new government programs so instead it should be attached to an existing one like Medicaid. Another said that this might be more palatable if positioned as a public/private solution, or a modest change to the Medicaid program. In fact, some thought the utilization of Medicaid administrative and operational capabilities might be desirable because of its strength in working with individuals in need of the types of services this program would be providing. Key, however, to any relationship with Medicaid would be the need to demonstrate Medicaid savings as a benefit of creating any such program.

In addition to those concerns, others were identified such as whether blending insurance and Medicaid might be problematic since Medicaid would still want to use its asset and income tests as well as its own health assessment (and not the HIPAA trigger used by insurers).

### 4.2 OPTION 1 VERSUS OPTION 2 (COMPREHENSIVE VERSUS CONDITION SPECIFIC)

While there was some interest in the idea of the condition specific program approach that covered chronic conditions, stakeholders favored the comprehensive approach by far. They pointed out the difficulties of drawing the line on what conditions should be included or excluded using a condition specific approach. Stakeholders also felt that from a perceived fairness point of view, the comprehensive approach was better in that it covered most typical situations that would trigger long-term care. [Note: Many condition-specific diseases would be eventually covered in Option 1, but only when they reached a high level of severity.]

For those who liked the condition specific approach (Option 2) reasons varied but some common themes were:

1. Simpler to explain if it just covers Alzheimer's/dementia (and cheaper)
2. Able to offer as "Alzheimer's Insurance" (for example) since that might be easier to explain and educate
3. It includes the more catastrophic kind of events
4. Insurers may also be able to fill the gap around it better

But those favoring Option 2 did recognize that phasing in conditions could be problematic. For instance, no one knows in advance exactly what condition(s) might trigger a care need. In addition, there was push back with the notion that Option 2 might lead to greater acceptance on the part of consumers. It might be the reverse if people assume they will not be in that group who might trigger it, especially since they might be working for decades before coming anywhere near to triggering the benefit. On top of that, it might create a difficult situation with many disease-specific organizations vying to be included among the covered conditions.

### 4.3 AFFORDABILITY

There was definite concern by stakeholders on the size of the estimated payroll deductions (which was explained as between 1-2% of payroll). Some stakeholders advised trying to modify the program so the ultimate payroll deduction percentage was significantly lower. Suggestions included increasing the waiting period or reducing the benefit.

Another set of suggestions was to look at those contributing to payroll. One idea was to allow low wage workers to be admitted into the program without contributing to payroll deduction (meaning not have the work requirement apply to them) or perhaps allow an employer match. A related suggestion was to subsidize lower income workers by making percentages higher for higher income workers.

In a completely different direction were other suggestions to eliminate the payroll tax approach altogether, and tax insurance companies or providers, or even going with a wealth tax instead.

### 4.4 MANDATORY VERSUS VOLUNTARY ENROLLMENT

Although the idea of forcing anything to be mandatory was thought to be challenging, most stakeholders felt that the program's fiscal sustainability requirements would require an "all in" approach. Several stated that was consistent with a "common good" approach that states like Minnesota have traditionally held.

One way to split the difference is to require mandatory enrollment but allow for an opt out. Almost all stakeholders opposed this. One stakeholder pointed out that a program like this – funded from early working years – would be likely to see a great deal of opt out or even lack of enrollment if it was voluntary because people don't see the risk they may face 30 or 40 years down the road. One stakeholder wondered if opt out could be permitted to facilitate initial implementation, but in practice, make it difficult for an employee to do so. Yet another approach that was pointed out instead of opting out was to provide some sort of discount against payroll deduction to recognize those who either purchased or had LTC insurance coverage when the program was enacted.

On a related note, in the State of Washington there was a strong push to include an opt out for those buying private LTC insurance since there was a perceived overlap (in terms of the period covered) between the state program and private LTC insurance. The potential design for Minnesota that the authors presented differs since the catastrophic design complements and even encourages the purchase of private insurance to fill the gaps for the period of time before catastrophic coverage begins.

Having said that, there was some discussion about the need to allow some parts of the population to either opt out or never be included. One person wondered if people with disabilities should be exempt. Others wondered about enrollees who are only in the state for a limited time or live outside the state. These issues will be discussed under portability.

#### 4.5 FRONT-END VERSUS BACK-END

When asked whether they preferred a front-end program that would enable access to a broader population (more enrollees being able to take advantage of benefits) versus a back-end program which would be less broad in coverage but deeper, stakeholders, particularly those more involved with the legislature, indicated that a broader program would be easier to implement but not necessarily a “better” idea. Overall, however, most stakeholders supported the idea of catastrophic back-end coverage which would cover more of those at greater financial risk.

#### 4.6 EDUCATION AND MARKETING

Several respondents mentioned the need for an education/marketing approach that would focus on the need for the product but also clearly indicate the potential financial benefits of the product for program participants. This educational effort was felt to be important during the program’s evaluation phase in addition to the implementation phase to overcome potential resistance among stakeholders, consumers, employers, and state legislators to the payroll deduction required to fund the program

Among the challenges raised by stakeholders were:

- How to justify the fact that some will pay and get nothing, but others will get far more than their contribution
- How to break thru to the younger employees who might well see this as a distraction from their current needs
- How to justify the “value proposition” to lower income employees
- How to address concerns of higher income employees who may feel the program is unfair in taking more money from their paycheck but also making them qualify for benefits after a longer waiting period
- How to include reaching out not just to employees but employers since this is the key avenue for implementation of the program

Regarding the last point, stakeholders pointed out lessons learned from other experiences where the employer community needed to be brought into the educational process from the beginning since they were on the front-line in terms of communications to their employees as well as administering any payroll deduction.

Somewhat minor though it may be, it was also suggested that we use months and not years to minimize “cliffs” in eligibility. Also suggested was to speak of the payroll deduction in terms of \$1 a day instead of \$30/month; \$3/day instead of \$90/month.

#### 4.7 TRUST FUND

Minnesota stakeholders generally favored the concept that the monies for the program should go into a dedicated fund of some kind that would be less likely to be shifted for use for other purposes in the state budget. They felt that future stability was an important element of the design going forward. Therefore, some kind of “protected” fund should be part of the final product design. The example given by one

stakeholder was funding of some insurance programs via a provider tax, which may encourage proponents to keep the trust fund dedicated for this purpose. If the payroll route is used the program needs to find employers or others who would fulfill that role.

There was not a great deal of discussion about what the trust fund would look like, but one stakeholder was adamant that the fund should invest in stocks and bonds and not government instruments in order to generate greater investment return. Another suggested though that this model should follow the approach of mutual insurance companies versus publicly traded (i.e., stock funded) insurers.

#### **4.8 EMPLOYMENT AND EMPLOYER ISSUES**

Stakeholders brought up that employers would be worried about cost of administering this as well as whether they might end up having to contribute to the costs in addition to their employees. It was pointed out that the money should go into a trust for employees and assurances would have to be given if the program ran short on funds. Several stakeholders stressed the need for certainty about pricing and benefits, as well as what happens if initial assumptions are not correct. They stated the need to communicate how those aspects would be addressed at the beginning of the program and not as an ad hoc response in later years.

Another shareholder flagged that there might be problems with ERISA compliance, which would impact employer interest.

#### **4.9 WORK REQUIREMENT AND PAYROLL DEDUCTION**

While most stakeholders favored the idea of a work requirement, there was a significant comment and feedback about the nature of the work requirement, specifically when to start it and who to include. For instance, should the payroll deduction start at age 18, 21, 26 or later? [Note: The impact on revenue and hence pricing of any approach that extended the age when program deductions began would need to be factored in going forward.]

One potential advantage of payroll deduction is that if properly designed employees could see a regular link between what is being deducted and what they may be entitled to later in life. However, more than one stakeholder pointed to the disconnect between the deductions by all workers and the target audience (seniors in need of care). One suggestion was starting the payroll deduction at age 50 to better align who pays versus who receives the benefits.

As mentioned by one person, the payroll deductions could be for decades before someone needs care and their income then could be radically different. Also, concerns were expressed about those with a disability early in life or already retired when the program starts. Non-working spouses came up as an issue as well as individuals who have to leave employment in order to be caregivers. It appeared that many stakeholders viewed the work requirement as problematic and, as such, might be one of the elements that requires redesign, with fixes for different population cohorts.

#### **4.10 BENEFIT AMOUNT AND DELIVERY SITUATION**

Most stakeholders reacted positively to the adequacy of the benefit level of \$5,000 per month (\$165/day) although it was pointed out that while adequate for home and community-based services (HCBS) some doubted it would be enough for facility care. Of note, Medicaid in Minnesota uses a “true cost” system to reimburse nursing homes. Their payments average more than \$300 per day in Minnesota.

This may present an opportunity to clarify the role of Medicaid. There was perceived value in supporting HCBS for some underserved populations (Hispanic, Asian) which culturally tend to favor keeping seniors out of facility care. [Note: The BIPOC (Black Indigenous People of Color) will soon be 20% of Minnesota’s population.] Several suggested the idea of a complementary catastrophic coverage program helping people to stay at home working with Medicaid and its focus on those in nursing homes.

#### **4.11 BENEFIT QUALIFICATION**

Stakeholders who were insurers favored using the HIPAA trigger commonly employed by LTC insurance carriers to determine qualification for benefits versus the more complex need-based trigger used by Medicaid. The HIPAA trigger means in order to qualify an applicant needs either an inability to perform at least two out of six Activities of Daily Living (ADLs) like toileting, eating, transferring, or being diagnosed with a severe cognitive impairment.

From the insurer’s perspective that would allow them to more easily integrate their existing systems and products with the new state program and minimize the need for additional invested resources. It would also help prevent transition problems if someone had insurance and then was “handed off” to the catastrophic program.

On the other hand, Medicaid experts we interviewed would prefer to align program benefits, services, care providers and even rates using Medicaid as the base. This would allow them to maximize a seamless transition experience for those needing care already on Medicaid and those who potentially could be eligible in the future.

When asked, those stakeholders involved with administering benefits indicated that any trigger (Medicaid or HIPAA) would be doable in terms of administration. But for any program like this to move forward these significant philosophical and operational differences need to be addressed.

#### **4.12 ROLE OF MEDICAID**

Stakeholders, even some who were LTC insurance carriers and/or agents, were quite positive about the potential role Minnesota’s Medicaid program might play in helping manage a state-based catastrophic program. Elements of their rationale included:

- The Medicaid Program in Minnesota already has a well-functioning administrative capability
- Medicaid program managers already understand the issues of Minnesotan’s need for and funding for long-term care
- Medicaid has a process, albeit a complex one, for determining eligibility, so they have the capability to do that
- Utilizing the Medicaid program (including its use of the Aging services network) would be easier and require fewer resources than starting from scratch to build a new state administrative organization

Stakeholders didn’t provide clear consensus on the specific relationship of a catastrophic program to Medicaid, but they did raise some issues that could require more in-depth study. Specifically, differences in program design, program qualification and overall administration were brought up as key concerns.

#### **4.13 INCOME-BASED VARIABLE WAITING PERIOD**

Stakeholders understood the need for a waiting period and why it might make sense to vary it by income to help accommodate those with lower lifetime incomes. But stakeholders had a lot of questions and

comments on the details of how that would work; whether it should include assets to capture those with lower incomes but significant assets; how to calculate lifetime income and whether there would be a lot of “gaming the system” to get a shorter waiting period. In addition, concerns were raised about the process for calculating lifetime income and whether that would be too complex for many to understand. For these reasons, and to keep the program simpler and easier to understand, stakeholders gravitated to a fixed waiting period (typically saying it should be one to two years for all), as opposed to the variable income-based waiting period that was offered.

The most common statement was that an income test would not capture assets. Indeed, the income/asset distinction really was not relevant if people can get advice on how to move their money around (“gaming the system”), ending up with a program that looks a lot like Medicaid estate planning. To bridge that, it was suggested using income for the waiting period but adding a secondary test, e.g., assets, for those claiming.

Other advice from stakeholders, if income is used as a test, is to use the highest five years to determine lifetime income to help people figure out sooner where they are in terms of waiting period/what needs to be covered. In other words, if you expect people to take precautions early, for instance buying LTC insurance, they will need very early information on lifetime earnings estimates.

Also, the idea of a “double whammy” was raised by several stakeholders with respect to having higher income employees seeing more deducted from their paychecks (due to the use of a percent of income formula with no cap), when coupled with a longer waiting period.

#### **4.14 RELATIONSHIP TO PRIVATE LTC INSURANCE**

Stakeholders agreed that this program design should be able to encourage growth of the private LTC insurance market. Regarding potential opt-outs for those who owned this insurance, Minnesota stakeholders viewed the opt-out essentially as a way to provide an off-ramp for people to avoid enrollment in the program. That said, stakeholders generally agreed with the concept of providing credit to those who already have a long-term care insurance product, and potentially incentives to purchase a policy as a gap filler, but not necessarily a full opt-out of the program.

#### **4.15 CASH VERSUS REIMBURSEMENT**

In terms of cash versus reimbursement, the general thought was that cash provides a desirable flexibility for enrollees and may be perceived as more acceptable. In addition, some thought it would be a more helpful way to enable family/informal caregiving.

On the other hand, reimbursement may be better than cash for collecting data, controlling delivery, and minimizing the opportunity for fraud.

Some liked the idea of cash for the individual at home but reimbursement for providers if/when a person goes into a facility for care. But other stakeholders pointed out the exact opposite; it would only be good in nursing facility settings, not home care, due to potential fraud in the home setting. Insurance oriented stakeholders were especially concerned about this.

One way to deal with the difference in thoughts here may be to allow a mix of reimbursement for paid caregivers, but also have an option for cash payments (which could be capped) for family members who would otherwise be unpaid caregivers.

#### 4.16 PORTABILITY

Portability was a subject of considerable discussion among stakeholders. This was comprised of two main components. One pertains to non-Minnesota residents working in the state who would have their wages subject to this deduction, but not qualify for benefits due to not being a Minnesota resident. The other would be those Minnesota residents who have worked and paid into the program but retire to another state and, as such, might not be qualified for the benefit. Overall, the feeling was that anyone contributing to the program should have the opportunity to get some benefit from it.

#### 4.17 COORDINATION

Several ideas sprang up around the notion of structuring the program administration around coordination and navigation. Suggestions were that Medicaid, or the Area Agencies on Aging (Triple A) programs could be paid to do this, as well as any wellness add-ons if such were to be part of the program. In fact, there was a suggestion that anyone coming into claims status could enter the system via a single “door” perhaps operated by Medicaid and then get sorted out. That could help make the new program seamless with existing programs. [Note: This would also be true if someone had LTC insurance and that insurer took responsibility for persons entering their claims system.]

Another topic of interest was coordination of benefits (COB) for both public programs (primarily Medicaid and Medicare) as well as private LTC insurance. It was pointed out that the catastrophic program could be good for the private LTC insurance market but that there was a need to spell out how the COB would work.

Stakeholders also thought enrollees should stay in Medicaid if they triggered that way; those familiar with the Medicaid system thought their trigger, which is administratively more complex, is “harder” to qualify than the LTC insurance trigger. Some more familiar with LTC insurance thought the opposite. As was mentioned earlier, with a meaningful part of the population in Minnesota being BIPOC it is important to make sure anyone accessing the system, gets services of value to them, particularly HCBS.

#### 4.18 WELLNESS

Overall, reaction to the idea of wellness being part of the offering was mixed. Many stakeholders liked the idea of wellness/prevention idea as a way to address claims mitigation and/or reduction. This might include adding a benefit prior to triggering a claim. The thought is that a pre-claim intervention when someone is assessed as having, for instance, one ADL, might be more effective rather than waiting until they qualified for benefits. It was also thought that employers might like programs that help their employees handle caregiving needs and reduce absenteeism.

However, there was debate as to whether a wellness benefit would be of interest to most people, much less help many people late in life. Part of the thinking here seemed to be that wellness programs are currently available via the health care system and coming through the catastrophic program at or after age 65 would be too late. Others thought if it was an assessment (i.e., early detection of a problem) and not true wellness that it might be more popular. Others thought that even at age 65 it had value if the employee otherwise did not have access to something like this.

#### 4.19 ALTERNATIVES

There was an interesting discussion of alternative approaches to the design we presented. For instance, some thought it would be okay if it was not true catastrophic to keep premiums down by, for example, capping benefits after 10 years. Others liked the approach of giving people something at the front end. Other alternatives that were brought up appear in Appendix F.

#### **4.20 ADDITIONAL INPUT ON DEI AND SDOH**

Appendix G represents additional input on issues related to Diversity Equity and Inclusion (DEI) and Social Determinants of Health (SDoH) and how they could be dealt with in a state based catastrophic insurance program. The main interview effort yielded little on how to reach underserved communities and identify ways to ensure delivery of appropriate services to them. Given that, the authors undertook an additional outreach effort specifically on issues surrounding DEI and SDOH.



## Section 5: Conclusions and Recommendations

### 5.1 KEY CONCLUSIONS

While there may be challenges to any new state LTC funding program in Minnesota, many stakeholders thought a program that included a combination of private and public insurance might work as long as there was a minimal perception that this would be a new tax.

The catastrophic approach was generally appreciated for its benefit level and duration, its potential to provide a funding alternative to Medicaid without the negatives associated with that program, and the idea that enrollees would be required to take some personal responsibility to contribute for their care before the program kicked in. That said, the 1-2% of salary was thought by many to be too expensive.

However, to have any chance of success many discussed the need for a well thought out marketing approach that clearly delineated the potential benefits of this program and that communicated this to a range of stakeholders, including the public. A key element of that approach was thought to be garnering support from critical stakeholders, such as long-term care providers, employers, and the insurance industry.

While there was significant stakeholder interest in a catastrophic coverage approach it appeared that interest might be enhanced and potentially more feasible with a simplified, more affordable, less robust offering. That led to the notion that it may be desirable to create a new or dramatically modified design. Option 3 would be an example of that (see Appendix E). This is not a classic catastrophic program but more of a transition program that reflects stakeholder interest in a leaner and less expensive program that would be available without the need to go through extensive income and asset testing. It could still be seen as valuable, would be easier to explain, and more acceptable overall.

### 5.2 KEY RECOMMENDATIONS

This study was intended to be Phase 1 of a two-part study, with Phase 2 being an actuarial study with the objectives of:

- Estimating the program costs more accurately for the plan design components that stakeholders gravitated toward
- Exploring, analyzing, and pricing other funding options beyond or in addition to payroll deduction
- Providing a financial analysis for the projected impact of such a comprehensive program on other state funded programs providing services to Minnesota's older adults

Based on this report's findings the authors recommend a Phase 2 follow-up study with the following considerations:

- Analyze Option 1, the comprehensive option, with these plan design changes:
  - A two-year single or universal period for all enrollees from the time of recognized need for service
  - A flexible work requirement coupled with reduced benefits for those nearing retirement age (e.g., 50 or 55 and over)

In addition, the Phase 2 study should look at and analyze the impact of the following:

- The pricing impact of several lower but still meaningful monthly/daily benefit levels than the originally proposed \$5,000/month
- An analysis of the pricing impact of the various lifetime benefit caps (i.e., six, eight and 10-year caps)
- A workable definition of two program interaction scenarios: how the transition from private insurance to catastrophic coverage could work most effectively; and second, how the Medicaid program could supplement catastrophic funding particularly for more expensive institutional care. This may include an analysis of how an expanded administrative role for the state's Medicaid program might operate as the program Administrator to avoid the need to create a new bureaucracy
- A specific analysis of the impact of portability approaches to provide viable and supportable solutions for out of state employees who work in Minnesota but may not be eligible for future services because of their residency; and those Minnesota residents who move out of state and don't want to lose what they've contributed
- An analysis of any possible legal restrictions or limitations on a state's ability to set up such a program.



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Finally, we also want to express our appreciation to LaRhae Knatterud with the Minnesota Department of Human Services where our inquiries began.

## Section 7: Interviewee Affiliations

Chronologically we interviewed the following Affiliations. All were held and recorded virtually, via Zoom.

| AFFILIATION                             | DATE   |
|---|--------|
| LTC Policymaker                         | Jun-21 |
| Aging Advocacy                          | Oct-21 |
| Aging Advocacy                          | Oct-21 |
| State Regulator                         | Oct-21 |
| Aging Service Provider                  | Oct-21 |
| LTCI Agent                              | Oct-21 |
| Aging Policy                            | Nov-21 |
| Aging Service Provider                  | Nov-21 |
| MINNESOTA finance Dept                  | Nov-21 |
| Business Organization                   | Nov-21 |
| LTC Marketing                           | Nov-21 |
| Consultant Aging Policy                 | Dec-21 |
| Data Analysis                           | Dec-21 |
| Health Policy Consultant                | Dec-21 |
| Aging Services Provider                 | Dec-21 |
| State Legislator                        | Dec-21 |
| Aging Advocacy                          | Dec-21 |
| Aging Services Provider                 | Dec-21 |
| Industry Trade Association              | Jan-22 |
| Insurer                                 | Jan-22 |
| Insurer                                 | Jan-22 |
| LTC Insurer                             | Jan-22 |
| LTC Insurer                             | Jan-22 |
| LTC Insurer                             | Jan-22 |
| Financial Services Provider             | Jan-22 |
| Medicaid Policy and Operations          | Feb-22 |
| Medicaid Policy                         | Feb-22 |
| Long-Term Care Administration           | Mar-22 |
| Aging and Adult Services<br>Policymaker | Mar-22 |
| Medicaid Policy and<br>Administration   | Mar-22 |
| Medicaid Policy and<br>Administration   | Mar-22 |
| Aging Policy                            | Apr-22 |

## Appendix A: Stakeholder Documents - Program Design

### Program design for public catastrophic LTC insurance in MN

#### Option 1-Comprehensive Option

##### CONCEPT:

A mandatory state insurance program that would provide funding to Minnesota residents to help pay for long lasting, catastrophic long-term care expenses.

##### WHO IS ELIGIBLE?

- All MN residents aged 65 and older will be eligible for benefits
- Working and non-working spouses WILL be eligible
- Those with a pre-existing disability will be eligible for the program but like others will have to go through the waiting period

##### WORK REQUIREMENT

- Similar to Social Security there will be a MN work requirement of 10 years or 40 quarters of employment before an individual can be vested to receive benefits under the program

##### QUALIFYING FOR BENEFITS

- Participants qualify for benefits when they need help performing two or more of the Activities of Daily Living or are Severely Cognitively Impaired

##### BENEFITS

- Participants can receive up to \$5,000/month (\$165/day) as reimbursement for their long-term care expenses for as long as they meet the qualification requirements
- Benefit inflation: Benefit levels will increase annually based on increases on long-term care costs

##### DEDUCTIBLE/WAITING PERIOD

- To keep the program affordable there will be a waiting period
- During this waiting period, consumers will be responsible for funding long-term care expenses out of personal savings, assets, private long-term care insurance benefits, personal caregiving, or a combination of these

The waiting period will vary based on the individuals “average annual earnings” (see example below).

| Individual Income level | Waiting Period |
|-------------------------|----------------|
| Over \$120,000          | 4 years        |
| \$80,000 to \$120,000   | 3 years        |
| \$50,000 to \$80,000    | 2 years        |
| Less than \$50,000      | 1 year         |

TRUST FUND

- The program will be self-funded by a state specific payroll deduction for all Minnesota workers aged 21 and over. Those deductions will continue as long as the individual continues working. The deductions will go into a restricted fund for this program’s use only.

OTHER PROGRAM ASPECTS

The disproportionate number of deaths and serious illness for seniors that have occurred in congregate living facilities due to COVID-19, suggests that this program should help participants remain healthy at home.

- WELLNESS INTERVENTIONS: A small percentage of the Monthly benefit (~1%) will be available to seniors aged 65 and over for qualifying wellness, prevention, and stay at home benefits
- SOCIAL DETERMINANTS OF HEALTH: Some environmental situations, like food security, accessibility to nutritious food choices, housing and utility services, social and community inclusivity and availability of transportation may also be part of this programs design.

PROGRAM COSTS

- It is estimated that Option 1 of this program as described will result in a payroll deduction increase of between 0.75% and 2.25% for Minnesota workers
- That range translates to a \$30 to \$90 increase per month for the typical Minnesota worker

**Option 2: Condition Specific Option**

CONCEPT:

A mandatory state insurance program that would provide funds to help pay for long-lasting, long-term care expenses that are specific to certain conditions such as Alzheimer’s, Parkinson’s, ALS, and MS.

DIFFERENCES VERSUS OPTION 1:

- Benefit payout will be based on medical diagnosis of specific conditions
- The waiting period will be shorter (see example below)

DEDUCTIBLE/WAITING PERIOD:

- As with the Comprehensive Program, during this waiting period, consumers will be responsible for funding long-term care expenses out of personal savings, assets, private long-term care insurance benefits, personal caregiving, or a combination of these
- The waiting period will vary based on the individuals average annual earnings (see below)

| Income level   | Waiting Period |
|----------------|----------------|
| Under \$50,000 | 1 year         |
| Over \$50,000  | 2 years        |

- Individuals with average annual earnings over \$50,000 would have a “waiting period” of two years. Individuals with average earnings below that would have a waiting period of one year

- It is estimated that Option 2 will result in a payroll deduction increase of between 0.5% and 1.75% for Minnesota workers
- That range translates to a \$20 to \$70 per month increase for the typical Minnesota worker

#### OPTION 2 CHARACTERISTICS INCLUDED:

- PROGRAM ELIGIBILITY: All MN residents aged 65 and older
- VESTING: 10 years or 40 quarters of employment
- BENEFIT PAYOUT: \$5000/month (\$165/day) for as long as the benefit qualification is met
- WELLNESS INTERVENTIONS: A small percentage of the Monthly benefit (~1%) will be available to seniors aged 65 and over for qualifying wellness, prevention, and stay at home benefits
- INFLATION ADJUSTMENTS: Annual increases based on CPI or similar index
- FINANCING/TRUST FUND: The program will be self-funded by a mandatory state payroll deduction for all Minnesota taxpayers aged 21 and over that will go into a trust fund

#### PROGRAM MERITS:

- Limited to those with specific long-lasting conditions
- While this approach limits the reach of those included it likely would resonate with consumers as these specific conditions are among the most feared conditions afflicting age 65 persons
- There will produce a lower overall cost to the program

## Appendix B: Stakeholder Documents - Interview Guide

### What do we want to learn?

Thank you for agreeing to talk with us today about this research project. I'm John O'Leary and I'm a consultant focusing on long-term care financing and healthy aging. I'm joined on the phone today by John Cutler. John is also a consultant with a strong public policy background, and we've been hired by the Society of Actuaries Research Institute to conduct this research to look at the feasibility of developing a state-based program to help consumers pay for the high costs of long duration care resulting from conditions like Alzheimer's, Parkinson's, ALS etc.

The discussion should take about an hour. With your permission, we will record this conversation, and incorporate your feedback as one of many stakeholders, but your specific comments will be kept confidential.

As a reminder, we also need to share with you this disclaimer from the Society of Actuaries Research Institute:

**While this research is being conducted in the state of Minnesota it is not a state sponsored or funded activity. Minnesota was chosen by the researchers from among a group of states because of its proactive leadership in promoting the health and well-being of its senior population.**

Questions:

1. Based on the information you've seen do you think you have an understanding of what is being described as a catastrophic LTC insurance program for Minnesota? Do you have any questions that might clarify your understanding?
2. What is your overall reaction to a state sponsored catastrophic LTC program for Minnesota?
3. What is your reaction to the idea of a public insurance program funded via a trust fund (meaning an account set up and funded separately for the program) versus a program to address these catastrophic funding needs funded out of the annual state budget?
4. What do you think about the idea that the program would be mandatory for all working age Minnesotans?
5. What is your reaction to the concept of a work requirement similar to Social Security i.e., 10 years or 40 quarters that would be a requirement for you and other Minnesotans to be eligible for the program?
6. What is your reaction to the estimated amount that would be necessary to be deducted from your pay for this program to be adequately funded?
7. How about the idea of a waiting period that could be as high as four years where you would need to find other ways to pay for the first few years of your care?
8. What about the idea of varying the waiting period based on average annual income?
9. Do you have any thoughts about how this program should relate to people on the state's Medicaid program?
10. How would you feel if you knew it would save a significant amount of state Medicaid expenditures?
11. How do you think this program should relate to private long-term care insurance?
12. What are your thoughts on the idea of potential opt-outs for those who may already have some private insurance coverage?



13. A cash benefit for the program would be more flexible but costs more than expense reimbursement. Would you prefer to receive your benefit in cash versus as an expense reimbursement even if the cash benefit amount was 25% lower?
14. Should the program include a wellness program that would encourage and incent healthy aging behaviors (i.e., nutrition, exercise, stress management, sleep, socialization, and intellectual stimulation)?
15. What are your thoughts about ways we could reach out to communities disproportionately impacted by long-term care needs?
16. This program would provide help for 15-20% of seniors with truly severe long lasting LTC issues (a “back-end” approach). Is this design a better use of public funds than a “front end” program (like one in the State of Washington) which would cover more people sooner but with significantly lower benefits both in amount and duration?
17. Do you have any ideas that we haven’t talked about that you feel would be important to this program?

## Appendix C: Stakeholder documents - Purpose Statement

### Purpose Statement for Catastrophic Coverage Plan

*This research project is designed to explore the feasibility of a state-based catastrophic long-term care plan. The Society of Actuaries Research Institute is funding this research to investigate whether and how a state-based, publicly funded catastrophic or “back-end” Long-Term Care (LTC) funding program could work. While this specific study is focused on the state of Minnesota, if the approach shows promise, it is contemplated that it could be explored in other states as well.*

*Note: For this research, the terms long-term care (LTC) and long-term services and supports (LTSS) are used interchangeably to describe the types of non-medical care provided to people with chronic conditions.*

**Disclaimer: While this research is being conducted in the state of Minnesota it is not a state sponsored or funded activity. Minnesota was chosen by the researchers from among a group of states because of its proactive leadership in promoting the health and well-being of its senior population.**

- The goal of this research is to investigate the feasibility, the issues around and the potential barriers that would be entailed implementing a state funded and supported catastrophic program by getting stakeholders’ reactions to key issues including:
  - The overall concept
  - The program structure including eligibility for this program
  - Key elements of the Plan Design
  - The potential costs and benefits to be derived
  - Possible ways to finance this program
  - Integration with private insurance and Medicaid
  - Other potential issues, including the political landscape that may help or hinder certain approaches

#### Background

- The current landscape for funding LTC is complex, uncoordinated and not well equipped to cope with the growing need for long-term care services.
- The need is growing. In the coming years, 70% of those turning 65 will need some LTC services and more than 50% will meet the threshold for paid LTC services during their lifetimes.
- Care duration will vary. For the majority, care will last two years or less. But for more than a quarter of those over 65 and needing care, they will need it for five years or more. This is what is generally considered catastrophic care.
- Nationwide, the number of seniors needing LTC will nearly triple in the coming decade from approximately six million in 2015 to 15 million in 2050.
- The Minnesota senior population is estimated to double by 2050 and with increased LTSS usage among seniors those with an LTSS need in the state could exceed 500,000 by 2050.
- Catastrophic care is significantly more costly and less predictable than shorter duration care. As such it represents the biggest financial challenge for consumers, public programs and private long-term care insurance.

#### Funding for Long-Term Care/LTSS

- Consumer out of pocket accounts for over 50% of LTC spending

- Nationally, Medicaid pays 42% of total LTC spending
- Private long-term care insurance (LTCi) represents about 5% of LTC spending
- Minnesota's experience is roughly analogous to the national experience

### Medicaid

- Medicaid is jointly funded out of state and the Federal budgets with the Federal Government responsible for approximately 50% of this cost
- Medicaid already poses a significant budget issue for both states and the federal government
- This situation promises to get worse as the need for LTC increases in the future
- To qualify for Medicaid, applicants must meet strict income and asset criteria
- Households with modest assets, LTC out of pocket spending, and no LTCi coverage are likely to spend down assets and go on Medicaid which will exacerbate the Medicaid fiscal situation in the coming decades

### Private LTC insurance

- Private LTCi in its current configuration, has not proven to be as viable a funding option for LTC expenses as once hoped
- Today LTCi is characterized by declining sales, large premium increases, carriers having exited the market and consumers losing trust in the product
- For insurers, private LTCi represents a higher financial risk than many have been willing to take
- The carrier risk has surfaced primarily on longer-duration catastrophic claims where difficulty accurately predicting future claims has proven to very problematic
- In 2018 there were only approximately 60,000 LTCi policies sold with an average annual premium of nearly \$3,000
- In terms of market penetration, only about 10% of consumers over age 40 have a policy that could be used to pay for LTC expenses

### Caregiving and Personal Resources

- There is already a caregiving crisis
- With the demographic changes coming, the gap between number of available caregivers compared to those needing care will continue to widen
- Paid caregivers are underpaid and there aren't enough of them. Providing additional funding can help with recruitment, support and job retention.
- Unpaid caregivers, mostly family members, are stressed. As the population ages there will be fewer family caregivers relative to family members needing care. Having a mechanism to support those caregivers would be very desirable.
- According to SOA Research Institute retirement research, many people do not adequately plan for or insure for their long-term care needs in retirement
- Lack of planning tends to mean fewer good solutions when a person's care needs exceed the resources that can be provided by families
- Many people with this mindset end up dealing with adverse events on an ad hoc basis as opposed to planning for them. That exacerbates caregiver stress and leads to less desirable care outcomes.
- The research also shows that this group tends not to spend down their assets, so they would be available if/when catastrophic events happen. This mindset tends to be a barrier to carefully thinking through long-term care financing options.

### The Funding Dilemma

- There is and will continue to be a growing need for viable LTC funding options particularly for middle income consumers
- There is a potentially viable business opportunity for private LTCi to provide coverage options for the shorter duration care needs
- While helpful, that approach won't do enough to address the needs for the 25-plus percent of those needing care for five years or more
- Medicaid does provide funding for long-duration care however:
  - To qualify, consumers have to meet strict income and asset criteria which often means spending down assets and limiting income which many do not want to do
  - Medicaid budgets are already strained. With increased demand for care in the future they will become unsustainable in many states.
  - Further burdening the existing Medicaid program, without fundamental changes, would not appear to be a fiscally sound public policy

### State-Based Catastrophic Long-Term Care

Several national aging related organizations including Leading Age, the LTC collaborative, and the Bi-partisan Policy Center have recommended the concept of private LTCi for shorter duration front end coverage combined with a publicly sponsored back-end catastrophic plan. That approach would help protect consumers against catastrophic situations and could stabilize the private long-term care market. Some plans of this type have been modeled on a national basis, but not on a state basis. States have incentives to try to minimize their overall Medicaid expenses which a state-based catastrophic plan would do, but state efforts to date (i.e., Washington and Hawaii) have been focused on front end solutions.

### The Research Plan

- O'Leary Marketing Associates through John O'Leary and John Cutler will conduct 25-30 in-depth one-hour discussions with interested Minnesota stakeholders to explore the state-based catastrophic approach and issues outlined above.
- Meetings are being scheduled to begin late in the first quarter of 2020 and continue until completed
- We plan to record these interviews, with the consent of interviewees; however, they will be private and strictly confidential. No thoughts will be attributed back to the stakeholder.
- We envision some in person and some skype-like phone conversations
- The interviews will be dynamic, meaning that they may change as we learn more
- The interviews will be conducted using a Topic Discussion Guide

Findings and key learnings from the interviews will be summarized in a written document to the Society of Actuaries Research Institute and made publicly available.

## Appendix D: Stakeholder documents – Email communication

### Text for emailing Stakeholders

Dear \_\_\_\_\_:

Greetings. We are sending you this e-mail as a request to participate in a research project on long-term care issues in Minnesota. Your time commitment would be brief, essentially reading background material and then participating in a one-hour conference call with the researchers.

This research project is designed to explore the feasibility of a state-based catastrophic long-term care plan. The Society of Actuaries Research Institute is funding this research to investigate whether and how a state-based, publicly funded catastrophic or “back-end” Long-term Care (LTC) funding program could work. While this specific study is focused on the state of Minnesota, if the approach shows promise, it is contemplated that it could be explored in other states as well.

Several national aging related organizations including Leading Age, the LTC collaborative, and the Bipartisan Policy Center have recommended the concept of private LTC insurance for shorter duration front end coverage combined with a publicly sponsored back-end catastrophic plan. That approach would help protect consumers against catastrophic situations and could stabilize the private long-term care insurance market. Some plans of this type have been modeled on a national basis, but not on a state basis. States have incentives to try to minimize their overall Medicaid expenses which a state-based catastrophic plan would do, but state efforts to date (i.e., Washington and Hawaii) have been focused on front end solutions.

The goal of this research is to investigate the feasibility, the issues around and the potential barriers that would be entailed implementing a state funded and supported catastrophic program by getting stakeholders’ reactions to key issues including current funding for LTC/LTSS, Medicaid, private LTC insurance, caregiving and personal resources.

### The Research Plan

- O’Leary Marketing Associates through John O’Leary and John Cutler will conduct 25-30 in-depth one-hour discussions with interested Minnesota stakeholders to explore the state-based catastrophic approach and issues outlined above
- Meetings are being scheduled to begin late in the first quarter of 2020 and continue until completed
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- We envision some in-person and some skype-like phone conversations
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**Disclaimer: While this research is being conducted in the state of Minnesota it is not a state sponsored or funded activity. Minnesota was chosen by the researchers from among a group of states because of its proactive leadership in promoting the health and well-being of its senior population.**

## Appendix E: Possible Option 3 Design

### DISCUSSION

As mentioned in the report, there were a range of issues with the presented “strawman” plan designs that would need to be addressed to optimize the chances of the program’s success. With that in mind the authors developed an Option 3 to address many of those issues. It is a leaner and less expensive program that is more likely to be something that policymakers, employers, and employees can get behind.

This research was intended to be Phase 1 of a two-phase report with the second being an actuarial analysis. It is important to the evaluation of this design, or a modified Phase 1 design that an actuarial critique and analysis be conducted to determine if the benefits are in line with acceptable costs.

While this is not an attempt to create as comprehensive a catastrophic program as some would like, it adds value by filling the gaps between existing state programs including Medicaid and private LTC insurance. In fact, this recommends Medicaid as the agency to be used to provide services and operational support for this option and along with employers, to provide outside oversight to ensure the monies are not tapped for other state needs.

### Features of Option 3

#### CONCEPT:

A mandatory state insurance program that would provide funding to Minnesota residents to help pay for most long lasting, catastrophic long-term care expenses. Key elements include:

#### ELIGIBILITY:

- All Minnesota residents aged 65 and older will be eligible for benefits
- Working and non-working spouses will be eligible
- Those with a pre-existing disability will be eligible for the program but like others will have to go through the waiting period

#### MANDATORY ENROLLMENT-NO OPT-OUT:

- Enrollment in the program is mandatory with no need for an “opt-out” option for those with LTC insurance since that coverage would be helpful in covering the waiting period

#### PORTABILITY:

- The coverage will be portable for those residents who have paid into the program and leave the state after vesting. The program also needs to address the concerns of non-residents with either a meaningful benefit or an opt-out option.

#### WORK REQUIREMENT:

- Like Social Security there will be a Minnesota work requirement of 10 years or 40 quarters of employment before an individual can be vested to receive benefits under the program
- The authorizing legislation needs to address phase-in issues for workers who cannot meet the 10-year requirement.

#### PAYROLL DEDUCTIONS:

- Payroll deductions would begin when employees reach age 50. [Note: There should be a sensitivity analysis to determine what age is best in terms of the interaction between coverage and premium affordability]
- If an individual continues to work after age 65, payroll deduction will cease unless it is necessary for them to continue collecting quarter hours

#### CAREGIVING AND OTHER CREDITS:

- Credit hours to unpaid caregivers, those who are already disabled and receiving benefits from another source or those whose employment income is so erratic that the quarter hour approach does not work. The program would provide credit hours toward the work requirement.

#### TWO WAYS TO QUALIFY FOR BENEFITS:

- Participants qualify for benefits either under the HIPAA standard (when they need help performing two or more of the Activities of Daily Living or are severely cognitively impaired) or under Medicaid eligibility requirements
- For individuals who do not have LTC insurance the Medicaid medical eligibility requirements will be used (but not Medicaid's income and asset tests)
- For those who have LTC insurance; they will qualify through the HIPAA provisions

#### MEDICAID INTEGRATION:

- For individuals already on Medicaid when they become claim-eligible, the program may cover the first two years if the individual continues to meet their eligibility requirements. Medicaid may also cover the gap in coverage over the next 10 years if the individual has expenses greater than \$100/day (again, assuming they otherwise continue to meet Medicaid's criteria). Finally, though it will likely be a very small population, any Medicaid-eligible individuals who are still in claim when the catastrophic program ceases to pay claims will continue to have coverage via Medicaid.

#### BENEFITS:

- Participants can receive up to \$3,000/month (\$100/day) as reimbursement for their long-term care expenses, up to their lifetime cap
- Benefits will be paid as reimbursements for expenditures, but the program managers should be allowed to provide cash benefits where that makes sense. Examples could include unpaid family caregivers or benefits paid to Minnesota residents who have retired out of the state.

#### BENEFIT DURATION:

- Benefits are capped to end after either five or 10 years, (or some interim timeframe) depending on results of the proposed actuarial modeling. If someone is still on claim when the cap is hit, they can transition to Medicaid without meeting eligibility tests.

## INFLATION:

- Benefit levels will increase annually based on increases on Minnesota CPI (not on long-term care costs) since HCBS are primarily wage-driven and need not reflect greater inflation protection for more medically-oriented coverage

## DEDUCTIBLE/WAITING PERIOD:

- The waiting period is a flat “universal” period of two years

## TRUST FUND:

- The program will be self-funded by a state specific payroll deduction for all Minnesota workers aged 50 and over [Note: It would be worth exploring other ages and funding sources in the Phase 2 actuarial study]]
- Payroll deductions will go into a dedicated fund for this program’s use only
- Funds will be invested following practices used by long-term care and life insurers
- The authorizing legislation should address how potential revenue shortfalls or higher than expected claims will be handled

## OTHER PROGRAM ASPECTS:

- HOME AND COMMUNITY BASED SERVICES: The focus of the program will be HCBS: This program should help participants remain healthy at home
- WELLNESS INTERVENTIONS: A small percentage of the Monthly benefit (~1%) will be available for assessments and other related benefits even prior to claim
- SOCIAL DETERMINANTS OF HEALTH: Some environmental situations, like food security, accessibility to nutritious food choices, housing and utility services, social and community inclusivity and availability of transportation may also be part of this programs design
- COORDINATION OF BENEFITS (COB): COB provisions will be needed so the program meshes well with Medicaid, Triple A programs, private long-term care insurance and even the Medicare program
- GAP FILLING: Since this design leaves a potential gap for individuals spending more than \$100/day long-term care insurers will be encouraged to provide gap coverage for this as well as the initial two-year vesting period
- TAX QUALIFICATION: If the insurance policy design prevents the insurance from being Tax Qualified (TQ) Minnesota will offer equivalent “MQ” tax deductibility. Life and annuity companies will also be allowed to fill this gap if they choose.

## PROGRAM COSTS AND ADMINISTRATION:

- So the program does not duplicate existing structures to provide care, the program will contract with the Minnesota State Medicaid program to administer this program. For individuals with LTC insurance, their carrier will continue to provide these services. Any services not in the insurance program will be delivered by the carriers in a TPA arrangement.
- Initial seed money will come out of the state Medicaid program. The state is encouraged to seek grant or other money from the federal government via a waiver or other mechanism to launch this innovative program.



- While it is not necessary for the program to be based out of DHS, this agency (along with Commerce and Revenue) would be critical in the early years. Funding for education outreach to employees and employers will be critical to a successful launch.

## Appendix F: Alternative Stakeholder Ideas

We believe the following ideas are worthy of further research by the SOA Research Institute (or others) but were outside the scope of this research effort.

### Medicaid

One idea would be to use the payroll tax approach to fund Medicaid itself, rather than create a new "Office of Catastrophic Coverage" or something similar for catastrophic coverage. The goal is the same, namely, to move money from a source outside the state's normal tax mechanisms and move that into the future to take care of long-term care needs. This could either look like Medicare in the sense the money is collected from everyone but used broadly for anyone in need of care. Or it could look like Social Security in the sense the money is "tagged" to the individual for their personal use. The former is pure insurance. The latter approach though may be of interest in the sense it addresses equity issues better, namely that individuals who are having part of their paycheck deducted for future needs should have the sense they directly benefit from this.

Another approach using Medicaid could best be described as restructuring the catastrophic coverage to use Medicaid as a platform for a "pay forward" program in which you could fund your care via Medicaid. Enrollees in this coverage would be entitled to Medicaid without being subject to aspects such as spend down; the asset test and the 60-month look back rule. In effect this could be a Medicaid LTSS program for the middle class.

### Medicare

This concept would be to focus the catastrophic coverage around Medicare similar to how Medicare non-medical benefits have been expanded in Medicare Advantage. This could include medigap coverage as well but could also be outside Medicare and operate instead as a "tag-along" program. This has the advantage of not having to sell a completely new Program to employers and employees. See above for thoughts on how to design the collection. But this option would be more like Medicare than Social Security in that no one gets a specific identified benefit from the payroll deduction.

An approach somewhat different but also based on how Medicare functions today, is to have enrollment at age 65. As with Medicare supplement insurance (Medigap) people would get the option for catastrophic coverage at age 65. They are still in most cases decades away from needing it but, like Medigap, they are in an age cohort which will likely lead to high take up. Give them the same six months guarantee issue opportunity. After that they would have to go through underwriting. Before MA came along just about everyone signed up for Medigap notwithstanding its cost.

### Bonds and Reinsurance

Funding could be found in novel ways not usually in play for health and long-term care. One would be for the state to field 30-year bonds to move money from today into the home and facility needs of the future. A more limited approach more directly linked to the current catastrophic outline would be to sell bonds to cover cost of the gap period people need to meet before benefits begin.

Reinsurance also came up both to protect the catastrophic program from actuarial misestimates but also in other ways. Reinsurance could be used to cover just the high-risk population. Long-term care insurers do this now to some extent, so this is an idea that has design and pricing work already available.

**HSA Analog**

Another idea is similar to an HSA or perhaps a 401(k) program in that your contributions (or at least some portion of them) can be identified as your own account. This would allow an enrollee the flexibility to potentially use the cash value of their contributions in a way not currently allowed under LTC insurance rules. While potentially too complex a notion to create, it starts to address the concern many insureds have of paying in for years and feeling like they are getting nothing back.

## Appendix G: Stakeholder Input on Diversity, Equity and Inclusion and Social Determinants of Health

The authors and the Society of Actuaries Research Institute believed that the report would be strengthened with additional feedback on the issues of Diversity Equity and Inclusion (DEI) as well as Social Determinants of Health (SDoH) and how they could be dealt with in a state based catastrophic insurance program.

The authors undertook additional research from the existing list of stakeholders as well as fielded a small number of interviews with individuals in the Minnesota Department of Health who had specific expertise in reaching and serving “underserved” communities. The goal was to gain additional input on how this type of long-term care catastrophic coverage program could better address the issues of DEI and whether it could have any impact on SDoH and, if so, how.

As background, DEI is defined as a conceptual framework that promotes the fair treatment and full participation of all people, especially in the workplace, including populations who have historically been underrepresented or subject to discrimination because of identity, disability, race, or gender.

SDoH can best be described as factors in the environment where people are born, live, learn, work, play, worship, and age and the impact of those environments on their overall health and well-being. In other words, SDoH involves environmental elements like food security, accessibility to nutritious food choices, housing and utility services, social and community inclusivity and the availability of transportation to necessary services.

In addition to this follow-on work for catastrophic coverage, readers may be interested in another publication on related DEI issues that the SOA Research Institute sponsored through its Diversity, Equity and Inclusion Strategic Research Program: “[Long-Term Services and Supports: Usage and Payment by Race/Ethnicity and Socioeconomic Factors](#)” by Brian Kaul, et al.

Five key issues related to underserved communities arose from the additional research that was conducted.

### Outreach and Marketing

First, the need for more personalized and culturally appropriate outreach and marketing was identified by the participating stakeholders in order to make the catastrophic program more relevant, useful and available to underserved communities. A key component of this was the need to identify and educate community organizations and thought leaders within them to communicate the need for -- and ways to access -- programs like this. One tactic that came up that is already being used to some extent, was the need to increase the hiring of multilingual staff to better interface and communicate with members of the various underserved communities. These individuals act as a bridge between the government programs and those living in underserved communities.

A related issue is that the community organizations and the state often have not had sufficient money, resources or time to translate government materials and tailor them to specifically deal with cultural differences of the various underserved communities. This should be addressed from the outset.

### Program Eligibility

A second key issue was that stakeholders indicated that there has been discussion about changing/reducing the eligibility ages for some of the Aging programs for those in underserved communities in order to make them more meaningful to these groups. The reason cited was that the

demographic profiles of some of the traditionally underserved groups often indicate shorter lifespans, poorer overall health and higher chronic care needs. For these populations use of 65, or even younger, as an age criterion would deny them needed care until they reached that age. In addition, the waiting period envisioned in our catastrophic model might also mean services could reach many of them too late. For the catastrophic program then, the question would be how -- and at what cost -- it would work if the eligibility triggers were modified for underserved populations.

### **Premiums and Payroll Deductions**

A third key issue that emerged was the problem of how lower income populations would be able to afford the premium. For many of these populations who are working paycheck to paycheck a 1% to 2% payroll tax increase would be an unaffordable burden. While this was also addressed in the main report, it was definitely of greater concern for those in the underserved communities. Not only are they less likely to have higher paying jobs but many might be working "off the grid" or in smaller organizations where payroll deductions logistically may be much more difficult.

### **Service delivery**

A fourth issue that surfaced was how those services would be delivered and what could be delivered to the underserved communities. Often the systems and structures typically used to deliver support to the aging adult communities simply do not work as well for underserved communities. One major problem cited was the restrictions of payment structures that accompany government programs. An example cited was some reimbursements for services being too tightly designed, i.e., 15-minute increments to complete narrowly defined tasks.

In a related comment, another stakeholder pointed out that many programs have a "4 walls" requirement that payments will only be made to institutions with a building to deliver care. But if the community (the native American population was mentioned) does not have a building or prefers not to receive their care that way, then such a requirement is tantamount to denying those individuals coverage.

### **Program Design**

A fifth issue that came up was the need for flexibility in the program plan design. An example of this was the idea of what could be called "flex dollars." This was addressed in the main report in terms of cash versus reimbursement. While it might make actuarial calculations more difficult, having a "flex dollars" approach was thought to be more useful and attractive to members of these communities. The idea is that it puts the client and not the government in the driver's seat (as one stakeholder put it). For underserved communities, especially those with cultural differences from the mainstream, having the ability to direct money to family or other informal caregivers was thought to be more attractive -- and effective -- for them. This is even more true in some of these communities because access to formal caregiving whether at home or in a facility is problematic.

### **Summary**

Addressing these issues would all make the state based catastrophic program more appealing and effective for Minnesota's underserved populations. But they likely will come at both increased program costs and complexity. The exact impact of addressing these issues from a cost and complexity perspective should be a key focus of a second actuarial phase of this study.

## Endnotes

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- <sup>ii</sup> “Initial Recommendations to Improve the Financing of Long-Term Care,” (BPC February 2016) at <https://bipartisanpolicy.org/report/long-term-care-financing-recommendations/> and “How Americans Can Afford Long-Term Care,” (BPC July 2017) at <https://bipartisanpolicy.org/press-release/how-can-americans-afford-long-term-care-bpc-releases-new-recommendations/>
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## About the Society of Actuaries Research Institute

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Representing the thousands of actuaries who help conduct critical research, the SOA Research Institute provides clarity and solutions on risks and societal challenges. The Institute connects actuaries, academics, employers, the insurance industry, regulators, research partners, foundations and research institutions, sponsors and non-governmental organizations, building an effective network which provides support, knowledge and expertise regarding the management of risk to benefit the industry and the public.

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