

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

A Report to the Minnesota Legislature

**Minnesota Department of Human Services
Continuing Care Administration**

January 15, 2005

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Executive Summary

This report examines the issue of financing long-term care¹ 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.

A. Background

The 2003 Minnesota Legislature called for a study of long-term care financing options. It required that the Department of Human Services complete a report that included a new mix of public and private approaches to the financing of long-term care. The report was to examine the feasibility of initiating a Partnership program; using state medical assistance funds to subsidize the purchase of private long-term care insurance by individuals unlikely to purchase it without a subsidy; adding a nursing facility benefit to Medicare-related coverage in Minnesota, and establishing government or private loans or lines of credits for individuals and families for the purpose of meeting long-term care needs.²

B. What This Report Includes

The department has been working on this study since it was commissioned in 2003. The decision was made early on to identify and analyze a broad array of potential public and private financing options in order to “leave no stone unturned” in the quest for practical and perhaps overlooked options for paying for long-term care. Because of that strategy, this report includes nine different financing options that were analyzed for their potential to maximize private dollars and minimize Medicaid liabilities. These include:

1. Long-term care insurance (LTCI) options, including the use of medical assistance funds to subsidize the purchase of private LTCI by individuals who would be unlikely to purchase it without a subsidy (specifically mentioned in the legislation).
2. The Partnership for Long-Term Care program (specifically mentioned in the legislation).
3. Adding a nursing facility benefit to Medicare-related coverage (specifically mentioned in the legislation).
4. Health insurance options that combine health and long-term care coverage.
5. Life insurance options that include long-term care coverage.
6. Reverse mortgages.
7. Family loan and line of credit program (specifically mentioned in 2003 legislation).
8. Universal long-term care savings plans, called CarePlus, passed by the Hawaii Legislature in 2003 and subsequently vetoed by the governor.
9. Long-term care annuities.

¹ Long-term care is defined as “assistance given over a sustained period of time to people who are experiencing long-term disabilities 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.

² The study of the loan program was held over from an earlier legislative report in order to complete analysis on all the financing options at the same time.

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. The intent was to identify which options have the greatest potential for achieving the state's policy goals, and to identify the most effective tools to increase the use of these options, such as tax incentives, regulation of financial or insurance products, consumer education and information, or targeted subsidy for specific products or groups. That analysis is not yet complete. It will be submitted to the Legislature as soon as it becomes available, by March 2005.

Thus, this report describes the current context of the state's long-term care financing problem and includes descriptive analyses of nine financing options. Also included are a proposed new mix of public and private approaches to the financing of long-term care, and more specific recommendations for next steps the state should take to address this critical issue. Attached to the report are two appendices, one that summarizes the results of "straw votes" by participants at the December 3 conference on long-term care financing, and another that provides detailed information on each of the options analyzed in this study.

C. Current Context of Long-Term Care Financing

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. Because of poor lifetime savings rates and fewer family members available to provide care, the sheer numbers of people needing and eligible for publicly funded long-term care by 2030 could overwhelm the state budget.

After 2020, the numbers of older persons needing long-term care will rise dramatically. The numbers will increase (even though age-specific disability rates are declining about 1 percent per year), because of the double-digit increases in older people in Minnesota between 2000 and 2030. Moreover, there are troubling signs that disability rates among the nonelderly (those under 65) are rising. Poor lifestyle choices are increasing levels of obesity, diabetes and other conditions. Rather than continuing to decline, our disability rates may unfortunately begin to rise in the future, putting even more pressure on the state's long-term care system.

Families now provide 91 percent of all the assistance needed by the elderly in Minnesota, down from 97 percent about 15 years ago. We expect that families will continue to be the major provider of care to the elderly in the future, but the overall amount provided could decline even more due to increased labor force participation by women ages 45 – 64 who are the typical caregivers. These caregivers will, out of necessity, increasingly reach out to community-based and formal long-term care services to supplement what they are able to provide.

Currently, long-term care for the elderly in Minnesota is paid for through Medicaid, Medicare (for short-term post-hospital care) and out-of-pocket expenditures by the elderly and their families, with a small portion paid by private insurance. 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.

If the dollar value of family caregiving is added to the total, the 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.

In addition, recent research on the adequacy of retirement income of future elderly to pay for necessary health and long-term care expenses provides both good and bad news. If *younger* boomers increase their savings by 5 percent of earnings for their remaining working years, most will have sufficient retirement income to pay for their health and long-term care expenses. However, large numbers of *current* elderly and *older* boomers, especially single women, will not have adequate retirement income to pay for their health and long-term care. For example, in 2001, the Survey of Older Minnesotans found that the median per capita annual income for persons 65+ was \$16,800.

Minnesota boomers are now moving into their pre-retirement years, and surveys indicate that they are thinking more about retirement and old age. As they care for their parents, they see what long-term care means and experience the inadequate patchwork of services and funding. This could prompt them to take responsibility to plan for their own long-term care.

D. Review and Analysis of Specific Financing Options

The report describes each of nine financing options that were reviewed during the study, presents information on the market for that option, and discusses the advantages and disadvantages of each option. The options include four insurance options, two that borrow money to pay for long-term care costs, and two that use savings for 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. Other benefits include the peace of mind that, if a catastrophic event happens, individuals will not be “wiped out” financially. The health insurance options have one distinct advantage over all the others: they not only provide a financing mechanism to pay for long-term care, but also have the potential to reduce or change the individual’s level of disability and thereby reduce the long-term care services needed.

Two options that borrow money were studied – reverse mortgages and the family loan program, an example of a loan or line of credit option. These options have somewhat higher costs than insurance because of the interest rates that are charged (as in all loans). However, they have the advantage of providing cash for long-term care almost immediately and the benefit of flexibility that cash offers, so that the money can be used for any purpose, e.g., making home modifications, paying for assisted living, paying for prescription drugs (in the case of the loan program the money goes to the long-term care provider). 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 only used if and when money is needed.

The options studied also included two savings options, one public savings option, namely the CarePlus program, and one private savings option, the long-term care annuity. (Personal savings and pensions were not specifically included, since these options are ones that should be used along with all the options studied here.) In the CarePlus option, if it were implemented as designed, participants would include all residents of a state that file income tax, i.e., a universal insurance and savings approach. As such, it is the least expensive per person (\$120/year) because the risk of needing long-term care is spread across the whole population. It requires that everyone pay in so that benefits will be available to those who need them. The private saving option, the long-term care annuity, probably requires the largest investment of any of the options, since it includes funding of an immediate annuity that pays additional cash income if long-term care is needed. Both of these options provide the flexibility of cash that can be used to pay for long-term care in any way the individual wishes.

E. Recommendations

The report proposes a new mix of public and private approaches to long-term care financing. These approaches address the issue at several levels. There is great concern about the financial burden that might be placed on Medicaid as the need for long-term care rises dramatically. Sending a clear message about the limits of Medicaid is critical. In addition, the state has the responsibility to encourage its citizens to take prudent steps and ensure that they are financially secure in their old age, even if they are not at great risk of ever spending down to Medicaid. The state also needs to pursue other key policy directions to improve the outlook for all its older residents as they face their long-term care.

Concerns about Future of Medicaid

At the heart of the issue of long-term care financing is the concern that, by 2030, more people than ever before will turn to Medicaid as the way to finance their long-term care. This could include those who are already “Medicaid-bound” as well as those who have been called the “tweeners,” that is, a group with lifetime income and assets adequate for retirement but inadequate for long-term care costs. Even the “financially independent” boomers, those who could self-fund their long-term care, may feel a sense of entitlement to a public program like Medicaid, because it pays for an expensive product that most people do not like and do not want to pay for with their own money.

The Medicaid challenge is a prime example of the policy debate going on now in the nation regarding what the balance should be between the responsibility of individuals to protect themselves against the risks and vicissitudes of old age, and the responsibility of government to provide universal programs that spread this risk across a whole population. The current Social Security and Medicare discussion are other examples where the same issues are being debated.

An important motivation for long-term care financing reform is that long-term care is a major contributor to the cost of the Medicaid program. Long-term care accounted for 49 percent of Medicaid spending in Minnesota in 2004. Given this context, it is simply not possible to address the future costs of Medicaid without addressing how long-term care will be financed.

Another motivator to reform long-term care financing is the current structure of Medicaid. Its current structure as a “welfare” program presents a number of perverse incentives to elderly and their families faced with long-term care costs. Critics claim that there are strong incentives to transfer assets using a number of legal mechanisms. Critics also claim that the program insulates individuals against the true risk of long-term care because they assume that “the state” will help pay for long-term care if all else fails. This attitude works against the message from insurance agents, financial planners and the government about the need to protect oneself against the risk of long-term care. A recent study goes even farther and concludes that the existence of Medicaid in its present form as a payer of last resort presents a fundamental impediment to the growth of any private coverage, and that changes in the structure of Medicaid are necessary but not sufficient to spur expansion in the private long-term care markets.

Eliminate mixed messages

While there are great differences and opposing points of view on these issues, this study found strong consensus in discussions with many stakeholders that, in the case of Medicaid, we need to eliminate the mixed messages that the general public receives about its personal responsibility for long-term care on the one hand, and perceptions of easy access to publicly funded long-term care on the other.

One of the most vocal critics of the Medicaid/long-term care provisions has completed an extensive profile of ten states and their relative support of private payment of long-term care vs. use of Medicaid. Minnesota is included in this analysis and is named as the best state of the top five “Private plus/Medicaid minus” states because of our balance of incentives and provisions that encourage personal responsibility and discourage reliance on the Medicaid program. This ranking reflects our strong Minnesota value of not being dependent, even though you may be entitled to assistance.

New Mix of Public and Private Approaches for Long-Term Care Financing

There are several policy approaches available to change the incentives within the current financing structure. Three approaches involve making it more difficult to voluntarily impoverish yourself to qualify for Medicaid benefits, creating more incentives for individuals to purchase or use private financing options, and, in order to prepare for the longer term, rethinking and restructuring the public and private responsibility for long-term care financing.

Three other approaches, while not focusing on individual financing, are just as necessary to meet future challenges in the financing of long-term care. These include increasing our efforts to support family caregivers, preventing disabilities that lead to long-term care costs in the first place, and increasing the number of “age-friendly” communities in Minnesota.

1. Implement the asset transfer waiver, once approved.

The 2003 Legislature required that the Department of Human Services apply to the federal government for an asset transfer waiver, which would limit the methods available to individuals to transfer their assets, presumably to voluntarily impoverish themselves in order to become eligible for Medicaid. The department submitted this request in March 2003 and it is still waiting for approval. Negotiations on the terms of the waiver are underway with CMS officials regarding specific issues in the waiver request. Implementing this plus other measures to tighten estate recovery would create disincentives for voluntary impoverishment.

2. Provide incentives for private payment of long-term care.

Minnesota needs to create incentives for individuals to take personal responsibility for their long-term care. One type of incentive is provision of credible, accurate information about the risk of long-term care, and what individuals can and should do about this. The state’s goal should be that every Minnesotan has a plan to address their long-term care needs as a part of their retirement plan. All the options reviewed in this report can play a role in helping individuals plan to meet their long-term care needs.

Another type of incentive is financial. The analysis being completed by University of Minnesota’s SHADAC by March 2005 will provide recommendations on the types of specific incentives that would be most effective and in the interest of the state to offer to individuals or employers to increase uptake of the various financing options described in this report. However, some general comments can be made now. From the state’s perspective, any financial incentives or subsidies need to target those most at risk of using Medicaid and help them purchase products that would delay their entry into Medicaid. The use of state funds for more general subsidy of persons whose income and assets make them unlikely Medicaid users does not achieve the intended goal of reducing the state’s Medicaid liability.

3. Rethink and restructure the public and private roles in long-term care financing.

During this study, there has been broad consensus among many stakeholders that the best long-term solution to this financing issue is to rethink and restructure the public and private roles in long-term care financing. This rethinking should include articulating a clear specific message about the level of personal responsibility that individuals have for their own long-term care, while articulating the level and type of assistance that the public sector will provide, similar to how the Partnership for Long-Term Care program now works.

4. Intensify our efforts to support family caregivers.

Even though families are stretched, they continue to have a deep sense of obligation to care for their spouses/parents in old age. For most elderly, family care is their preferred option. For many low-income elderly, family care is the only affordable option available. The dollar value of the enormous amount of care families provide is estimated at \$4.58 billion in Minnesota alone, and represents the largest funding source for long-term care support. If we assume that a loss of informal care will primarily affect those in greatest need and that the public sector supports about two-thirds of the cost of such care, *each percentage point drop in family caregiving means an additional \$30 million that the public sector must bear.* Thus, support of family caregivers is not just “nice;” it has enormous economic ramifications, and it is in the economic interest of the state to prevent future declines in the portion of care provided by families.

5. Prevent disability that causes the need for long term care.

Another way to address long-term care financing in the future is to promote strategies that emphasize healthy behaviors, and the personal responsibility of all to stay healthy and prevent illness and disability. We must also develop better models for delivering chronic care management so that future elderly can benefit from better care. Other important preventive strategies include increased use of technology, especially technology that helps people help themselves.

6. Increase the number of “age-friendly” communities in Minnesota.

Caring for the frail elderly in their homes is cheaper than caring for them in nursing homes. There is evidence that the elderly – even quite frail elderly – are able to stay in their current homes and communities if they have strong informal networks and their community offers certain essential physical, social and service supports that ease their ability to remain independent. Minnesota has excellent examples of age-friendly communities and many champions of this approach to building better communities. These efforts need to be expanded and made universal across the state.

Recommendations on Retirement and Long-Term Care Planning

Our research has documented that individuals are more likely to take action and make decisions regarding the use of long-term care financing options when they understand the need and the risks they may face as they retire and grow old. Our efforts to increase private financing of long-term care must be pursued within the broader context of retirement planning, especially in the workplace, where employees are already making retirement, health and other insurance decisions. We need to identify key “trigger points” within the lifecycle where retirement and long-term care planning can occur naturally, and “institutionalize” those trigger points.

The state needs to develop a comprehensive strategic plan for addressing its policy goal of helping Minnesotans plan for their retirement and old age.

1. The state needs to work with a broad coalition of employers, employees and those that develop and market insurance and financial products, to develop and implement this strategic plan.

- The plan should include a retirement and long-term care planning campaign to reach all workers between age 40 and 70 in the state. It should offer incentives for employers to provide individualized, comprehensive retirement planning and counseling, and provide materials, curriculum and other resources for distribution to employees.
- The state should seek funding in partnership with the University and employer groups to create a Minnesota Center for Retirement Security and Wellness, to work with Minnesota employers to develop and test a new generation of retirement, health and insurance benefits to support the state's aging workforce and address the need for retirement and long-term care planning.

2. The state should continue to seek designation as one of the next states to roll out the federally sponsored long-term care planning information and education campaign, which is now underway in five states across the nation.

Recommendations on Specific Financing Options

There is no “silver bullet” or one option that is the answer to the private financing of long-term care. Nearly all the options reviewed in this study have some potential to address the issue. Therefore, to maximize the utilization of private dollars, there needs to be a variety of options available to individuals, which utilize different combinations of insurance, borrowing, savings and informal care and other affordable options.

This report includes 16 recommendations on the specific financing options reviewed in this study, actions that can be taken to expand awareness and utilization of the options, develop additional products, improve consumer protection, and evaluate and monitor progress on the uptake of some of the newer options.

The University of Minnesota will be completing more detailed fiscal analyses of the impact of the various options on Medicaid savings and making recommendations to the state on which financial incentives have the greatest potential for achieving the state's policy goals of increasing uptake, maximizing private dollars and minimizing Medicaid liability.

I. Purpose of Report

This report examines the issue of financing long-term care³ 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.

Background

The 2003 Minnesota Legislature called for a study of long-term care financing options.

“The commissioner of human services shall report to the legislature by January 15, 2005, on long-term care financing reform. The report must include a new mix of public and private approaches to the financing of long-term care. The report shall examine strategies and financing options that will increase the availability and use of nongovernment resources to pay for long-term care, including new ways of using limited government funds for long-term care. The report shall examine the feasibility of: (1) initiating a long-term care insurance partnership program, similar to those adopted in other states, under which the state would encourage the purchase of private long-term care insurance by permitting the insured to retain assets in excess of those otherwise permitted for medical assistance eligibility, if the insured later exhausts the private long-term care insurance benefits. The report must include the feasibility of obtaining any necessary federal waiver; (2) using state medical assistance funds to subsidize the purchase of private long-term care insurance by individuals who would be unlikely to purchase it without a subsidy, in order to generate long-term medical assistance savings; and (3) adding a nursing facility benefit to Medicare-related coverage, as defined in Minnesota Statutes, section 62Q.01, subdivision 6. The report must quantify the costs or savings resulting from adding a nursing facility benefit. The report must comply with Minnesota Statutes, sections 3.195 and 3.197.” Laws of MN First Special Session 2003, Ch. 14 Art. 2, Sec. 55.

What This Report Includes

The department has been working on this study since it was commissioned in 2003. The decision was made early on to identify and analyze a broad array of potential public and private financing options in order to “leave no stone unturned” in the quest for practical and perhaps overlooked options for paying for long-term care. Because of that strategy, this report includes nine different financing options that were analyzed for their potential to maximize private dollars and minimize Medicaid liabilities. These include:

³ Long-term care is defined as “assistance given over a sustained period of time to people who are experiencing long-term disabilities 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.

1. Long-term care insurance (LTCI) options, including the use of medical assistance⁴ funds to subsidize the purchase of private LTCI by individuals who would be unlikely to purchase it without a subsidy (specifically mentioned in the legislation).
2. The Partnership for Long-Term Care program (specifically mentioned in the legislation and described in more detail on page 14).
3. Adding a nursing facility benefit to Medicare-related coverage (specifically mentioned in the legislation).
4. Health insurance options that combine health and long-term care coverage.
5. Life insurance options that include long-term care coverage.
6. Reverse mortgages.
7. Family loan and line of credit program (specifically mentioned in 2003 legislation).⁵
8. Universal long-term care savings plans, called CarePlus, passed by the Hawaii Legislature in 2003 and subsequently vetoed by the governor.
9. Long-term care annuities.

The state contracted with the University of Minnesota's State Health Access Data Assistance Center (SHADAC) to complete a more detailed policy and fiscal analysis of each of the options listed in the legislation. The intent was to identify which options have the greatest potential for achieving the state's policy goals, and to identify the most effective tools to increase the use of these options, such as tax incentives, regulation of financial or insurance products, consumer education and information, or targeted subsidy for specific products or groups. That analysis is not yet complete. It will be submitted to the Legislature as soon as it becomes available, by March 2005.

Thus, this report describes the current context of the state's long-term care financing problem and includes descriptive analyses of nine financing options. Also included are a proposed new mix of public and private approaches to the financing of long-term care, and more specific recommendations for next steps the state should take to move forward on this critical issue. Attached to the report are two appendices, one that summarizes the results of "straw votes" by participants at the December 3 conference on long-term care financing, and another that provides detailed information on each of the options analyzed in this study.

⁴ Throughout this report, the term "Medicaid" is used to refer to the federal and the state Medicaid program, rather than the term "medical assistance" or "MA" as it is called in Minnesota.

⁵ The study of the loan program was held over from an earlier legislative report in order to complete analysis on all the financing options at the same time.

II. Current Context of Long-Term Care Financing

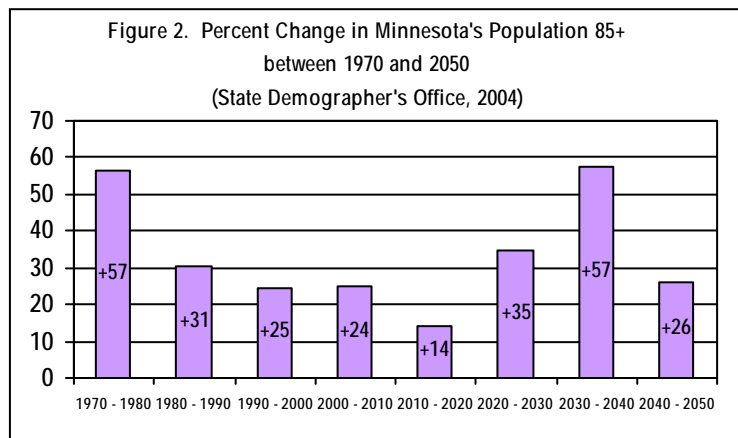
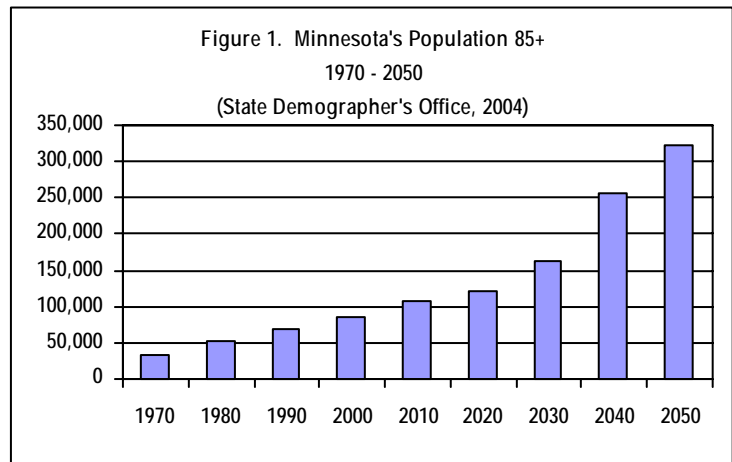
In 2011, just six years from now, the baby boom generation will begin to turn 65, and as they grow old, many predict that providing long-term care for this large group of older people will quickly become one of the state’s most critical issues. Because of poor lifetime savings rates and reductions in available family members to provide care, the sheer numbers of people needing and eligible for publicly funded long-term care by 2030 could overwhelm the state budget. In order to understand why this issue is so critical, we must understand its demographic drivers and the social and economic context of long-term care financing.

Increased growth in oldest age groups

Minnesota’s population is aging and along with that change, the need for long-term care is increasing. This increase is closely linked to the rise in the 85+ population.

The number of older people 85+ in Minnesota has been growing steadily over the past 30 years and that growth will accelerate in the next 30 years as the baby boom generation ages (see Figure 1). In 1970, there were 33,740 persons 85+ and over. By 2000, this number had grown to 85,601 persons. Between 2000 and 2030, the number will double, increasing to 163,310 and then double again by 2050, rising to 323,603. After 2050, the increases in the 85+ population are expected to stabilize, but an older population will be a permanent fixture of our demographic landscape.

Figure 2 below illustrates the percent change in the 85+ in each decade over the past 30 years and over the next 50 years. It is noteworthy that each decade

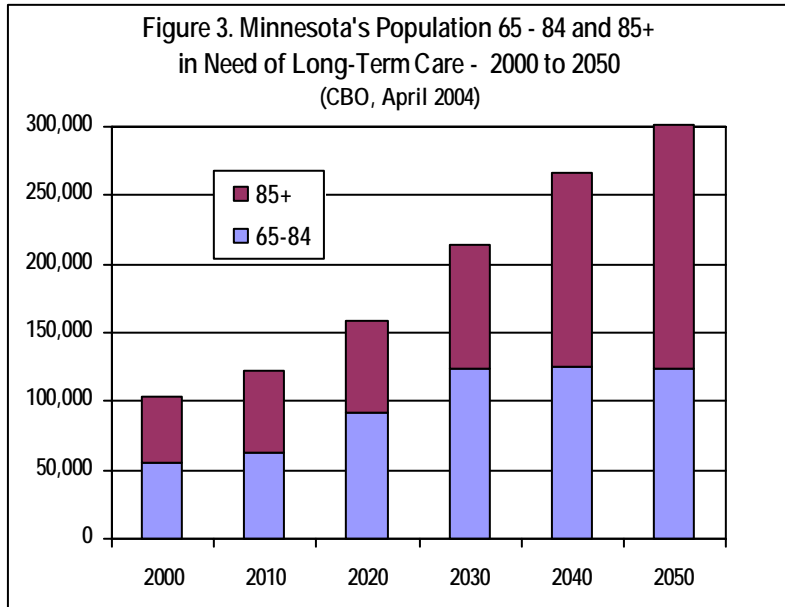


has seen large growth in the 85+ population, but the smallest increases will occur during the next two decades, and then begin rising quickly as the baby boom generation grows old.

Some experts feel that the relatively small increases in the elderly population over the next 20 years give us a window of opportunity to prepare (both as individuals and as a society) for the challenges of a permanently older society.

The need for long-term care doubles by 2030 and triples by 2050

Minnesota’s population is aging and age is related to increased disability. As the number of older people in Minnesota grows, the number with disabilities that require long-term care will also grow. Figure 3 presents the number of persons ages 65 - 84 and 85+ in Minnesota estimated to need long-term care between 2000 and 2050. Essentially, the number needing long-term care doubles between 2000 and 2030, and nearly triples between 2000 and 2050. Based on estimates by the Congressional Budget Office, about 11 percent of the 65 -84 population has disabilities that can require long-term care assistance. About 55 percent of those over 85 have disabilities that require long-term care assistance.⁶



There is some good news about disability in old age. There is now clear evidence that the age-specific disability rates in the United States are decreasing modestly. Disability rates among the elderly have declined by 1 percent or more per year for the past 20 years. Experts say that these declines are the result of advances in health and medical care widely utilized by older people, e.g., hip or knee replacements, prescription drugs that improve functioning and the use of assistive devices and other forms of technology.

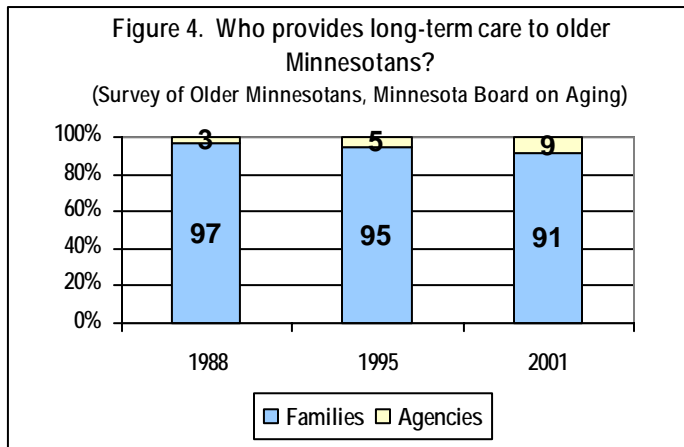
While it is difficult to predict whether (and at what rate) disability rates will continue to decline, especially in the face of alarming increases in obesity, there is no question that the *number* of disabled elderly needing long-term care will continue to rise even while disability rates decrease, because of the large increases in the overall number of elderly. Without the declines in disability rates, the number and proportion of elderly needing long-term care would be even higher in the next 30 years.

Moreover, there are troubling signs that disability rates among the nonelderly (those under 65) are rising. Poor lifestyle choices are leading to increasing levels of obesity, diabetes and other conditions. More individuals will enter their retirement and old age with already existing chronic conditions that bring with them increased long-term care needs. Therefore, rather than continuing to decline, our disability rates may unfortunately begin to rise in the future, putting even more pressure on the state’s long-term care system.

⁶ Congressional Budget Office. (April 2004). *Financing Long-Term Care for the Elderly*. The Congress of the United States. Washington, D.C., page ix.

Changes in families may reduce care available to elderly

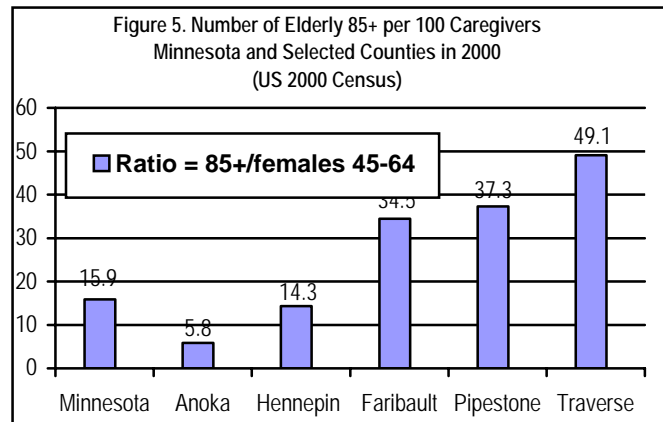
Demographic changes will reduce the number of family members and workers available to provide care at the very time when the need for long-term care will be at an all-time high. Families provide the vast majority of long-term care needed by frail elderly. As Figure 4 illustrates, unpaid family caregivers (primarily spouses and daughters, but increasing numbers of husbands and sons) provide over 90 percent of the long-term care needed by the elderly. Minnesota has been tracking the amount of care that families provide for almost 20 years and while still very high, the percent is declining gradually, in a clear trend that means more elderly and their families are using “formal”



services to supplement what the family can do. The biggest factor in this decline is the increased female labor force participation rate, now at an all-time high of 66.4 percent in Minnesota, the highest in the nation. Experts predict that this trend will continue to limit the amount of care women are able to provide to their older relatives. It also raises the issue of what can be done to help willing families continue to provide as much care as they are able.

The size of the average family is also declining, reducing the number of members available to provide care. In 1940, the average family was 3.8, in 2000 it was 3.1 and by 2040, it is expected to fall to 2.8.⁷ These demographic trends mean that while the older population is doubling in size, the younger age groups will increase by only 25 percent. One way to measure the impact of these population changes is the “caregiver ratio.” The data in Figure 5 shows the ratio of the number of 85+ persons to the number of females ages 45 – 64 (who are the typical caregivers) for the state and various counties. The data indicates that for the state as a whole, there are 15.9 persons 85+ for every 100 caregivers. In the urban/suburban areas with younger populations, caregiver ratios are lower. But in the more rural counties with fewer younger people and higher proportions of persons 85+, the caregiver ratios are already extremely high. The limited numbers of caregivers mean fewer daughters, daughters-in-law and workers available to fill long-term care jobs.

The size of the average family is also



⁷ Congressional Budget Office, op. cit., p. 28.

Who pays for long-term care now?

The major payer for long-term care for persons 65+ now is the federal and state government. Both nationally and in Minnesota, the Medicare and Medicaid programs bear about 60 percent of the total estimated costs for paid long-term care. The estimated cost of long-term care in Minnesota in 2004 was \$2.26 billion. The largest payer was Medicaid, at \$913 million, representing about 40 percent of the total.⁸ Out-of-pocket expenditures by the elderly and their families totaled about \$745 million, representing about 33 percent of the total. The other large payer was Medicare at \$443 million, representing about 20 percent of the total. Private insurance and other sources totaled \$159 million, or about 7 percent.

Because family care is so significant in Minnesota, we used new figures just computed by a national group that estimate the dollar value of caregiving in each state including Minnesota. The value of family caregiving of the elderly in Minnesota is more than \$4.58 billion per year, with one in four adults involved at some level with caregiving for older relatives.⁹ When this amount is added to the “formal” long-term care expenditures, the total expenditures reach \$6.84 billion. The dollar value of informal care far outweighs the other amounts, representing fully two-thirds of the total investment. (See Figures 6 and 7 below.)

Estimated Long-Term Care Spending for the Elderly in Minnesota in 2004

Figure 6. \$2.26 billion without informal care

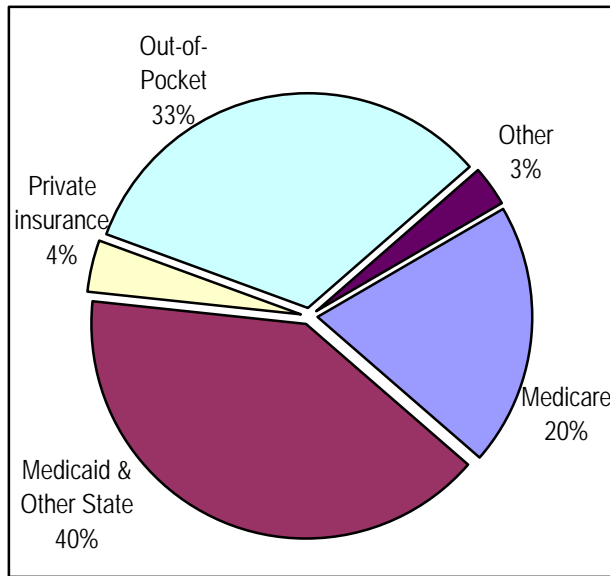
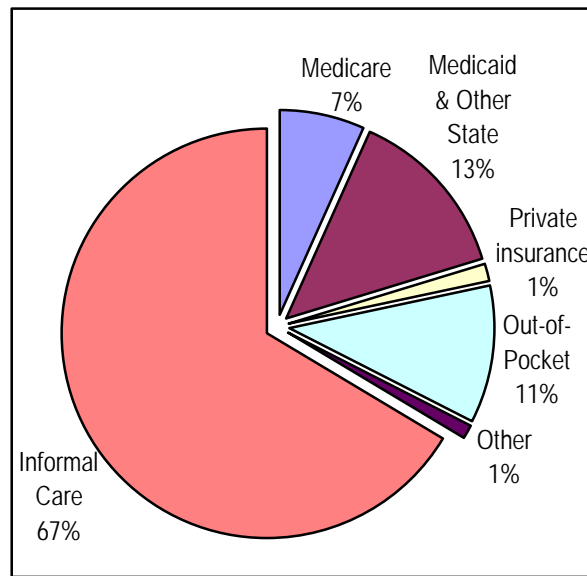


Figure 7. \$6.84 billion with informal care



Sources: Medicare figures are from the CBO and AARP, 2004; Medicaid figures are from DHS Forecast, November 2004; private insurance figures are estimated from CBO report and Eileen Tell presentation at December 3, 2004 conference; “other” is estimated based upon CBO report, 2004; value of informal care for Minnesota is the estimate included in *State of the States in Family Caregiving Support: A 50-State Study*, 2004. See references for complete citations.

⁸ The Medicaid dollar figure includes both Medicaid as well as other state dollars spent on long-term care for the elderly, primarily through the state-funded Alternative Care program.

⁹ Family Caregiver Alliance. *Profile of Minnesota in “The State of the States in Family Caregiver Support: A 50-State Survey.”* Washington, D.C., December 2004.

Who will pay for long-term care in 2030?

Given the demographic and other trends described in this report, the greatest concern of many policymakers is whether the future elderly in Minnesota will have the financial resources (income and wealth) needed to cover both their basic living expenses and any health and long-term care needs, and how many will turn to Medicaid for assistance.

The current elderly population is not well-prepared to pay for their long-term care needs. Nationally, in 2000, only about 7 percent of seniors had incomes above \$50,000, and nearly 50 percent of the elderly had total assets (including housing equity) below \$100,000.¹⁰ Minnesota statistics bear this out. In 2001, the Survey of Older Minnesotans found that the median per capita annual income for persons 65+ was \$16,800, and 56 percent of married seniors had total assets (excluding housing equity) below \$50,000, and 77 percent of unmarried seniors had assets below \$20,000.¹¹

Retirement income likely to be inadequate to pay for long-term care

The Employee Benefits Research Institute (EBRI) has collected data on retirement savings, pensions, costs of major sources of expenditures (housing, food, health insurance) as well as the probability and cost of health and long-term care. Using this information, EBRI created models that estimate what percent of the people in the United States will not have sufficient income and wealth in retirement.¹² *These estimates are optimistic in that they include the assumption that everyone will start saving an additional 5 percent of their income now and continue until they retire.*

These estimates show that more than half of the people currently at retirement age (65-69 years old) will not have sufficient resources to pay for health and long-term care, and this is true for all family types (single women, single men, and couples). Even having a relatively high income at retirement does not guarantee retirement security if people are already close to retirement. Over 50 percent of single women and men and over 30 percent of people who are married and *retire with the highest incomes* may not be able to meet their expenses.

The projections become less bleak for younger age cohorts because the additional savings accumulate for a longer time before long-term care expenses are incurred. For example, 63 percent of people currently 65-69 years old who are married when they retire will not have sufficient income and wealth to pay for health and long-term care. However, for people currently 55-59 years old, this falls to 29 percent.

While people who have a longer time to save for retirement are more likely to have the money to pay for their retirement and long-term care expenses, some portions of the population are more likely to face a retirement deficit than others. Women who are single at retirement (whether they

¹⁰ Knickman, J.R., et al. "Wealth Patterns Among Elderly Americans: Implications For Health Care Affordability." *Health Affairs* (May/June 2003) 22:3: page 170.

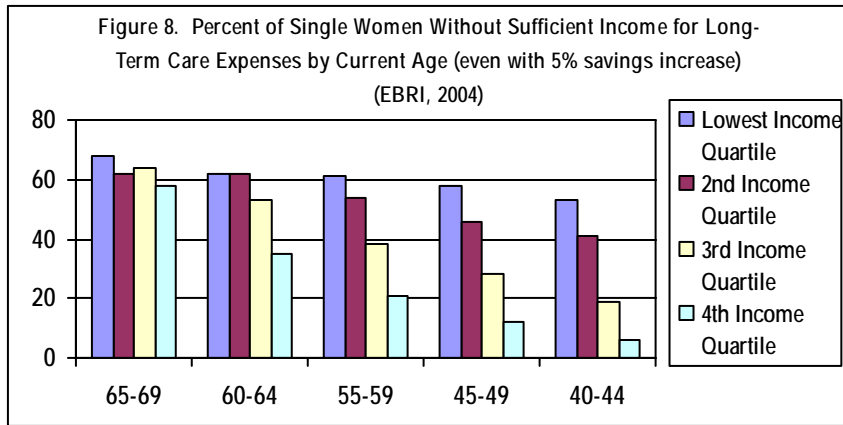
¹¹ Minnesota Board on Aging. *Survey of Older Minnesotans*. 2001. This is a telephone interview/survey with a random sample of older Minnesotans completed periodically to track the status and needs of Minnesota's older population.

¹² SHADAC at the University of Minnesota is using the EBRI national data to develop projections for Minnesota. The data presented here are preliminary and are examples of the type of data to be included in an issue brief SHADAC is preparing that will be available in March 2005.

were ever married or not) and people with the lowest incomes are most likely to lack sufficient retirement resources.

Single women are at greatest risk

The majority of single women who retire with incomes below the median (in the lowest or second income quartile) will not be able to cover basic retirement, health and long-term care expenses. Even women with higher incomes and more assets are at risk. More than half--53 percent--of women currently 60-64 years old who retire with incomes above the median are projected to have insufficient retirement funds, as are 21 percent of women with the highest incomes who are currently 55-59 years old. (See Figure 8.)

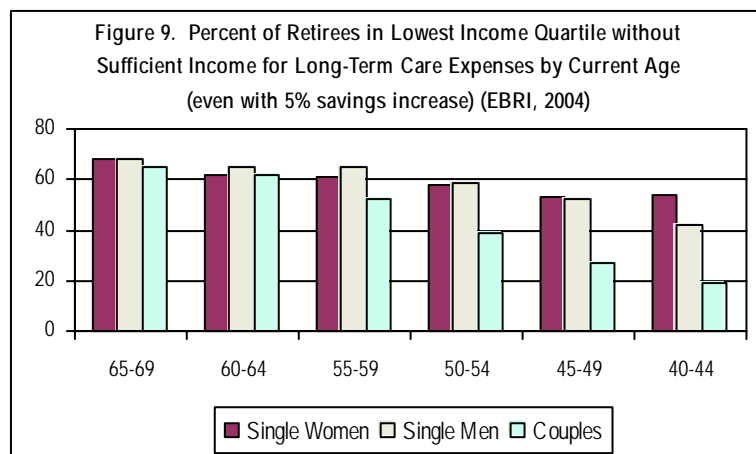


Older married persons who fall in the lowest income quartile are also at risk. Estimates are that 62 percent of those currently 60-64 years old and 52 percent of those 50-54 years old will have more expenses than resources in retirement. (See Figure 9.)

Not all projections are as pessimistic as these. Knickman et al (2003) has suggested that a significant group of the elderly in 2030 will have more resources than current elderly to pay for catastrophic health and long-term care needs. For example, he estimates that the percent of elderly in 2030 that is “financially independent” will grow from 27 percent in 2000 to 38 percent in 2030 and that the “Medicaid-bound” will decline from 45 percent in 2000 to 29 percent in 2030.

However, the group called the “tweeners,” that is, the group “that often spends down to Medicaid levels if they have a catastrophic health or long-term care need but could have afforded private long-term care coverage if they had been encouraged to purchase it during their working years,” will grow from 28 percent in 2000 to 33 percent in 2030.¹³

This is the group most sensitive to the interplay between personal and social responsibility for long-term care.



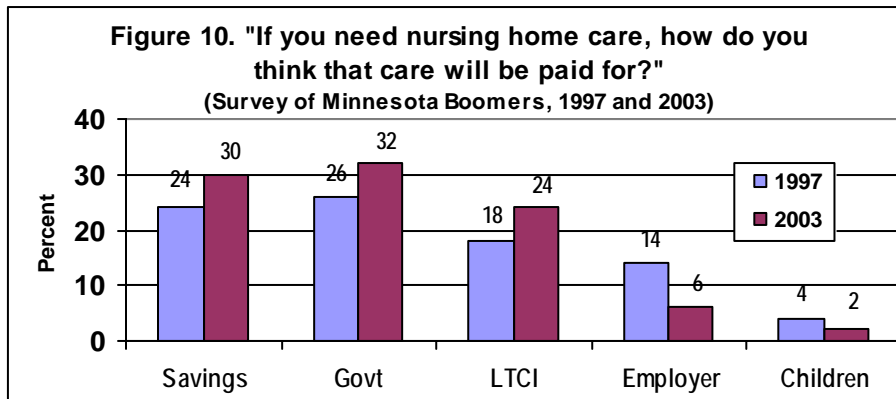
¹³ Knickman, op. cit., p. 170.

How are baby boomers preparing for retirement and old age?

Given all the interest in how boomers are preparing for retirement and old age, Project 2030 completed a telephone survey of a random sample of boomers in Minnesota in 1997 to ask about their plans for retirement including their interest in long-term care insurance. To find out how retirement attitudes and plans had changed since 1997, the Department completed another telephone survey of boomers in April 2003, asking the same questions that were asked in the 1997 survey, as well as some new questions.¹⁴

Some of the responses to the questions changed only slightly. However, others showed significant changes in attitudes. Most likely this shift was due to the fact that the boomers are now six years older and the prospects of retirement, disability and other concerns have become more real.

Boomers were asked to respond to a list of concerns some people have about retirement. Comparing the 1997 responses with those from 2003, certain concerns showed marked increases in importance. The proportion that feels “you won’t be able to do the things you want in retirement because of poor health” increased dramatically, from 47 to 70 percent. The boomers who believe that “you will outlive your retirement savings” increased from 50 to 62 percent. The boomers who believe that “you should be spending more time developing hobbies and interests for retirement NOW” increased from 48 to 60 percent. The proportion that thinks it is “very or somewhat likely” that “you will need nursing home care for an extended period of time when you are elderly” rose from 43 to 48 percent.



As Figure 10 indicates, major shifts occurred in the boomer’s response to the question “If you need nursing home care when you are elderly, how do you think that care most likely will be paid for?” “My own savings, a government program that pays for health services and long-

term care insurance” all increased in importance, while payment through “my employer’s insurance” and “my children or other family members” decreased in importance. Those with lower incomes and women, especially non-married women, were more likely to answer that they would depend upon government programs for payment of long-term care.

The percent of boomers that said they were “covered” by long-term care insurance offered by an employer or a private insurance policy declined from 44 to 33 percent, and the proportion that said they *were not* covered by such insurance rose from 32 to 61 percent. This may be the result of greater understanding and awareness by individuals about what is included in their employer-provided health insurance rather than major shifts in the long-term care insurance market.

¹⁴ For more information on both the 1997 and the 2003 surveys, methods, sampling, survey instrument and overall results, contact the Project 2030 staff at the Department of Human Services, Continuing Care Administration.

Over 80 percent of those surveyed in 2003 said they had started planning for retirement. When asked what factors make sources of information about retirement planning most useful, the boomers said simple, straightforward answers (35 percent), credible, objective sources (23 percent), using real-life examples (16 percent), or sources that have your interests in mind (20 percent).

Over one-third (35 percent) of those interviewed in 2003 were involved in providing long-term care to parents or other elderly relatives, and 66 percent said that providing this care had changed the way they think about retirement and how to prepare for it. This underscores the consensus of many experts that the caregiving experience is a critical “teachable” moment in the lives of adult children. As they care for their parents, they see what long-term care really means and they work with the inadequate patchwork of long-term care services and funding. This could prompt them to take responsibility to plan for their own long-term care.

What motivates boomers to take action and purchase insurance products?

The Family Social Science Department at the University of Minnesota is studying what factors motivate individuals to take personal responsibility and prepare financially for their retirement and old age. Knowing more about how individuals make these decisions will be crucial to develop strategies that take advantage of this knowledge and lead to successful education campaigns.

Preliminary findings from this work were shared at the December 3 conference on long-term care financing. Analyzing information obtained through interviews with buyers and nonbuyers of the state-sponsored long-term care insurance (LTCI) program in Minnesota in 2000, Professor Marlene Stum has isolated some of the key differences between these two groups. State employees were more likely to enroll in the LTCI program when they discussed the issue of LTCI with family and co-workers, used several information sources, and had prior long-term care experience. They were also more likely to enroll when they were less of a risk taker, had good vs. excellent health, knew more about long-term care risk, costs and financing options, believed in the role of private insurance and trusted that the employer would negotiate a good product and a fair price. Factors that were not significant in explaining the differences between buyers and nonbuyers included age and gender, availability of tax incentives, income and assets. The buyers also had strong feelings about personal responsibility to plan and pay for long-term care and did not want to burden family with caregiving or the financial costs of long-term care.

Thus, it appears that one key factor in motivation is education of potential buyers about the lifecycle risk of long-term care and the potential financial implications. The fact that they trust their employer to negotiate a good product may mean that uptake of long-term care products could be increased if more products were made available through the workplace.

III. Review and Analysis of Financing Options

A. Process to Analyze Available Options

The Department of Human Services undertook a variety of activities in order to review available private financing options for long-term care. Only limited analysis had been completed on the options available in Minnesota, so collecting basic information and educating staff and stakeholders were considered important first steps.

Series of policy briefings on financing options

To launch the study, the Department of Human Services and the Minnesota Board on Aging sponsored a series of seven half-day policy briefings between March and October 2004 where different financing options were described and discussed by a wide range of stakeholders. These briefings were in the form of videoconferences offered at approximately 12 locations around the state including the DHS main office in St. Paul.

The briefings were advertised through press releases, the DHS website and extensive email announcements to all stakeholders. A total of 250 individuals attended the series of briefings, representing state and local government staff, long-term care providers and representatives from the financial and insurance industries. Altogether, the briefings included over 30 national and local experts on the various financing options and provided a wealth of information on the current status of the options in Minnesota and nationwide. A listing of the topics for the briefings is included in Table 1.

**Table 1. Long-Term Care Financing Policy Briefings
March – October 2004**

Date	Title of Briefing	Options Discussed
March 5, 2004	“Long-Term Care Insurance (LTCI) Options”	<ul style="list-style-type: none"> • Long-term care insurance (LTCI) • Partnership for LTC program • Subsidizing purchase of LTCI for individuals unlikely to purchase otherwise
April 2, 2004	“Use of Life Insurance and Related Options for LTC”	<ul style="list-style-type: none"> • Use of life insurance for LTC costs • An annuity approach to retirement and LTC income
May 7, 2004	“Service and Financial Incentives for Family Caregiving”	<ul style="list-style-type: none"> • Service and financial needs of caregivers • Family caregiving in American Indian culture • The Elder Care Loan program for senior living • Eldercare benefits at the workplace and within the state budget
June 4, 2004	“Private and Public Savings Plans for LTC”	<ul style="list-style-type: none"> • Personal savings for retirement and LTC • Public savings plan – Hawaii’s CarePlus
August 6, 2004	“Use of Housing Equity for LTC”	<ul style="list-style-type: none"> • Ways to use housing equity to support aging in place • Reverse mortgages
September 10, 2004	“Combining Health Insurance Options and LTC Coverage”	<ul style="list-style-type: none"> • Adding a nursing facility benefit to Medicare-related coverage • Public and private health care products that add LTC coverage • Health savings accounts and their potential
October 4, 2004	“Strategies for Making LTC Affordable”	<ul style="list-style-type: none"> • Reducing need for and costs of LTC • Hiring your own worker • How age-friendly communities support their older residents • Making housing more affordable and reducing social isolation – the Golden Girls homes model

Conference on “Long-Term Care Financing in the 21st Century”

On Friday, December 3, 2004, the Department of Human Services and the University of Minnesota Center on Aging and the Minnesota Area Geriatric Education Center sponsored a statewide conference where financing options identified through the policy briefings were further discussed, especially to compare and contrast the various options. The attendees were asked to vote on which options had the most appeal for use by Minnesotans, and what strategies would be most effective as ways to encourage greater use of these private options. Results of the electronic voting process are included in Appendix A.

Additional research to enhance analysis and understanding of issues

The University of Minnesota’s State Health Access Data Assistance Center (SHADAC) and the Department of Family Social Sciences are working on studies that will further delineate the extent of the long-term care financing problem in Minnesota, analyze the policy options and potential incentives from a fiscal perspective (SHADAC), and identify the factors that motivate individuals to take action to minimize their long-term care risk (Department of Family Social Sciences). These results will be available by March and June 2005, respectively.

Inter-agency work group

In 2003, the department formed an inter-agency advisory group made up of policy staff from state and legislative agencies with expertise in the issues related to long-term care financing. The group has met monthly to advise the department on the study and communicate study results to other state staff and related groups. The group includes staff from the Minnesota State Retirement System (MSRS), the Legislative Commission on the Economic Status of Women, the state demographer’s office, the departments of finance, commerce, employee relations, health, revenue, and the housing finance agency.

B. Review of Options Included in the Study

For each of the nine options reviewed in this study, the report presents a brief description, information on the market in Minnesota (if applicable), and a summary of key advantages and disadvantages for each option based upon available research and discussions about the option at the policy briefings and conference. For comparative purposes, the ranking that each of the options received (from #1 to #8) at the December 3 conference is included next to the title. Since the summaries here are brief, more detail on each of the options is included in Appendix B.

Options that Use Insurance to Pay for Long-Term Care

The options here include five insurance options: two that use long-term care insurance, two health insurance options and one life insurance option. The insurance options all involve purchase of policies that protect against the risk of 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. Other benefits include the peace of mind that, if a catastrophic event happens, individuals will not be “wiped out” financially. The health insurance options have one distinct advantage over all the others: they not only provide a financing mechanism to pay for long-term care, but also have the potential to reduce or change the individual’s level of disability and thereby reduce the long-term care services needed.

1. Long-term care insurance (LTCI) Ranking at Conference: #3
Summary: Option with the largest uptake in Minnesota;
employer market has potential

Description. For most Minnesotans, the first option for financing long-term care they think of is long-term care insurance (LTCI). LTCI is private insurance that is purchased before long-term care is needed. If care is needed, the insurance policy pays benefits as stipulated in the policy purchased. Policies can be individual or group-based. Group LTCI is available through employers or associations. Some of the features/benefits that can be purchased in a policy include the types of services covered, how much coverage is purchased, when benefits are paid and what triggers eligibility for benefits, how benefits are paid, inflation protection, and nonforfeiture of benefits, e.g., if the policyholder cannot continue paying premiums, is there some provision for partial benefits to be paid.

Market in Minnesota. An estimated 114,000 long-term care insurance policies were in force in Minnesota in 2004, which represents 9 percent of the state’s population between 50 and 84 years of age. This makes Minnesota the 13th highest state in sales penetration in the nation. It is estimated that LTCI purchasers in Minnesota have average annual incomes of \$75,000, and are, on the average, about 58 years old.¹⁵

The State of Minnesota sponsors a state employee-paid LTCI plan that was implemented in 2000 and 2001. The enrollment was done as a part of open enrollment during 2000 for employees and 2001 for retirees, and generated the highest participation rate of any public employee plan at that time in the nation with a 17% enrollment rate.¹⁶ The state offers a \$100 tax credit for taxpayers who own a qualified policy, although the Department of Revenue estimates that fewer than half (about 42,000) of Minnesotans who own a policy claimed the \$100 LTCI credit on their state tax return in 2003.

Sixty-seven companies were licensed to sell LTCI in the state in 2004. This number has declined in the past few years, as a number of companies once active in the market have either quit selling completely or are not selling new policies. The products continue to evolve with new products becoming available in response to consumer demand. However, as new products enter the market, consumers face increased complexity when they try to compare policies.

Advantages. Those who purchase LTCI policies report that they value the asset protection, the ability to control long-term care decisions and choices, and the ability to pass on an inheritance to family members instead of using assets to pay for long-term care. Purchasers do not want to be a burden on their families. It is perceived as a good way of assuming personal responsibility for the risk of long-term care rather than being unprotected should a catastrophic event occur. It is also protection against spending down and becoming dependent upon Medicaid. There appears to be growth potential in employer-sponsored LTCI, based upon surveys of both employers and employees reviewed in this study.

¹⁵ Strebe, Paul. “Status of LTCI in Minnesota.” Summary of Policy Briefing. March 5, 2004. Minnesota Department of Human Services. St. Paul, MN. Tell, Eileen. “Overview of LTCI: National Perspective.” Presented at December 3, 2004 conference “Financing Long-Term Care in the 21 Century.”

¹⁶ Strebe, Paul. “Status of Long-Term Care Insurance in Minnesota.” Summary of Policy Briefing, March 5, 2004. Minnesota Department of Human Services. St. Paul, MN.

Disadvantages. Both researchers and advocates suggest that LTCI is not necessarily the best option for lower income individuals. They suggest that long term care insurance is not appropriate for someone with less than \$35,000 in assets or if the monthly premium cost represents more than 7 percent of income.¹⁷ Purchasing long-term care insurance usually means buying a product that will not be used for a number of years. Early purchase locks in lower premiums, but there is still potential for premium increases and covered services that are outdated by the time they are needed. Dramatic premium increases, as high as 45 percent, have occurred recently in Minnesota and across the country, and have raised fears about the stability of the product.¹⁸ The Minnesota Department of Commerce completed a report in January that provided an overview of long-term care insurance in Minnesota, including what's behind the recent rate increases, the current market in Minnesota, and the effect of the current regulations. The report indicates that rate increases will be less frequent in the future, and sales of new policies appear to have plateaued in Minnesota, although more seniors may purchase LTCI in the future depending upon changes in Medicaid and/or tax treatment of LTCI premiums.¹⁹

2. Partnership for Long-Term Care **Ranking at Conference: #1**
Summary: Option sends clear message about
public and private responsibility for long-term care costs

Description. The Partnership for Long-Term Care is a program (now available in only four states) that allows these states to provide Medicaid long-term care coverage to individuals who have purchased a “qualified” LTCI policy in that state, have exhausted those benefits and still need long-term care. Partnership policyholders receive a disregard of the maximum asset limit to be eligible for Medicaid long-term care coverage, and a disregard of an equivalent amount of assets in estate recovery after the individual’s death. The disregard is equal to the value of the LTCI policy, but in some states it can include all assets. One of the chief goals of the Partnership is to broaden the LTCI market so that it is attractive to those who have been hesitant to buy coverage in the past.

National Partnership Experience. This program is currently limited to four states by federal law, and is not available in Minnesota. There is substantial interest in establishing the program in the state, when and if the federal prohibition is eliminated. As of December 2003, a total of 180,000 policies had been purchased in the four Partnership states between 1993 and 2003. During that time, 2,000 policyholders had received payments under their LTCI policy, and 89 had exhausted these benefits and accessed Medicaid.²⁰

¹⁷Tell, Eileen, “Looking at Personal Planning Options for Financing Long-Term Care Needs”, prepared for the Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2003.

¹⁸The Senior LinkAge Line® (SLL) is a telephone information and assistance service operated by the Minnesota Board on Aging that links callers to staff trained to answer questions about insurance, services and other aging programs. The SLL is receiving more calls about LTCI each year, a total of 1,600 calls in 2003. Many of the callers have had questions about rate increases.

¹⁹ For a copy of the report go to:

http://www.state.mn.us/mn/externalDocs/Commerce/LTCReport_to_the_Commissioner_013105101815_LTCReportforWeb.pdf

²⁰ University of Maryland Web site at <http://www.hhp.umd.edu/AGING/PLTC/index.html>.

The Partnership for Long-Term Care has not expanded beyond its initial demonstration states of New York, Connecticut, Indiana, and California because in 1993, as part of the Omnibus Budget Reconciliation Act (OBRA '93), Congress removed the asset protection provision, except for the states with already existing programs, thus requiring estate recovery and making the program less attractive to individuals and states. Efforts are underway to eliminate this prohibition at the federal level, and if successful, a number of states would be seriously interested in offering the program. The elimination of this prohibition on asset protection was included in the Bush administration's Medicaid budget proposals last year, and legislation to do so was introduced in Congress last year. This provision is again included in the administration's Medicaid budget proposal this year (2005). There is also growing interest in the possibility of making the program national in order to standardize the program and eliminate the state reciprocity issue.

Advantages. Proponents of the Partnership program cite its potential for expanding the market for LTCI products. The additional consumer protections put in place through the development of Partnership-qualified policies have set a new standard for the industry. It is estimated that the Partnership program doubles the size of the potential market for LTCI and reduces the incentive to transfer assets in order to qualify for Medicaid. The state then saves money under the Partnership program to the extent that those who purchase the LTCI products are at some real risk of spending down to Medicaid. The Partnership states of California, Connecticut and Indiana have estimated combined Medicaid savings in the range of \$8-\$10 million during the relatively short time their programs have been operational.

Disadvantages. If individuals purchase a Partnership-qualified product instead of a conventional LTCI product, it may cost the state more if they need large amounts of long-term care because of the state's inability to recover assets. Thus far, it is unclear whether the program has successfully targeted the individuals most likely to use Medicaid, or whether those who have purchased the policies are individuals who would not have purchased LTCI otherwise. In Minnesota, some in the LTCI industry have complained that the minimum requirements for a Partnership-qualified policy would make these policies more expensive and harder to sell, e.g., inflation protection, minimum coverage thresholds. The current lack of reciprocity among states is also cited as a drawback to the purchase of these products.

3. Nursing facility benefit into Medicare-related coverage Ranking at Conference: #7 **Summary: Option should not be mandated especially now when** **the effects of Medicare reform are still evolving**

Description. Medicare-related coverage (in this section referred to as Medigap policies) are insurance plans that seniors on Medicare purchase to cover the co-pays and deductibles within the Medicare program. These plans are standardized, and at this point, there are 10 different plans to choose from. One of the options that the Legislature asked DHS to address in this report is the mandating of a nursing facility benefit for Medicare-related coverage written in the state.²¹ Based on our review of the issues and the other studies completed on this option, it appears that innovative combinations of health insurance and long-term care coverage should be encouraged, but not mandated, especially at this time of dramatic change within the federal Medicare program.

²¹ This study did not address all long-term care benefits. The legislative language stipulated that the study look at nursing facility benefits mandated in Medicare products, but did not mention other long-term care services, such as home and community-based services.

Mandate would have negative effect on Medigap market

A Minnesota Department of Health report to the Legislature in January 2000 concluded that mandating the addition of a “long-term care benefit to Medicare supplemental insurance policies would drive up the cost substantially, likely causing current purchasers to drop their coverage.”²² The Health Department study compared what was then the average monthly cost of a LTCI policy of \$229, to the then average monthly cost of the basic Medigap plan (the most popular plan to supplement Medicare in Minnesota) of \$65 per month. It pointed out that “substantial numbers of people will drop coverage as it becomes unaffordable.” If the requirement to add an expensive benefit to this supplemental coverage were to apply to all existing and new policies, it would force many elderly to drop their Medigap policies and rely solely on traditional Medicare, which does not have *any* long-term care coverage (except short-term post-hospital care).

A second dynamic has developed due to passage of the federal Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003. Many aspects of Medicare’s future are either uncertain or untested because of MMA. MMA prohibits Medigap plans from future sales of policies offering a drug benefit, and this could affect the Minnesota Medicare market significantly because of our relatively high use of Medigap policies, especially in Greater Minnesota. A total of 44 percent of Minnesota’s Medicare beneficiaries have Medigap policies, twice the national rate of 22 percent, and this rises to 57 percent in Greater Minnesota.²³

Industry experts say that if new Medigap policies cannot include drug coverage, and a nursing facility benefit is mandated, this would greatly increase the premium and the products would lose their market viability when Medicare Part D (drug benefit) is implemented in January 2006.

If a nursing facility benefit were mandated only for new policies, the effect would be different and smaller, but still negative. It could conceivably encourage seniors to move to the Medicare Advantage plans where no long-term care benefit could be mandated. In either scenario, it is unlikely that more elderly would have long-term care coverage as a result of this change, and some elderly may end up with even less overall health coverage because they would drop their Medigap coverage. This would increase the numbers spending down to Medicaid because of higher medical expenses.

4. Health insurance options that include long-term care Ranking at Conference: #5 **Summary: Options with the most long-term potential, because they integrate medical and long-term care service, management and financing**

Health insurance options that include long-term care coverage are in flux right now due to the emerging Medicare reform at the federal level. Most of the media attention on the MMA has focused on the drug benefit and drug card aspects. However, other components of the MMA call for research and demonstrations on chronic care and disease management, improved risk adjustment payments for prepaid Medicare Advantage plans, and a new category of special needs plan (SNPs) to serve those with chronic care needs. These could all play a part in the future development of Medicare plans that include coverage and management of both medical and long-term care risk.

²² Minnesota Department of Health. “Adding Long-Term Care Coverage to Medicare Supplemental Insurance: Report to the Legislature.” January 2000.

²³ Sonier, Julie. “State Health Policy Perspective on Health Insurance Options.” September 10, 2004. Policy Briefing. Minnesota Department of Human Services. St. Paul, MN.

A. Private approaches that combine healthcare and long-term care coverage

Description. There are only a few private options that now offer integrated medical and long-term care coverage to the Medicare population. Many of the health plans that contract with Medicare on an at-risk (capitated) basis in Minnesota have developed care coordination approaches to improve the quality of care and outcomes for their enrollees who are receiving privately paid long-term care supports, but they do not cover these long-term care costs. Social HMOs are one example of a completely integrated medical and long-term care model that does offer standard Medicare benefits, plus long-term care and drug benefits.²⁴ There was a Social HMO product in the Twin Cities area from 1985 until it closed in 1995.²⁵

B. Public approaches that combine health care and long-term care coverage

Description. In contrast to the limited private plans, several public health insurance options include medical and long-term care services for the elderly on Medicaid. In the mid 1980s, the Program for All-inclusive Care of the Elderly (PACE) model and components of the Social HMO structured for the dual-eligible were developed in many communities around the country. While neither of these options is now available in Minnesota, there is growing provider interest in developing the PACE model. In 1995, the Minnesota Senior Health Options (MSHO) project began operation under federal waivers as the first-ever capitated Medicare and Medicaid program for the dual-eligible elderly managed by a state. Wisconsin and Massachusetts have followed with similar programs. All of these programs use Medicare and Medicaid funding to provide the full array of Medicare, Medicaid (including community waivers), and substantial benefits that are similar to Medigap plans. These programs incorporate creative incentives to improve care delivery and chronic care management.

Another set of programs integrates the medical and long-term care benefits of Medicaid alone—without the integration of Medicare services. New York, Arizona, Texas, and Florida have developed models for their Medicaid-eligible elderly and disabled that manage both the medical and long-term care services. Minnesota’s effort to integrate the Elderly Waiver (EW) services with the Prepaid Medical Assistance Program (PMAP) services under a new Minnesota Senior Care approach is similar to these other state efforts.

Advantages. These health insurance options have an advantage that other options do not have, namely that they not only pay for long-term care, but also have the potential to improve the coordination and management of medical care and long-term care, to slow the progression of disability and possibly reduce the need for long-term care. Surveys of the elderly served by these integrated models have shown high satisfaction levels. The plans have strong incentives to use noninstitutional settings, which consumers prefer, and access to care is frequently improved. In addition, providers and health plans experience equal or better financial results, and most states experience small decreases in expenditures or expenditures equal to those in their fee-for-service programs.

²⁴ Social HMOs are a twenty-year-old Medicare demonstration with four active sites across the country serving over 90,000 Medicare beneficiaries. Social HMOs provide the Medicare+Choice standard benefit, plus limited home and community-based and institutional care benefits, plus drugs. For enrollees who are also enrolled in Medicaid, a complete array of long-term care services is covered.

²⁵ Ripley, Jeanne, Hallelund Health Consulting. “Health Insurance Options that Include Long-Term Care.” September 10, 2004. Policy Briefing. Minnesota Department of Human Services. St. Paul, MN.

Disadvantages. The complexity of developing integrated health insurance models is a significant drawback to further expansion of these options. Thus, these options are not available to most elderly on Medicare, but are more available to elderly on Medicaid. The potential providers of these models need to be able to obtain adequate reimbursement through Medicare and Medicaid in order to provide both medical and long-term care benefits. It is still unclear whether the provisions in the MMA will offer providers enough financial coverage to develop and offer more of these products, and whether there are clear cost savings to the Medicare and Medicaid programs.

C. Health Savings Accounts (HSAs)

Description. Health savings accounts (HSAs) represent a new health insurance model that couples a high deductible medical insurance policy with a tax-deductible annual health care savings account. The President's 2005 budget proposals include several strong tax provisions to encourage the growth of HSAs and related high deductible catastrophic health insurance.

Market in Minnesota. Experts say that employers in Minnesota and the nation, worried about rising health insurance costs, are turning to HSAs as a way to control the growth in their employee health costs. Through this option, more of the upfront health care spending decisions are turned over to employees, who use the funds saved tax-free in the HSA (and often supplemented by the employer) to pay for routine health care expenses. If not used for health care in a given year, the remaining funds can be rolled over into the next year, rather than being lost (as is now the case for flexible spending accounts). Some has seen HSAs as attractive options for individuals to save money to pay for health and long-term care costs in retirement. However, early research identifies several barriers to the use of HSAs to fund health and long-term care costs in retirement.

Advantages. HSAs increase the consumer's prudent use of money for health care expenses, and heighten their sensitivity to the price of health care services because they are using their own money to pay the bills. A further incentive is the ability to "roll over" any unspent funds into future years for later use. The funds are flexible, so they can be used for a wide variety of health care costs as well as long-term care expenses, such as LTCI premiums.

Disadvantages. There are some potential problems in using HSAs to fund health and long-term care in retirement. Medicare beneficiaries are not eligible to contribute to HSAs, so the benefits of HSAs are limited to individuals before they become eligible for Medicare, or to the use of any excess money in their account to pay for health and long-term care expenses after they are on Medicare. The HSA funds cannot be used to pay the premiums of Medigap policies. Further analysis also suggests that large numbers of individuals would typically have nothing to "roll over" into their retirement years to use for health and long-term care spending at that time. Figure 10 below shows the effects of rolling over 50 percent or 90 percent of an annual HSA. It does not result in significant amounts of dollars available to pay for health care or long-term care needs in retirement. In addition, research has found that large numbers of individuals and families expend more each year for health care than what they have in their health spending accounts.²⁶

²⁶ Julie Sonier, Assistant Director, Health Economics Program, Minnesota Department of Health. "Health Insurance Options that Include Long-Term Care." Policy Briefing. September 10, 2004. Minnesota Department of Human Services. St. Paul, MN.

Table 2.*
How Much Money Can be Accumulated in an HSA for Health Care Needs in Retirement?

	50% of end-of-year account balance rolled over	90% of end-of-year account balance rolled over
After 10 years	\$2,000	\$8,000
After 20 years	\$2,000	\$13,000

*Account balance assuming \$1,000 annual contribution and 5% rate of return.
 Source: Paul Fronstin and Dallas Salisbury. "Health Care Expenses in Retirement and the Use of Health Savings Accounts." Employee Benefits Research Institute Issue Brief No. 271, July 2004.

5. Life insurance used to pay for long-term care Ranking at Conference: #2
Summary: Option offers multiple protections/uses through one policy

Description. There are two types of life insurance—permanent and term insurance--and they can both be used for long-term care. Permanent (sometimes called whole life) is the type of life insurance that is usually used to pay long-term care costs. Provisions that can cover long-term care costs include accelerated death benefits, life settlements, single premium life/long-term care policies, and viatical settlements. These provisions use (and thus reduce) the cash value of the policy in order to provide cash for long-term care costs. (See Appendix B for details on these provisions.)

Market in Minnesota. It is estimated that about 40 percent of adults has some type of life insurance. About 20 percent of all adults carry some type of permanent insurance, although this percent has been declining in recent years. Thus, in theory, the option of using life insurance they already own to cover long-term care costs is available to a many individuals. As insurers continue to struggle with the pricing of LTCI policies, experts familiar with both the life insurance and the LTCI market predict that linked benefit policies (life insurance and LTCI) will become more popular and offer a more cost-effective option for clients.

Advantages. One of the chief advantages of using life insurance for long-term care coverage is that the client receives cash that they can use in any way they want to pay for long-term care-related expenses. In addition to this flexibility, the premium is guaranteed or locked in and will not rise, in contrast with LTCI premiums that have experienced significant premium increases in recent years. In a life insurance policy, the client gets a death benefit, a long-term care benefit and can also access the cash value of the policy as a loan if needed. If the long-term care benefit is never used, clients still get the death benefit.

Disadvantages. Perhaps the chief drawback to using life insurance products to cover long-term care costs is that the amount of money available may not be adequate to cover needed long-term care costs, compared to what is available in a LTCI policy, either because of the low face value of the policy or lack of features like inflation protection. In addition, the client must continue to pay premiums even when receiving long-term care coverage. The disadvantage of the single premium policy option is the sizable amount of money the client needs in order to fund this type of policy, typically about \$50,000. In addition, underwriting can be a barrier since the policy considers both mortality and morbidity factors.

Options that Borrow Money to Pay for Long-Term Care

Two options that borrow money to pay for long-term care were studied – reverse mortgages and the family loan program, an example of a loan or line of credit option. These options have somewhat higher costs than insurance because of the interest rates that are charged (as in all loans). However, they have the advantage of providing cash for long-term care almost immediately and the benefit of flexibility that cash offers, so that the money can be used for any purpose, e.g., making home modifications, paying for assisted living, paying for prescription drugs. Unlike insurance, where people may pay premiums for years to protect themselves from a risk that may or may not occur, the financing options that borrow money to pay for long-term care are only used if and when money is needed.

6. Reverse mortgages

Ranking at Conference: #6

**Summary: Most universally available option
because majority of elderly own their homes**

There are many ways that housing equity can be used to support individuals in their decision to “age in place” in their original home. Individuals may need money to pay for mortgages, taxes, repairs, home safety features, accessibility or other home modifications, short-term services or long-term care services. (All the ways that housing or housing equity can be used to meet long-term housing and service needs are summarized in Appendix B.) This study focused specifically on reverse mortgages and the role they could play in paying for long-term care costs.

Description. A reverse mortgage is a loan against home equity that provides cash advances to the homeowner and requires no repayment until the last surviving borrower sells, moves, or dies. There are two major types of reverse mortgages: 1) HUD-insured mortgages called home equity conversion mortgages (HECMs); and 2) proprietary mortgages available from Fannie Mae and Financial Freedom.

Market in Minnesota. Reverse mortgages have been available since the 1970s, but it is only recently that they have become more well-known and utilized. In Minnesota, there have been 2,618 reverse mortgages loans made, 531 of them insured by HUD. There was a 50 percent increase in reverse mortgage closings from 2003 to 2004. About 400,000 homeowners in Minnesota are older and theoretically eligible for reverse mortgages. About 80 percent of Minnesota’s older households (defined as 62+) own the unit they live in and 72 percent of those homes have no mortgages. About \$2 trillion nationwide is locked up in the home equity of older homeowners. In addition, according to national surveys completed by AARP and generally supported by the Survey of Older Minnesotans, 85 percent of older homeowners want to stay in their homes and age in place.²⁷

Advantages. Reverse mortgages are potentially available to large numbers of older persons (over age 62). Reverse mortgages provide cash that can be used for any purpose including long-term care-related housing and service expenses. The money is available to people regardless of their insurability and can be obtained relatively quickly. The money received from a reverse mortgage is considered a loan, not income, so it is tax free. There are fairly significant consumer protections in place for reverse mortgage buyers. HUD requires that all applicants receive intensive counseling

²⁷ Minnesota Board on Aging. *Survey of Older Minnesotans*. 1995.

prior to their closing, and this counseling must be provided by designated independent agencies that have received specific training.

Disadvantages. Reverse mortgages can be relatively expensive ways to borrow smaller amounts of money, since most of the fees paid are the same regardless of the amount of the reverse mortgage. In addition, there are important realities about the local housing market that can affect reverse mortgages. The home to be mortgaged needs to be in a market where home values are high enough to yield sufficient cash back to make it worth the effort and cost to the older homeowner. Unfortunately, some markets in Minnesota, especially the rural areas in Greater Minnesota, have depressed housing values that affect the reverse mortgage market. For example, county median home values for homes sold in 2003 ranged from a low of \$35,750 in Greater Minnesota to \$227,000 in the Twin Cities area.²⁸ In addition, many debt-free homes owned by seniors may be in need of extensive repairs or renovation when appraised for purposes of these mortgages. There also has to be a lender in the community qualified to process reverse mortgages, and that may not be the case in all parts of the state.²⁹

The baby boomers have taken great advantage of rising home values to refinance and use their available home equity for a variety of expenses. It is very possible that they will understand and embrace the concept of reverse mortgages, perhaps more than their parents. However, many of them may not have enough equity in their home when they retire to make the proceeds from a reverse mortgage worth the time and cost. Thus, reverse mortgages may be an option that has more potential among current seniors than future elderly retirees. However, among the current senior population there appears to be some reluctance to dip into the housing equity in order to pay for long-term care. “Only 13 percent of older homeowners in a recent national survey said they were likely or very likely to use such loans, citing fears of losing their homes or depleting their children’s inheritance, despite the fact that the adult children of the homeowners said that using home equity to pay for long-term care needs was a great idea.”³⁰ Since this represents the largest asset for many current and future seniors, more information is needed on the factors affecting the interest in using home equity to pay for long-term care by current seniors, older boomers and younger boomers.

²⁸ Minnesota Housing Finance Agency, 2004.

²⁹ *Ibid.*, 2005.

³⁰ “*Elderly Resist Using Mortgages to Cover Their Care.*” Wall Street Journal. January 27, 2005.

7. Family loan program or line of credit

Ranking at Conference: #8

Summary: Option provides most immediate access to cash when and if needed and helps families

Description. This option³¹ provides a personal, nonsecured loan or line of credit to families who want to help an older relative pay for long-term care costs. As currently available in several states, this type of loan is most often used by families of potential residents of assisted living or nursing facilities as a way to make immediate move-ins possible. The senior pays what she/he can out-of-pocket each month, the loan administrator pays the rest to the assisted living provider, while the children/family make monthly payments over time to repay the amount borrowed. The interest rate on the loan is similar to that for other unsecured loans, 4 percent to 7 percent over the prime rate. The funds can be used for any type of long-term care expense, e.g., home care, adult day care, assisted living, nursing home care.

Market in Minnesota. The “Family Payment Plan,” an existing program that illustrates the concept of family loans, is now available in four states but not Minnesota. Groups in several states including Minnesota have expressed interest in this plan or something similar. The loan is not much different in structure from any “personal loan” that one can obtain now. What is different is that it must be used for long-term care, and it is serviced by an organization that provides additional guidance to families as they try to meet the long-term care needs of their older relatives. Given the high level of family care in Minnesota, there may be greater interest in some type of loan here than in other states. For example, caregivers spend an average of \$300 per month of their own money providing for the needs of the relatives they are caring for, and this can represent a significant burden on their household budget.³²

Advantages. The family loan concept provides an option to families with several adult children or other relatives who all want to participate in paying for an older relative’s long-term care costs. Of all the options, it provides the most immediate cash to pay for long-term care housing and services. The rates on a personal loan may be better than using a credit card to finance expenses, which some families have done in order to pay for services and other needs of their older relatives. A loan facilitates situations where the family needs money to finance an immediate move and cannot sell the senior’s original home that quickly.

Disadvantages. A loan adds to the debt incurred by the children of the elderly, and it may or may not be paid off with the proceeds from the older relative’s estate. Depending upon the interest rate at the time of the loan, it could be a relatively expensive way to finance long-term care. Bankers may be reluctant to make these kinds of loans because the money is used for services and collateral is not provided. This option would not be available to families with poor credit ratings.

³¹ For purposes of this study, we reviewed a model program that illustrates the concept of a family loan or line of credit, developed and operating in several other states, called the Family Payment Plan.

³² “Family Caregiving: Options for Financing.” Policy Briefing. May 7, 2004. Minnesota Department of Human Services. St. Paul, MN.

Options that Use Savings to Pay for Long-Term Care

The options studied included two savings options, one public savings option, namely the CarePlus program, and one private savings option, the long-term care annuity. (Personal savings and pensions were not specifically studied, since these options are ones that should be used along with all the options.) The CarePlus option is a universal insurance and savings plan. As such it is the least expensive per person (\$120/year) of all the options because the risk of needing long-term care is spread across the whole population. The private saving option, the long-term care annuity, probably requires the largest investment of any of the options, since it includes funding of an immediate annuity that pays additional cash income if long-term care is needed. Both of these options provide the flexibility of cash that can be used to pay for long-term care in any way the individual wishes.

8. Universal LTC Savings Plan - Hawaii CarePlus Ranking at Conference: #4 **Summary: Option that is the least expensive per person and provides universal coverage**

Description. In 2003, Hawaii became the first state to enact a long-term care financing program that was intended to ensure universal coverage. However, it was not implemented because it was vetoed by the Governor of Hawaii. CarePlus was a compulsory social insurance program designed to supplement an individual's own long-term care funding. The program was to be funded through a \$10 per month payment that every adult age 25 and older filing a state income tax return would pay. To be eligible for a claim, the beneficiary would need to have two deficiencies in Activities of Daily Living (ADLs) or cognitive disabilities such as Alzheimer's. The program would then make payments of \$70 per day for 365 days (not necessarily consecutive) after a 30 day deductible.

Market in Minnesota. This option is not available in any state at the moment. A number of states are reviewing the concept and considering how and if it might be implemented.

Advantages. This approach creates a large risk pool and provides benefits to everyone in the pool who needs them. It spreads the risk of paying for long-term care across the state's adult population. As a result, the cost per person is small. Everyone in the program receives the same benefit payment, so it is equitable across income levels. It provides flexible money that the beneficiaries can use to pay whomever they want for whatever services they feel are necessary. It protects the public dollars in Medicaid for the truly needy. It was hoped that it would motivate the private LTCI industry to develop affordable plans to wrap around the public benefits.

Disadvantages. The program is an entitlement program (like Medicaid) and some feel it discourages the use of other products such as LTCI and weakens the goal of personal responsibility. All participants are charged the same premium regardless of level of risk or income, so the payments made into the system are somewhat regressive. If long-term care needs last more than one year, some participants may not have adequate provision for additional services and may still need Medicaid. There was concern by some that the program was not actuarially sound, although independent actuaries assessed it as sound.

9. Long-term care annuities

Ranking at Conference: # NA

Summary: Option offers protection for both long life and long-term care risk

Description. Long-term care annuities are an example of a combined savings and insurance product where an individual purchases an annuity and along with that, also purchases long-term care coverage. When the long-term care benefit is triggered, the monthly cash amount is increased over and above the basic annuity, for use in paying long-term care costs.

Market in Minnesota. Generally, the market for this option is relatively small in Minnesota and elsewhere. One reason for this is the relative lack of awareness about these products among most people and the limited number of products available. These products require a significant investment as currently structured and this also limits the market. Research into this option is continuing, in order to see how this product could be more available to additional groups within the population, including those with lower levels of assets, those with already existing health conditions, and those who have annuities or investments that could be converted into long-term care annuities.³³

Advantages. The advantage of this option is the combination of an annuity with a long-term care policy that covers individuals against both the risk of outliving their money and the risk of needing long-term care. For individuals who have long life expectancies or lots of chronic illness in their families, this type of product offers protection on both fronts. Another advantage is that people who have poor health or who are already receiving long-term care can still utilize this option because the underwriting takes into account both mortality and morbidity. This option provides another alternative for certain individuals who may have needs and also have some liquidity in cash or other investments to set up such an annuity. Unused portions of the annuities can be inherited.

Disadvantages. The amount of money needed to fund this product may be prohibitive for many individuals especially the “tweeners” who do not have large amounts of excess cash. Individuals using this option need to have enough assets to fund this annuity and not require that money for other purposes. Few people are aware of this option, because these combined products are not well-known at this point. There is some potential that the additional income paid for long-term care will be inadequate to cover the additional expenses required.

C. Comparison of Options

1. Straw Votes on Options and Strategies

Participants at the December 3 conference voted on the options presented here (except for the long-term care annuity) to determine whether they were very appealing, appealing, neutral, unappealing or very unappealing. Table 3 below summarizes the results of this “straw vote.” While not scientific, the results provide a sense of the potential for these options to be of interest to Minnesotans in general. The participants voting included state and local government staff (27 percent), health and long-term care providers (22 percent), representatives of the legal, insurance and financial services industries (33 percent), academics (4 percent), consumers and consumer advocates (6 percent) and other occupations (7 percent).

³³ Spillman, Brenda C., et. al. “Policy Implications of an Annuity Approach to Integrating Long-Term Care Financing and Retirement Income.” *Journal of Aging and Health*, Vol. 15, No.1, February 2003.

As Table 3 indicates, all of the options received some votes as very appealing or appealing. Highest overall rankings went to the Partnership program, life insurance options and long-term care insurance. The audience was also asked which strategies would be most effective to encourage greater use of private options.³⁴ In these responses, the options receiving most votes were tax credits to individuals (46 percent), rethinking and restructuring the public and private responsibility for long-term care payment (40 percent) and a public information and education campaign (36 percent). See Appendix A for more results of the electronic voting process.

Table 3
“Please assign a value to each of the following LTC options in terms of its potential for use by individuals/families to pay for long-term care costs.”
Responses of Attendees at December 3 Conference*

Option	Very Appealing	Appealing	Neutral	Un-appealing	Very Un-appealing	Ranking
Private long-term care insurance	28%	44%	15%	9%	4%	3
Health insurance that includes LTC benefits	23%	41%	12%	14%	10%	5
Reverse mortgages	15%	44%	22%	15%	4%	6
A loan program for families	4%	27%	28%	29%	11%	8
Life insurance that also pays for LTC	21%	60%	8%	8%	2%	2
Hawaii’s public savings plan	33%	27%	23%	12%	5%	4
Putting LTC benefits into Medicare supplemental plans	11%	39%	15%	19%	17%	7
Partnership for LTC program	28%	48%	22%	2%	0%	1

*percentages do not add to 100 because of rounding. N = 97.

2. Comparison of Options on Key Elements

Table 4 compares all nine options on several key elements. Generally, nearly all the options are ranked medium or high in complexity for the consumer. Since many of them involve legal contracts of some type, they do require that an individual understand the implications of the action they are taking. Many (five of the nine) of the options are not available in our market yet. Although it is difficult to generalize, there is considerable range in the costs of these products, with the Hawaii plan and the life insurance option rated low, the nursing facility benefit added to Medigap policies, reverse mortgages and the long-term care annuity rated as high, and the Partnership program, LTCI and the health insurance options rated as medium. About one-half of the options provide benefits that can only be used for long-term care services (and some are more flexible in how the benefits are paid than others), and the other half provide cash that can be used for any purpose and in any way. Most of the options do not require additional administrative support from the state (except for the Partnership program and the Hawaii plan) but would need continuing staff time for regulatory, consumer information and consumer protection activities.

³⁴ Polling of conference attendees on some of these questions was completed after the conference via an E-mail survey.

Table 4. Comparison of Public and Private Financing Options on Key Elements³⁵

Type	Option	Complex for consumer?	Product already in the market?	Cost to consumer ³⁶	Benefit used only for LTC needs?	Administrative Costs to the state?
Insurance	Long-term care insurance	Medium	Yes	Medium	Yes	Low
	Partnership for Long-Term Care program	High	No (not in MN)	Medium (but some assets are protected from spend down)	Yes	Medium
	Nursing facility benefits into Medicare supplemental plans	Low	No	High	Yes	Low
	Health insurance with long-term care coverage	Medium	Private - No Public - Yes	Medium to High	Yes	Low
	Life insurance options that pay long-term care costs	Medium	Yes	Low (if consumer already owns a policy; excludes single premium policy)	No	Low
Borrowing	Reverse mortgage (home equity conversion)	Medium	Yes	High (but rolled into closing fee)	No	Low
	Family loan program	Medium	No (not in MN)	Medium (includes interest payment)	Yes (bank pays LTC provider)	Low
Savings	Public savings plan (Hawaii's CarePlus)	Low	No	Low	No	Medium
	Long-term care annuities	Medium	Yes	High	No	Low

³⁵ Information on potential for Medicaid savings of each option will be included in the University of Minnesota analysis available in March 2005.

³⁶ For comparison purposes, the typical cost of a long-term care insurance policy for a 55 year old was used as a “medium” cost. That cost = \$1,200 per year.

IV. Recommendations

The report proposes a new mix of public and private approaches to the financing of long-term care. These approaches address the issue at several levels. There is great concern about the financial burden that might be placed on Medicaid as the need for long-term care rises dramatically. Sending a clear message about the limits of Medicaid is critical. In addition, the state has the responsibility to encourage its citizens to take prudent steps and ensure that they are financially secure in their old age, even if they are not at great risk of ever spending down to Medicaid. The state also needs to pursue other key policy directions to improve the outlook for all its older residents as they face their long-term care.

Concerns about Future of Medicaid

At the heart of the issue of long-term care financing is the concern that, by 2030, more people than ever before will turn to Medicaid as the way to finance their long-term care. This could include those who are already “Medicaid-bound” as well as those who have been called the “tweeners,” that is, a group with lifetime income and assets adequate for retirement but inadequate for long-term care costs. Even the “financially independent” boomers, those who could self-fund their long-term care, may feel a sense of entitlement to a public program like Medicaid, because it pays for an expensive product that most people do not like and do not want to pay for with their own money.³⁷

The Medicaid challenge is a prime example of the policy debate going on now in the nation regarding what the balance should be between the responsibility of individuals to protect themselves against the risks and vicissitudes of old age, and the responsibility of government to provide universal programs that spread this risk across a whole population. The current Social Security and Medicare discussions are other examples where the same issues are being debated.

An important motivation for long-term care financing reform is that long-term care is a major contributor to the cost of the Medicaid program. Long-term care accounted for 49 percent of Medicaid spending in Minnesota in 2004. Given this context, the state cannot address the future costs of Medicaid without addressing how long-term care will be financed.

Another motivator to reform long-term care financing is the current structure of Medicaid. Its current structure as a “welfare” program presents a number of perverse incentives to the elderly and their families faced with long-term care costs. Critics claim that there are strong incentives to transfer assets using a number of legal mechanisms. Critics also claim that the program insulates individuals against the true risk of long-term care because they assume that “the state” will help pay for long-term care if all else fails. This attitude works against the message from insurance agents, financial planners and the government about the need to protect oneself privately against the risk of long-term care. A recent study goes even farther and concludes that the existence of Medicaid in its present form as a payer of last resort presents a fundamental impediment to the growth of any private coverage, and that changes in the structure of Medicaid are necessary but not sufficient to spur expansion in the private long-term care markets.³⁸

³⁷ The three groups referred to here are named as such by Knickman and Snell in their article “The 2030 Problem: Caring for Aging Baby Boomers.” *Health Services Research* 37:4 (August 2002), p. 863.

³⁸ Brown, Jeffrey R., Finkelstein, Amy. “*The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market.*” National Bureau of Economic Research. Working Paper 10989. December 2004. p. 3.

Eliminate mixed messages

While there are great differences and opposing points of view on these issues, we have had strong consensus in our discussions with many stakeholders that in the case of Medicaid, we need to eliminate the mixed messages that the general public receives about its personal responsibility for long-term care on the one hand, and perceptions of easy access to publicly funded long-term care on the other.

One of the most vocal critics of the Medicaid/long-term care provisions has completed an extensive profile of ten states and their relative support of private payment of long-term care vs. use of Medicaid. Minnesota is included in this analysis and is named as the best state of the top five “Private plus/Medicaid minus” states because of our balance of incentives and provisions that encourage personal responsibility and discourage reliance on the Medicaid program.³⁹ This ranking reflects our strong Minnesota value of not being dependent, even when you may be entitled to assistance.

A. New Mix of Public and Private Approaches for Long-Term Care Financing

There are several policy approaches available to change the incentives within the current financing structure. Three approaches involve making it more difficult to voluntarily impoverish yourself to qualify for Medicaid benefits, creating more incentives for individuals to purchase or use private financing options, and, in order to prepare for the longer term, rethinking and restructuring the public and private responsibility for long-term care financing.

Three other approaches, while they do not focus on individual financing options, are just as necessary to meet future challenges in the financing of long-term care. These include increasing our efforts to support family caregivers, preventing disabilities that lead to long-term care costs in the first place, and increasing the number of “age-friendly” communities in Minnesota.

1. Implement the asset transfer waiver, once approved.

The 2003 Legislature required that the Department of Human Services apply to the federal government for an asset transfer waiver, which would limit the methods available to individuals to transfer their assets, presumably to voluntarily impoverish themselves in order to become eligible for Medicaid. The department submitted this request in March 2003 and it is still waiting for approval. Negotiations on the terms of the waiver are underway with CMS officials regarding specific issues in the waiver request. Implementing this plus other measures to tighten estate recovery would create disincentives for voluntary impoverishment.

2. Provide incentives for private payment of long-term care.

Minnesota needs to create incentives for individuals to take personal responsibility for their long-term care. One type of incentive is provision of credible, accurate information about the risk of long-term care, and what individuals can and should do about this. The state’s goal should be that every Minnesotan has a plan to address their long-term care needs as a part of their retirement plan. Nearly all the options reviewed in this report can play a role in helping individuals plan to meet their long-term care needs.

³⁹ Center for Long-Term Care Financing. September 4, 2004. *The Realist’s Guide to Medicaid and Long-Term Care*. Seattle, Washington, page 52.

Another type of incentive is financial. The analysis being completed by University of Minnesota's SHADAC by March 2005 will provide recommendations on the types of specific incentives that would be most effective and in the interest of the state to offer to individuals or employers to increase uptake of the various financing options described in this report. However, some general comments can be made now. From the state's perspective, any financial incentives or subsidies need to target those most at risk of using Medicaid and help them purchase products that would delay their entry into Medicaid. The use of state funds for more general subsidy of persons whose income and assets make them unlikely Medicaid users does not achieve the intended goal of reducing the state's Medicaid liability.

3. Rethink and restructure the public and private roles in long-term care financing.

During this study, there has been broad consensus among many stakeholders that the best long-term solution to this financing issue is to rethink and restructure the public and private roles in long-term care financing. This rethinking should include articulating a clear specific message about the level of personal responsibility that individuals have for their own long-term care, and at the same time, articulating the level and type of assistance that the public sector will provide, similar to how the Partnership for Long-Term Care program now works.

4. Intensify our efforts to support family caregivers.

Even though families are stretched, they continue to have a deep sense of obligation to care for their spouses/parents in old age. For most elderly, family care is their preferred option. For many low-income elderly, family care is the only affordable option available. The dollar value of the enormous amount of care families provide is estimated at \$4.58 billion in Minnesota alone, and represents the largest funding source for long-term care support. If we assume that a loss of informal care will primarily affect those in greatest need and that the public sector supports about two-thirds of the cost of such care, *each percentage point drop in family caregiving means an additional \$30 million that the public sector must bear.* Thus, support of family caregivers is not just "nice;" it has enormous economic ramifications, and it is in the economic interest of the state to prevent future declines in the portion of care provided by families.

5. Prevent disability that causes the need for long term care.

Another way to address long-term care financing in the future is to promote strategies that emphasize healthy behaviors, and the personal responsibility of all to stay healthy and prevent illness and disability. We must also develop better models for delivering chronic care management so that future elderly can benefit from better care. Other important preventive strategies include increased use of technology, especially technology that helps people help themselves.

6. Increase the number of "age-friendly" communities in Minnesota.

Caring for the frail elderly in their homes is cheaper than caring for them in nursing homes. There is evidence that the elderly – even quite frail elderly – are able to stay in their current homes and communities if they have strong informal networks and their community offers certain essential physical, social and service supports that ease their ability to remain independent.

- The social networks include families, but also friends, neighbors and volunteers from local groups such as faith communities that fill in as family substitutes and provide daily supports and connections to the broader community.
- Physical supports that age-friendly communities provide include transportation for those who no longer drive, housing options so that elderly can move within their home

communities if they need or prefer to move, and public spaces designed to accommodate persons of all abilities.

- Service supports include assistance with chores, in-home help, access to health care and a range of community services, businesses and locations where elderly can shop, meet, volunteer, work, learn and continue to be engaged in and contribute to the wider community.

Minnesota has excellent examples of age-friendly communities and many champions of this approach to building better communities. These efforts need to be expanded and made universal across the state.

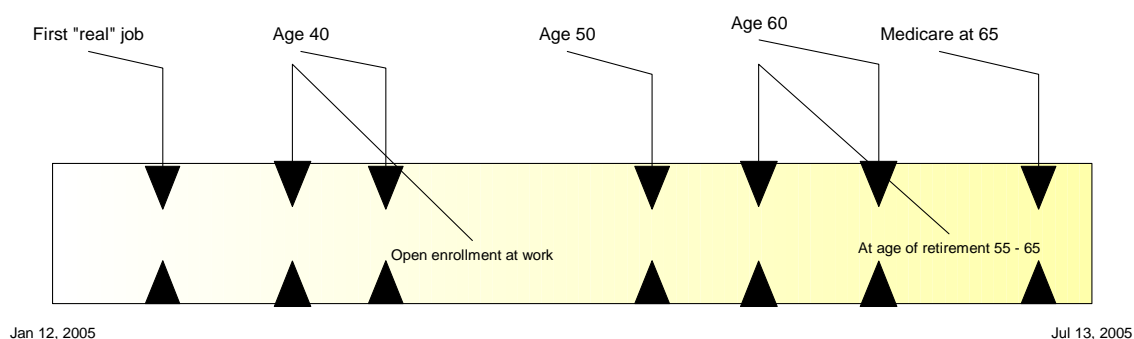
B. Recommendations on Retirement and Long-Term Care Planning

Our research has documented that individuals are more likely to take action and make decisions regarding the use of long-term care financing options when they understand the need and the risks they may face as they retire and grow old. Our efforts to increase private financing in long-term care must be pursued within the broader context of retirement planning, especially in the workplace, where employees are already making retirement, health and other insurance decisions.

We need to identify key “trigger points” within the lifecycle where retirement and long-term care planning can occur naturally, and “institutionalize” those trigger points. Currently, there are triggers for a number of the financial decisions in life: buying a car triggers mandated purchase of auto insurance, buying a house triggers mandated purchase of property insurance, birth of a child often triggers establishment of savings accounts for college. We do not have well-established trigger points for retirement and long-term care planning. However, some possible points could include when individuals start their first “real job,” open enrollment periods each year at work, celebration of significant birthdays like 30, 40 or 50, reaching retirement age or age of Medicare eligibility, 65. (See Figure 11.)

Generally, as a society, we spend more time planning annual vacations than we do our retirement and old age, which can last 30 years or more. In order to counteract the built-in reluctance of individuals to plan for the future, there needs to be universally available information and education on retirement and long-term care planning that provides opportunities for individuals to make necessary plans about what type of retirement they want and how to achieve their goals.

Figure 11. Possible Trigger Points in the Life Cycle for Retirement and Long-Term Care Planning



There are excellent resources available to support this type of retirement education, including curriculum developed by the University of Minnesota Extension Service faculty in the Department of Family Social Science, state agencies such as MSRS, DOER, Project 2030, and a web-based planning tool for baby boomers in development by the Minnesota Board on Aging's Senior LinkAge Line that will be available in spring 2005.

The state needs to develop a comprehensive strategic plan for addressing its policy goal of helping Minnesotans plan for their retirement and old age.

1. The state needs to work with a broad coalition of employers, employees and those that develop and market insurance and financial products, in the development and implementation of this strategic plan.

- The plan should include a retirement and long-term care planning campaign to reach all workers between 40 and 70 in the state.⁴⁰ It should offer incentives for employers to provide individualized, comprehensive retirement planning and counseling and provide materials, curriculum and educational resources for distribution to employees. It should include information on all the financing options described here as a part of a broader campaign to educate individuals about their risk for long-term care and what they can do for themselves.
- The state should seek funding in partnership with the University and employer groups to create a Minnesota Center for Retirement Security and Wellness. This center would work with Minnesota employers in order to develop and test a new generation of retirement, health and insurance benefits needed to support the state's increasingly older work force. It could also do relevant research and development on other retirement and wellness issues of concern to the state's employers, including the issues of retirement and long-term care planning.

2. The state should continue to seek designation as one of the next states to roll out the federally sponsored long-term care planning information and education campaign, which is now underway in five states across the nation.

C. Specific Recommendations on Private Financing Options

There is no "silver bullet" or one option that is the answer to the private financing of long-term care. Nearly all the options reviewed in this study have some potential to address the issue. Because the family circumstances, and the income and assets of each individual are different, there is no one financing option that can meet the needs of all individuals. Therefore, to maximize the utilization of private dollars, there needs to be a variety of options available that utilize different combinations of insurance, borrowing, savings and informal care and other affordable options. Based upon the

⁴⁰ Beginning in January 2005, CMS and its parent agency, the federal Department of Health and Human Services (DHHS) are joining with the National Governors Association and the National Council of State Legislators to undertake a broad long-term care planning campaign in five states in the nation. The plans call for a letter from the governor to be sent to all individuals between 50 and 70 in each of the states, promotion of a website with information on long-term care planning tools, and a 1-800 number to call to receive materials to help with long-term care planning. While the State of Minnesota has asked to be chosen as one of the next states for the roll-out of this campaign, we could begin our own such effort independent of the national program, and develop a marketing plan best suited to our needs.

discussions and analysis completed in this study, we have made several recommendations to increase the utilization of these private financing options by Minnesotans.⁴¹

1. Long-term care insurance

- Ensure that Minnesota's consumer protection measures for LTCI are comprehensive and address the issue of premium increases for current and future policyholders.
- Follow-up on the expressed interest of Minnesota employers to distribute information from the state on long-term care issues and long-term care insurance.
- Evaluate the feasibility of expanding the current state employee long-term care insurance program to additional groups of public employees, as originally envisioned in 2000.

2. Partnership for Long-Term Care Program

- Monitor developments at the federal level regarding authorization to expand the Partnership program to other states.
- Study the possibility of broadening the Partnership concept and allowing private dollars invested in long-term care through other products in addition to LTCI to count toward asset protection.

3. Health insurance options that include long-term care coverage

- Work with Minnesota's health plans to explore how the integrated medical and long-term care model for low-income elderly can be made available to pre-dual elderly in Minnesota. For example, a model might be developed to serve the Specified Low Income Medicare Beneficiaries (SLMBs), Qualified Medicare Beneficiaries (QMBs)⁴² and Alternative Care (AC) recipients who have been screened and are at risk for institutionalization, using the new special needs plan referenced in the 2003 Medicare Modernization Act.
- Encourage the development of these types of integrated plans for the general senior Medicare population, using the lessons learned from the model developed to serve the dually eligible elderly, i.e., Minnesota Senior Health Options (MSHO) project.

4. Nursing facility benefits added to Medicare-related coverage

- This option should not be mandated.
- Medicare plans should be allowed to offer long-term care benefits if they wish or if they see a market opportunity as the elements of federal Medicare reform become clearer.

5. Life insurance options that pay for long-term care costs

- Encourage development of linked benefit policies that provide both life insurance and long-term care insurance protection.

6. Reverse mortgages

- Explore the impact of a state discount of a portion of the reverse mortgage fees if the homeowner uses the funds to meet long-term care needs.

⁴¹ Specific recommendations on financial incentives are not included here, but will be included in the issue brief completed by SHADAC by March 2005.

⁴² SLMBs and QMBs are persons with limited resources whose incomes are at or below the national poverty level. For these individuals the Medicaid program covers the cost of Medicare premiums, deductibles, coinsurance and certain non-Medicare covered services that Medicare beneficiaries normally pay out of their own pockets.

- Further evaluate the demand for reverse mortgages among the current and future elderly to determine the potential use in Minnesota for paying long-term care costs, especially by the “tweeners.”

7. Family loan program and line of credit for long-term care

- A family loan program should be initiated in Minnesota, and its progress monitored, to learn more about who is served, how the funds are used, and how it might fit into a comprehensive family support strategy in the state.

8. Public savings plan (Hawaii’s CarePlus)

- Monitor the efforts of other states currently reviewing this model, and if implemented, their experience during its operation.

9. Long-term care annuities

- Encourage additional development of these types of products especially at more affordable prices, so that a broader group of individuals might be able to consider the option.

10. Financial Incentives

- Consider the implementation of financial incentives identified in the SHADAC analysis that best achieve the state’s policy goals of ensuring that individuals have plans for retirement and long-term care, maximizing private dollars used for long-term care, and reducing future Medicaid liabilities.

* * * *

The department sees this report as an important first step in the state’s efforts to respond to one of the greatest demographic and fiscal challenges of the 21st century.