

Medicare Supplemental Enhanced Home Care Benefit

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Why Medicare?

- Medicare is a trusted government-run insurance program
- Coverage is well-nigh universal, even when looking at only those with supplemental coverage ($\cong 85\%$) and not just in Original Medicare
- Medicare reaches existing seniors compared to solutions requiring the purchase of insurance in advance
- No underwriting or income limitations

Minnesota Environment

- ~ 1,000,000 Medicare beneficiaries in Minnesota
 - ~ 560,000 in Medicare Advantage plans
 - ~ 120,000 in Medigap plans
- At-home care is limited to medical services approved by Medicare
- This leaves many beneficiaries without support for household and personal needs after hospitalizations or illnesses
- Possibly leads to new injuries or hospital readmission

Funding for Analysis

- Own Your Future received \$450,000 from a large federal SIM grant awarded to Minnesota by CMMI/CMS in mid-2016
- The funding was used to complete research studies on the potential role that Minnesota's two product ideas could play in helping middle-income households pay for long-term care costs

Studies/Work Completed on Minnesota Long-Term Care Financing Reform

1. Actuarial analysis to estimate premium level for both products
2. Consumer testing of two new products: focus groups with potential purchasers to determine product interest and the price they will pay
3. Creation of a MN-specific simulation model, to provide a tool to assess the effect of various LTC financing options on different payers
4. Contracts with national experts on Medicare and life/long-term care insurance to assist in the evaluation of these new products

Home Care Add-On to Medicare Supplemental Plans

Embed a non medical home care benefit in all Medigap and Medicare Advantage plans sold in Minnesota and fund this benefit primarily through beneficiary premiums

- Pay for qualifying home care services that help individuals stay at home safely
- Lifetime pool of up to either \$50,000 or \$100,000 with a daily cap of \$100
- Affordable premium that does not increase the cost to Medicare

Essential Community Supports (ECS)

- Existing program at DHS
- ECS provides home supports through 8 services
- Goal is to keep the individual in his/her home as long as possible
- Elderly eligible for this program are individuals with low functional needs but no longer eligible for Medicaid elderly waiver and alternative care services – level of care was raised effective 2015
- Limitations of scope
 - Ages 65+ only
 - Means tested

Proposed Benefit Package

- The essential service package includes services documented by DHS to be the key services to help seniors with low needs to stay in their home
- Services are authorized when Medicare approves home-based medical care and/or therapies
- (family provides many of these services but that is changing)
 - emergency response system (PRES)
 - homemaker services
 - chore services
 - caregiver training/education
 - home delivered meals
 - adult day services
 - service/care coordination
 - community living assistance
- PCA assistance

Potential expansion of EHC Benefit to include Personal Care Assistance

- Based on assessed need directly related to the condition for which the individual is receiving Medicare-approved home medical care
- Short-term assistance with dressing, grooming, bathing, eating, transferring, positioning, toileting
- Bill paying, List making, Meal planning
- Example: Broken limb
- Cost to cover PCA services is higher, so premiums were provided with and without this coverage

EHC Benefit Triggers

- Medicare-approved to receive home medical care
 - Under doctor's care and with a plan of care
 - Doctor-certified need for certain kinds of care
 - Must be expected to improve in a reasonable period of time or need skilled therapist to prevent deterioration of condition
 - Doctor-certified to be homebound
- All Medicare beneficiaries are eligible
 - No means testing and no age limitations
- Services are authorized when Medicare approves home-based medical care and/or therapies

Estimated Monthly Premiums 2017 basis

	without PCA	with PCA
Medigap	\$8.49	\$21.38
MA / MA Cost	\$6.79	\$17.09

Reasons that premiums may be lower than expected

- Medicare benefit trigger
- Community aging rating
- Broad coverage in all plans
 - Limits members opportunity to select against the plan
 - Members will pay EHC premium even after they exhaust benefits
- Expected utilization based on current use of programs
- Minnesota profile for utilization is different from other states

Areas of Special Consideration

Under-65 Disabled, Claim Savings

- Based on the actuarial analysis, aggregate costs increased only modestly when under-65 persons with disabilities were included. Makes more sense to include them:
 - Under-65 disabled (including ESRDs) get an open enrollment window to Medigap in MN, and
 - MA/MCP plans must enroll them during annual open enrollment period
- Reduced hospital inpatient or SNF costs if member has at-home support
- We found studies which demonstrate savings in similar (but not directly parallel) situations. However, the actuarial work assumes no savings, so is conservative in this respect

Areas of Special Consideration (con't)

Utilization Management

- Benefit trigger is Medicare HHC approval
- Adding a vesting period could help reduce adverse selection, if this was felt necessary
- Elimination periods would help but seem inconsistent with the purpose of the coverage
- Member cost-sharing – perhaps an initial deductible, as well as 25% or 50% cost-sharing for PCA
- Portability of lifetime maximum benefit limits strategic disenrollment or re-enrollment
- Differences between Medigap and MA plans

Results from Focus Groups

- Six focus groups were conducted throughout Minnesota in September and October 2017
- Research done by Office of Measurement Services at the University of Minnesota
- Total of 63 individuals in the following locations around Minnesota
 - Austin
 - Fergus Falls
 - North St. Paul
 - Maple Grove
 - Minnetonka
 - St. Cloud
- Questions asked about their current supplemental coverage, in-home health experience and expectations, pricing of the new product and interest in having the new benefit added to existing supplemental plans

Comments Made by Focus Groups

- “I think it would be good...I don't have personal experience and I think it would be very, very helpful to have these kind of services if I'm in this situation.”
- “I like the automatic enrollment.”
- “Some people don't have family to help or trained family. This is good for them.”
- “These are absolutely necessary.”
- “Having all of these services would allow someone to go home safely and be more cost effective.”
- “There's a lot of stuff here that would be very helpful I think.”
- “This would give me such a sense of security.”
- “To me, the ultimate is being able to stay at home, to have the support there.”
- “Insurance people need numbers. I'd go for the mandatory. It'll be so much lower if everybody is enrolled.”

More Comments from Focus Groups

- “I am concerned about the costs going up.”
- “Who would decide who the provider would be and if the services is needed?”
- “Not economically feasible at \$20/month.”
- “What are the problems it will address? How will this affect costs? In rural areas how will recipients be handled?”
- “Recovery time is ambiguous. It is hard for a doctor to make all these determinations; not all doctors would make the same decisions.”
- “Concept must be refined and better defined before it is added to the supplemental plan.”
- “I like having choice; don’t like anything mandatory.”
- “I like where it’s going but there are too many unanswered questions.”

Research by SHADAC

- The third leg of our research was undertaken by the State Health Access Data Assistance Center (SHADAC) earlier this Fall
- SHADAC tested various designs and impact from 2015 to 2030 showing savings to the state Medicaid program due to increase in coverage on the Medicare side
- By the end of that 15 year period it was projected that Minnesota would save hundreds of millions if the EHC benefit were implemented

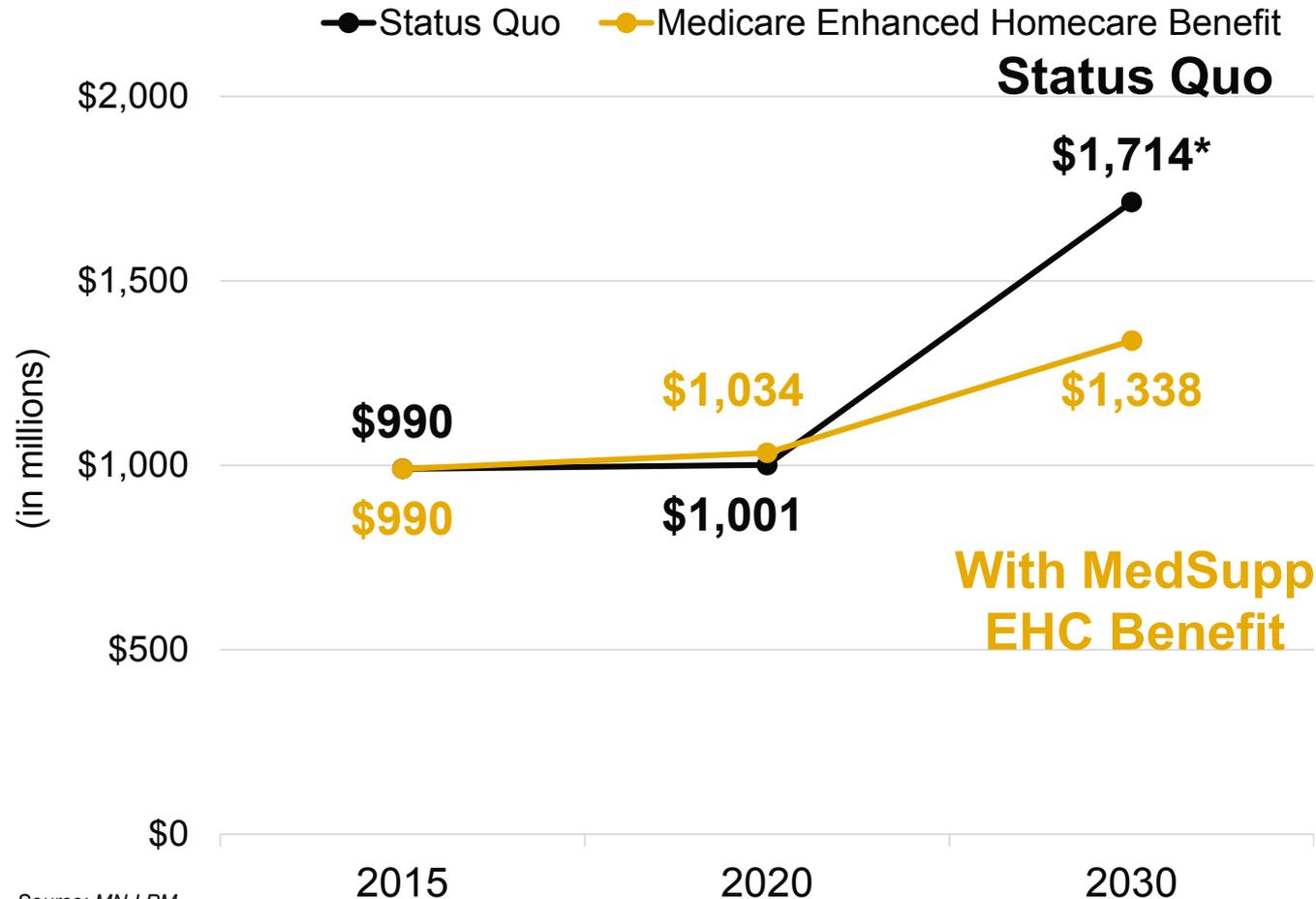
SHADAC in their own words:

Medicaid Savings of \$376 million

Our 2015 baseline costs of [Minnesota] Medicaid LTSS for individuals 65 and older is \$990 million. With no change in state policy, we project total Medicaid spending on LTSS in 2030 to grow by more than 70 percent to \$1.714 billion (assuming an expected annual inflation rate of 2%). Our preliminary analysis projects that adopting the Enhance Home Care Benefit as a supplemental benefit to all Minnesota Medicare Advantage and Medigap policy holders would save the state \$376 million with a projected 2030 spending of \$1.338 billion (assuming and expected annual inflation rate of 2%).

EHC Benefit in MediSupp Plans

Preliminary Results



Estimated 22% Savings of Baseline Projection or \$376 million (in 2030 dollars)

Source: MN-LPM
 These projections assume a medium scenario for Medicaid eligibility and LTCi
 Estimates assume an average inflation rate of 2%

* Statistically different

New Federal Developments

- CMS allows Medicare Advantage plans to add non-medical services starting in 2019
- Because the approval came late in the planning process, most MA plans are not doing anything in 2019 but most observers expect plans to do more in 2020
- CMS not as forthcoming in Plan negotiations (in contrast to what was in their Call Letter)
- The CHRONIC Act also goes into affect in 2020 -- aimed at beneficiaries with more serious complex medical conditions

New Developments (continued)

- MA plans in about 20 states are piloting various benefits; often limited rather than a larger list as found in Minnesota's proposal
- Unlike Minnesota the CMS change in policy only applies to MA plans so beneficiaries in Original Medicare (with or without Medigap coverage) do not have access to these
- More popular benefits added by MA plans so far (some differing from what Minnesota proposes):
 - Caregiver support services
 - In-home support and personal care services
 - Social worker phone line
 - Adult day care

Next Steps

- Monitor implementation by MA plans of benefits allowed under new CMS approach
- Determine whether Original Medicare and/or Medigap might be included
- More detailed discussion about how and when the enhanced home care benefit could be made available; complete a timeline for the initiation of a pilot or demonstration for this benefit
- Discussions with key stakeholders; get buy-in at federal and state level and work on any needed changes at the federal and state levels
- Determine if further research is needed on EHC savings or design structure

Thank You

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