Minnesota Medicare Home Care Benefit
Product Development Phase of Own Your Future Minnesota
June 15, 2016

I. BACKGROUND

Own Your Future Minnesota is an initiative of Governor Mark Dayton's Administration, to encourage and help Minnesotans plan for their long-term care, including how to pay for it.[1] The Governor began this initiative in 2012 and it includes three interlocking phases:

1. Implement a public awareness campaign that educates individuals about the need to plan for their long-term care. With longer life expectancies, increasing numbers of individuals will live long enough to experience the need for long-term care and need to plan for that eventuality.
2. Identify more affordable insurance and financial products for middle income households to use to pay privately for their long-term care. Even though family provides the vast majority of care for their older relatives, when family can no longer provide this unpaid care, individuals need to pay for care provided by formal agencies and facilities, and that care is very expensive.
3. Evaluate ways to change Medicaid to better incent private payment for long-term care. Because long-term care is cost-prohibitive, some individuals do not even investigate possible private financing options but instead plan to apply for Medicaid to pay for their care. We need to identify options that could be built into Medicaid that would provide incentives for those who invest in a private financing option to pay for their long-term care.

The initiative is currently focusing on phase two of the effort. In 2014, a subgroup of the overall Own Your Future Advisory Panel made its recommendations after a yearlong study, identifying 15 proposals for refreshed and new insurance and financial products that would meet the criteria set by the subgroup, especially the need for products to appeal to the middle income. The proposals included five categories:

1. Stimulate the long-term care insurance market to develop more consumer-driven starter or basic policies that better meet the needs of middle income households.
2. Modify legislation or regulations to make new or existing products more effective and attractive to consumers.
3. Explore the possibility of incorporating a long-term care benefit into Medicare Advantage and Medigap policies, as well as modernizing Medicare's post-acute benefits.
4. Make it safer and easier for consumers to access the existing equity in their homes to help fund their long-term care.
5. Make it easier for consumers to use tax-favored savings plans to pay for long-term care.

Of the 15 proposals, this paper discusses the idea of embedding a home care benefit in all Medicare Advantage and Medigap policies sold in Minnesota. A very large proportion (75 percent) of Minnesota's Medicare beneficiaries purchase one of these policies to pay for health care costs not covered by Medicare. By embedding a home care benefit in all these policies, Medicare beneficiaries would have coverage for nonmedical home care and personal care, which would complement the more medical home health care now provided through Medicare. (See Table 2 for comparison of Medicare benefits, typical wrap-around benefits in Advantage and Medigap policies and the proposed home care benefit.) Minnesota home care

[1] For this initiative, long-term care is defined as the assistance with personal care and household tasks that people need as they grow older as a result of physical and/or cognitive impairments, or if they experience an injury or illness earlier in their lives.

benefits would be unique and would provide services that people need as they begin to “frail” and need support to stay in their home.

II. THE HOME CARE BENEFIT IN MINNESOTA ADVANTAGE AND MEDIGAP POLICIES

Table 1 below provides a preliminary sketch of a home care benefit that could be included in all Minnesota Advantage and Medigap policies sold in Minnesota, and possible options for addressing the issues that surround the creation of this benefit. These options grew out of discussions with a number of stakeholders, with the goal of developing a benefit design as a place to start. Any or all of the specifications described here can be reconsidered or revised as additional discussions are held with Minnesota's health plans and other national organizations interested in these issues.

Table 1: Minnesota's Home Care Benefit Description[2]

ELEMENT	BENEFIT SPECIFICATIONS	IDEAS DISCUSSED	COMMENTS
Universality	• Benefit would be embedded in all: • Medicare Advantage (MA) plans • Advantage Cost plans • Medigap policies This would include all the policies sold in Minnesota by carriers outside Minnesota	• We want all policies to include the home care benefit • There are special issues with the current Medigap beneficiaries, including their advanced age and diminishing numbers • We need input from Medigap carriers as to how to structure their enrollment in this product	• There are separate tracks needed for approval to mandate embedding this benefit • Approval for Medigap policies is at the state level • Approval for Advantage plans (including cost plans) is at the federal level • Need to nail down exact approval process
Coverage included in benefit design	• Main elements of the benefit are the services included in the Minnesota "Essential Community Services" package: [3] >> personal emergency response system >> homemaker services >> chore services >> training and education of family caregivers >> home delivered meals >> adult day services >> service coordination (aka care coordination) >> community living assistance (assistance in coordinating and	• Since the "Essential Community Services" package does not include hands-on or stand-by assistance (the terms used in long term care insurance), we would add personal (custodial) care to provide greater support • This type of care is desired by seniors and important in supporting aging in place • Second tier benefit based on the long term care insurance model could be added, and would need to include underwriting	• Probably best to characterize the benefit as "non-medical home care" • We need to find a new name so that it is not confused with Medicare home health benefits • Test various names: >> In-home supports >> In-home services >> In-home assistance >> help at home • The LTCI industry can decide if it wants to capture a potential market by offering policies that expand on

[2] See more discussion about these benefits on pages 5 - 8.

[3] The Essential Community Services" Program is one that the state now funds and offers to older people who are no longer eligible for Medicaid because of low need, but who need some support in order to stay in their homes. For further information, see Essential Community Services Bulletin, DHS, 2014, http://www.dhs.state.mn.us/main/groups/publications/documents/pub/dhs16_191570.pdf

	using a package of services in order to stay at home) • Benefit also includes personal care services, the kind provided by PCAs or similar universal workers that may be recruited from an individual's natural helping network	• At this time we are not suggesting that a second tier benefit be included, because individuals who want more complete coverage (assisted living, nursing homes) can buy LTC insurance	what the supplemental home care benefit offers
Benefit parameters including waiting and vesting periods	• The benefit period would be one year if the benefit was used at the full rate • The period would be cumulative (not consecutive) • Coverage would be up to $100/day, and this would create a pool of $36,500 (which is also the lifetime cap) • We also want to see pricing for creating a pool of $50,000 as a lifetime cap (with no daily cap) • Benefit has no vesting period, i.e., period when coverage is not available until enrollee has been member for specified period of time • There would be a 90-day elimination (waiting) period, i.e., an enrollee has to be eligible for 90 days before the benefit can be accessed	• We prefer creating a pool of $50,000 as a lifetime cap (versus the concept of $100/day x 365 days), but need to see the price • We could test the effect of having a vesting period ranging from one to three years to see if it would drop the premium price • We could also test a 120 day and 180 day elimination period to see the effect on premium price • No inflation protection built into the benefit (users of this product are closer to claim and so inflation is not an issue as it is with long term care insurance sales to younger age buyers)	• Adding a vesting period might be perceived as overly limiting and would not necessarily alter the premium that much • A vesting period for this benefit would add a complex layer of administration for the health plans • Ask the health plans for thoughts and preferences on the benefit caps, vesting and elimination periods • We also recognize that the absence of a vesting period may have a larger impact on price than we expect and are open to pricing this if necessary
Enrollment	• Benefit would be imbedded in all Medicare Advantage plans, cost plans and Medigap policies • Individuals who are dually eligible for Medicare and Medicaid would not be included because they already have better coverage for LTC (through Medicaid) than provided by this benefit • Persons on Medicare by reason of disability or ESRD are included if they purchase a supplemental policy	• Imbedding this benefit must be mandatory across all plans because the voluntary approach would raise the issue of adverse selection • Medigap policyholders would probably only be enrolled as they turn 65/first sign up. • How to handle the Medigap folks is part of a larger discussion we need to have with the carriers that offer Medigap policies	• Very few if any duals or persons with disabilities purchase supplemental plans – we need to find out how many do purchase these policies • Opt out was discussed for different reasons (for instance persons with stand-alone LTC insurance) but the final decision was that there should be no exceptions to coverage

	• Opt-out would not be offered unless it is required by state/federal approvers		
Portability	• Portability of this benefit would be allowed; a record of utilization would need to be transferred to new plan	• Overall, very little plan switching occurs except when rates are changing or increasing	• Prohibit movement to new plan while on claim? This should be discussed with the health plans • Portability here means within the state (between plans) so a question that has not been resolved is how this would work for so-called "snow birds"
Underwriting and rating issues	• These plans are and should be community rated with no gender pricing allowed • No underwriting would be allowed, except as now allowed after the first six months of eligibility in Medigap policies	• No other options have been considered	• Community rating is required in Medicare • Gender pricing not allowed in Medicare
Premium Subsidy	• None included in the design described here	• Explore possibility of additional premium subsidy for low income beneficiaries	• Existing subsidy programs (QMBY and SLMBY) were viewed as sufficient
Triggers for the Benefit	• Equivalent of 1 ADL or moderate cognitive impairment to be eligible for benefit • Insurance company would be responsible for signing off on this but independent third party appeal rights in Medicare would allow for challenge by beneficiary if denied	• Goal is not necessarily to use HIPAA triggers but we wanted benefit eligibility to be earlier/lighter than LTC insurance (2 ADL/severe cognitive impairment)	• Talk to clinicians to see if there are alternative tests, e.g., HEDIS, that they would prefer to assess eligibility; could also use hospitalization as a trigger, i.e., the person is deemed eligible upon discharge

III. DISCUSSION OF BENEFIT ISSUES

Below is a summary of points made in Own Your Future staff discussions with various stakeholders about how to design the home care benefit to be embedded in the Medicare Advantage and Medigap policies sold in Minnesota.

Universality and Enrollment

The best option appears to be to imbed the benefit as a mandated offering in all Advantage and Medigap policies sold in Minnesota rather than adding this as a voluntary product. The "mandatory versus voluntary" debate, which was a major issue within the CLASS Act and is a huge issue in any LTC coverage, clearly shows that adverse selection issues arise quickly, given the relatively low take up of benefits like the one we want to add to the Advantage and Medigap policies.

We believe that Minnesota's Medicare beneficiaries should be enrolled in a plan that includes this new mandated offering, rather than having those already in Medicare continue with their current plan options. Doing it that way would add administrative complexity, needing to maintain more kinds of plans. The sheer number of plans already makes the marketplace very complex for the consumer.

Persons who are dual eligible enrollees in Minnesota receive these home care benefits as well as other Home and Community-based Services (HCBS), customized living and nursing facility care through Medicaid. Since duals are low income and already covered by both Medicare and Medicaid, the vast majority do not purchase or use other policies. If they wish to purchase a plan with their own funds, they should be able to do so. In the past, Medicaid has not paid for these policies for duals.

The conclusion was tha,t other than the duals, there would be universal inclusion and no opt out options. We had, for instance, discussed opt outs for people who have LTC insurance. However, since that triggers at 2 ADLs and our home care benefit would trigger earlier, there is reason to think these two insurance products are really not duplicative.

Some distinctions need to be made between Medicare Advantage (which includes cost contracts) and Medigap policies.

- For those covered by Medicare Advantage plans including the cost plans, this benefit will include all enrollees--those already enrolled and those newly enrolled each year.
- Medicare Advantage plans are renewed each year, each year new Medicare enrollees join the program, so it makes sense to have it cover everyone in the Advantage plans, including those in the cost plans.
- Medigap, however, is a guaranteed renewable product, so this benefit may not be able to be added for current enrollees, only new enrollees in Medicare.
- If Medigap coverage is only for new people coming in, you have to make that distinction and carry it through, meaning the carrier ends up with two pools of beneficiaries and there could be problems with the older blocks becoming closed blocks (because they have no new enrollees).
- Also, if only new enrollees are included each year, this is a relatively small number and it would take years to reach all Medicare beneficiaries who have Medigap coverage with this new benefit.
- We need to talk to the carriers offering Medigap policies to obtain their suggestions on who to handle these issues for that group.

- Other issues include how to handle movement of beneficiaries between MA and Medigap as well as “snow birds.”
- In addition, some plans operate in several states so we need to address this when plans contract with Medicare (however, examples exist for doing this, e.g., Florida).

Pricing and Subsidy Issues

A major overall issue for this new benefit is the price point discussion. This issue can make or break the concept workability, and so it must be addressed carefully for this project to succeed. For instance, adding a benefit such as this could have the unintended consequence of making the overall policy unaffordable to some individuals, thus forcing them to choose between this coverage and drug coverage, possibly resulting in them going "bare” without other important coverage.

This would be contrary to achieving desirable public policy objectives. For that reason our discussions focused on the importance of starting with a “thin” product. The benefit replicates Minnesota’s Medicaid Essential Community Services program (see below for more on this). However, we recognize that others may be interested in a more substantial benefit. In fact, the national Urban/Milliman modeling to date has looked at a benefit more like what long term care insurance provides. However, we know that trying to provide that level of benefit would negatively impact the Advantage and Medigap market.

One solution to this situation would be creation of a two-tier benefit (i.e., one base plan and a “buy up” option). We opted to include only the one tier concept (that is the base plan for all plans) due to the complexity and the cost of the second tier.

Recognizing that the price sensitivity in this market is huge, the other option explored was the notion of a subsidy. That exists now for lower income seniors (LIS) for the Part D drug benefit. The subsidy is through (to) the carrier for administrative efficiency and we could do the same for this benefit. Going forward, we’d want to see how this would work with the QMBY and SLMBY populations. (QMBY is shorthand for “Qualified Medicare Beneficiary” and SLMBY for “Specified Low-Income Medicare Beneficiary.) For purposes of going forward, at this point in time we believe the QMBY and SLMBY subsidies should be adequate. However, if more is needed we assume that the funding for the subsidy would be state general funds, and this request would need to be included in any package of authorizing language when we move forward with required legislative actions.

Related pricing issues not discussed in detail include use of integrated care systems. The difference in fee for service versus capitated systems gives hope that health plans could offer these benefits and capture the savings. If so, the need for premium charges to enrollees goes away. As with wellness and preventive benefits, the carrier will re-capture initial costs for providing these core benefits from fewer hospital admissions and SNF/home health use.

Benefit design and parameters related to design

The core benefit is taken from the Minnesota Essential Community Services. This provides:

- personal emergency response
- homemaker services
- chore services
- training and education of family caregivers
- home delivered meals

- adult day services (ask the health plans if this service is an appropriate one to include in this package?)
- service coordination (care coordination)
- community living assistance (assistance in coordinating and using a package of benefits in order to stay at home)

In addition, stakeholders recommended that we add personal care to this package to provide assistance with ADLs and minor cognitive impairment as individuals begin to "frail" and need some help. However, we are open to testing the price implications of this addition. But an important element going forward would be to gain more information around how the core benefit is being utilized and the cost of these separate components.

It is probably best to characterize the benefit as "non-medical home care." We need to find new names for this type of care so that it is not confused with Medicare home health benefits or long-term care insurance. As part of consumer testing of the benefit (down the road a ways) we could test various names: In-home supports, In-home services and In-home assistance, help at home, etc.

Another issue discussed is the type of benefit period to use – consecutive or cumulative? We preferred cumulative up to 365 days per year. However, we thought the individual should be able to roll over any unused time to the next year.

A related issue was whether to have monthly versus daily caps… or none. Discussion around caps was extensive. It is necessary to have some control to keep the price down. Some suggested a daily cap of $100 up to 365 days. However, we need to see the price of this benefit and then determine the maximum amount of funding that could be made available on a yearly basis. An actuarial analysis will be necessary to determine the amount. Inflation protection would not be specified. If needed, cost increases would be accommodated on an annual basis, as they are in most health insurance plans.

Waiting/Vesting and Portability

Our design contains a 90 day elimination period (like LTC insurance); an individual has to be eligible for 90 days before benefits begin. The elimination period is akin to a waiting period. We are open to modeling 120 day and 180 day elimination periods.

Also discussed was the notion of a vesting period, meaning coverage would not be available until an enrollee had been a member in the plan for a certain number of years. This is done in products like dental and vision insurance where there would be adverse selection for certain benefits if an enrollee could join the plan one day and apply for covered services the next. We decided against vesting. Coverage without this barrier would be more attractive for the consumer, less complicated to administer, and connect with overall Medicare benefit (where there is no vesting). In addition, re-enrollment with a different carrier would be more difficult.

The issue of portability is an example of one issue among a myriad of administrative complex issues for the health plans. The option of portability would seem attractive for the consumer. We understand that there is little movement between plans for the vast majority of Medicare enrollees. But if portability were offered, there would be administrative decisions to be made to address the need for adjustments, the record of cumulative days within the benefits, etc. Not only are these challenging but may be expensive and time consuming, and need to be acknowledged and addressed. We need to ask the health plans what their thoughts are about portability.

Underwriting and rating issues
There would be no gender or age pricing. This is in keeping with Medicare. However, a "thin" benefit might not be enticing enough for large adverse selection issues. The product should be community rated like Medicare itself. There would be no underwriting, again, like Medicare and Medigap. Note that individuals who sign up for Medigap after that first 6 month period are subject to underwriting at the option of the insurance company and this would be true for our benefit as well. This is another example of where suggestions from the carriers offering Medigap would be valuable.

Triggers
We had extensive discussions of various elements of triggers in Medicare versus long-term care insurance. LTC insurance uses HIPAA which requires 2 ADLs or severe cognitive impairment. For a benefit such as ours – home care – it seemed a trigger like that would be too high. Instead it would be something more like one ADL/moderate cognitive impairment. IADLs were discussed too but since they are not found in either Medicare or long-term care insurance it was felt that it might be too great a stretch to use those. IADL triggers are more subjective and difficult to measure.

Medicare itself has a trigger for post-acute care (essentially LTC) that requires a 3 day prior hospitalization. The 3 day trigger is easy to administer but typically waived by Advantage plans. Maybe it could be reinstituted for purposes of the home care benefit. Another thought is to tie the benefit to completion of an observation stay. In essence, if the person has been admitted for observation they have some level of medical need going on and could be discharged at that point either into the Medicare benefit structure – SNF or home health – or back home and utilize this benefit if they don't trigger the more comprehensive care. In any event, the goal is to fund the most appropriate care for the individual and this additional benefit allows for a better (more diverse) range of care options.

Other options include the use of some other measure, possibly the Care of Older Adults measure (HEDIS) or a Physician office/Health Risk Assessment (HRA). There is also a care coordination measure for chronic care populations, although that may not be the right one. There are also others such as the Health of Seniors (HOS). More research/input from the clinician is needed here to determine the most efficient way to trigger the benefit.

In home visits for assessments and diagnostics are some mechanisms that health plans could use. Advantage plans are able to do assessments; it is a burden but doable. We are looking for things that the plans can use as a platform but recognize it would still be a brand new system. For health plans the question is what's the easiest and most useful measure or assessment to build on for purposes of this benefit?

IV. NEXT STEPS

The group had various discussions around next steps and our timeline.

- If we can get agreement on the benefit and the other features of the program, then the next step is the actuarial analysis to see how the pricing looks. There may need to be several iterations of that benefit, trying to come up with an appropriate price and an attractive benefit.

- After that work, there needs to be consumer testing of the benefit (and maybe several variations on a theme) to see what the consumer thinks of the product and how much they would pay for the benefit.
- Then decisions could be made on the final product design and next steps could begin.
- We would have to be finished with the design work by mid-2017, in order to implement in 2019.
- Marketing for 2018 will have to be done early, because of the expected changes, so it might not be realistic to plan to have this benefit ready by 2018. Hence we are looking at 2019 but a start date of 2019 coincides with the end of MA "cost" contracts. Similarly, there will be market changes in 2020 as medigap "first dollar" coverage goes away. Many expressed a preference for starting this new benefit at the time when the cost plans need to be replaced.

Most importantly, we need continued buy in from the health plans and other health and insurance organizations, recognizing that there are health plans and insurance companies that sell product in Minnesota but are not based here. We also need more actuarial input on the cost to consumers of this benefit. Likewise as to savings to Medicare and Medicaid. We believe both will be true. For instance, providing services such as we have suggested would potentially help Medicare by delaying or preventing hospitalization or, if the person does go to the hospital, a readmission. Likewise, if the person does not have to spend down, or it is delayed, that would help Medicaid financially.

At the proper time, we would begin outreach to a number of state and federal parties to describe what we are doing and why, and garner their support for the concept.

Table 2. Comparison between Original Medicare "LTC" Benefit, Typical Advantage and Medigap "LTC Coverage" and Minnesota LTC Benefit

Original Medicare	Typical Advantage and Medigap Policies	Minnesota LTC Benefit
Nursing Facility (NF) Coverage o 100 days of coverage per benefit period o Days 1 – 20 are covered in full if qualifying daily skilled services are provided o Days 20 – 100 are coinsurance days and the beneficiary pays an amount for each of these days. (See supplemental plan for more detail on this) o All nursing services, therapy services and other skilled services and ancillary items are included in this Part A coverage o Part B can also cover therapies in a SNF if not covered under Part A	**Nursing Facility Coverage by: Cost plans** Days 1 – 20 $0 copay per day for each Medicare-covered stay Days 21 – 100 $0 copay per day for each Medicare-covered stay **Nursing Facility Coverage by: PPO plans** In-network o Days 1 – 20 - $0 co pay per day o Days 21 – 100 - $160 copay per day Out-of-network – 20 - 50% coinsurance for each NF stay (No prior hospital stay required) **Nursing Facility Coverage – HMO and PFFS plans** o Days 1 – 20 - $40 copay per day o Days 21 – 100 - $0 copay per day o (No prior hospital stay required) **Nursing Facility coverage – Medigap plans** o Most plans cover full coinsurance – some cover 50% – 75%	**Nursing Facility Coverage** • No coverage
Home Health Coverage o Up to 35 hours of home health care per week can be covered o Intermittent skilled nursing and rehabilitative home care services are covered if physician certifies they are medically necessary o This certification means that skilled home health services can be provided, e.g., help with bathing, other personal care and household tasks o Skilled home health care services include wound care, skilled therapies, skilled monitoring and treatment of a condition from which the beneficiary is recovering	**Home health coverage – Cost plans** o $0 copay for each Medicare – covered visit **Home health coverage – PPO plans** In-network - $0 copay for Medicare-covered visits Out-of-network – 50% coinsurance for Medicare-covered visits (once annual deductible is met) **Home health coverage – HMO plans and PFFS plans** o $0 copay for each Medicare – covered visit **Home health coverage – Medigap plans** o $0 copay for each Medicare – covered visit	**Home health Coverage** No coverage for skilled nursing, therapies and related skilled home health services

o The services must be skilled and not custodial care services o Services covered y Part A do not have a copayment or coinsurance (except for durable medical equipment)		
Hospice Coverage o Physician must certify that beneficiary has a terminal illness with life expectancy of 6 months or less o Many services are covered, except room and board o The following services are covered: o Doctor services o Nursing care o Medical equipment o Medical supplies o Prescription drugs for symptom control and pain relief o Hospice aide and homemaker services o Physical and occupational therapy o Speech-language pathology services o Social work services o Dietary counseling o Grief and loss counseling for you and your family' o Short-term inpatient care (for pain and symptom management) o Short-term respite care o Any other Medicare-covered service needed to manage your pain and other symptoms related to your terminal illness, as recommended by your hospice team o No cost to Medicare beneficiary except co insurance of 5% for respite care and no more than $5 copayment for prescription drugs for pain and symptom relief	**Hospice Coverage** • No additional coverage provided by plans because the services under original Medicare are comprehensive • No cost to Medicare beneficiary except co insurance of 5% for respite care and no more than $5 copayment for prescription drugs for pain and symptom relief	**Hospice Coverage** No additional coverage is provided
Nonmedical home care None provided except:	**Nonmedical home care** None provided	**Nonmedical home care**

• When provided as part of skilled services in home health coverage for limited period of time/visits • When provided as part of hospice services (hospice aide and homemaker services)		A set of nonmedical home care services are covered, including o Emergency response o Homemaker services o Chore services o Training and education of family caregivers o Adult day services (?) o Home delivered meals o Service coordination (sometimes called care coordination) o Community living assistance (assistance in coordinating and using a package of benefits in order to stay home) Personal care to assist with ADLs