SHADAC
STATE HEALTH ACCESS DATA ASSISTANCE CENTER

Retirement Security and Minnesota's Elderly Population

Minnesota Legislature
March 30, 2005

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DHS Long-Term Care Financing Study

- Legislature asked DHS to study the issue of public and private financing options for long-term care.
- Report is available at www.dhs.state.mn.us.
- DHS contracted with SHADAC to complete reports that address two critical issues:
  - How many of Minnesota's future elderly will have problems paying for their long-term care?
  - What incentives should the state use to encourage individuals to pay privately for long-term care?

Overview of Presentation

- Retirement Security and Issue Brief #1
- EBRI Simulation Model
- National Findings
- Minnesota Findings
- Policy Implications
- Next Steps: Issue Brief #2

Issues

- Will Minnesotans have enough retirement income to cover their expenses?

  ⇨ ***Retirement Security***

- Who is at risk of not having enough resources?
- What can be done now to assist them?
- What is the anticipated impact on public programs (e.g., Medical Assistance) of helping people plan for basic retirement and LTC expenses?

Retirement Resources

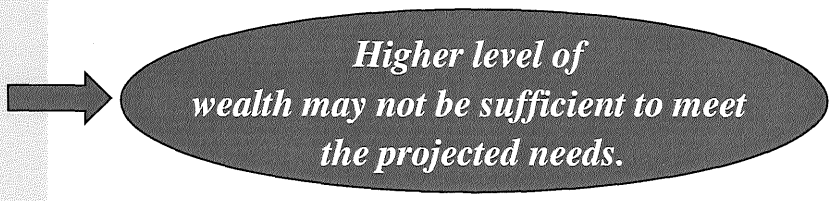
- Social Security
- Pensions (Defined Contributions, Defined Benefits)
- IRAs
- Interest/Gains from Savings and Investments
- Housing Equity
- Business/Farm Equity
- Insurance (Life, Disability, Long-term Care)

Retirement Expenses

- Housing (rent/mortgage, taxes, maintenance)
- Utilities and Other Housing-related Items
- Food
- Transportation
- Clothing and Personal
- Health Insurance Premiums (Medicare Part B and supplemental)
- Out-of-Pocket Medical Costs (co-pays, deductibles, treatments not covered)
- Prescription Drugs (the "doughnut hole")
- Long-Term Care (nursing home, home health)

Trends

- Future retirees are likely to have more wealth than earlier generations.
- However, due to changes in:
  - Demographics
  - Retirement Resources
  - Retirement Expenses



Changing Demographics

- Longer Life Expectancy
- Fewer Children to be Informal Caregivers
- Child-Rearing Expenses Later in Life

Changing Resources

- Changing Retirement System
- Shift from Defined Benefits to Defined Contributions
- Increase in Social Security Retirement Age
- Proposals to Privatize Social Security
- Uncertain Rates of Return

EBRI Model

(Employee Benefit Research Institute)

EBRI Simulation Model

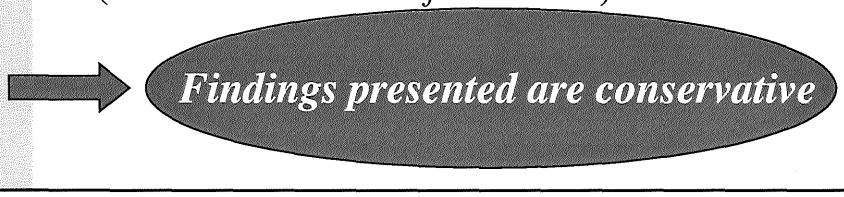
- Employee Benefit Research Institute – Retirement Security Model
- Based on Six Years of Data
  - More that 10 million 401(k) retirement plan participants
  - Information from the US Department of Labor on other defined contribution plans
  - Data from several public surveys.
- Projections based on assumptions about Social Security benefits, housing equity, and saving behavior

EBRI Simulation Model-Advantages

- Unique and Large Data Set
  - Includes actual pension/retirement data
- Combines Projections for Wealth/Income with Projected Expenses
- Past EBRI Work with States
  - Kansas, Massachusetts, Oregon
- Policy Interest in Applying National Model to State Needs

EBRI Simulation Model-Disadvantages

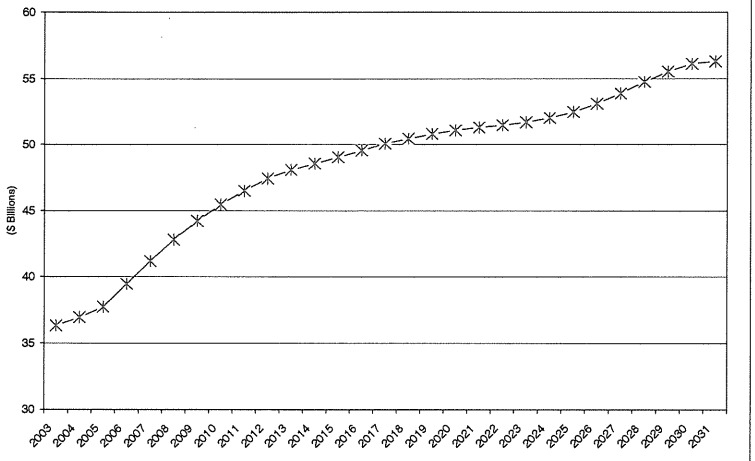
- National Model - assumptions and results for US
- No access to micro-data to adjust assumptions
- Complicated theory and application
- Do not know when during their retirement people experience a deficit
- Implied 5% additional savings in estimates of percentage of people with insufficient resources (*we could not remove from model*)



National EBRI Findings

National Projections of Retirement Shortfall – Ages 65+

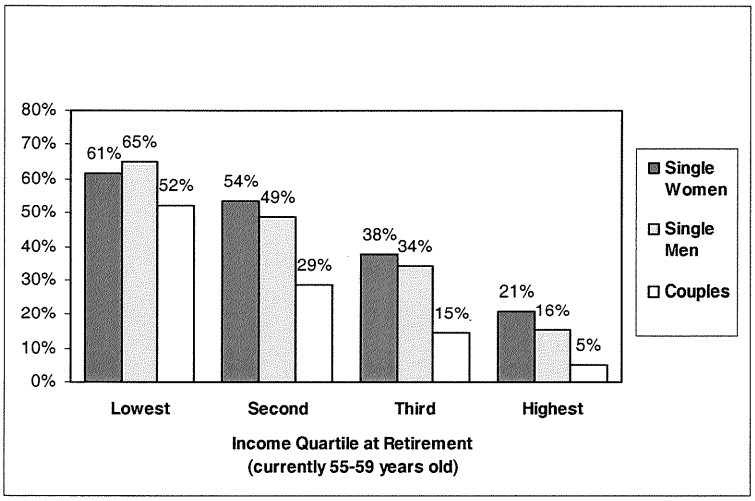
By the year 2030 retirees will have expenses that exceed resources by as much as $56 billion



Source: EBRI-ERF Retirement Security Projection Model. A/Assuming status quo for Social Security benefits, housing equity is not liquidated, and that current retirees are similar to the oldest cohort of current workers.

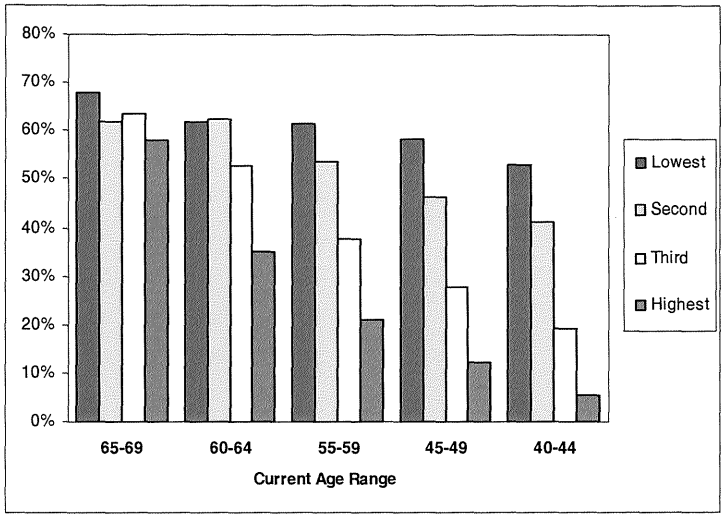
Percent in U.S. Lacking Sufficient Retirement Resources

Low-Income single men and women fare the worst



U.S. Single Women Lacking Sufficient Resources

Across all age cohorts low-income women fare the worst



Minnesota Estimates

How Would Minnesota Be Different?

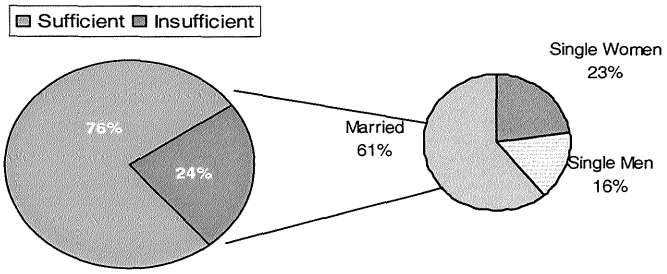
- Higher than average incomes
  - More retirement resources
- More likely to be married and dual-income
  - More retirement resources
- Minnesotans live longer on average
  - Potential greater retirement expenses
- Minnesotans are healthier on average
  - Potential lower medical expenses

Key Points About Data

- Data on Minnesotans born 1936-1965
- Now are ages 40-69
- Projections are calculated using cumulative totals based on Social Security life tables
- *EBRI projections assume 5% additional savings up to retirement*

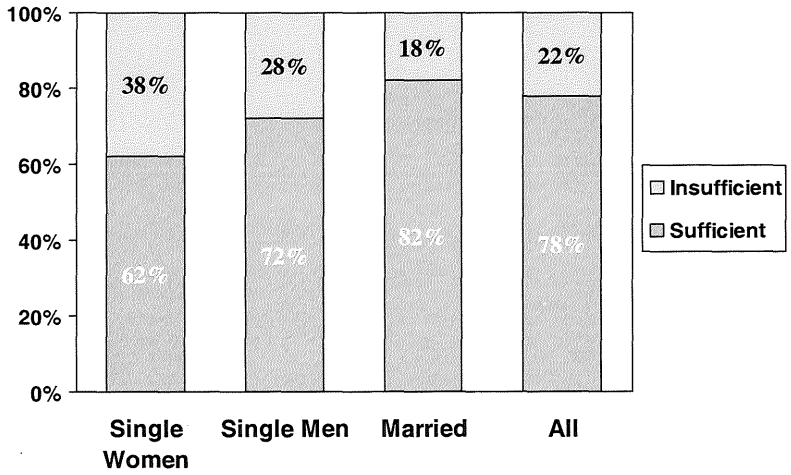
Projected Sufficiency of Retirement Resources for Minnesotans Born 1936 - 1965

24% of Minnesotans currently age 40-69 may are at risk



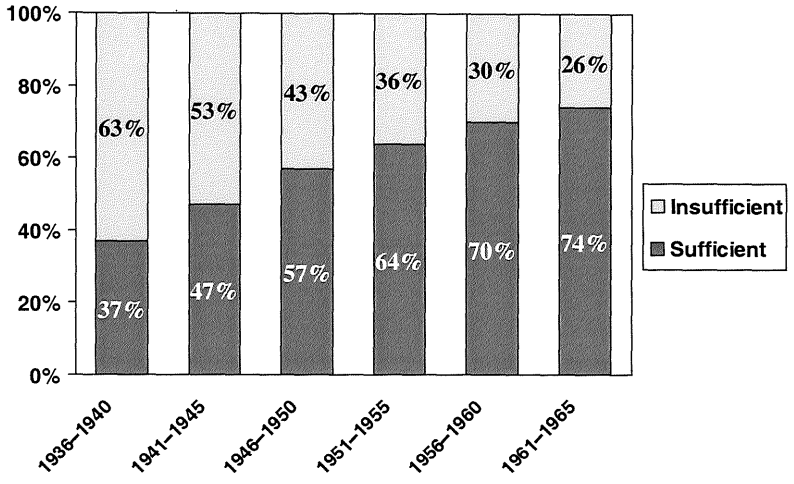
Projected Percent of Minnesota Baby Boomers with Insufficient Retirement Resources

Single women have the greatest risk – 38%



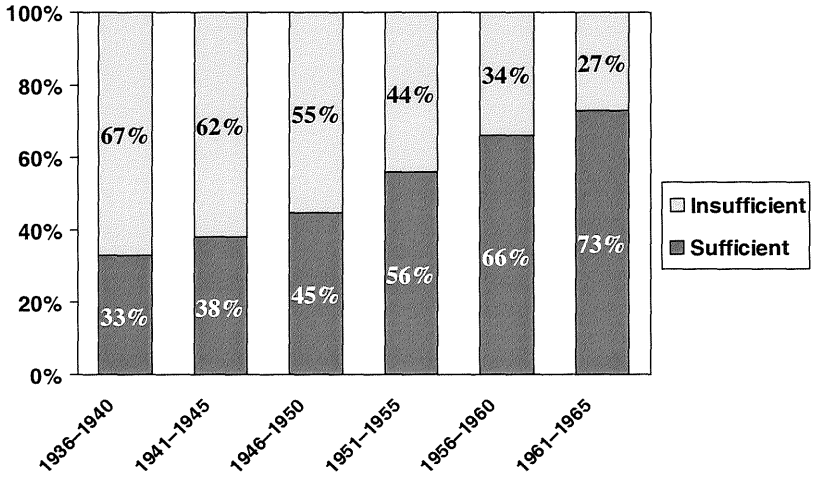
Projected Percent of Single Women MN with Insufficient Retirement Resources

Those retiring now are more likely to be at risk – no time to save



Projected Percent of MN Baby Boomers in Lowest Income Quartile with Insufficient Retirement Resources

Those with low-incomes also at risk



Low-Income Quartiles Only

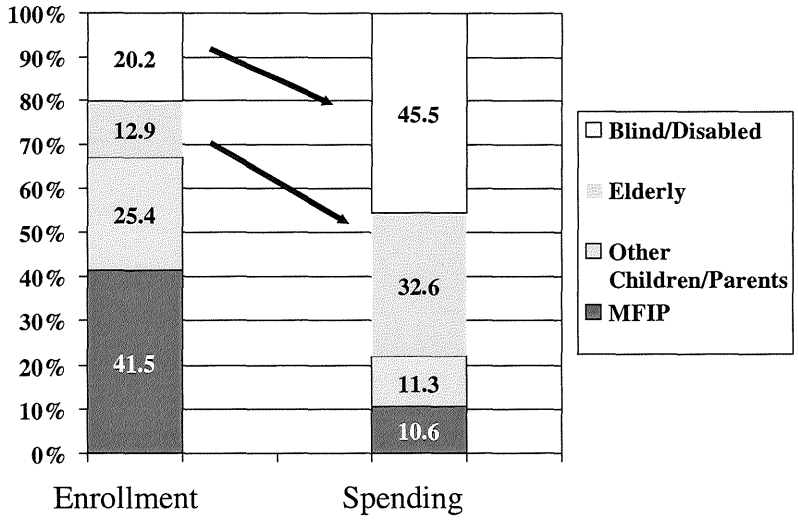
Minnesota's Projected Retirement Resource Insufficiency

- The number of Minnesota retirees who will be at risk of retirement insecurity will increase dramatically
  - 90,000 in 2005 to over 225,000 by 2021
- The number at risk each year will more than double in just 9 years
  - 188,461 by 2014

Impact on Public Policy

MN Medical Assistance Spending, 2001

Elderly and Blind/Disabled consume 78% of MA Budget



Policy Implications

- A significant portion of MN retirees may not have enough resources to pay for their own long-term care
- Diversity of retirees requires diversity of financial incentives and programs; unlikely one policy will be the solution
- For some, financial options are not viable. Non-financial means of reducing risk of Medicaid long-term care are needed

Next Steps

Planned Information Dissemination

- Issue Brief #1: Retirement Income Security and Minnesota's Elderly Population
- Issue Brief #2: Evaluation of several long-term care policy options
  - Initial Findings
  - Final Complete Mid-to-late April

Issue Brief #2

Evaluation of Policies from State Policy Perspective

Long-Term Care Insurance

- Tax Credits
- Subsidy of purchase

Reverse Mortgage

- Subsidize costs if proceeds are used for LTC

Partnership Model

- Private coverage allows some asset protection if Medicaid is needed
- 4 states have a program for tong-term care insurance

Family Loan Program

Basis for Evaluation of Policies

- General Public Good vs. Medicaid Savings
  - Encouraging retirement and long-term care planning may be one goal of policies
  - Realizing Medicaid savings requires targeted policies
- Target Population for Financial Interventions
  - Likely to need formal long-term care
  - Have some resources, but likely to spend-down to Medicaid

Identifying the Target Population

- EBRI estimates of additional savings needed to ensure retirement security
  - Consistent with Issue Brief #1 Estimates
  - General Model is the same, even though MN numbers will not match exactly
  - Uses the same socio-demographic subgroups
- Thresholds vary according to income quartile

Utility of this Approach

- Possible to identify characteristics of the people in the three categories:
  (1) home ownership
  (2) home value
  (3) urban/rural place of residence
- Estimate whether and how groups will be affected by policies:
  - Impact expressed in terms of effect on groups most likely at risk
  - Use impact on people as indicator of potential Medicaid savings

Initial Target Population Estimates

- Distribution of MN population by risk of spending down to Medicaid eligibility
- Born 1936-1965
  - Very High Risk 540,795 28.9%
  - Moderate to High 328,513 17.5%
  - Low to Moderate 1,004,418 53.6%
- Target Population
  - Very High Risk 540,795 28.9%
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Contact Information

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Public and Private Long-Term Care Financing: Options for Minnesota

Summary of Legislative Report

Senate Health and Human Services Budget Committee
Linda Berglin, Chair

March 30, 2005

Complete report is available on the DHS website at
http://www.dhs.state.mn.us/main/groups/aging/documents/pub/dhs_id_025734.hcsp

About the report

The report examines the issue of financing long-term care[1] in the future as the number of older Minnesotans that need long-term care dramatically increases. It describes a variety of public and private financing options that may have some potential for addressing this critical issue, and offers recommendations to the State of Minnesota for actions that should be taken to prepare for these long-term care challenges.

The 2003 Minnesota Legislature called for a study of long-term care financing. It required that the Department of Human Services complete a report that included a new mix of public and private approaches for financing long-term care, and analysis of four options mentioned specifically in legislation.

The study was broadened to include nine different options analyzed for their potential to maximize private dollars in long-term care and minimize Medicaid liabilities. The options include five insurance options, two options that borrow money, and two that use savings. (Retirement income from all sources including public and private pensions and savings are assumed to be available for long-term care, in addition to the options individuals can use to specifically cover their long-term care needs.)

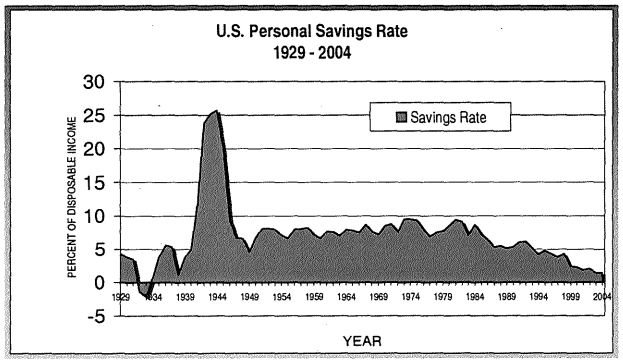
[1] Long-term care is defined as "assistance given over a sustained period of time to people who are experiencing long-term inabilities in functioning because of a disability." (*Ladd, Kane, Kane, 2000*). For purposes of this report, long-term care refers to care provided in all settings, including homes, apartments, residential settings and nursing homes. While the options are analyzed from the perspective of the elderly, many of the options may be relevant to younger individuals who need long-term care services.

The state contracted with the University of Minnesota's State Health Access Data Assistance Center (SHADAC) to complete more detailed policy and fiscal analysis of each of the options listed in the legislation. This analysis is not yet complete but will be submitted to the Legislature as soon it is available, by March 2005.

Why is this issue important?

In 2011, just six years from now, the baby boom generation will begin to turn 65, and as they grow old, many predict that providing long-term care for this large group of older people will quickly become one of the state's most critical issues. The sheer numbers of people needing and eligible for publicly funded long-term care by 2030 could overwhelm the state budget. Below are some of the factors contributing to this problem.

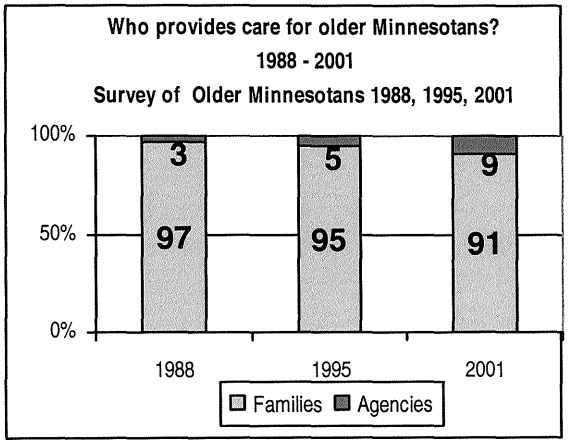
- The U.S. personal savings rate in 2004 was 1.2 percent, the lowest since the Depression, leaving many individuals with few personal resources to pay for long-term care.



- As many as 45 percent of the state's future elderly (the baby boom generation) may have inadequate retirement income to pay for health and long-term care costs.
- The number of individuals needing long-term care will triple between 2000 and

2050. This increase assumes a *continuing decline* in elderly disability rates. If these rates begin to increase (and they are going up in the under-65 age group), even more individuals will need long-term care.

- The vast majority of long-term care for the elderly is provided by families, but the overall level is declining. The number of available "caregivers" is already very low in the state's rural areas.



- In 2004, an estimated $2.26 billion was spent on long-term care for the elderly in Minnesota: 40 percent was Medicaid, 33 percent was out-of-pocket expenses by the elderly and their families and 20 percent was paid by Medicare. About 7 percent came from other sources, including private insurance.
- When the dollar value of family caregiving is added to the total, the 2004 long-term care expenditures increase to an estimated $6.84 billion. The value of family care, about $4.58 billion, far outweighs the other sources, representing two-thirds of the total expenditures.
- If the number of disabled elderly grows faster than it has in the past, is coupled with reductions in the amount of family care, *and* if the percent of elderly with inadequate means to pay for long-term care grows, the total demand for Medicaid funding for long-term care could rise to unsustainable levels.

Review of private financing options

The report describes each of nine financing options that were reviewed during the study for their potential to help individuals pay for their own long-term care and make them less likely to turn to Medicaid for coverage. The options use insurance, borrowing or savings to cover long-term care costs.

The insurance options all include payment of premiums for protection against the risk of larger long-term care costs, with benefits paid or provided if policyholders become eligible for services. A chief advantage of the insurance options is the ability to pool the risk of long-term care. The Partnership program also protects some assets from Medicaid spend down if private insurance is exhausted and Medicaid is utilized, and is thought to expand the long-term care insurance market.

Two options that borrow money were studied. These options have somewhat higher costs than insurance because of the interest rates that are charged (as in all loans). Unlike insurance, where people may pay premiums for years to protect themselves from a risk that may or may not occur, the options that borrow money are used only if and when money to pay long-term care costs is needed.

Two savings options were also studied. Both options provide the flexibility of cash that can be used to pay for long-term care in any way the individual wishes. In the CarePlus option (enacted by the Hawaii Legislature in 2003 but vetoed by the new governor), if implemented as designed, participants would include all residents of a state who file income tax. It is the least expensive per person ($120/year) of all the options because the long-term care risk is spread across the whole population and the

program pays a somewhat lower per day benefit. The private saving option, the long-term care annuity, probably requires the largest investment of any of the options, because it includes an immediate annuity combined with long-term care coverage that pays additional income if long-term care is needed.

Recommendations

There is no "silver bullet" or one option that is the answer to the private financing of long-term care. Because of differing individual circumstances, nearly all the options reviewed in this study have some potential to address the issue and increase the use of private dollars for long-term care. Of the nine, only one – mandating nursing home coverage in Medicare supplemental products – is not supported as a viable option.

New mix of public and private approaches

Given the demographic and economic realities, many are concerned about the future pressure on Medicaid to pay the long-term care costs for an ever larger proportion of the elderly population. To address this scenario, a new mix of public and private approaches must be utilized.

On the financing issues, specifically:

1. Tighten up asset transfer and estate recovery.
2. Provide incentives for private payment of long-term care – both through more public information about the options and financial incentives that achieve the state's goals.
3. For the long-term, rethink and restructure the public and private responsibility in long-term care, perhaps similar to how the Partnership concept works.

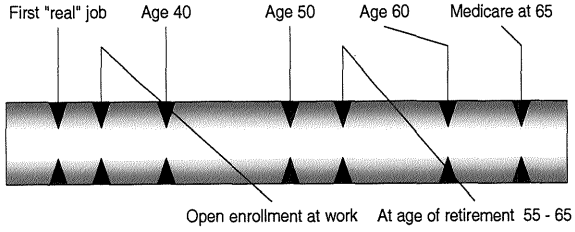
Other essential policies include:

4. Support family caregiving. For every percent that family care declines, it can cost the public sector $30 million per year.
5. Create age-friendly communities that provide the essential supports that help frail elderly remain in their homes longer.
6. Prevent or delay the disabilities that cause long-term care needs, and improve management of chronic disease for all ages.

Every worker must have retirement and long-term care plans

We spend more time planning summer vacations than we do planning our retirement, which can last 30 years or more. Retirement planning must be integrated into and become a normal part of decisions workers make about their benefits and their future.

Possible Trigger Points in the LifeCycle for Retirement and Long-Term Care Planning



1. Work with a broad coalition of employers, employees, and those that develop and market long-term care products to develop and implement a strategic plan to ensure Minnesotans have retirement and long-term care plans.
2. Seek funding in partnership with others to create a Minnesota Center for Retirement Security and Wellness to work with Minnesota employers on retirement, health and insurance benefits to support our state's aging workforce, and to expand retirement and long-term care planning.

Public and Private Financing of Long-Term Care in Minnesota
Summary of Legislative Report
February 2005

Long-Term Care Financing Options: Pros, Cons and Recommendations

Option	Pros	Cons	Recommendations
. Long-term care insurance (LTCI)	• Most recognized and utilized option • Pools the risk of LTC • Targeted specifically at LTC	• Only one of many risks that younger people must address, and seen as lower priority • Must be purchased before needed	• Ensure comprehensive consumer protection measures. • Follow up on employer interest in distributing information on LTC. • Evaluate feasibility of expanding current state LTCI program to all public employees.
2. Partner-ship for long-term care	• Clarifies and sets level of individual expenditure for LTC and once met, offers "back-end" coverage of remaining LTC costs through Medicaid • Increases consumer protections by setting standards for LTCI policies	• Requires Congressional action to allow more states to establish program • Medicaid savings unclear (how many Partnership members would have purchased LTCI anyway, and if they would have used Medicaid)	• Monitor efforts at the federal level to eliminate prohibition on new state programs. • Study possibility of broadening concept of partnership to allow other LTC expenditures to count toward asset protection.
3. Nursing home care into Medicare-related overage	• Ideally, this would expand number of seniors with some coverage for nursing home care	• Would damage the Medigap market by making premiums unaffordable for most current policyholders	• Do not mandate this option. • Medicare plans should be allowed to offer LTC benefits if they see a market for this as Medicare reform becomes clearer.
4. Health insurance options that include long-term care coverage	• Only option that can address the conditions that cause LTC need • Public sector options use this model to improve chronic care management	• No options now available in Minnesota for general Medicare market	• Work with health plans to explore how integrated acute and LTC could be made more available to pre-Medicaid elderly and the general Medicare population.
5. Life insurance options that include long-term care coverage	• Permanent insurance option provides multiple uses through one vehicle—life insurance, LTC coverage, possible loan/savings	• LTC coverage more limited than what is available through LTCI or health insurance	• Encourage development of linked benefit products that provide both life and LTCI.
6. Reverse mortgages	• This option can be accessed by nearly all elderly individuals 62+ because of high homeownership rates	• Relatively expensive because of the fees and cost of mortgage and annuity	• Explore impact of state discount of fees if money is used for LTC costs.
7. Family loan or line of credit	• Most immediate source of money to pay for LTC • Only used if and when needed	• Increases debt of adult children especially if proceeds from estate are not available to help repay loan	• This type of program should be initiated in Minnesota and monitored to see how it might fit into a comprehensive family support strategy.
. Universal public savings plan	• Most inexpensive option per person because it spread the costs and risk across all taxpayers in state	• Provides only one year of benefits and those covered may not take steps to provide additional coverage	• Monitor efforts by other states to review or implement this model.
9. Long-term care annuity	• Combines risk of long life with LTC risk	• Current products require substantial investment	• Encourage additional development of these products at a more affordable price.

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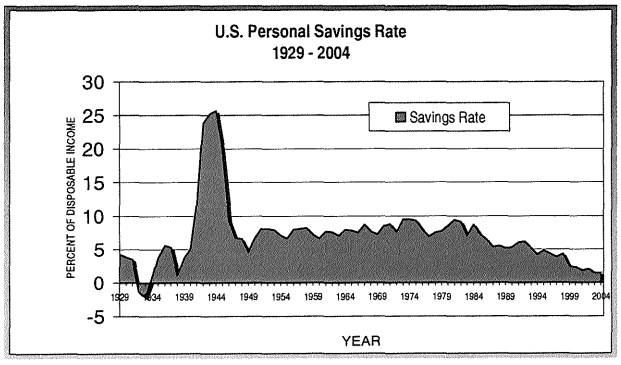

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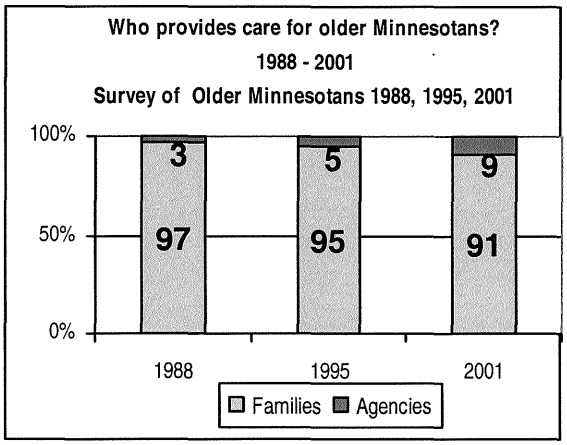

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The insurance options all include payment of premiums for protection against the risk of larger long-term care costs, with benefits paid or provided if policyholders become eligible for services. A chief advantage of the insurance options is the ability to pool the risk of long-term care. The Partnership program also protects some assets from Medicaid spend down if private insurance is exhausted and Medicaid is utilized, and is thought to expand the long-term care insurance market.

Two options that borrow money were studied. These options have somewhat higher costs than insurance because of the interest rates that are charged (as in all loans). Unlike insurance, where people may pay premiums for years to protect themselves from a risk that may or may not occur, the options that borrow money are used only if and when money to pay long-term care costs is needed.

Two savings options were also studied. Both options provide the flexibility of cash that can be used to pay for long-term care in any way the individual wishes. In the CarePlus option (enacted by the Hawaii Legislature in 2003 but vetoed by the new governor), if implemented as designed, participants would include all residents of a state who file income tax. It is the least expensive per person ($120/year) of all the options because the long-term care risk is spread across the whole population and the

program pays a somewhat lower per day benefit. The private saving option, the long-term care annuity, probably requires the largest investment of any of the options, because it includes an immediate annuity combined with long-term care coverage that pays additional income if long-term care is needed.

Recommendations

There is no "silver bullet" or one option that is the answer to the private financing of long-term care. Because of differing individual circumstances, nearly all the options reviewed in this study have some potential to address the issue and increase the use of private dollars for long-term care. Of the nine, only one – mandating nursing home coverage in Medicare supplemental products – is not supported as a viable option.

New mix of public and private approaches

Given the demographic and economic realities, many are concerned about the future pressure on Medicaid to pay the long-term care costs for an ever larger proportion of the elderly population. To address this scenario, a new mix of public and private approaches must be utilized.

On the financing issues, specifically:

1. Tighten up asset transfer and estate recovery.
2. Provide incentives for private payment of long-term care – both through more public information about the options and financial incentives that achieve the state's goals.
3. For the long-term, rethink and restructure the public and private responsibility in long-term care, perhaps similar to how the Partnership concept works.

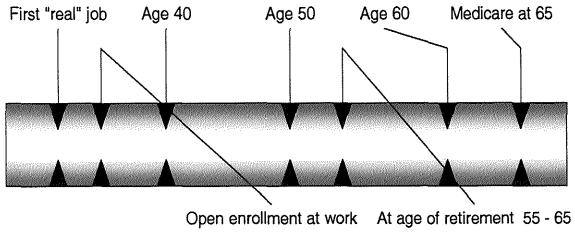
Other essential policies include:

4. Support family caregiving. For every percent that family care declines, it can cost the public sector $30 million per year.
5. Create age-friendly communities that provide the essential supports that help frail elderly remain in their homes longer.
6. Prevent or delay the disabilities that cause long-term care needs, and improve management of chronic disease for all ages.

Every worker must have retirement and long-term care plans

We spend more time planning summer vacations than we do planning our retirement, which can last 30 years or more. Retirement planning must be integrated into and become a normal part of decisions workers make about their benefits and their future.

Possible Trigger Points in the LifeCycle for Retirement and Long-Term Care Planning



1. Work with a broad coalition of employers, employees, and those that develop and market long-term care products to develop and implement a strategic plan to ensure Minnesotans have retirement and long-term care plans.
2. Seek funding in partnership with others to create a Minnesota Center for Retirement Security and Wellness to work with Minnesota employers on retirement, health and insurance benefits to support our state's aging workforce, and to expand retirement and long-term care planning.

Long-Term Care Financing Options: Pros, Cons and Recommendations

Option	Pros	Cons	Recommendations
1. Long-term care insurance (LTCI)	• Most recognized and utilized option • Pools the risk of LTC • Targeted specifically at LTC	• Only one of many risks that younger people must address, and seen as lower priority • Must be purchased before needed	• Ensure comprehensive consumer protection measures. • Follow up on employer interest in distributing information on LTC. • Evaluate feasibility of expanding current state LTCI program to all public employees.
2. Partnership for long-term care	• Clarifies and sets level of individual expenditure for LTC and once met, offers "back-end" coverage of remaining LTC costs through Medicaid • Increases consumer protections by setting standards for LTCI policies	• Requires Congressional action to allow more states to establish program • Medicaid savings unclear (how many Partnership members would have purchased LTCI anyway, and if they would have used Medicaid)	• Monitor efforts at the federal level to eliminate prohibition on new state programs. • Study possibility of broadening concept of partnership to allow other LTC expenditures to count toward asset protection.
3. Nursing home care into Medicare-related coverage	• Ideally, this would expand number of seniors with some coverage for nursing home care	• Would damage the Medigap market by making premiums unaffordable for most current policyholders	• Do not mandate this option. • Medicare plans should be allowed to offer LTC benefits if they see a market for this as Medicare reform becomes clearer.
4. Health insurance options that include long-term care coverage	• Only option that can address the conditions that cause LTC need • Public sector options use this model to improve chronic care management	• No options now available in Minnesota for general Medicare market	• Work with health plans to explore how integrated acute and LTC could be made more available to pre-Medicaid elderly and the general Medicare population.
5. Life insurance options that include long-term care coverage	• Permanent insurance option provides multiple uses through one vehicle—life insurance, LTC coverage, possible loan/savings	• LTC coverage more limited than what is available through LTCI or health insurance	• Encourage development of linked benefit products that provide both life and LTCI.
6. Reverse mortgages	• This option can be accessed by nearly all elderly individuals 62+ because of high homeownership rates	• Relatively expensive because of the fees and cost of mortgage and annuity	• Explore impact of state discount of fees if money is used for LTC costs.
7. Family loan or line of credit	• Most immediate source of money to pay for LTC • Only used if and when needed	• Increases debt of adult children especially if proceeds from estate are not available to help repay loan	• This type of program should be initiated in Minnesota and monitored to see how it might fit into a comprehensive family support strategy.
8. Universal public savings plan	• Most inexpensive option per person because it spread the costs and risk across all taxpayers in state	• Provides only one year of benefits and those covered may not take steps to provide additional coverage	• Monitor efforts by other states to review or implement this model.
9. Long-term care annuity	• Combines risk of long life with LTC risk	• Current products require substantial investment	• Encourage additional development of these products at a more affordable price.

SHA DAC

STATE HEALTH ACCESS DATA ASSISTANCE CENTER

Retirement Security for Minnesota's Elderly Population

March 2005

Issue Brief #1 Executive Summary

As the population ages there is increasing concern about whether older Minnesotans will have sufficient resources to fund their retirement.

Expenses incurred during retirement include living expenses, Medigap insurance, and out-of-pocket expenses including those for long-term care services.

The concerns about "retirement security" are two-fold: 1.) that people are not financially prepared to support their basic retirement expenses which may span several decades; and 2.) that people will be unprepared to cover the additional costs of long-term care if they suffer cognitive decline or become physically disabled with age.

More than one out of five Minnesotans born from 1936 to 1965 are projected to have insufficient retirement resources.

Additional savings may improve the situation for those who are younger. Single women and people who retire at lower income levels are disproportionately at risk of needing public support, and savings are unlikely to be sufficient to improve their situation.

Issue Brief #2 reports on efforts to evaluate the ability of proposed policies to help groups likely to have insufficient retirement resources.

Will Minnesotans have enough retirement income to cover their expenses?

This issue brief focuses on whether Minnesotans will have enough money for their retirement and long-term care needs and estimates how many Minnesotans are at risk of having insufficient resources during their retirement years. This gap between wealth and expenses raises public policy issues as Minnesotans at risk of having insufficient retirement resources are more likely to need public support and assistance.

What is the problem?

The number of retirees will grow exponentially as the baby boomers age. This could potentially have a large impact on state Medicaid budgets if people do not have the means to privately pay for their retirement and long-term care needs. This is particularly a concern as Medicaid accounts for a significant amount of state expenditures and the federal government has proposed new limits on federal participation in the financing of Medicaid.

What is the anticipated impact on Minnesota?

Minnesotans likely to fare better than nation

Minnesota has several advantages over the nation as a whole—its population is slightly younger, healthier, significantly less disabled, more likely to be married, and has higher incomes. This means Minnesotans may have more formal and informal resources available to respond to their retirement and long-term care needs.

Minnesota still faces significant challenges

Combining a national model, which includes a 5% savings assumption, with Minnesota data suggests that over the course of their retirement:

- 24% of Minnesotans currently ages 40-69 (a total of over 441,000 out of 1.8 million) may not have sufficient resources to cover their retirement and long-term care expenses.
- Single women have the greatest risk with 38% likely to have insufficient retirement resources.
- Single men also have a higher risk with 29% likely to have fewer resources than needed.
- Married people fare the best but still almost 20% will have more expenses than income and wealth.

Examining this year by year and considering that people are at risk in the years between retirement and expected mortality, it is possible to estimate that:

- The number of retired Minnesotans at risk of "retirement insecurity" will increase dramatically from about 90,000 in 2005 to over 225,000 in 2021.
- The problem is also acute for the short term. The numbers at risk of having insufficient resources to meet their retirement needs will more than double in just 9 years, reaching 188,461 in 2014.
- Those at greatest risk include people already near retirement, in lower income groups, and most low-income single women. These groups will not be able save enough and will need mechanisms other than savings to fund any long-term care needs.

Retirement Security for Minnesota's Elderly Population

The EBRI-ERF Retirement Security Projection Model

This issue brief uses a national model to assess the situation specific to Minnesota. The model developed by the Employee Benefit Research Institute Education & Research Fund (EBRI-ERF) draws on a unique database of information for 10 million 401(k) participants and 30,000 retirement plans.

The EBRI model was used to estimate Minnesota-specific numbers for several reasons: we had access to some of the data produced by the EBRI; there was an interest by state policy makers in applying EBRI analysis at state level; the EBRI projections are based on the most complete retirement saving information currently collected; and we wanted to determine how well a national model could be adapted for state needs.

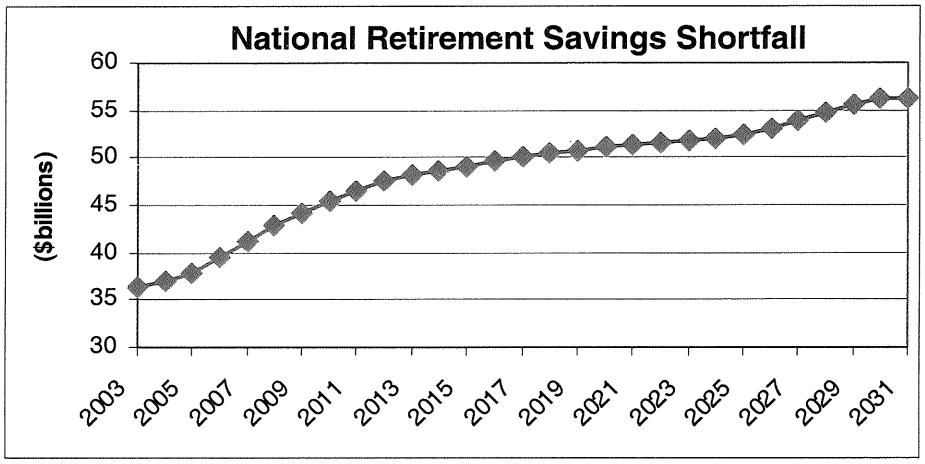
EBRI estimates of the percentage of retirees with and without sufficient retirement income/wealth include the assumption that individuals save an additional 5% of their income through retirement. Because of this assumption, estimates of the percentage of youngest boomers with insufficient resources are conservative.

Using a national model does not account for the uniqueness of the Minnesota population. Some characteristics such as the higher marriage rate have been incorporated into the adaptation of the national results. Including other differences, such as the fact that Minnesotans are healthier and wealthier than the national population, would require access to intermediate outputs or to the entire model.

Why are state and national policy makers concerned about retirement security?

Estimates indicate that the gap between retirees' resources and their estimated expenditures during retirement is growing

- By the year 2030 the national model estimates that U.S. retirees will have expenses that exceed their retirement resources by as much as $56 billion.
- It is estimated that the aggregate shortfall between retirement expenses and retirement resources for the decade 2021-2030 may total more than $400 billion.



Source: EBRI-ERF Retirement Security Projection Model, 2003. *(Assumes status quo for Social Security, that housing equity is never liquidated, and that current retirees are similar to the oldest cohort of current workers.)*

Retirees without sufficient resources may require public assistance including state Medicaid support for long-term care expenses

- Long-term care currently accounts for 34% of all Medicaid spending in the U.S. representing over $82 billion expenditures.
- The elderly represent a significant component of state Medicaid expenditures. In Minnesota the elderly represent only 13% of Medicaid enrollees but 33% of Medicaid expenditures.
- Medicaid is assuming a larger and increasing share of state budgets.

What are the policy implications?

State and national policy makers need to:

- Develop public-private partnerships that provide diverse financial options and incentives for people to plan for long-term care.
- Supplement financial options with programs that support informal care, prevent or delay disabilities, and encourage the development of supportive communities.

Analysis based on data from "Can America Afford Tomorrow's Retirees: Results from the EBRI-ERF Retirement Security Projection Model." Jack VanDerhei and Craig Copeland. Washington, DC: The Employee Benefit Research Institute Education and Research Fund (EBRI-ERF). November 2003.

Prepared by Annette Totten, Ph.D. and Lynn Blewett, Ph.D., of the State Health Access Data Assistance Center (www.shadac.org), University of Minnesota Division of Health Services Research and Policy, with funding from the Minnesota Department of Human Services. March 2005.

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STATE HEALTH ACCESS DATA ASSISTANCE CENTER

Minnesota Long-Term Care Financing

Issue Brief #1, March 2005

Retirement Security and Minnesota's Elderly Population

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Retirement Security

As the population ages there is increasing concern about whether older Minnesotans will have sufficient resources to fund their retirement. The fact that people are living long enough to retire, and are retired for years or even decades, is a reflection of our success in increasing longevity, improving the elders' health, and providing financial mechanisms that support retirement such as pensions and Social Security. However, employment, savings and financial planning patterns and practices have not caught up with changes in demographics and society. The concerns are 1.) that people are not financially prepared to support their lifestyles for decades without wages and salaries, and 2..) that people will be unable to pay for the long-term care they may need should they suffer cognitive decline or become physically disabled as they age. Policy discussions and economic analyses often combine these issues under the term "retirement security."

When elders need long-term care services and have limited resources they become eligible for Medicaid coverage for nursing home care, Medicaid waiver home and community-based services, and other public programs. Even stable rates of long-term care usage will result in a significant increase in expenditures as the largest generation in American history, the baby boomers, approaches retirement age. If a larger percentage of older Minnesotans are at risk of needing services and having insufficient resources to pay for these services, Medicaid expenditures may grow even more dramatically. Likewise, if long-term care costs grow faster than state revenues, the needs of the aging population may contribute to state budget difficulties[1].

The concerns over "retirement security" have become a significant state policy issue as spending on the elderly and disabled for acute and long-term care services have continued to grow. While elderly, blind and disabled make up only 27% of Medicaid enrollment, they account for almost three quarters (71%) of total Medicaid expenditures In addition, Medicaid accounts for almost half (48%) of all nursing home expenditures (O'Brien and Elias, 2004).

Policy makers fear that the costs associated with the aging of the population could overwhelm available state resources in the future. Medicaid currently makes up, on average, 15% of state general fund budgets (19% in Minnesota) and policy makers look to Medicaid and other public programs as a means to meet balanced budget requirements. Medicaid is also growing faster than other spending categories, growing an average of 12.8% per year in 2002 (Kaiser Commission on Medicaid and the Uninsured 2003). This introduces additional fiscal tension due to decreases in state revenue while health care spending continues to grow at double digit increases.

Estimates of future Medicaid expenditures and the evaluation of policies designed to reduce Medicaid expenditures for long-term care depend on two principal factors: the need for

[1] It is important to note that recently (2002) Medicaid spending on long-term care nationally has grown more slowly than Medicaid spending for acute care (8.5% for long-term care compared to 13.5% for acute care). (O'Brien and Elias, 2004)

long-term care services, and the ability of individuals to pay for these services privately. This issue brief focuses on the second factor; whether Minnesotans will have enough money for their retirement and long-term care needs. In order to put this in very concrete terms, we estimate how many Minnesotans and, more specifically, *which* Minnesotans are at risk of having insufficient resources to meet their long-term care needs. A subsequent issue brief will examine the potential impact of several proposed public policies on individual planning for long-term care expenditures.

The Minnesota-specific estimates contained in this Issue Brief were created based on national projections made by the Employee Benefit Research Institute (EBRI). EBRI bases its analyses on extensive data collected on earnings, pensions and retirement savings combined with survey information on general expenditures, long-term care service usage, and information on the cost of nursing home and home care. In 2003, EBRI focused attention on the issue of retirement security and the ability to pay for long-term care when it released a report projecting a $45 billion shortfall in 2030 for American retirees—an increase of $17 billion from 2003—and estimated that for the decade from 2020 to 2030 the cumulative shortfall would be at least $400 billion. This large deficit is likely to translate into increased demands on public, charitable and family resources.

Measuring and Modeling Retirement Income Sufficiency

Over the last two decades economists, demographers, and other researchers have developed models designed to predict whether future elders will have sufficient retirement wealth and have used these models to estimate how many people may access public programs in order to obtain long-term care. The conclusions drawn from these studies have often been contradictory. These differences can be explained in part by variations in the sample of people studied, the data available to the researchers on current income and wealth, and the assumptions underlying the projections of future resources and needs. Appendix 1 contains a description of three examples of studies of retirement security.

For many people the ultimate use of the information from these models and analyses is as a basis for action, such as the development and evaluation of public policies. However, developing state-level policy solutions is challenging as both the inputs and results are based on a consideration of the entire US population and national trends. Rarely are state-level analyses done or are the potential impact of state-level differences discussed in detail[2]. As these types of analyses are often based on multiple simulations, intermediate values (e.g., the estimated wealth at retirement of a married woman who is 50 today) are often not available, making application to a specific state, and specific subpopulations within the state, difficult. Nevertheless, understanding these models and attempting to specify their implications for Minnesota can potentially provide insights into future issues state programs may face, as well

[2] The exception is the work done by EBRI which began with state-level analyses for Oregon, Kansas, and Massachusetts and later a national study. The Massachusetts and Kansas studies can be accessed via EBRI's website at http://www.ebri.org

as the impact that long-term care financing policies may have on the state budget, particularly the Medicaid program, and the general Minnesota population and economy.

Overview of Modeling Approaches

One of the consequences of the aging of the population is concern over how the basic needs of older persons will be met after they either voluntarily retire or end employment for other reasons. This issue is frequently quantified in two ways: dependency ratios and retirement resource sufficiency.

Dependency ratios are the number of people estimated to be working (and therefore paying taxes) divided by the number of people not expected to be working. In its simplest forms, these are based purely on age (i.e., ≤18, 18-64, and >65) and do not consider that some working age people may be disabled or dependent for any number of reasons, or that people younger and older than the standard working age may be employed. While these ratios are useful descriptors of populations trends, they are of little help in evaluating policies designed to either reduce disability or encourage people to plan for their own long-term care needs because they consider neither the risk of needing long-term care nor a person's ability to pay for this care.

Consideration of retirement resource sufficiency involves moving beyond simple categorizations of the population age distribution. It is usually defined as the relationship between the income and wealth people are likely to have after they leave the workforce and the expenses they are likely to incur. The resources a person has after ceasing to work for wages are referred to as retirement wealth. This wealth represents money, benefits, and assets that have been accumulated or earned over a person's working life. For any one person retirement wealth is likely to come from various sources, as indicated in Table 1. Estimating a person's retirement wealth is easiest when they are close to retirement or already retired because a significant amount of savings has already occurred. The further a person is from retirement, the more assumptions have to made about his or her job trajectory, earnings, savings behavior, access to pension plans, and accumulation of equity.

The expenses a person faces in retirement vary based on lifestyle, preferences and circumstances. Certain costs may remain the same while others decline (e.g., transportation for commuting) or increase (e.g., health care) when a person retires. Estimates of the percentage of pre-retirement annual salary a person will require to maintain their standard of living range from 50 to 80 percent. The ability to pay for long-term care or other major health-related expenses has been categorized as an "aging shock" (Knickman and Snell, 2002) and is specified as resources that must be available in addition to the base percentage.

Table 1: Types of Retirement Resources and Retirement Expenses

Retirement Resources	Retirement Expenses
• Social security payments • Defined benefit pensions • Defined contribution pensions • IRAs • Interest and gains from savings and investments • Wages or salaries from employment • Housing equity • Business/farm equity • Insurance (life, disability, long-term care)	• Housing (rent/mortgage, taxes, maintenance) • Utilities • Food • Transportation • Clothing and personal expenses • Health insurance premiums (Medicare Part B and Supplemental) • Out-of-pocket medical care expenses (co-pays, deductible, treatments not covered) • Travel and recreation • Long-term care

In a 2003 report, the Congressional Budget Office reviewed major studies of retirement preparedness published from 1993 to 2003. This review found, not surprisingly, that different conclusions were reached depending on whether baby boomers are compared to preceding generations or if the future difference between the wealth and needs of boomers is based on projections. Most studies conclude that future retirees are likely to have more wealth in absolute dollars when they retire than earlier generations. However, they caution that changes in demographics (longer life expectancy, fewer children to be informal caregivers, child-raising expenses later in life), the retirement system (shift from defined benefits to defined contributions and increase in the Social Security retirement age), and the uncertainty of rates of return may mean that this higher level of wealth will not be sufficient to need the projected needs.

The CBO review examined differences in the data and assumptions used in these analyses, but it did not explicitly compare how these models incorporated the probability of long-term care expenses. Appendix 1 includes summaries of three studies that have been frequently quoted in the literature about whether future retirees will be able to privately fund their long-term care. These studies, like those that were done earlier, differ in the specifics of their approaches and whether they are optimistic or pessimistic about the future. However, there are some similarities that are worth noting:

- All conclude that there is significant diversity among future retirees—that is, some subgroups will have enough wealth to meet their needs in retirement and others will not.
- The studies produce consistent conclusions as to which subgroups are likely to have insufficient retirement income and therefore are at risk of resorting to Medicaid should they need long-term care. Single people, particularly women, people with lower levels of income as they approach retirement, people who are disabled, and people who live

beyond 75 years old are all less likely to be able to pay for any long-term care needs they may have.

The EBRI Model: Overview and Summary of National Results

The Employee Benefit Research Institute Education and Research Fund (EBRI-ERF) Retirement Security Project Model combines six-years of data on more than 10 million 401(k) retirement plan participants, information from the US Department of Labor Form 5500 on other defined contribution plans, and data from several public surveys. Projections based on different assumptions about Social Security benefits and housing equity are also included. Once the starting wealth at retirement is determined, estimates of the expenditures that all retirees will face, such as food, services, housing, entertainment and health expenditures (including out-of-pocket and insurance premiums) are made based on demographic information and geographic region of residence. For each year that it is projected a person will live beyond retirement, he or she is assigned to either receive home care, enter a nursing home or need neither of these services based on the probability of these events happening for the age and gender stratum of the population to which the person belongs. Lengths of stay and discharge status are also estimated and used to model the cost of long-term care which is then added to the other types of expenditures.

For this modeling, people born from 1936 to 1965 were divided into six 5-year birth cohorts, 3 family categories (single women, single men, and married), and 4 income quartiles. For each of the resulting 72 subgroups (6 birth cohorts x 3 family types x 4 income levels) several different analyses are done. These analyses include estimating the size of the national retirement savings shortfall, the additional savings that would be needed to cover basic retirement expenses, and the percentages of retirees that will and will not have sufficient retirement resources even if they save an additional 5% consistently until retirement.

An example of the national results for one birth cohort (born 1946-1950), currently 55 to 59 years old, is provided in Figure 1. That more people who are single—as opposed to married—will not have sufficient retirement resources is replicated across the other five birth cohorts examined. As would be expected, more people who retire in the lowest income quartile are predicted to have insufficient resources, but even some in the highest quartile will be unable to meet all their retirement and long-term care needs. Figure 2 presents the same national information for one household type, single women, for all birth cohorts. Single women have the highest overall rate of insufficient retirement wealth and Figure 2 shows that the percentages decline for the younger age groups, but more markedly for the higher income groups. The majority of single women with incomes below the median will not have sufficient retirement income regardless of how much time they still have to save. While single women are the majority of users of formal long-term care services, this projection represents a significant increase in the number at risk of requiring publicly-supported services.

Figure 1: Estimated Percent of US Population in 1946-1950 Birth Cohort (age 55-59) with Insufficient Retirement Resources, by Income Quartile (even with 5% additional savings)

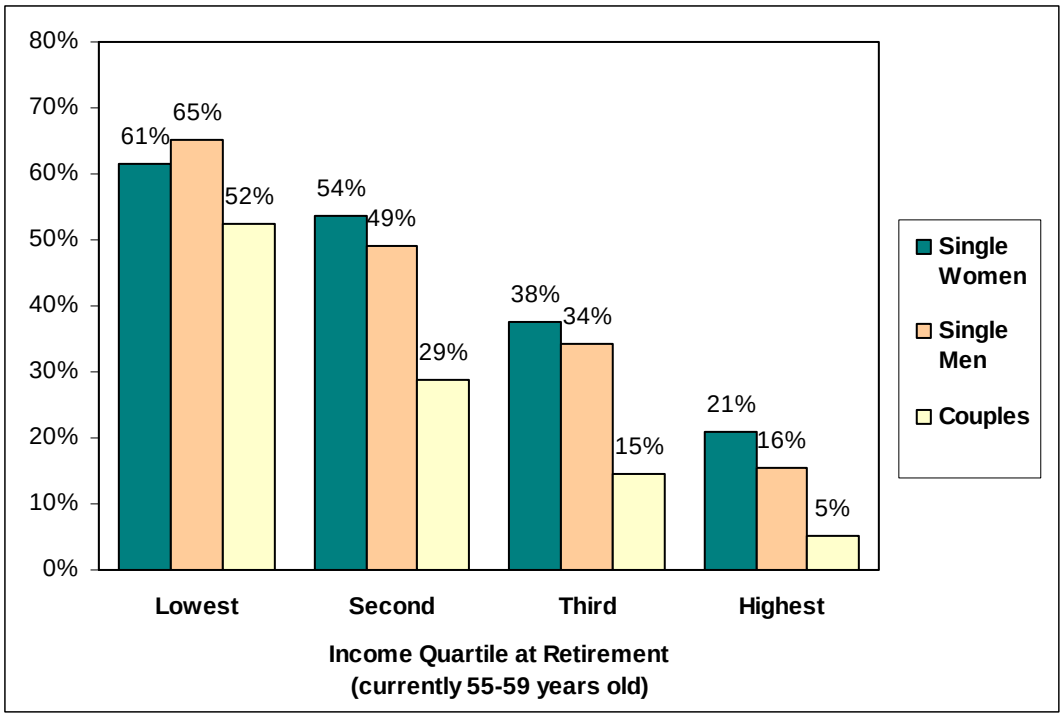
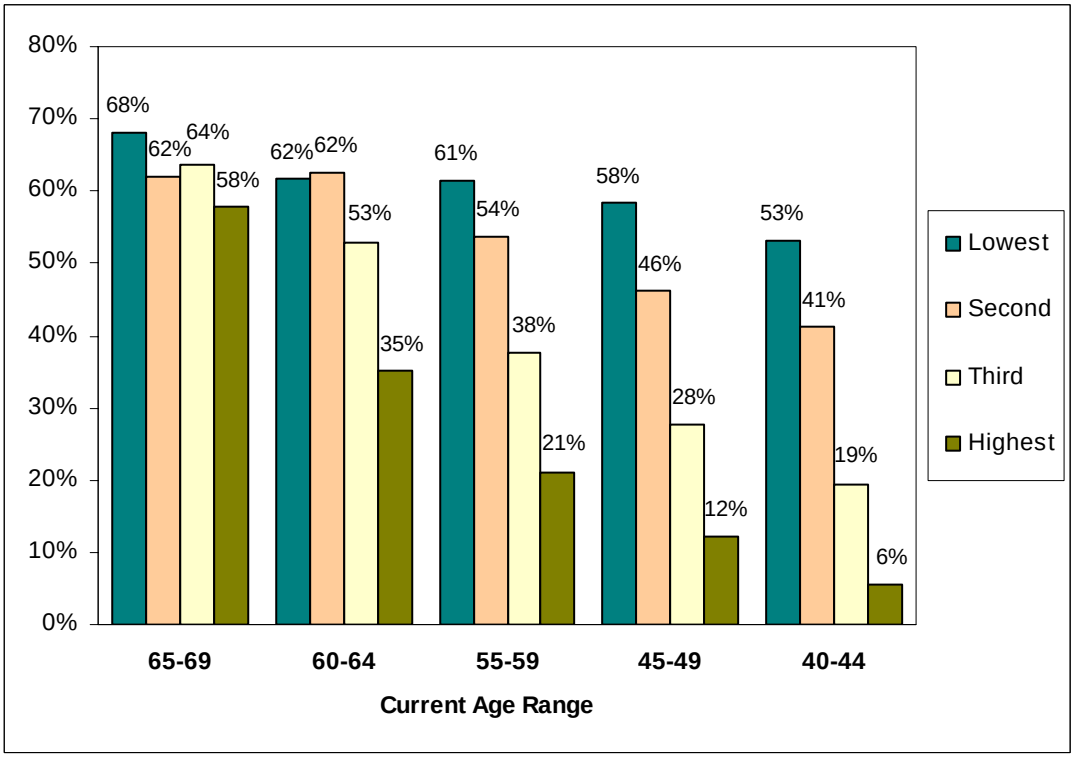
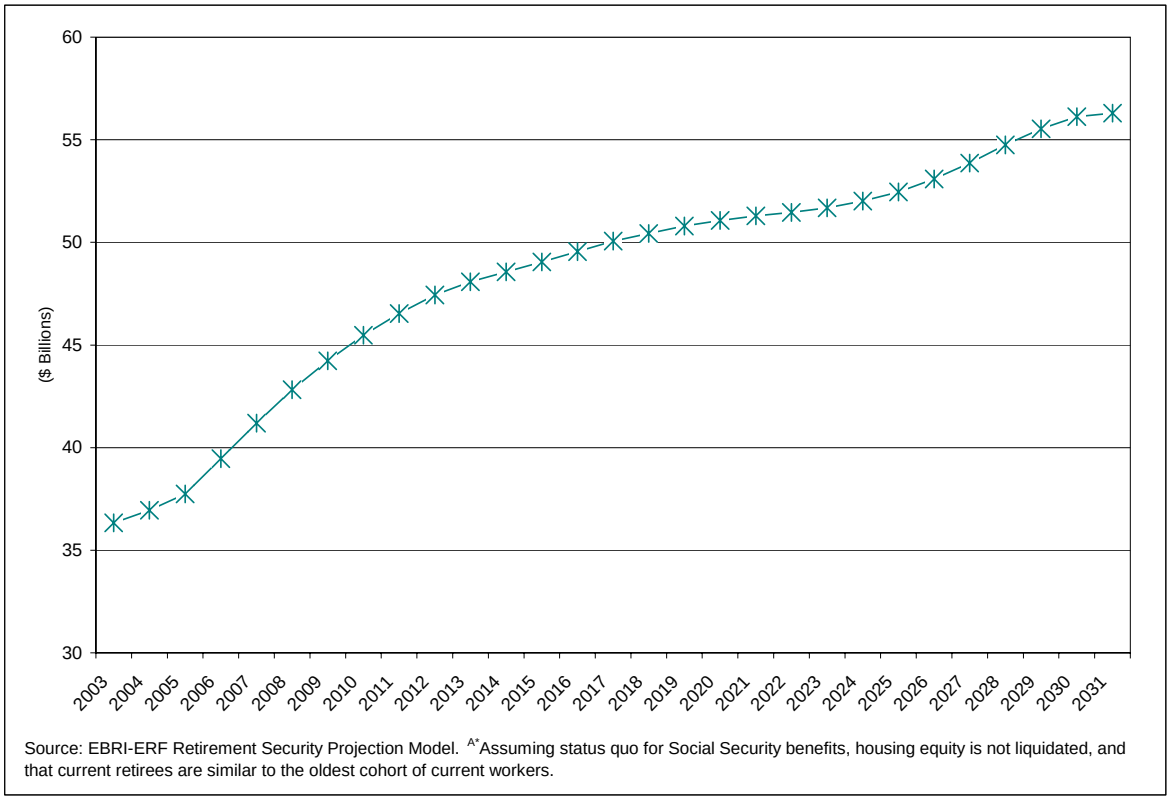


Figure 2: Estimated Percent of Single Women in US Population with Insufficient Retirement Resources (even with 5% additional savings)



From these simulations, EBRI was then able to combine the magnitude of the deficit for all these groups with the estimated number of people in each category based on population trends. The model projects that the total retirement income shortfall for the US will grow from $38 billion in 2005 to $56 billion in 2030, and total at least $400 billion for the decade 2021-2030.

Figure 3: Projected National Retirement Savings Shortfall for Population Age 65 and Over



Source: EBRI-ERF Retirement Security Projection Model. A* Assuming status quo for Social Security benefits, housing equity is not liquidated, and that current retirees are similar to the oldest cohort of current workers.

While aggregate conclusions like these raise alarms and awareness, they are almost too huge to comprehend and cannot be easily translated into information that would help the State of Minnesota target and evaluate policies designed to minimize its portion of this shortfall. Absent a state-specific simulation or the results generated by each step of the modeling, it is impossible to determine precisely what the total retirement income shortfall would be for the state of Minnesota. However, Minnesota-specific information can be used to generally estimate the number of Minnesotans who are unlikely to have sufficient retirement resources if the assumptions underlying the national model are accepted as generally applicable.

Estimating the Number of Future Retirees at Risk in Minnesota

Going from national models to estimates of the future experience of a particular state is difficult. In some cases the data used as the basis for the simulations may not contain a large enough sample from a particular state or the data may not be identifiable at the state level. Even if data are available, multistep simulations may encounter intractable problems when used with a new data set. Replicating these types of analyses with state-level data is likely to require high levels of expertise and significant amounts of money and time. These factors limit both the feasibility and the utility of exactly duplicating these types of models in order to generate information that can inform state policy development.

The fact that the modeling cannot be easily done on a state level does not preclude any use of these types of analyses. The combination of national results with state-specific data provides information that could help states target long-term care financing policies and evaluate the potential impact of different policy options. This Issue Brief focuses on the results of efforts to interpret the results of the simulations done by the Employee Benefit Research Institute (EBRI) in terms of their implications for the state of Minnesota.

The EBRI model was selected for several reasons. Public officials and agencies in Minnesota have followed the model's development as they and the EBRI researchers were part of a collaboration sponsored by the Millbank Memorial Fund. Because of this affiliation and because EBRI had done this modeling for three states as well as the nation, more detail about the assumptions and results were available. In addition, the model estimates retirement income and retirement expenses based on multiple scenarios for each person. Results have then been reported in several ways, one of which is estimates of the percentage of retirees in subgroups defined by age, marital status, and income quartile that will and will not have sufficient resources to meet expenses.

Modeling Approach

To estimate how many Minnesotans are at risk of not having sufficient resources in retirement to maintain their standard of living and pay for long-term care services, one component of the results of the EBRI modeling was combined with information about Minnesotans from the 2000 US Census obtained from the Integrated Public Use Microdata Series (Ruggles et al., 2004). Specifically, EBRI model projections of the percent of retirees without sufficient retirement income and wealth for each of 72 subgroups of the population were used as the basis for Minnesota estimates.

These estimates for Minnesota were generated by applying the EBRI predictions to Minnesota population data. First, the percentage estimated to have insufficient resources was combined with the number of Minnesotans in each subgroup to get an overall estimate of the number of the Minnesota-born from 1936 to 1965 predicted to have insufficient retirement resources at some time between retirement and death. A second analysis estimates the total potentially at risk each year, based on the number of people who reach the Social Security

retirement age by that year, and estimates of the survival rates (US Social Security Administration, 2004) of these retirees.

Results: Overall Estimates of Minnesotans at Risk

As mentioned earlier, EBRI divided the population into six birth cohorts, then by marital status, resulting in 18 groups, and then each of these is split into four income quartiles for a total of 72 subgroups. Table 2 reports the Minnesota estimates for each of these subgroups while Table 3 and Figure 4 provide summaries of the results of applying the EBRI estimates of the percentage with insufficient retirement resources for each birth cohort, household type, and income quartile subgroup to the numbers of Minnesotans in each subgroup.

Table 2: Minnesotans with Insufficient Retirement Resources at Some Time During Retirement by Birth Cohort, Household Type and Income Quartile (even with 5% additional savings)

Birth Cohort	Income Quartile	Single Women	Single Men	Married	Total for Birth Cohort
1936–1940	Lowest	4,526	2,804	21,405	
	Second	4,116	2,811	20,766	
	Third	4,227	2,566	17,637	
	Highest	3,857	2,102	11,249	
					98,066
1941–1945	Lowest	4,760	3,637	26,600	
	Second	4,806	3,398	20,545	
	Third	4,065	2,780	13,685	
	Highest	2,710	1,765	5,632	
					94,381
1946–1950	Lowest	6,427	5,738	28,936	
	Second	5,618	4,314	15,954	
	Third	3,946	3,026	8,054	
	Highest	2,197	1,372	2,815	
					88,398
1951–1955	Lowest	7,152	6,814	25,312	
	Second	5,667	4,090	7,797	
	Third	3,405	2,131	3,345	
	Highest	1,503	746	532	
					68,495
1956–1960	Lowest	7,489	7,582	20,162	
	Second	5,834	2,946	3,532	
	Third	2,736	1,075	995	
	Highest	780	227	125	
					53,483
1961–1965	Lowest	7,881	6,601	13,820	
	Second	5,385	1,313	1,246	
	Third	1,625	427	230	
	Highest	277	43	16	
					38,864
TOTALS		**100,991**	**70,308**	**270,389**	**441,688**

As the totals in Table 2 indicate, most of the Minnesotans projected to be at risk of not having enough resources for a secure retirement are married. This is also demonstrated in Figure 4 in which the 24% of the Minnesota population studied is estimated to have insufficient resources. Of this group, 61% are married people, 23% single women, and 16% single men. This reflects the fact that more Minnesotans in the age groups studied are married than single. When these projected numbers are compared to the totals in each household type in Minnesota as in Table 3 and Figure 5, it becomes clear that single women are disproportionately more likely to not have sufficient retirement resources than are single men or people who are married.

Figure 4: Projections of Retirement Security: Percent of Minnesota Population born between 1936 and 1965

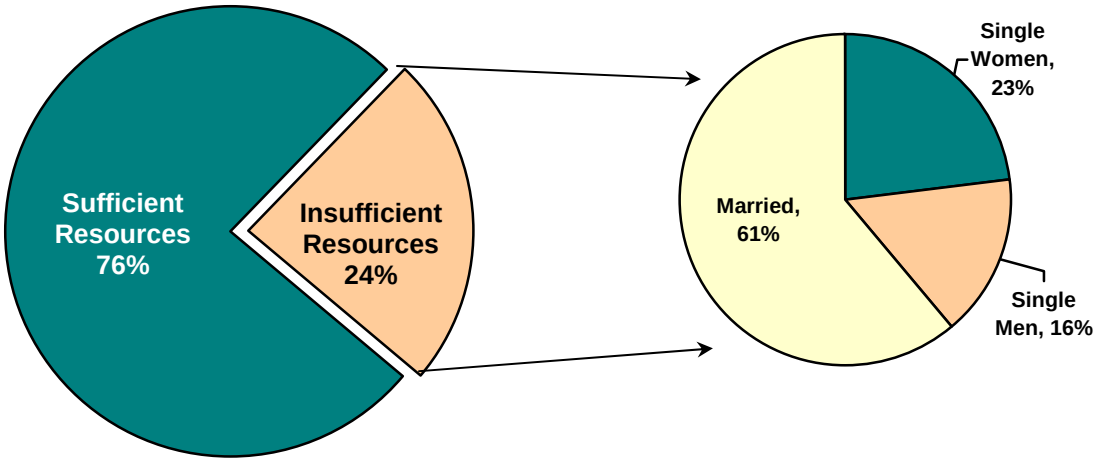
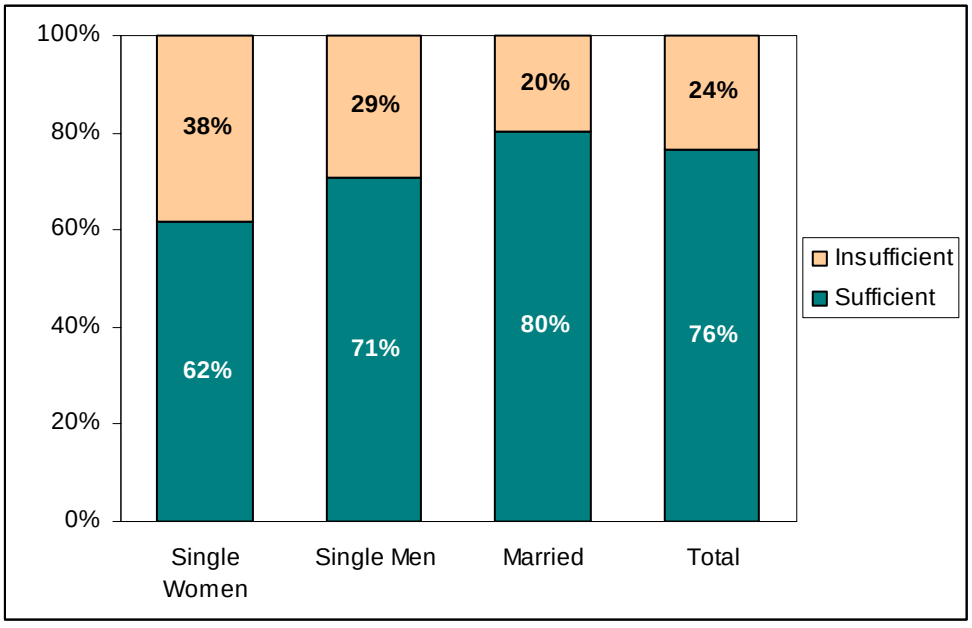


Table 3: Projections of Retirement Security for Minnesotans Born between 1936 and 1965 (even with 5% additional savings)

Household type	Population from 2000 Census	Insufficient Retirement Resources	
		Estimated number	Percent of household type
Single Women	262,801	100,991	38%
Single Men	241,430	70,308	29%
Married	1,369,495	270,389	20%
Total	1,873,726	441,688	24%

Figure 5: Projections of Retirement Security for Minnesotans born between 1936 and 1965

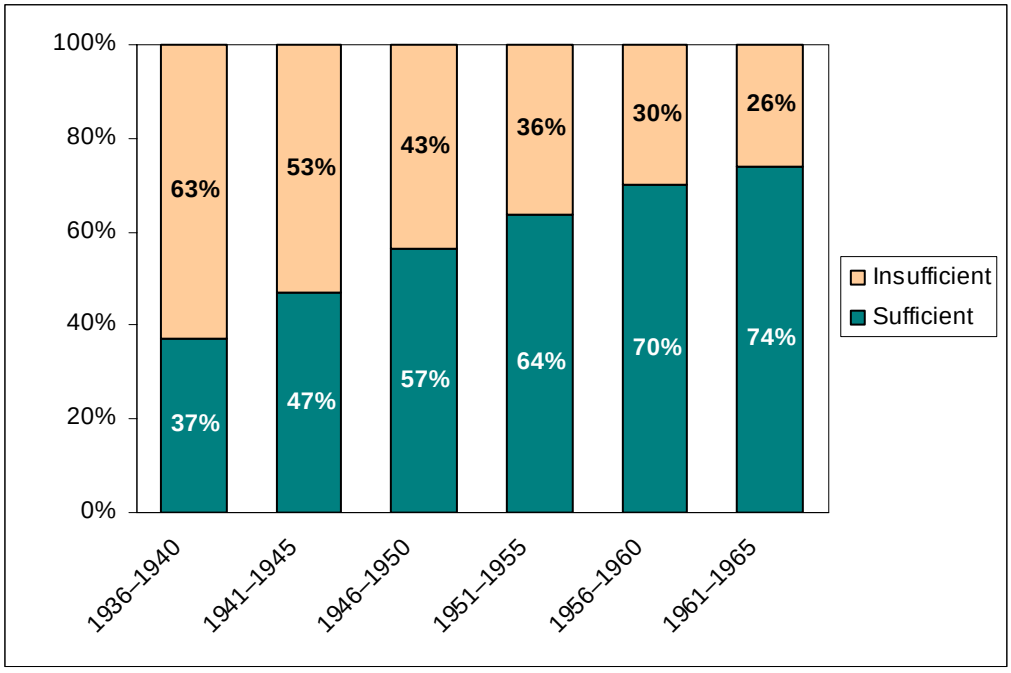


The impact on single women is demonstrated in more detail in Table 4 and Figure 6. These report the number of single women in each age group projected to have sufficient and insufficient retirement resources as well as the percentage of single women in each birth cohort projected to have insufficient retirement resources.

Table 4: Projections of Retirement Resource Insufficiency for Single Women in Minnesota (even with 5% additional savings)

Birth Cohort	Total Single Women	Sufficient Retirement Resources	Insufficient Retirement Resources	
			Estimated number	Percent of birth cohort
1936–1940	26611	9885	16726	63%
1941–1945	30797	14456	16341	53%
1946–1950	41870	23681	18189	43%
1951–1955	49076	31349	17727	36%
1956–1960	56447	39608	16839	30%
1961–1965	58000	42832	15168	26%

Figure 6: Projections of Retirement Resource Insufficiency for Single Women in Minnesota

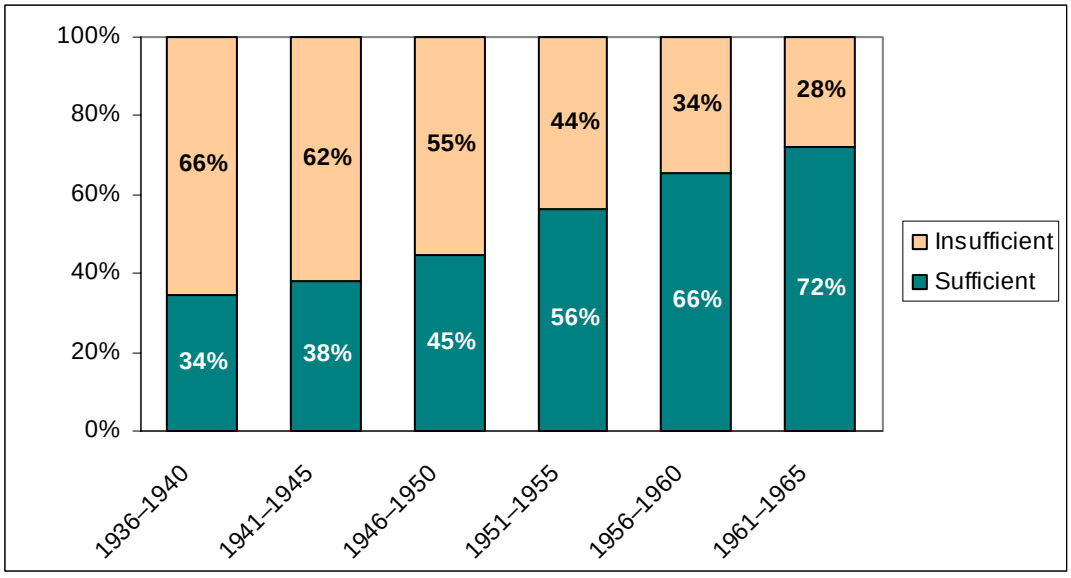


While single women are one group at a disadvantage, not unexpectedly people who retire at lower income levels are also disproportionately at risk. Table 5 details the number and percentage of Minnesotans in the lowest income quartile who are projected to have insufficient income and wealth to privately finance their retirement and long-term care needs.

Table 5: Projections of Retirement Resource Insufficiency for Minnesotans in the Lowest Income Quartile (even with 5% additional savings)

Birth Cohort	Total in Lowest Income Quartile	Sufficient Retirement Resources	Insufficient Retirement Resources	
			Estimated number	Percent of birth cohort
1936–1940	43802	15067	28735	66%
1941–1945	56354	21358	34996	62%
1946–1950	74611	33509	41101	55%
1951–1955	89483	50205	39278	44%
1956–1960	102464	67230	35234	34%
1961–1965	101718	73416	28302	28%

Figure 7: Projections of Retirement Resource Insufficiency for Minnesotans in the Lowest Income Quartile



In both the case of single women and those Minnesotans in the lowest income quartile, the percentage estimated to have insufficient retirement resources is lower for the younger birth cohorts. This can be attributed to the fact that the additional savings incorporated in the model have a longer time to accumulate.

These estimates provide a sense of the magnitude of the challenge Minnesota faces. This combination of results from a national model of retirement security and demographic patterns in Minnesota produces an estimated that more than one-fifth of future retirees may not have the resources necessary to meet their long-term care needs in addition to their basic retirement expenses at some point during their retirement[3].

Results: Year-by-Year Estimates of the Number of Retirees at Risk

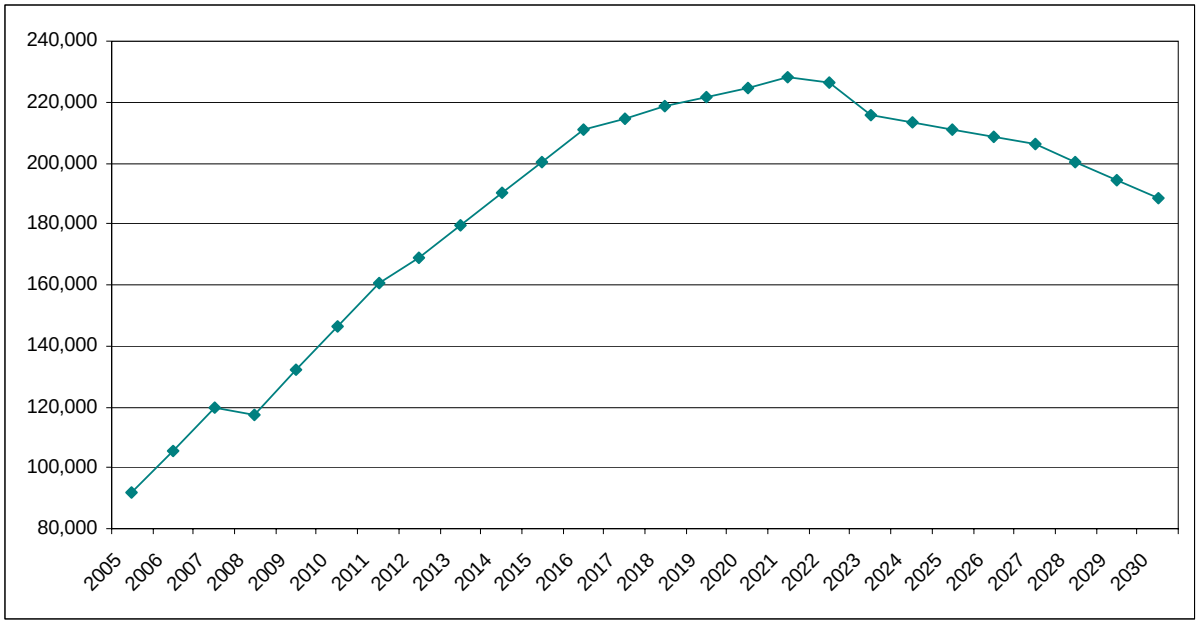
The numbers above are based on the number of people alive in 2000 and the prediction is that they will have problems at some time in the future after retirement. The next step in the estimation combines these results with a temporal component that accounts for mortality as the people in the birth cohorts age and the year in which they are eligible for full Social Security retirement benefits. Although information on when people experience a gap between their financial resources and needs is not available, we do know that this is limited to the years between retirement and death. The goal of this year-by-year approach is to estimate how many Minnesota retirees will be at risk of having insufficient resources each year from 2005 to 2030.

These estimates start with the number of people who will be at retirement age in 2005. Each year additional retirees are added in, while the number of people who are predicted to have died based on life tables that consider age and gender are removed.

Figure 8 presents the number of Minnesotans these projections estimate are at risk of having insufficient retirement resources. In 2005 the projected number is 89,861 and rises through 2021 to 225,923. After 2021 the projected number levels off, then declines slightly and ends at 186,133 in 2030. Projecting beyond 2030 is not possible because the EBRI results that are essential to these projections do not include people born after 1965, making it impossible to add in new retirees in years farther in the future.

[3] The EBRI model estimates available resources and projected expenses from the time of retirement until the estimated year of death. A person is counted as having insufficient resources if expenses exceed resources at any point post–retirement. The results do not specify when (at what age or at how many years into retirement) a person begins to have a deficit.

Figure 8: Number of Retired Minnesotans Projected to have Insufficient Resources even with 5% Increased Savings[4]



These estimates are sensitive to the assumptions that could not be removed from the model results before combining them with Minnesota demographic data. The EBRI analysis used assumes that everyone saves an additional 5% of their compensation from now until they retire. This additional savings accumulates for a longer period for the younger cohorts, increasing the percent estimated to have sufficient income and wealth by retirement. For this reason the estimate is increasingly conservative for younger cohorts (who can continue this additional savings for a longer period of time). Table 6 provides the detailed estimates for each year by gender and marital status.

[4] The EBRI estimate of the percentage of people in each subgroup with and without sufficient retirement resources includes the assumption that people begin saving an additional 5% of compensation in 2003 and continue until they retire. This assumption may make this a conservative estimate (the number without sufficient resources would be greater without this additional savings) as people who were able to start this additional savings at a younger age will have accumulated more wealth before retirement.

Table 6: Estimates of the Cumulative Number of Minnesota Retirees at Risk of Retirement Income Insufficiency (even with 5% additional savings)

Year	Single Men	Married Men	Single Women	Married Women	Total
2005	9,228	32,700	15,608	32,325	89,861
2006	10,906	37,708	18,123	36,839	103,576
2007	12,687	42,495	20,925	41,622	117,729
2008	12,347	41,341	20,562	40,899	115,149
2009	13,984	46,701	23,334	46,193	130,213
2010	15,401	51,862	25,856	51,248	144,366
2011	17,261	56,333	28,376	56,519	158,489
2012	18,446	58,272	30,657	59,324	166,698
2013	20,192	61,113	33,114	63,029	177,448
2014	22,116	64,200	35,456	66,688	188,461
2015	23,845	66,297	37,913	70,068	198,123
2016	25,752	68,711	40,747	73,498	208,708
2017	26,855	68,624	42,607	74,462	212,548
2018	27,945	68,636	44,621	75,383	216,586
2019	28,969	68,491	46,074	76,245	219,779
2020	30,034	67,888	47,796	76,948	222,665
2021	31,073	67,494	49,736	77,620	225,923
2022	31,316	65,575	50,836	76,685	224,412
2023	29,752	61,657	48,978	73,486	213,872
2024	29,821	59,559	49,655	72,154	211,189
2025	30,324	57,485	50,557	70,814	209,180
2026	30,402	55,406	51,367	69,300	206,475
2027	30,571	53,366	52,185	67,800	203,922
2028	30,073	50,503	52,534	65,270	198,380
2029	29,570	47,594	52,433	62,658	192,255
2030	28,858	44,757	52,560	59,958	186,133

Summary

The results of national models of retirement income resources and estimates of whether future retirees will be able to privately pay for their long-term care needs have understandably raised concerns that reliance on public programs for long-term care will exceed capacity and that there will be increasing demands placed on state Medicaid budgets. While different studies have reported different results, if even the relatively optimistic estimates are correct, states face the possibility of significant increases in Medicaid and other public program expenditures for long-term care as the baby boom generation ages. Minnesota has several advantages in that its population is wealthier, slightly younger, less disabled, and more likely to be married and therefore, may have more informal supports and higher income at their disposal (see Appendix 2 for details). However, it is unrealistic to assume that these differences will be sufficient to protect Minnesota from the risk this Issue Brief has attempted to enumerate.

Combining the estimates from a national model of retirement income security created by EBRI with Minnesota-specific data results in estimates that as many as 24% (over 441,000 out of 1.8 million) of Minnesotans born from 1936 to 1965 may not have sufficient resources to privately finance both their general needs during retirement and any formal long-term care services they may require at some point during their retirement. Not unexpectedly, single women and people who are in the lowest income quartile at retirement are at higher risk of having insufficient resources than are people who are married and retire at higher levels of income. As these Minnesotans retire and age, the numbers of people projected to not have enough resources each year increases dramatically from approximately 90,000 in 2005 to over 225,000 in 2021. While experience suggests that some people will "get by" without formal services and others will go to extreme measures to avoid using Medicaid, such a large increase in the number of people without sufficient resources is likely to translate into a corresponding increase in the need for Medicaid support when long-term care services are required.

These estimates for Minnesota—based on national models—highlight the need to diffuse the impact on state budgets and improve the health and well-being of Minnesota's older citizens. The finding that younger members of the baby boom generation are more likely to have sufficient resources with a 5% increase in savings underscores the potential of savings as one approach to this problem. Likewise, the fact that even this increased savings is unlikely to be the solution for a significant portion of the population provides the motivation to consider other financial and non-financial approaches. New policies, demonstrations and experiments are needed to reform a financing system that most people find disjointed and irrational, and to create incentives for individuals to plan for and privately finance their long-term care. Additionally these finding suggest that financial solutions alone will not be enough. Programs and policies that encourage informal care, prevent or delay the onset of disability, and promote the development of supportive communities could reduce the need for formal long-term care services and help some people avoid reaching the point where their needs exceed their resources.

The future of the Minnesota economy, as well as public financing for long-term care, will depend on plans and policies made today and in the very near future. Without reform, the public safety net for long-term care will become overextended and less viable, while a growing number of older citizens will shift from contributing to the state's economy in myriad roles such as consumers and volunteers, to depending on the state for basic care.

Faced with this scenario, the current focus of the public policy discussion is on how to leverage private and public dollars to help assure that the majority of people will be able to obtain the long-term care services they may need. Most experts agree that something needs to be done, but there is less consensus surrounding what incentives are likely to be effective. This is due in part to the lack of data and the barriers to obtaining state-level estimates of retirement income, the need for long-term care, and present and future costs of programs and policies.

This Issue Brief is the first in a two-part series on long-term care financing. The second Issue Brief evaluates policy options in terms of (1) their ability to improve that likelihood that retirees will be able to privately finance their long-term care and (2) the estimated present and future costs to the state of Minnesota. Both of these briefs were produced under a contract from the Minnesota Department of Human Services to the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota (www.shadac.org). More information about the long-term care financing reform initiative in Minnesota can be found at:
http://www.dhs.state.mn.us/main/groups/aging/documents/pub/DHS_id_003448.hcsp

Appendix 1: Three Examples of Studies of Retirement Security

	Source		
	VanDerhei and Copeland, 2003	**Knickman and Snell, 2002**	**Scholtz et al., 2004**
Model	EBRI-ERF Retirement Security Projection Model	Long Term Care Financing Model (Lewin)	Optimal preparation for retirement incorporating a life-cycle model of decisions
Sample	10 million 401 (k) participants	Complete March 1994 Current Population Survey Sample	6,322 households
Principal Data Source	6 years of data from EBRI data base on 401(k) participants and retirement plans	April 1993 and March 1994 Current Population Survey	Health and Retirement Survey (HRS)
Age Cohorts	Born 1936-1965	All 65 and over in 2000, 2015 and 2030	Born 1931-1941
Source of Data on Income	EBRI data; National Surveys (SCF, CPS and SIPP) and US Dept. of Labor Form5500 For initial wages, participation in pensions/IRAs and account balance.	The Pension and Retirement Income Simulation Model (PRISM)	41 years of Earnings from Social Security Records use to simulate future earns and SS payments
Assumptions: return investments	Social Security Administration's MINT model	Intermediate Scenario in 1999 Social Security Trustees Report	4% real rate of return
Data on non Long-Term Care Retirement Expenses	Consumer Expenditure Survey (national and regional); Average Medicare Part B & Supplemental Premiums	Not part of model	Not part of model
Data on LTC	1999 National Nursing Home Survey & the 200 National Home and Hospice Care Survey Probabilities calculated for each year based on demographics and the surveys above	1994 National Long Term Care Survey for disability prevalence rates Not always included—one analysis estimates if persons can afford long-term care, whether they need it or not	Not part of model
Cost of Long-Term Care	Based on national estimate of what person will pay for simulated length of stay. Medicaid payments are not considered in deficit calculations	Based on cost of 3 year stay in a nursing home in most parts of the US	Uses replies to 4 HRS questions about out-of-pocket expenses for medical expenses
Overall Conclusions	Given current patterns of savings Americans will have $45 billion less then they need in retirement. Increasing savings now would provide some future retirees with enough resources to meet both basic expenses and long-term care needs	Optimistic that that private wealth will be available for needed services in retirement. "The elderly will be much wealthier and better able to handle health-related financial shocks in 2030 then they were in 2000."	80 of households will have enough retirement wealth; this declines to 58% if only half of home equity is counted
Groups most at risk	Women single at retirement; People in the lowest income quartile.	People over 75, the disabled elderly and the single elderly	Single compared to married households (married 27.2 percentage points less likely to have deficit
Utility for state level estimates	Estimates done for OR, KS, MA	Unclear. Would need to be assessed by Lewin	May depend on representation in HSR; model takes 6 days to run

Appendix 2: How the Minnesota Population differs from the US Population:
Comparison of Minnesotans and US Population (born 1936-1965) on key Characteristics

	Minnesota	US Population
Household Type		
Married	73.1%	69.1%
Single Women	14.0%	17.2%
Single Men	12.9%	13.8%
Age Distribution		
% younger (35-50 in 2000)	66.2%	64.7%
Disabilities (% reporting that they have a disability)		
Disability that affects work	9.2%	13.3%
Disability limiting mobility	4.0%	7.0%
Personal Care Limitation	1.4%	2.3%
Physical Difficulties	6.4%	8.9%
Difficulty Remembering	3.0%	4.1%
Vision or Hearing Difficulty	2.2%	3.0%
Total Personal Income		
25% percentile	8,000	5,800
50% (median)	21,300	18,000
75% percentile	38,000	35,000

Source: Ruggles, S, M. Sobek, et al., 2004

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A bill for an act

relating to health; requiring the commissioner of commerce to study provision of language interpreter services.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [LANGUAGE INTERPRETER SERVICES STUDY.]

The commissioner of commerce, in consultation with the commissioners of health, human services, and employee relations, and representatives of health plan companies, health care providers, and limited-English-speaking communities, shall study and make recommendations on providing language interpreter services to limited-English-speaking patients in order to facilitate the provision of health care services by health care providers and health care facilities. The recommendations shall include:

(1) ways to achieve the needed availability of professional interpreter services and an accreditation system for language interpreters, which includes appropriate standards for education, training, and credentialing; and

(2) criteria for determining financial responsibility for providing interpreter services to enrollees of health plans, including the responsible party for arranging interpreter services and for reimbursement for these services.

The commissioner of commerce shall submit these recommendations to the legislature by January 15, 2006.

795-1A

Fiscal Note – 2005-06 Session

Bill #: S0795-1A **Complete Date:** 03/08/05

Chief Author: HIGGINS, LINDA

Title: HEALTH PLAN CO INTERPRETER SVC STUDY

Fiscal Impact	Yes	No
State		X
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Commerce

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
-- No Impact --					
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
-- No Impact --					
Revenues					
-- No Impact --					
Net Cost <Savings>					
-- No Impact --					
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

Senate Counsel, Research, and Fiscal Analysis

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Senate

State of Minnesota

S.F. No. 795 - Language Interpreters (First Engrossment)

Author: Senator Linda Higgins

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801) KJC

Date: March 25, 2005

S.F. No. 795 requires the Commissioner of Commerce to study and make recommendations on providing language interpreter services to limited English-speaking patients in order to facilitate the provision of health care services by health care providers and facilities. The recommendations must include:

(1) ways to ensure the availability of professional language interpreter services and an accreditation system for language interpreters; and

(2) criteria for determining responsibility for providing interpreter services to enrollees of health plans, including determining the responsible party for arranging for interpreters and paying for the service.

The commissioner must submit these recommendations to the Legislature by January 15, 2006.

KC:vs

☑ VOTE YES!

HF 757 (Abeler)/SF 795 (Higgins)
Language Interpreter Services Study

- Health care evaluation and treatment requires clear communication between the patient and doctor, nurse or therapist to be effective.

- Language barriers impede this essential communication and may even result in an inaccurate diagnosis or poor patient compliance with treatment recommendations.

- Minnesota has been the destination for immigrants seeking new opportunities throughout its history. Recent waves of immigration largely from Somalia, Laos, Vietnam and numerous Spanish-speaking countries is enriching our communities in may ways, but also impacting how we provide services. Because many immigrants speak little or no English, it is essential that qualified interpreters be available when non-English speakers require health care services.

- Federal law, the Civil Rights Act of 1964 Title VII, requires health care providers to arrange for interpreter services, yet provides no payment mechanism.

- Minnesota law currently requires many payers to either provide translators or reimburse clinics and hospitals for these important services.

    - PMAP requires participating health plans to provide language interpreters and they all comply by keeping a roster of trained interpreters who are available on request.

    - Workers' Compensation insurance carriers are required to pay for language interpreter services.

    - No-Fault Auto insurance carriers are required to pay for language interpreter services for the benefit of persons injured in auto accidents.

    - Medical Assistance pays a small fee ($25/hour) for language interpreter services for eligible individuals.

- The balance of payers, including health plans such as Medica, Blue Cross and Blue Shield, and HealthPartners, are currently not required to reimburse for language interpreter services. Unreimbursed costs for language interpreter services falls disproportionately on clinics and hospitals located in communities with substantial numbers of recent immigrants.

- The study requires providers, health plans, translators and state agencies to work together in finding alternative forms of reimbursement, translator credentialing and coordination of efforts.

Please join these organizations
in supporting the

Language Interpreter Services Bill
SF 795 (Higgins)/HF 757 (Abeler)

Minnesota Medical Group Management Association

Minnesota Medical Association

Minnesota Academy of Ophthalmology

Hennepin Medical Society

Ramsey Medical Society

Minnesota Provider Coalition

Minnesota Society of Anesthesiologists

Hennepin Faculty Associates

Hennepin County Medical Center

Minnesota Rural Health Association

To: Senator Cohen, Chair

Committee on Finance

Senator Berglin,

Chair of the Health and Human Services Budget Division, to which was referred

S.F. No. 795: A bill for an act relating to health; requiring the commissioner of commerce to study provision of language interpreter services.

Reports the same back with the recommendation that the bill be amended as follows:

Page 1, line 10, delete "and" and after the second comma, insert "and communities who communicate through sign language,"

Page 1, line 12, after "patients" insert "and patients who communicate through sign language"

Page 1, line 21, delete "enrollees of health plans" and insert "patients"

Page 1, line 22, after "party" insert "or parties"

And when so amended that the bill be recommended to pass and be referred to the full committee.

Linda Berglin
(Division Chair)

March 30, 2005
(Date of Division action)

Senators Berglin, Foley, Koering, Lourey and Rosen introduced--
S.F. No. 1569: Referred to the Committee on Finance.

A bill for an act

relating to human services; changing long-term care provisions; amending Minnesota Statutes 2004, sections 144A.071, subdivision 1a; 256B.0913, subdivision 8; 256B.0915, subdivisions 1a, 6, 9.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

ARTICLE 1

LONG-TERM CARE FACILITIES

Section 1. Minnesota Statutes 2004, section 144A.071, subdivision 1a, is amended to read:

Subd. 1a. [DEFINITIONS.] For purposes of sections 144A.071 to 144A.073, the following terms have the meanings given them:

(a) "Attached fixtures" has the meaning given in Minnesota Rules, part 9549.0020, subpart 6.

(b) "Buildings" has the meaning given in Minnesota Rules, part 9549.0020, subpart 7.

(c) "Capital assets" has the meaning given in section 256B.421, subdivision 16.

(d) "Commenced construction" means that all of the following conditions were met: the final working drawings and specifications were approved by the commissioner of health; the construction contracts were let; a timely construction schedule was developed, stipulating dates for beginning, achieving various stages, and completing construction; and all zoning and building permits were applied for.

(e) "Completion date" means the date on which a certificate of occupancy is issued for a construction project, or if a certificate of occupancy is not required, the date on which the construction project is available for facility use.

(f) "Construction" means any erection, building, alteration, reconstruction, modernization, or improvement necessary to comply with the nursing home licensure rules.

(g) "Construction project" means:

(1) a capital asset addition to, or replacement of a nursing home or certified boarding care home that results in new space or the remodeling of or renovations to existing facility space; and

(2) the remodeling or renovation of existing facility space the use of which is modified as a result of the project described in clause (1). This existing space and the project described in clause (1) must be used for the functions as designated on the construction plans on completion of the project described in clause (1) for a period of not less than 24 months~~;-or~~

~~(3)-capital-asset-additions-or-replacements-that-are completed-within-12-months-before-or-after-the-completion-date of-the-project-described-in-clause-(1).~~

(h) "Depreciation guidelines" means the most recent publication of "The Estimated Useful Lives of Depreciable Hospital Assets," issued by the American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois, 60611.

(i) "New licensed" or "new certified beds" means:

(1) newly constructed beds in a facility or the construction of a new facility that would increase the total number of licensed nursing home beds or certified boarding care or nursing home beds in the state; or

(2) newly licensed nursing home beds or newly certified boarding care or nursing home beds that result from remodeling of the facility that involves relocation of beds but does not result in an increase in the total number of beds, except when the project involves the upgrade of boarding care beds to

nursing home beds, as defined in section 144A.073, subdivision 1. "Remodeling" includes any of the type of conversion, renovation, replacement, or upgrading projects as defined in section 144A.073, subdivision 1.

~~(i)~~ (j) "Project construction costs" means the cost of the following items that have a completion date within 12 months before or after the completion date of the project described in item (g), clause (1):

(1) facility capital asset additions~~,~~;

(2) replacements~~,~~;

(3) renovations~~, or~~;

(4) remodeling projects~~,~~;

(5) construction site preparation costs~~, and~~;

(6) related soft costs~~. Project construction costs include the cost of any remodeling or renovation of existing facility space which is modified as a result of the construction project. Project construction costs also includes the cost of new technology implemented as part of the construction project. Project construction costs also include~~; and

(7) the cost of new technology implemented as part of the construction project and depreciable equipment directly identified to the project, if the construction costs for clauses (1) to (6) exceed the threshold for additions and replacements stated in section 256B.431, subdivision 16. ~~Any new~~ Technology and depreciable equipment shall be included in the project construction costs ~~shall, at the~~ unless a written election ~~of~~ is made by the facility, ~~be included~~ to not include it in the facility's appraised value for purposes of Minnesota Rules, part 9549.0020, subpart 5~~, and~~. Debt incurred for ~~its~~ purchase of technology and depreciable equipment shall be included as allowable debt for purposes of Minnesota Rules, part 9549.0060, subpart 5, items A and C, unless the written election is to not include it. Any new technology and depreciable equipment included in the project construction costs that the facility elects not to include in its appraised value and allowable debt shall be treated as provided in section 256B.431, subdivision

17, paragraph (b). Written election under this paragraph must be included in the facility's request for the rate change related to the project, and this election may not be changed.

~~(j)~~ (k) "Technology" means information systems or devices that make documentation, charting, and staff time more efficient or encourage and allow for care through alternative settings including, but not limited to, touch screens, monitors, hand-helds, swipe cards, motion detectors, pagers, telemedicine, medication dispensers, and equipment to monitor vital signs and self-injections, and to observe skin and other conditions.

ARTICLE 2

CONTINUING CARE FOR THE ELDERLY

Section 1. Minnesota Statutes 2004, section 256B.0913, subdivision 8, is amended to read:

Subd. 8. [REQUIREMENTS FOR INDIVIDUAL CARE PLAN.] (a) The case manager shall implement the plan of care for each alternative care client and ensure that a client's service needs and eligibility are reassessed at least every 12 months. The plan shall include any services prescribed by the individual's attending physician as necessary to allow the individual to remain in a community setting. In developing the individual's care plan, the case manager should include the use of volunteers from families and neighbors, religious organizations, social clubs, and civic and service organizations to support the formal home care services. The county shall be held harmless for damages or injuries sustained through the use of volunteers under this subdivision including workers' compensation liability. The ~~lead agency~~ county of service shall provide documentation in each individual's plan of care and, if requested, to the commissioner that the most cost-effective alternatives available have been offered to the individual and that the individual was free to choose among available qualified providers, both public and private, including qualified case management or service coordination providers other than those employed by ~~the lead agency when the lead agency~~ any county; however, the county or tribe maintains responsibility for prior

authorizing services in accordance with statutory and administrative requirements. The case manager must give the individual a ten-day written notice of any denial, termination, or reduction of alternative care services.

(b) ~~If~~ The county ~~administering alternative care services is different than the county of financial responsibility, the care plan may be implemented without the approval~~ of service must provide access to and arrange for case management services, including assuring implementation of the plan. The county of service must notify the county of financial responsibility of the approved care plan and the amount of encumbered funds.

Sec. 2. Minnesota Statutes 2004, section 256B.0915, subdivision 1a, is amended to read:

Subd. 1a. [ELDERLY WAIVER CASE MANAGEMENT SERVICES.] (a) Elderly case management services under the home and community-based services waiver for elderly individuals are available from providers meeting qualification requirements and the standards specified in subdivision 1b. Eligible recipients may choose any qualified provider of elderly case management services.

(b) The county of service or tribe must provide access to or arrange for case management services.

Sec. 3. Minnesota Statutes 2004, section 256B.0915, subdivision 6, is amended to read:

Subd. 6. [IMPLEMENTATION OF CARE PLAN.] Each elderly waiver client shall be provided a copy of a written care plan that meets the requirements outlined in section 256B.0913, subdivision 8. ~~If~~ The care plan must be implemented by the county administering waivered services when it is different than the county of financial responsibility, ~~the care plan may be implemented without the approval of~~. The county administering waivered services must notify the county of financial responsibility of the approved care plan.

Sec. 4. Minnesota Statutes 2004, section 256B.0915, subdivision 9, is amended to read:

Subd. 9. [TRIBAL MANAGEMENT OF ELDERLY WAIVER.]

Notwithstanding contrary provisions of this section, or those in other state laws or rules, the commissioner ~~and White Earth reservation~~ may develop a model for tribal management of the elderly waiver program and implement this model through a contract between the state and ~~White Earth Reservation~~ any of the state's federally recognized tribal governments. The model shall include the provision of tribal waiver case management, assessment for personal care assistance, and administrative requirements otherwise carried out by counties but shall not include tribal financial eligibility determination for medical assistance.

Senate Counsel, Research, and Fiscal Analysis

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JO ANNE ZOFF SELLNER
DIRECTOR

Senate
State of Minnesota

S.F. No. 1569 - DHS Long-Term Care Policy Changes

Author: Senator Linda Berglin

Prepared by: David Giel, Senate Research (296-7178)

Date: March 28, 2005

S.F. No. 1569 makes a number of changes in statutes governing DHS long-term care programs.

ARTICLE 1
LONG-TERM CARE FACILITIES

Section 1 (144A.071, subdivision 1a) amends the list of definitions in the statute establishing the nursing home bed moratorium by adding a definition of "depreciation guidelines" and modifying several existing definitions. The definition of "project construction costs" is amended to provide that certain costs will be counted as construction costs unless the facility elects not to include them in appraised value.

ARTICLE 2
CONTINUING CARE FOR THE ELDERLY

Section 1 (256B.0913, subdivision 8) modifies the Alternative Care Program by transferring to the county of service from the county of financial responsibility certain duties, including the duty to arrange for case management services.

Section 2 (256B.0915, subdivision 1a) requires the county of service or the tribe to provide access to or arrange for Elderly Waiver (EW) case management services.

Section 3 (256B.0915, subdivision 6) clarifies that an EW care plan must be implemented by the county of service when another county has financial responsibility, and the county of service must notify the financially responsible county of the approved plan.

Section 4 (256B.0915, subdivision 9) expands to all tribal governments an EW pilot program now involving only the White Earth reservation. The program, operated through a contract between the state and the tribe, includes the provision of tribal waiver case management, assessment for personal care assistance, and administrative duties otherwise carried out by counties.

DG:rdr

Fiscal Note – 2005-06 Session

Bill #: S1569-0 **Complete Date:** 03/28/05

Chief Author: BERGLIN, LINDA

Title: MODIFY LONG TERM CARE PROVISIONS

Fiscal Impact	Yes	No
State		X
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Human Services Dept

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
-- No Impact --					
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
-- No Impact --					
Revenues					
-- No Impact --					
Net Cost <Savings>					
-- No Impact --					
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

NARRATIVE: SF 1569/HF 1951

Bill Description

Article 1

Section 1 - clarifies if a facility does not provide the department with a written election of their intention, the department will include the depreciable equipment and technology costs in their building construction project. The language also clarifies that facilities conducting small projects already receive an equipment allowance that covers their equipment and technology costs.

Article 2

Section 1, 2, and 3 - seeks to restore in law the county of service as the responsible agency for arranging case management services to reflect the current practice and policy in the Alternative Care and Elderly Waiver programs.

Section 4 - allows any Minnesota Tribe to manage Elderly Waiver or Personal Care Attendant services for their members. It provides eligible persons with a choice in management of their services between the county or tribe. This provision does not increase costs because it does not expand eligibility. The number of persons anticipated to be served by the tribes is expected to be small.

Assumptions

None.

Expenditure and/or Revenue Formula

This is a Department policy bill and has no fiscal impact.

Long-Term Fiscal Considerations

None.

Local Government Costs

None.

References/Sources

Continuing Care Research and Analysis

Agency Contact Name: Amy Dellwo 296-1368
FN Coord Signature: STEVE BARTA
Date: 03/23/05 Phone: 296-5685

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 03/28/05 Phone: 286-5618

To: Senator Cohen, Chair

Committee on Finance

Senator Berglin,

Chair of the Health and Human Services Budget Division, to which was referred

S.F. No. 1569: A bill for an act relating to human services; changing long-term care provisions; amending Minnesota Statutes 2004, sections 144A.071, subdivision 1a; 256B.0913, subdivision 8; 256B.0915, subdivisions 1a, 6, 9.

Reports the same back with the recommendation that the bill be amended as follows:

Page 5, line 22, delete "or" and insert "and"

And when so amended that the bill be recommended to pass and be referred to the full committee.

Linda A. Berglin
(Division Chair)

March 30, 2005
(Date of Division action)

A bill for an act

relating to health; providing for education of parents, primary caregivers, and child care providers on the dangers associated with shaking infants and young children; proposing coding for new law in Minnesota Statutes, chapters 144; 245A.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [144.574] [EDUCATION ABOUT THE DANGERS OF SHAKING INFANTS AND YOUNG CHILDREN.]

Subdivision 1. [EDUCATION BY HOSPITALS.] (a) A hospital licensed under sections 144.50 to 144.56 shall make available for viewing by the parents of each newborn baby delivered in the hospital a video presentation on the dangers associated with shaking infants and young children.

(b) A hospital shall use a video obtained from the commissioner or approved by the commissioner. The commissioner shall provide to a hospital at cost copies of an approved video. The commissioner shall review other video presentations for possible approval upon the request of a hospital. The commissioner shall not require a hospital to use videos that would require the hospital to pay royalties for use of the video, restrict viewing in order to comply with public viewing or other restrictions, or be subject to other costs or restrictions associated with copyrights.

(c) A hospital shall, whenever possible, request both parents to view the video. The patient's chart shall indicate

whether the parents are offered an opportunity to view the video.

(d) The showing or distribution of the video shall not subject any person or facility to any action for damages or other relief provided the person or facility acted in good faith.

Subd. 2. [EDUCATION BY HEALTH CARE PROVIDERS.] The commissioner shall establish a protocol for health care providers to educate parents and primary caregivers about the dangers associated with shaking infants and young children. The commissioner shall request family practice physicians, pediatricians, and other pediatric health care providers to review these dangers with the parents and primary caregivers of infants and young children up to the age of three at each well-baby visit.

Sec. 2. [245A.034] [CHILD CARE PROVIDER TRAINING; DANGERS OF SHAKING INFANTS AND YOUNG CHILDREN.]

The commissioner shall make available for viewing by all licensed and legal nonlicensed child care providers a video presentation on the dangers associated with shaking infants and young children. The video presentation shall be part of the initial and ongoing training of licensed child care providers. Legal nonlicensed child care providers may participate at their option in a video presentation session offered under this section. The commissioner shall provide to child care providers at cost copies of a video approved by the commissioner of health under section 144.574 on the dangers associated with shaking infants and young children.

Senate Counsel, Research, and Fiscal Analysis

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DIRECTOR

Senate

State of Minnesota

S.F. No. 538 - Hospital and Health and Child Care Providers Videos or Education on Dangers of Shaking Infants and Young Children (First Engrossment)

Author: Senator Dean Johnson

Prepared by: Joan White, Senate Counsel (651/296-3814)

Date: March 23, 2005

S.F. No. 538 educates new parents, health care professionals, and child care providers on the dangers associated with shaking infants and young children.

Section 1, subdivision 1, requires a hospital to make available for viewing by parents of newborns a video presentation on the dangers associated with shaking infants and young children. The hospital is required to use a video obtained from the commissioner or approved by the commissioner, and the commissioner is required to provide the video at cost. The commissioner shall review other video presentations for possible approval upon the request of a hospital. The commissioner is prohibited from requiring hospitals to use videos that would require royalty payments, force hospitals to restrict viewing to comply with public viewing restrictions, or make hospitals subject to issues associated with copyrights.

> **Subdivision 2.** The Commissioner of Health is also required to establish a protocol for health care providers to educate parents and primary caregivers about the dangers associated with shaking infants and small children. The commissioner shall request family practice physicians, pediatricians, and other pediatric health care providers to review these dangers with parents and primary caregivers of infants and young children up to age three at each well-baby visit.

Section 2 requires the Commissioner of Human Services to make available for viewing by child care providers a video presentation on the dangers associated with shaking infants and young children. The video shall become part of the initial and ongoing training of licensed child care providers, and

legal nonlicensed providers may participate at their option in a video presentation session offered under this section. The commissioner is required to provide the video approved by the Commissioner of Health to child care providers at cost.

JW:rdr

Consolidated Fiscal Note – 2005-06 Session

Bill #: S0538-1A **Complete Date:** 03/18/05

Chief Author: JOHNSON, DEAN E.

Title: SHAKING INFANTS DANGER EDUCATION

Fiscal Impact	Yes	No
State	X	
Local		X
Fee/Departmental Earnings	X	
Tax Revenue		X

Agencies: Health Dept (03/18/05) Human Services Dept (03/15/05)

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Net Expenditures					
General Fund	0	59	43	43	43
Human Services Dept	0	0	0	0	0
Health Dept		59	43	43	43
Revenues					
General Fund		6			
Health Dept		6			
Net Cost <Savings>					
General Fund	0	53	43	43	43
Human Services Dept	0	0	0	0	0
Health Dept		53	43	43	43
Total Cost <Savings> to the State	0	53	43	43	43

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund		0.50	0.50	0.50	0.50
Health Dept		0.50	0.50	0.50	0.50
Total FTE		0.50	0.50	0.50	0.50

Consolidated EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: CRAIG WIEBER
Date: 03/18/05 Phone: 282-5065

Fiscal Note – 2005-06 Session

Bill #: S0538-1A **Complete Date:** 03/18/05

Chief Author: JOHNSON, DEAN E.

Title: SHAKING INFANTS DANGER EDUCATION

Fiscal Impact	Yes	No
State	X	
Local		X
Fee/Departmental Earnings	X	
Tax Revenue		X

Agency Name: Health Dept

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund		59	43	43	43
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund		59	43	43	43
Revenues					
General Fund		6			
Net Cost <Savings>					
General Fund		53	43	43	43
Total Cost <Savings> to the State		53	43	43	43

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund		0.50	0.50	0.50	0.50
Total FTE		0.50	0.50	0.50	0.50

Bill Description

This bill requires hospitals to offer parents of newborns a video presentation on the dangers associated with shaking infants and young children. Hospitals must use a video obtained from or approved by the Department. The Department must provide copies of an approved video at cost, and must review other videos for possible approval if requested by a hospital. The Department may not require hospitals to use a video that requires restrictions or additional costs associated with copyrights.

The bill also requires the Department to establish a protocol for health care providers to educate parents and primary care givers about the dangers associated with shaking infants and young children, and to request pediatric health care providers to review these dangers at well-baby visits.

Assumptions

- There are 110 birthing hospitals in Minnesota. The cost to the Department to copy and distribute copies of a video currently being used in Minnesota to the birthing hospitals would be about $13,000. This amounts to a cost of $53 per hospital. $6,000 (excluding royalty costs) would flow through the Department on a reimbursement basis in the first year of implementation.
- Assumes a half-time nurse to develop the protocol and work with hospitals, health care providers, and childcare providers to implement and maintain the education program for parents and primary care givers. It is assumed that this position would be responsible for reviewing other videos for possible approval if requested.

Expenditure and/or Revenue Formula

EXPENDITURES	Sfy05	SFY06	SFY07	SFY08	SFY09
Salary – .5 Public Health Nursing Advisor		$27,484	$27,484	$27,484	$27,484
Fringe 29%		7,970	7,970	7,970	7,970
Subtotal Sal & Fringe		$35,454	$35,454	$35,454	$35,454
Supplies & Exp:					
Communications		600	600	600	600
Travel expenses		1,500	1,500	1,500	1,500
Supplies		1,500	1,500	1,500	1,500
Desktop computer		2,000	0	0	0
Videos		13,000	0	0	0
Operation Support Services 9.7%		5,243	3,788	3,788	3,788
Subtotal S & E		$23,843	$7,388	$7,388	$7,388
TOTAL EXPENSES		$59,297	$42,842	$42,842	$42,842

Revenue: The $6,000 cost for the videos (excluding royalties) will be reimbursed.

Long-Term Fiscal Considerations

This is assumed to be on-going funding.

Local Government Costs

None.

References/Sources

This information was based on data maintained by the Department, information from the Midwest Children's Resource Center, and personal correspondence from the New York researcher, as well as on the department's experience with similar activities.

Agency Contact Name: Pati Maier (651-281-9882)
FN Coord Signature: MARGARET KELLY

Date: 03/16/05 Phone: 281-9998

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: CRAIG WIEBER
Date: 03/18/05 Phone: 282-5065

Fiscal Note – 2005-06 Session

Bill #: S0538-1A **Complete Date:** 03/15/05

Chief Author: JOHNSON, DEAN E.

Title: SHAKING INFANTS DANGER EDUCATION

Fiscal Impact	Yes	No
State		X
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Human Services Dept

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund	0	3	0	0	0
Less Agency Can Absorb					
General Fund	0	3	0	0	0
Net Expenditures					
General Fund	0	0	0	0	0
Revenues					
-- No Impact --					
Net Cost <Savings>					
General Fund	0	0	0	0	0
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

MARRATIVE: SF 538-1A

Bill Description
This bill would require the commissioner of the department of human services to make available for viewing by all licensed child care providers a video presentation on the dangers associated with shaking infants and young children. It also requires the video presentation be part of the initial and ongoing training of licensed child care providers. Legal non-licensed providers may participate in these video presentations at their option. It requires the commissioner to provide to child care providers at cost copies of the video that is approved by the commissioner of health.

Assumptions
The statewide infrastructure of regionally based Child Care Resource & Referral (CCR&R) agencies is the central resource for child care provider training, including training required for licensure and training for legal non-licensed providers registered by counties for payment under the child care assistance program.

Training related to the dangers associated with shaking infants and young children would be made available through the existing CCR&R training system for licensed providers by incorporating it into the initial licensure training. The training would be made available on an ongoing basis to meet the training interval required for renewing CPR and First Aid (repeated every three years).

There is no training requirement under current law for legal nonlicensed providers. We assume that the CCR&Rs will make the video available to legal nonlicensed providers who want to participate in viewing the video.
The training videos would be made available through the CCR&R sites for purchase at cost, check-out or on-site viewing/training for both licensed and nonlicensed providers.

The Department of Health currently has identified a video called "Portrait of Promise - Preventing Shaken Baby Syndrome" which is available at the cost of $15 (bulk rate) through the Midwest Children's Resource Center. The video is currently available in English, Spanish, Hmong, and Somali.

We assume two copies of this video in each language would be provided to the 19 CCR&R sites. The total cost for the 190 copies at $15 each (bulk rate) would be $2,850. The agency would absorb these costs.

Upon request, a copy of the video would be given to providers at cost.

Expenditure and/or Revenue Formula
Providers will be asked to pay the cost of the video copy, so there is no fiscal impact to the agency.

Long-term Fiscal Considerations

Local Government Costs

References/Sources
Barb Yates, Department of Human Services
Partnerships for Child Development
(651) 282-3804

Agency Contact Name: Jenny Ehrnst 282-2595
FN Coord Signature: STEVE BARTA
Date: 03/10/05 Phone: 296-5685

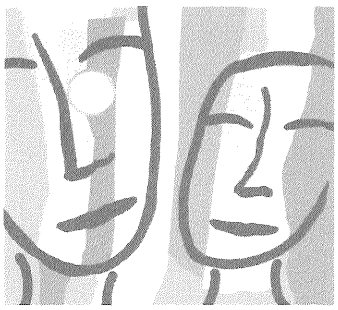
EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 03/15/05 Phone: 286-5618

Brain Injury Association of Minnesota

March 30, 2005



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Members of the Minnesota Senate Health and Human Services Budget Division
Testimony in support of SF 538

To Whom It May Concern:

The Brain Injury Association of Minnesota strongly supports Senator Dean Johnson's bill, Senate File (SF) 538. The Association serves the more than 94,000 Minnesotan's who have a disability as a result of traumatic brain injury.

- Each year, more than 3,500 Minnesotans are hospitalized due to Traumatic Brain Injury (TBI).
- In addition, another 10,000 individuals with TBI are treated only in the emergency room, each year about 1,500 TBI survivors will experience the onset of long-term disability and over 1,000 will die.
- Infants, age 0-1, have the second highest rate of traumatic brain injury of any age group under the age of 75.
- Battering/maltreatment is the second highest cause of brain injury among infants (16%), second only to falls (56%). Falls are based on care giver explanation and may involve some violence.

The economic consequences of brain injury are enormous.

- The cost of traumatic brain injury in Minnesota is estimated to be $1 billion annually. (Congressional Brain Injury Task Force) The annual cost of acute care and rehabilitation in Minnesota for new cases of TBI is estimated at $200 million.
- Approximately 1 in 4 adults with TBI is unable to return to work one year after injury.

Shaken Baby Syndrome (SBS), also know as inflicted traumatic brain injury, results from the violent shaking of an infant or small child causing a wide array of consequences that result in brain injury. It is a form of child abuse. Of these tiny victims, 25 -30% died as a result of their injuries. The rest, who live, will have lifelong complications as a result from their severe brain injury. SF 538 builds upon promising practices that have demonstrated a reduction in SBS.

You have heard from the Association previously about the staggering acute care cost of TBI, it is not unusual to run up hundreds of thousands of dollars in acute care expenses, spending months, even years in acute care settings. The Minnesota Department of Human Services reported eleven individuals with TBI in hospitals with an average length of stay of 2.34 years in 2001.

Follow that with a life time of long term care costs, and you can see soaring health care costs for decades to come. Preventing Shaken Baby Syndrome is good policy, it will save infants lives, it will prevent severe disabilities, it will save health care costs, and it is good policy for Minnesota. Please support SF 538.

For additional information or any questions on Shaken Baby Syndrome/Inflicted Brain Injury, please contact me.

Sincerely,

Tom Gode
Executive Director

To: Senator Cohen, Chair

Committee on Finance

Senator Berglin,

Chair of the Health and Human Services Budget Division, to which was referred

S.F. No. 538: A bill for an act relating to health; providing for education of parents, primary caregivers, and child care providers on the dangers associated with shaking infants and young children; proposing coding for new law in Minnesota Statutes, chapters 144; 245A.

Reports the same back with the recommendation that the bill be amended as follows:

Page 1, line 17, after "hospital" insert "and any interested individuals"

Page 2, line 20, delete "ongoing" and insert "annual"

Page 2, line 23, after "providers" insert "and any interested individuals"

Page 2, after line 26, insert:

"Sec. 3. [APPROPRIATION.]

$13,000 is appropriated from the state government special revenue fund to the commissioner of health for purposes of sections 1 and 2 for the biennium beginning February 1, 2005. The commissioner of health shall assess a fee to hospitals to cover the cost of the approved shaken baby video and royalties to be deposited in the state government special revenue fund."

Amend the title as follows:

Page 1, line 5, after the semicolon, insert "appropriating money;"

And when so amended that the bill be recommended to pass and be referred to the full committee.

Linda Berglin

(Division Chair)

March 30, 2005

(Date of Division action)