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# New Approaches to Long-Term Care Access for Middle-Income Households





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# INTRODUCTION

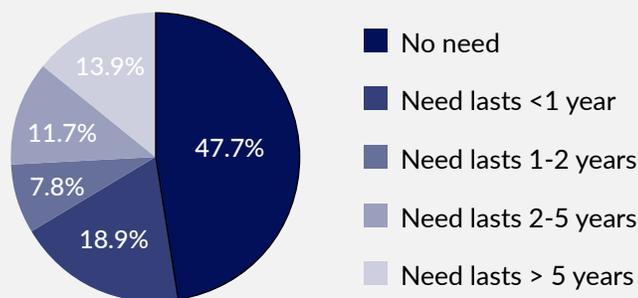
Americans often underestimate the type and level of care they will need as they age, specifically the services and supports necessary to maintain the essential functions of daily life. From mobility assistance to help with dressing and eating, these long-term services and supports, often referred to as long-term care (LTC), address a range of non-medical needs that may arise during our later years. It is an uncomfortable truth, but many of us will have to rely on others for our ongoing care, particularly for basic functions and tasks.

Harder still to contemplate are the financial costs related to LTC, either at home or in more formal settings like nursing homes and assisted living facilities. As a result, families too often find themselves ill-prepared when the actual need arises, whether from accident, disease, chronic illness, or age-related declines in balance, dexterity, and cognition. According to one study, middle-income households are especially vulnerable; by 2029, 54 percent of middle-income seniors will not be able to afford the care they need.<sup>1</sup> Their Medicare and Social Security benefits will not be sufficient, and they will be priced out of the private LTC insurance market, which has been shrinking in recent years. Nor will they qualify for LTC benefits via Medicaid, without first spending down their assets to the poverty level. The challenges that face our current care system are quite varied and vexing, and the public and private sectors must do more if they hope to ensure that people have access to the affordable and quality care they need.

Every day since 2010, roughly 10,000 baby boomers have turned 65. By 2030, the youngest of the “boomers,” people born between 1946 and 1964, will be at least 65. The oldest are turning 75 in 2021.<sup>2</sup> In all, roughly half (52 percent) of this generation

is expected to require a high level of LTC at some point, with care periods varying from less than a year (19 percent) to more than five years (14 percent)<sup>3</sup> (Figure 1). This care is costly on multiple levels, straining families financially and emotionally. Roughly 15 percent of boomers will incur expenditures exceeding \$250,000.<sup>4</sup>

**Figure 1: Projected Need for LTC for People Turning 65 in 2015–2019<sup>5</sup>**



Source: Favreault, M. and Dey, J. “Long-Term Services and Supports for Older Americans: Risks and Financing.” US Department of Health & Human Services. (2016)



The access, delivery, and financial challenges are too vast for either the private or the public sectors to shoulder alone. In different ways, each is in crisis from the mounting weight of need and costs. Health care is caught up in bureaucratic strangleholds, insurance is limited and costly, and the social health and safety net systems are underfunded historically. Yet if the public and private sectors find more ways to partner, they can help ensure that our aging populations can access affordable, quality, non-medical long-term care.

Based on extensive market research, the Milken Institute analyzed the most significant barriers to meeting the LTC needs of middle-income Americans and identified three of the most promising areas for increased financing and delivery opportunities: Medicare expansion solutions, technology solutions, and public and private long-term care insurance solutions. In November and December 2020, the Milken Institute partnered with Genworth to convene a series of Financial Innovations Lab® sessions, informed by the work of the Milken Institute Center for the Future of Aging. These convenings brought together a highly engaged group of experts from government and academia, as well as health care, insurance, long-term care delivery, senior housing, technology, and finance. Long-term care is a complicated issue, and many experts, organizations, and government entities have been working for decades to develop better ways to address this need.

*The Lab discussions focused explicitly on developing better metrics on the effectiveness of technology solutions for home-based care, scaling up promising integrated-care delivery programs, and designing complementary and affordable public and private LTC insurance solutions.*

### 1 / Barrier

Lack of large-scale testing of technology solutions to enhance home-based care with limited data sharing across care settings

### 1 / Solution

Design a large-scale Medicare Advantage demonstration project that tests technology solutions (telehealth and remote monitoring) to enhance home-based care

### 2 / Barrier

Lack of integrated care options for middle-income households

### 2 / Solution

Scale up promising integrated care programs currently in operation, prioritizing access for middle-income beneficiaries

### 3 / Barrier

Inadequate long-term care insurance options

### 3 / Solution

Develop complementary public-private insurance solutions that offer seamless, affordable coverage



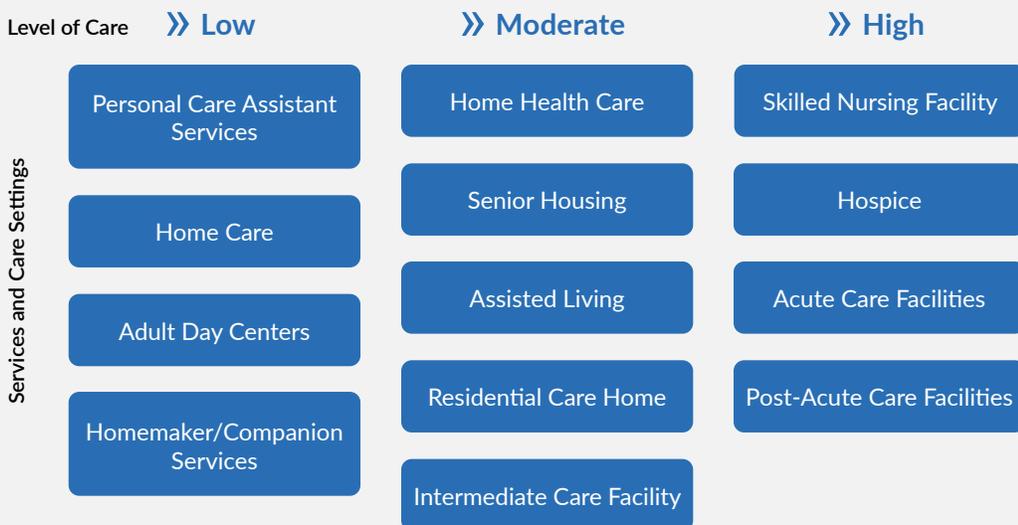
# ISSUES & PERSPECTIVES

## The State of the US Long-Term Care System

### Overview

Long-term care pertains to the assistance people need when they can no longer independently perform certain “activities of daily living” (ADLs). Specifically, it is non-medical assistance that helps support and maintain a person’s health and quality of life, as well as reduce the need for costly medical services. LTC may be delivered in the home or to residents in nursing homes and assisted living facilities. Adult day care centers and charitable organizations also provide services in the community. Many people receive unpaid care from family members or friends, though this informal care is not without cost. The caregivers themselves may personally experience adverse financial, professional, and emotional effects.<sup>6</sup> The following figure illustrates the different levels of care individuals may require and the corresponding range of services and care settings.

**Figure 2: LTC Range of Settings and Services**



Continuing Care Retirement Community (provides full continuum of care in one location)

Sources: Connecticut Association for Non-for-profit Providers for the Aging, Milken Institute (2021)



Among other weaknesses in the health-care system, COVID-19 exposed the dire need among older adults for access to affordable, quality LTC. The pandemic has touched every aspect of life, but older adults, especially those living in group settings, are experiencing profound effects. According to [The COVID Tracking Project](#), people living (and working) in LTC facilities, nursing homes, skilled nursing facilities, and assisted living facilities accounted for 38 percent of COVID-19 deaths across the country by year-end 2020.<sup>7</sup> The LTC system “is neither a sustainable system nor one prepared for future outbreaks,” according to a *Health Affairs* blog article that cites systemic inequalities, insufficient oversight, and outdated funding models.<sup>8</sup>

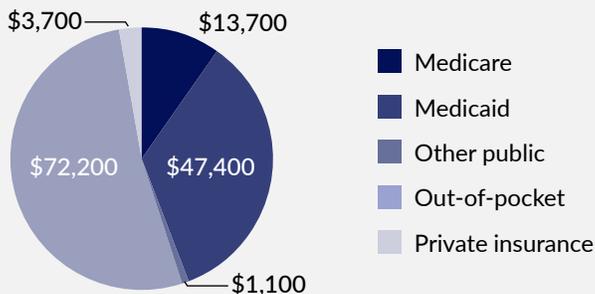
Yet there are hopeful signs: The pandemic has accelerated the shift from institutional care toward home-based care, a trend that aligns with older adults’ preferences. A recent AARP survey shows that 76 percent of Americans 50 and older say they want to remain at home as long as possible.<sup>9</sup> In addition, the pandemic has brought a broader adoption of technology (e.g., telemedicine) that can improve home-based monitoring and care.

### Public-Sector Programs

Like the broader health-care system, the LTC system suffers from fragmentation, inefficiencies, and gaps in coordinated care between federal, state, and local programs. Gaps in the public health insurance safety net have also hampered long-term care delivery, especially for 65-and-older middle-income households that typically rely solely on Medicare.

Much like a typical health insurance plan, Medicare provides benefits only for acute and primary care needs, such as hospitalizations, physician visits, and short-term post-hospital rehab or home care. However, people often mistakenly believe that Medicare or health insurance will cover non-acute LTC costs. For the most part, they are wrong. Older adults generally pay 52 percent of their LTC expenses out of pocket, a figure that comes to about \$138,000 from age 65 through death.<sup>10</sup>

**Figure 3: Average Sum of LTC Expenditures from Age 65 through Death Projected for Adults Turning 65 in 2015-2019 (in 2015 Dollars)<sup>12</sup>**



Source: Favreault, M. and Dey, J. “Long-Term Services and Supports for Older Americans: Risks and Financing.” US Department of Health & Human Services. (2016)

Medicaid is, however, the largest public-sector payer of LTC expenditures for people 65 and older. For adults who turned 65 between 2015 and 2019, Medicaid is projected to pay 34 percent of all LTC costs from age 65 till death.<sup>11</sup> (Figure 3). But middle-income households cannot qualify for Medicaid without spending down their assets to meet the strict income limits.



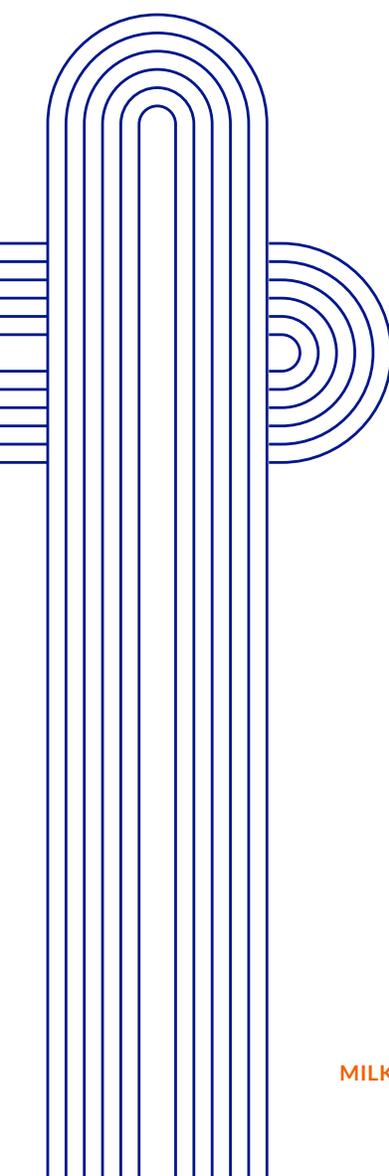
Medicare has begun experimenting with covering non-medical benefits such as home-delivered meals through its Medicare Advantage (MA) program. MA plans are Medicare-approved private health insurance plans that combine Medicare Parts A (hospital), B (medical), and usually D (prescription drugs), as well as other benefits an enrollee selects. MA plans operate under a capitated payment structure that differs from the traditional Medicare fee-for-service (FFS) model. The capitated payment structure requires MA plans to shoulder the full financial risk for each enrollee. If an enrollee's care costs exceed the fixed payment amount, the plan must cover the difference. This dynamic incentivizes the private insurer to offer coordinated care and comparatively improved care management.

A growing body of evidence confirms what public health experts have maintained for decades: that factors outside the clinical environment, namely nutrition, quality of housing, and access to transportation, affect health outcomes and overall health-care costs.<sup>13</sup> In 2018, the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act was signed into law, allowing for more flexibility in MA plans. The act allows MA plans to offer "special supplemental benefits," including non-medical benefits like expanded transportation services, food and produce, and structural home modifications.<sup>14</sup> It also enables plans to provide non-uniform benefits to enrollees in the same region.<sup>15</sup> This shift is a small but important step toward Medicare coverage of LTC for targeted enrollees.

MA plans cautiously rolled out these new benefits in 2020, and experts anticipate a broader distribution of benefits across markets in the future. The Centers for Medicare & Medicaid Services (CMS) has also tested and expanded the delivery of new benefits under its Value-Based Insurance Design (VBID) program. The VBID model is designed to motivate participating MA plans to offer incentives (e.g., reduced co-pays and supplemental benefits) to beneficiaries with specific chronic diseases.<sup>16</sup> The model is now permitted in all 50 states and will provide much-needed data about the impact of supplemental benefits on improving health outcomes.

Apart from expanding Medicare benefits, policymakers at both the state and federal levels have explored legislative approaches to address the LTC needs of their constituents. In 2010 the Affordable Care Act (ACA) established the Community Living Assistance Services and Supports (CLASS) Act, which would have provided a federally administered and voluntary long-term care insurance (LTCI) program. Ultimately, however, lawmakers deemed the program financially untenable and repealed it in 2013. In the years since, states have explored ways to design their own LTCI programs, with Washington state being the first to enact legislation, its Long-Term Care Trust Act, in 2019.

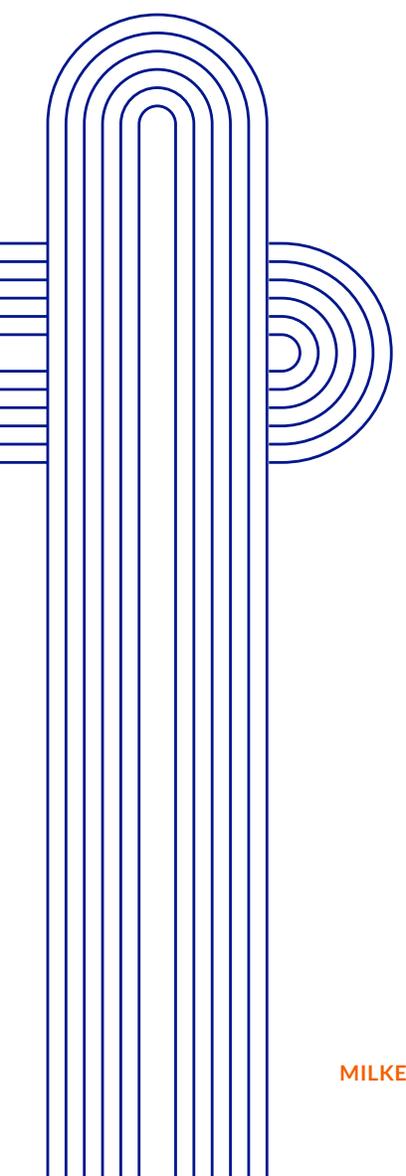
Beginning in 2022, Washington will fund its mandatory program through a payroll tax of 58 cents for every \$100 of income for all W-2 workers in the state; self-employed workers can participate if they choose. Once residents become eligible for benefits, they can access up to a maximum lifetime benefit of \$36,500 (indexed for inflation) in \$100 units. This is the first state-based social insurance program to





provide residents with a dedicated LTC benefit. It is not perfect—the benefit level may be inadequate for individuals who require high levels of care. And in November 2020, voters rejected a referendum to expand the types of investments available to the program’s trust fund to include private equities. As a result, the trust fund investments remain limited to corporate bonds and certificates of deposit.<sup>17</sup> These restrictions will cause the current level of payroll tax to be inadequate for funding the program in the long term, according to a study by Milliman.<sup>18</sup> Despite these drawbacks, the program will provide essential data and lessons for other states in the future.

### Private LTC Funding



With limited public-sector options, middle-income Americans are left to find alternative sources of funding for their care needs. A recent AP poll shows that 67 percent of respondents had done little to no planning for LTC, and 57 percent mistakenly believe that Medicare will cover their LTC costs.<sup>19</sup> According to Vanguard, in 2019, the average 401(k) account balance for those 65 and older was \$216,720, and the median was \$64,548.<sup>20</sup> These amounts are wholly inadequate when one considers that costs rise proportionally to the complexity and duration of care, quickly exhausting the personal savings of individuals with severe and extended care needs. As Genworth notes, the median cost of a private room in a nursing home totals \$105,850 per year.<sup>21</sup> In addition, significantly fewer private-sector workers—just 15 percent—have the kinds of traditional, defined-benefit pension plans that used to help fund retirement.<sup>22</sup> The shortfall in their retirement savings concerns many workers. According to MetLife’s 2019 Annual Employee Benefit Trends Survey, the second most common source of financial stress for employees was outliving their retirement savings.<sup>23</sup>

As outlined earlier, Medicare will cover only a limited amount of LTC costs. As a result, family members often step in as a substitute for paid in-home care, which can cost as much as \$4,385 a month.<sup>24</sup> This work is emotionally taxing, unpaid, and may require the family caregivers to incur expenses and experience adverse effects on their careers and financial position. The worker who leaves the labor force to take on a role as an unpaid caregiver will incur, on average, an estimated \$300,000 in lost wages and Social Security benefits.<sup>25</sup>

Another essential part of the LTC landscape is the private long-term care insurance (LTCI) industry. Unfortunately, private LTCI currently pays less than 3 percent of the total LTC costs, a minuscule share.<sup>26</sup> Over the past 15 years, the number of LTC insurers in the market dwindled from over 100 in 2004 to about a dozen in 2018.<sup>27</sup> This is attributed in part to inaccurate actuarial assumptions on older policies and the high levels of losses that insurers sustained. The actuarial shortcomings of legacy policies also resulted in sharp premium increases that made these policies unaffordable for some existing policyholders and unattractive to potential purchasers of new policies.



LTCI products now carry hefty premiums and cater chiefly to high-income households, leaving middle-income households with few private insurance options. There has been some experimentation with health insurance features like co-pays and deductibles to help bring down premium costs of traditional standalone LTCI, but the market penetration remains low.

Lack of awareness of LTCI options among consumers is also a challenge. The dearth of employer-sponsored group LTCI plans is one factor that impedes education and understanding. Much of our retirement education and planning happens through workplace benefits programs, yet less than 0.5 percent of employers offer long-term care insurance.<sup>28</sup> A 2017 survey by LifePlans Inc. shows more than half of respondents would be more inclined to purchase LTC insurance if their employers offered it.<sup>29</sup>

Recently, to promote market growth, insurers introduced hybrid products that combine life insurance (whole or universal) or annuity products with LTC coverage through the use of riders. These products do not have the “use it or lose it” drawback of traditional standalone LTCI products, in which policyholders who do not incur LTC costs in their life do not receive any financial benefit from the years of premiums paid while alive. Instead, hybrid products allow policyholders to draw down a portion of death benefits to pay for LTC if needed. If the policyholder does not need funds to pay for LTC, the full death benefit passes to heirs. Unfortunately, like traditional standalone LTCI, hybrid policies are also quite costly and out of reach for many. Underlying the challenges mentioned above is a lack of public understanding regarding the need to insure against this risk.

## Barriers

Through the Lab processes, we identified critical barriers in LTC funding and delivery that could benefit from innovative policy and financial solutions. Interviews and engagement with stakeholders narrowed the barriers to three areas of primary concern:

1 /

Lack of large-scale testing of technology solutions to enhance home-based care with limited data sharing across care settings

2 /

Lack of integrated care options for middle-income households

3 /

Inadequate long-term care insurance options



## 1) Lack of Large-Scale Testing of Technology Solutions for Home Based Care and Limited Data Sharing across Care Settings

The coronavirus pandemic ushered in a seismic shift in the rollout of virtual care for patients of all ages. For the Medicare population in April 2020, telehealth accounted for 44 percent of all primary care visits, compared with just 0.1 percent before the pandemic.<sup>30</sup> As of December 1, 2020, in a historic expansion of coverage, CMS permanently expanded the number of telehealth services included in the FY2021 Physician Fee Schedule Final Rule.<sup>31</sup>

Before the pandemic, telehealth was more likely offered as a supplemental MA benefit, but now, both traditional Medicare and MA provide telehealth benefits for beneficiaries indefinitely until the end of the public health emergency. Telehealth is just one tool among many tech-based interventions that Medicare employs to drive value for beneficiaries, insurers, and the overall health system. However, to date, there has been little evidence to quantify specific cost savings. Yet, the potential for these types of virtual care solutions is vast: McKinsey & Company estimates that 35 percent of home health services could be virtually enabled as of 2020.<sup>32</sup>

The role of technology-enabled care strategies that focus on preventive measures that reduce the risk of hospitalization has never been more urgent than during the past year when hospitals across the country faced unprecedented risks to capacity. From consumer wearables to remote monitoring, technology is well-positioned to help lower costs and improve quality of care. With the help of predictive analytics, these platforms have the potential to enable service providers and insurers to intervene earlier and in a more targeted manner for at-risk older adults.

Following the passage of the CHRONIC Care Act, MA plans have begun partnering with technology companies and have launched some studies to demonstrate the potential cost savings from technology and home-based interventions. However, these private-sector pilots are generally small, lack independent oversight, and do not employ standardized evaluation frameworks to optimize data sharing. The lack of integrated service delivery through existing channels of care has hampered the ability to combine consumer and payer data that could inform preemptive interventions.

When an older patient goes from a hospital stay to post-acute care and back home or to an institutional setting, providers, pharmacies, family members, and caregivers face an often-frustrating challenge of transferring critical health information from parties in a timely manner. This information is vital to successful care transitions between settings by providing a complete health picture that includes medical, behavioral health, and functional needs. This information discontinuity puts an older patient at a higher risk of adverse health events, including medication errors, infections, and ultimately re-hospitalization.<sup>33</sup> Lab participants agreed that this delay in information exchange between stakeholders hampers the execution of potentially



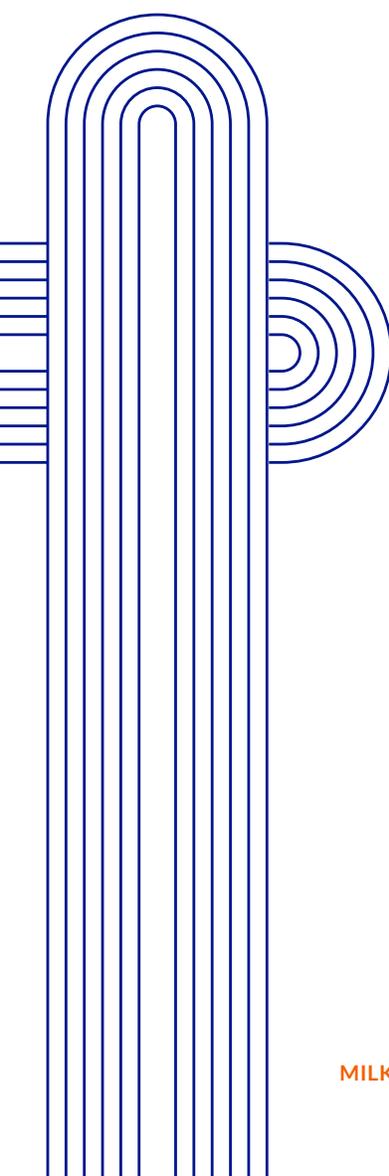
cost-saving interventions for at-risk beneficiaries. For example, health-care providers use electronic health records (EHRs) to assess patient histories, and MA plans hold enrollee claims data that give insight into long-term health trends. Integrating claims data and EHR data holds great potential for identifying the patients at risk of developing chronic conditions and improving care early on.

Lab participants agreed that interoperability (the ability for different systems, devices, and applications to access, exchange, and integrate data) must be better tested and scaled. In March 2020, in conjunction with the Office of the National Coordinator for Health Information Technology (ONC), CMS released the 21st Century Cures Act Final Rule for expanding interoperability among patients, health-care providers, and medical professionals. CMS also launched a program, [Hospitals Without Walls](#), in March 2020 to provide regulatory flexibility that allows eligible hospitals to provide services to qualified patients in their homes. This first-of-its-kind program will provide an important test case to optimize data sharing between providers, pharmacies, insurers, and caregivers providing remote services to older patients at home.<sup>34</sup> While this policy change is encouraging, more needs to be done to quantify the functional value of interoperable data sharing and its potential to improve short-term health outcomes.

## 2) Lack of Integrated Care Options for Middle-Income Households

Innovative integrated care programs have grown in recent years, enabling older adults with complex care needs to stay in their homes and communities longer and avoid much more costly institutional care. These programs have traditionally been targeted to dual-eligible beneficiaries, those qualifying for Medicare and Medicaid. Preliminary results from integrated care demonstrations for dual-eligible beneficiaries suggest that providing integrated primary, acute, behavioral health, and long-term care yields improved health, access to care, and patient/provider satisfaction.<sup>35</sup> However, all older adults with complex care needs could benefit, not just Medicaid beneficiaries.

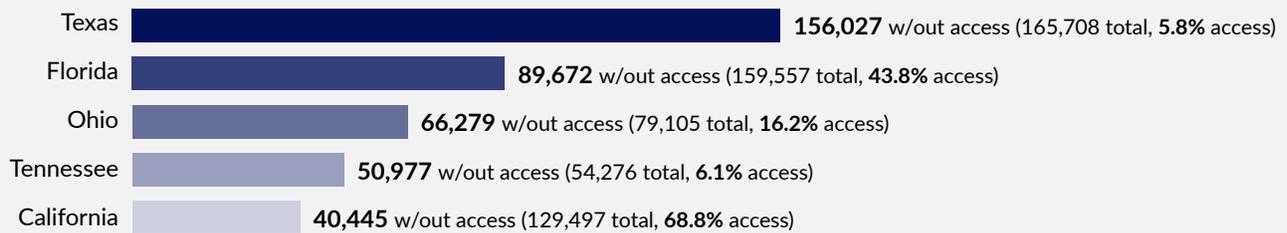
The Program for All-Inclusive Care for the Elderly ([PACE](#)), for example, provides comprehensive community-based care for some 54,000 enrollees. Eligibility is limited to older adults 55 and older who are nursing home eligible as defined by individual states.<sup>36</sup> In the age of COVID-19, PACE has received increased recognition for its ability to limit infection rates and provide more flexible care. In April through September 2020, participants had fewer positive COVID-19 tests than comparable programs, fewer hospitalizations, and lower death rates from the virus.<sup>37</sup> The PACE model faces barriers to scale due to a combination of both regulatory and financial factors. But the program's impressive track record in helping medically complex, dual-eligible older adults age in community and out of more expensive institutional settings, all while providing personalized, multidisciplinary care, has not gone unnoticed.



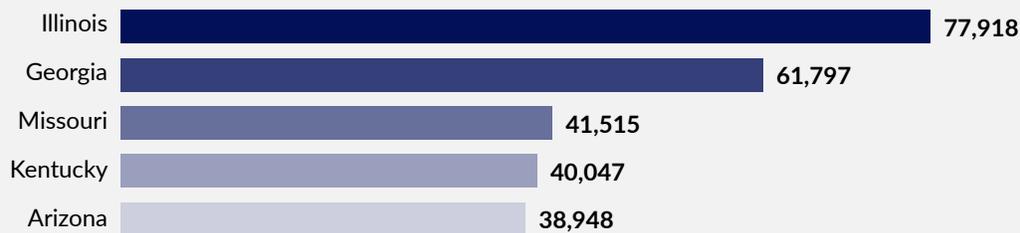
However, some 67 percent of adults 55 and older with complex care needs cannot access a PACE program due to geographic, financial, and regulatory barriers.<sup>38</sup> Medicare-only enrollee participation in PACE is currently limited because they must pay out-of-pocket the portion of the program premium that Medicaid would otherwise pay, which can cost on average \$4,088 per month.<sup>39</sup> Lab participants noted other barriers to scale, including fixed and expensive program design, high up-front costs, and state-by-state restrictions that cap enrollment or prohibit PACE altogether. Despite these challenges, the benefits of the program have captured the attention of policymakers and investors alike and warrant further exploration of how to best scale-up participation. Participants noted that, despite the smaller reach of many PACE organizations that have an average of 350 enrollees per plan, the largest plans have grown to serve more than 1,000 older adults, illustrating their ability to scale.<sup>40</sup>

Figure 4<sup>41</sup>

**4A: Top Five PACE States by Estimated Clinically and Financially Eligible Population without Access**



**4B: Top Five Non-PACE States by Estimated Clinically and Financially Eligible Population**



Source: National PACE Association (2021)

Other integrated care programs also face similar challenges in attracting Medicare-only beneficiaries. Special Needs Plans (SNPs) offer specific benefits, provider choices, and drug formularies to people with particular diseases or characteristics. There are three main types of SNPs. The first, Chronic-Condition SNPs (C-SNPs), are designed for individuals with specific chronic health diagnoses, like HIV/AIDS, chronic cardiac disorders, or cancer. Institutional SNPs (I-SNPs) benefit individuals



who live in institutional settings, such as nursing homes, or who require an equivalent level of care but reside in the community. The Dual Eligible SNPs (D-SNPs) are limited to individuals eligible for both Medicare and Medicaid.<sup>42</sup>

Though SNPs have a broader reach than PACE, they face similar limitations for Medicare beneficiaries who are not dually eligible. Today, 13 percent of MA beneficiaries are enrolled in SNPs, and 85 percent of that cohort are enrolled in D-SNPs.<sup>43</sup> For Medicare-only beneficiaries, premiums are comparable to other MA plans, but they still do not offer LTC. Participants noted that because SNPs for Medicare-only enrollees target a particular diagnosis, not functional needs, they are limited as vehicles to access community-based support and services beyond care coordination. Together, both PACE and SNPs illustrate promising integrated care programs that are largely inaccessible by Medicare-only middle-income individuals.

### 3) Inadequate Long-Term Care Insurance Options

Beyond the pricing barriers discussed earlier, LTCI products themselves are complicated. Purchasers must predict the level of coverage they may need decades in the future, a difficult task, and then compare plan details across different carriers. Additionally, there is lingering concern among consumers over potential future premium increases. Finally, there are no federal LTCI programs, and state-based solutions are in the early stages of development.

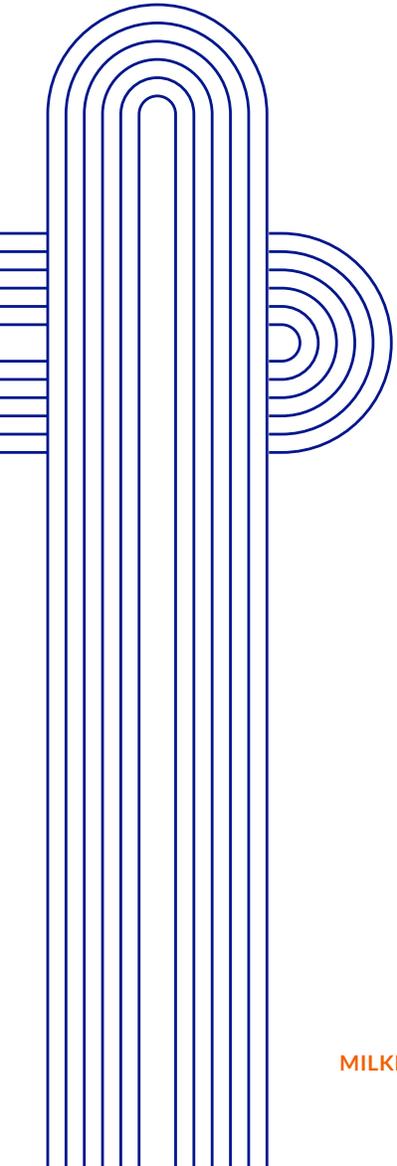
Lab participants from the LTCI industry expressed concern over some regulatory measures, including inflation protection options that insurers must offer to consumers and the process for administering premium rate increases on in-force policies. Some maintain that these regulations drive up costs and impede smooth market function.

Most important, Lab participants noted, there are no current complementary public and private LTCI solutions. Neither the public nor private sector can independently cover the full risk. Generally, the risk associated with LTC expenses is referred to as either “front-end” or “back-end” risk. The front-end risk is roughly the first one to three years of care an individual requires, and the back end is the care needed beyond that point. Clearly, the overall cost of LTC increases the longer an individual requires care. Lab participants suggested a more nuanced classification that further segments the risk to front-end, *middle*, and back-end tranches. Determining the sector best equipped to provide coverage for each portion of the risk is challenging, but designing complementary public and private solutions is paramount.

As we stand in early 2021, however, COVID-19 has decimated state budgets, making it more difficult to secure funding or the political will to raise the taxes necessary to build state-level public long-term care programs. Still, policymakers can work now to outline what these public programs should entail, how they can partner with private



LTCI products, and how to fund them when their states' financial outlooks improve. A 2020 study explores six states—California, Hawaii, Maine, Michigan, Minnesota, and Washington—in various stages of LTC finance reform and provides insights regarding the approach of each. It also articulates the “opportunistic” nature of moving reforms forward. There is a utility in developing a program and rallying support so that reforms advance when the timing is right.<sup>44</sup>





# INNOVATIVE SOLUTIONS

Lab participants discussed several pathways for improving the financing and delivery of long-term care to middle-income households, a cohort whose access to LTC is particularly constrained. Through the Lab process, three potential solutions emerged to address the barriers outlined in the previous section:

1 /

Design a large-scale Medicare Advantage demonstration project that tests technology solutions (telehealth and remote monitoring) to enhance home-based care

2 /

Scale up promising integrated care programs already in operation, prioritizing access for middle-income beneficiaries

3 /

Develop complementary public-private insurance solutions that offer seamless, affordable coverage

Below, for each area, we outline essential design elements and policy changes that could help ensure success. Because the Lab focused on middle-income access to affordable LTC, the discussion does not extend to Medicaid coverage of LTC.

## 1) *Design a Medicare Advantage Demonstration Project*

In earlier research, the Milken Institute identified the expansion of Medicare's coverage of LTC as one of the most promising approaches to provide more access to supportive services for Medicare enrollees.<sup>45</sup> Medicare Advantage enrollment has skyrocketed in recent years, nearly doubling in the past decade alone.<sup>46</sup> In 2020, more than 39 percent of Medicare beneficiaries were enrolled in MA plans, and the Congressional Budget Office projects that this share will rise to 51 percent by 2030. A wide range of technologies can provide both beneficiaries and health plans with preventive tools that may lower the need for costlier levels of care. Since the number of chronic conditions the average MA beneficiary faces is rising (see Figure 5), these technology-supported interventions could better enable home-based care, slow disease progression, and provide healthier years for an aging population. More



broadly, given that integrated care programs outside of MA, like PACE, focus on medically complex Medicare beneficiaries, these programs would benefit from the resulting data that can inform their use of technologies to enhance care.

**Figure 5: Medicare Advantage Beneficiary Demographic Characteristics, 2012 and 2015**

Beneficiary Characteristic	2012	2015
<b>Number of Chronic Conditions</b>		
Mean	4.5	4.7
0	9.7%	8.0%
1-3	29.3%	29.7%
4-7	46.1%	45.6%
8+	14.9%	16.7%

Source: Commonwealth Fund, <https://doi.org/10.26099/r9zs-qs77> (May 2020)

MA plans have increasingly launched their own pilot programs and initiatives to test different technology-based interventions for beneficiaries with complex care needs, often in partnership with community-based providers, such as Meals on Wheels. These pilot programs use tools like telehealth, remote patient monitoring, and predictive analytics within integrated data platforms to track health changes, target fall prevention, and improve transitions of care and overall care management. They are essential to

providing an evidence base to demonstrate the potential cost savings of technology- and home-based supplemental benefits for eligible beneficiaries. Yet, as noted earlier, they are typically small-scale and highly customized.

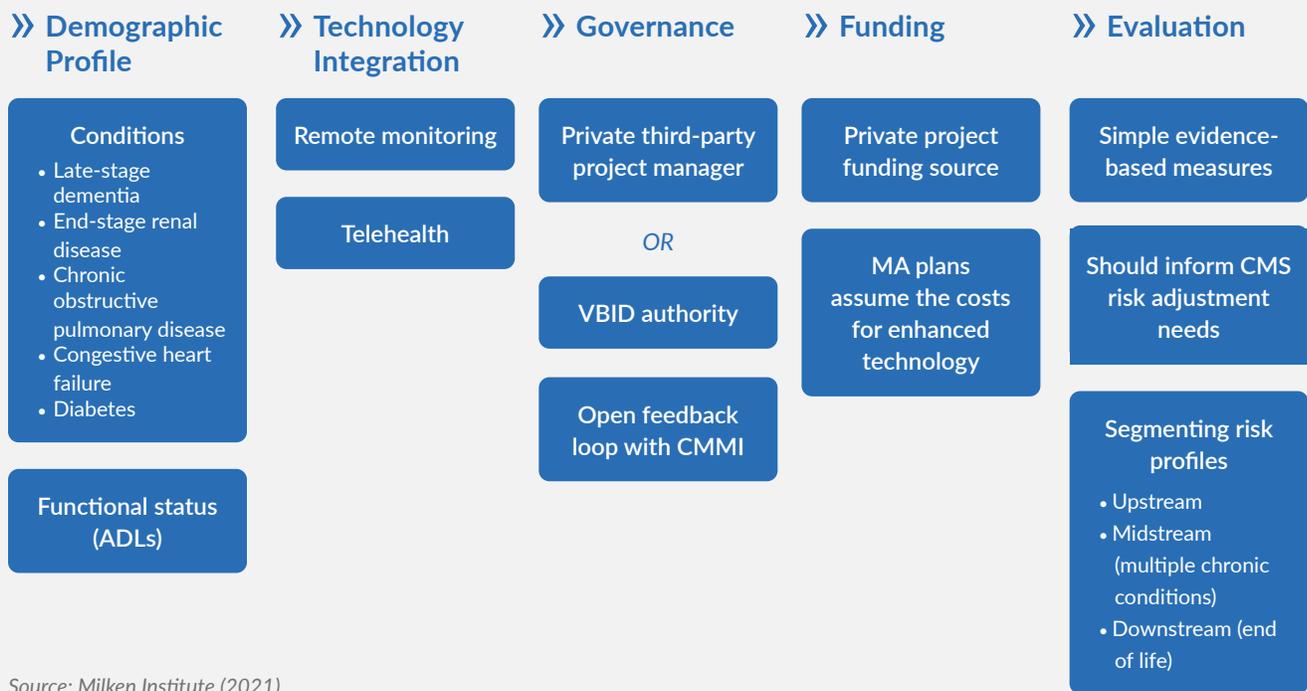
On the other hand, a large-scale demonstration project, with counsel from the Center for Medicare & Medicaid Innovation (CMMI) and funding and oversight from independent third-party organizers/evaluators, would result in credible, standardized, transparent, and beneficial data for public and private payers alike. Participants prioritized four goals for a demonstration project that would address middle-income LTC costs:

- It should explore one or more large-scale, cost-effective technology-based interventions and other preventive measures that would reduce the risk of these individuals becoming more medically complex and facing greater expenses.
- It should harness and standardize data from existing MA test pilots and complement the work of CMMI to inform CMS policy evolution.
- It should measure defined interventions that are *flexible* enough to attract MA plans, yet *standard* enough to align with current CMS rules, and *valuable* enough to attract consumers, including consumers of in-home LTC.
- It should provide useful data to bolster the evidence base of the need for a home-care LTC benefit for Medicare-only enrollees.

## Design Elements

Overall, a large-scale technology demonstration project should focus on distinct interventions that lower costs to health plans, consumers, and Medicare. The following are some of the project's critical design features and the related policy questions that may arise. This outline can help inform the independent organizing entity's project development and execution.

**Figure 6: MA Demonstration: Design Summary**



Source: Milken Institute (2021)



## Demographic Profile

Participants weighed several key parameters for an appropriate demographic profile target for the demonstration project. Some suggested 10,000 beneficiaries divided across two phases and launching a smaller pilot first. Others suggested deferring to the expertise of MA plans and their view of what constitutes a statistically significant participant size. Many agreed that targeting individuals with high-cost conditions who reside in the community would be the most beneficial. The top five include:

- Late-stage dementia
- End-stage renal disease
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Diabetes

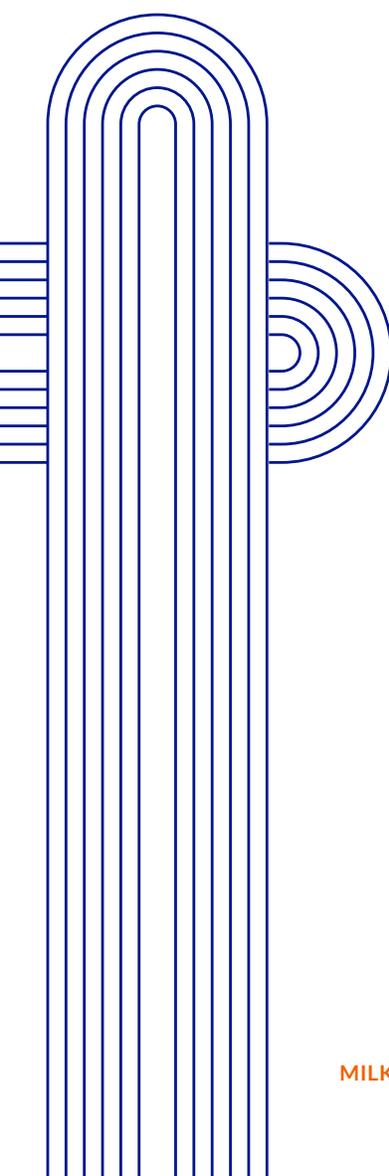
The last three chronic diseases/conditions often occur as comorbidities, meaning they are simultaneously present in the same individual. From a research standpoint, these three would present high-yield results due to the multiple data points per participant. But to make a project translatable for the long-term care industry, it must also target participants by their *functional ability* or their activities of daily living (ADLs).

## Technology Integration

Robust, remotely monitored behavioral data collection is critical for preventing progressive, costly health crises and ensuring more holistic and informed treatment of the individual. By achieving a complete health picture via remote monitoring, plans can bolster their predictive analytics capacity to intervene earlier. Similar to the smaller scale technology pilots mentioned earlier, Lab participants agreed that the proposed MA demonstration project should utilize integrated data platforms to track health changes, specifically examining the value of remote monitoring and telehealth.

Overall, participants suggested that a demonstration project could include specific interventions that would best fit with the demographic profile selected using both remote monitoring and telehealth, for example:

- Electrocardiogram and blood pressure devices to manage CHF<sup>47</sup>
- Telehealth dementia care services to reduce unnecessary emergency department visits<sup>48</sup>
- Remote health coaching to improve health-related quality of life and reduce hospital admissions in older adults living with COPD<sup>49</sup>





## Governance

Participants agreed that a non-governmental third party should oversee the demonstration project, and funding should come from the private sector (e.g., MA plans and philanthropic entities). Many also emphasized the need for open communication channels between the project manager and CMMI, which would help align the project with CMS's annual Final Rule issuances. An open feedback loop would allow MA plans to adapt to immediate regulatory action before they hit deadlines for bids and add to the body of interventions that CMMI is currently testing. Another advantage of utilizing a non-governmental third-party manager includes the expediency of the project's approval process. Participants added that partnering with CMMI in an advisory capacity would enhance the project design and evaluation quality.

Alternatively, the project could be channeled through CMS's Value-Based Insurance Design (VBID) infrastructure, within which many MA plans already engage. New VBID flexibilities approved for CY2022 allow MA plans to include "new and existing technologies or FDA-approved technologies"<sup>50</sup> as supplemental benefits. Working within the VBID infrastructure could attract far greater MA plan participation and agreement on the scope of benefits to test more broadly and in an orchestrated manner.

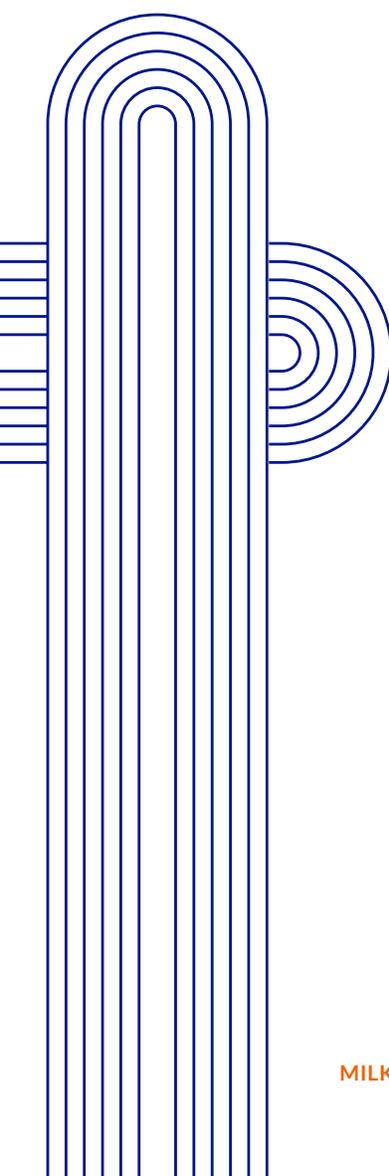
## Funding

As noted, participants agreed that a private funding source would be most expedient and politically feasible to conduct the demonstration. Many argued that the regulatory approval needed for a CMS-sponsored project would present too many constraints.

Several participants felt that MA plans should assume some of the costs of the demonstration project because they could benefit from testing the interventions as they inform payment models. Many noted that any future benefit design stemming from the project would likely lead to cost sharing between beneficiaries and plans. In particular, participants were encouraged by the potential for an MA plan to design a more self-directed model by scoping out a person-centered benefit design, especially for technology-enabled *home care*. This benefit would likely attract many beneficiaries, given the mounting burden of unpaid caregiving for millions of middle-income families.

## Evaluation

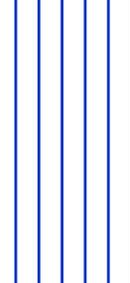
There was resounding agreement that an evaluation framework encompassing the four project goals—reducing Medicare costs, standardizing and harnessing existing data, defining tech interventions acceptable to all stakeholders, and bolstering the case for a home-care LTC benefit—should track a few simple, evidence-based



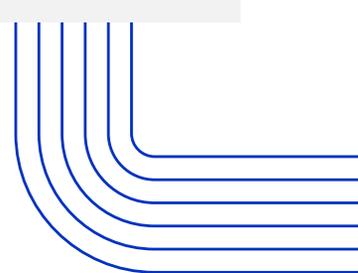


measures that can be standardized. This would be most useful to CMS, MA plans, and the LTCI industry. As for LTCI, industry experts explained that the most straightforward metric is the delay in claims or shortening in months of claims. For MA plans, the metrics are more complex and not as standardized with respect to health-care utilization costs. Still, many agreed that the most straightforward metric to track is the rising risk of functional need. Using the VBID model, the evaluation would inform potential CMS risk-adjustment scores (e.g., alternative Hierarchical Condition Category [HCC] codes designed to reflect patient “acuity” or the severity of illnesses of plan members). These kinds of coding changes could consider functional assessments and other key social determinants beyond strict clinical measures.

An evaluation framework that homes in on evolving risk profiles would likely help plans track the health journeys of beneficiaries across three thresholds: upstream (relatively healthy); midstream (the development of multiple chronic conditions); and downstream (progression toward the end of life, the costliest stage of care). Tracking interventions against the pace of change downstream could reveal cost savings that would, in turn, be reinvested upstream and ultimately provide broader benefits that focus on prevention. Participants representing MA plans agreed that tracking a specific high-risk cohort by pre-and post-benefit outcomes would bolster the case for upstream investment. The number of “medically complex” MA beneficiaries is rising, making it even more critical to track these trends and provide a standardized evidence base that outlines the benefits of technology and home-based interventions.



## Next Steps

- » Build consensus from experts to either recommend a third-party demonstration project manager or use CMS’ VBID authority.
  - » Identify key MA plans already participating in the CMS VBID model that are willing to share existing data from technology-based pilots to build an integrated data framework for the demonstration.
  - » Define the distribution of risk profiles to track key opportunities for technology- and home-based interventions to slow disease progression.
- 



## 2) Scale Up Integrated Care Programs

Even before the COVID-19 crisis, it was clear that improving access to integrated health and home care and bolstering community-based services were critical. With recent shifts in what Medicare will cover and the spotlight more focused on the role of affordable, safe in-home services, innovative solutions can move us toward a more integrated system of care. Scaling up existing models can help realize the goal of aging at home independently and reducing the overall cost of care.

Lab participants recognized the value of expanding integrated care programs beyond the primary communities, often low-income and high-need populations, they currently serve. More middle-income adults with complex care needs who are Medicare-only eligible would benefit if they could gain more access to the targeted benefits and care coordination available to those in SNPs, as well as the preventive and wraparound services available through community-based programs like PACE. The Lab participants decided to explore potential avenues for scaling up these two programs in part because, given the complexities of the health-care system, it is best to build off their successes rather than create something new.

Adapted integrated-care models and partnerships will need to address enrollment barriers, incentive alignments, and financing gaps for Medicare-only enrollees. Before deciding on the scale-up promise of SNPs and PACE, the Lab considered many impressive programs, including smaller statewide programs like Vermont's Supports and Services at Home (SASH) or CAPABLE from the Johns Hopkins School of Nursing, which operates in 28 rural communities around the country.

### Expanding SNPs

Participants praised SNPs for their scalability and levels of care coordination. To be eligible for an SNP, an individual must be enrolled in an MA plan and meet specific criteria, and the plan benefits are tailored to serve that population. Lab participants zeroed in on the need for a new type of SNP to better address the LTC needs of Medicare enrollees who are not dually eligible.

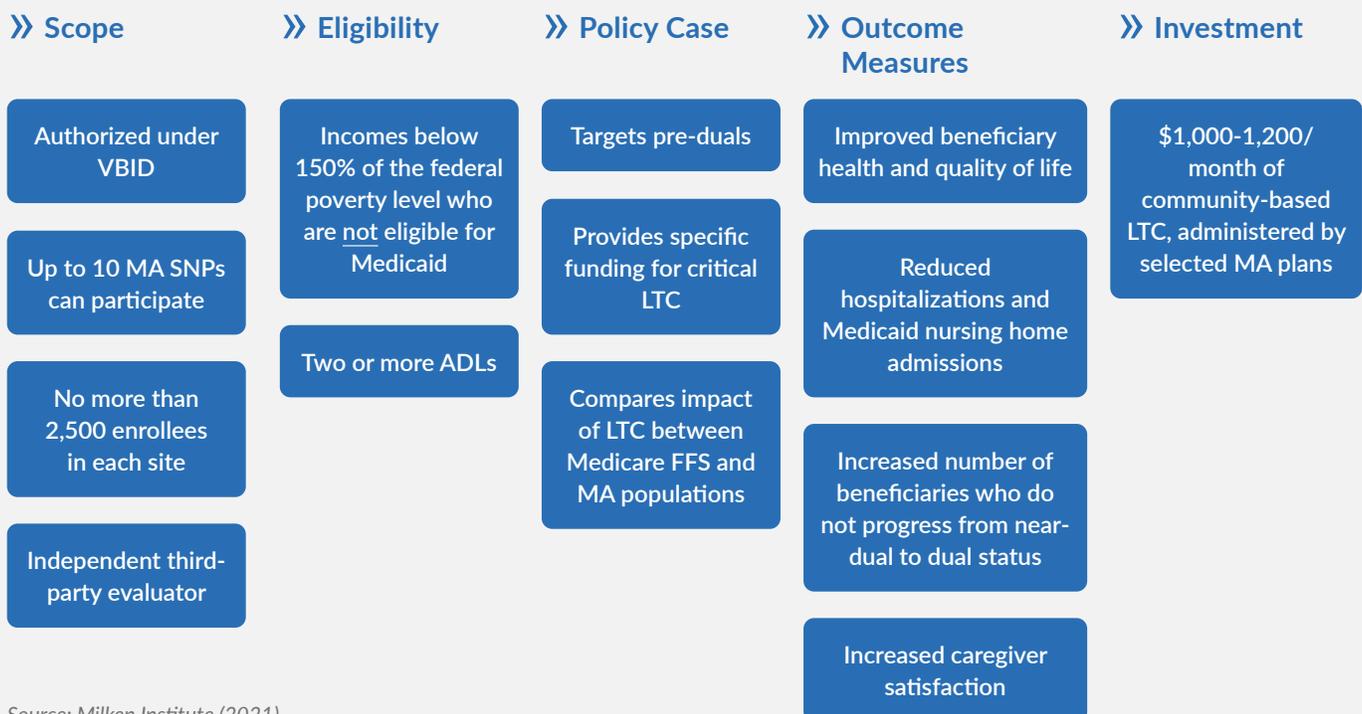
In 2019 the Community-Based Independence for Seniors Act (HR 3461) was introduced by Rep. Linda Sánchez to provide a framework to test the cost-saving potential of an LTC benefit for certain Medicare-only enrollees. The legislation called for a new plan, a Community-Based Institutional Special Needs Plan (CBI-SNP) demonstration program that would provide a benefit of up to \$400 per month for LTC within the community.<sup>51</sup> The program would target people 65 and older who are “pre-dual,” meaning their income is at or below 150 percent of the federal poverty level, but who are not yet eligible for Medicaid. Eligible beneficiaries would also reside in the community and lack the ability to perform two ADLs. The program would measure the LTC benefit's impact on (1) beneficiary health outcomes, (2) hospitalization and institutional care admission rates, and (3) avoidance of

progression down to dual status (spending down assets to the point of Medicaid qualification).<sup>52</sup> Unfortunately, this bill has not moved forward since it was introduced in the House and referred to the Subcommittee on Health in June 2019.

Lab participants saw the proposed CBI-SNP as an opportunity to test the value of LTC benefits for a Medicare-only population. Given that the bill has not moved forward, participants suggested developing a similar CBI-SNP concept via authorization by CMS using VBIID authority. They also identified several ways to tweak the program design to enable more robust proof-of-concept. Most importantly, they agreed that the \$400 monthly benefit was too low to cover anticipated costs; a benefit of \$1,000–\$1,200 per month would demonstrate better potential positive impact of long-term services and supports. They also suggested a tiered benefit structure based on need and noted that the demonstration program, as originally proposed, would not be large enough. It had called for five CBI-SNPs with no more than 1,000 enrollees per site. Lab participants described an ideal model with 10 CBI-SNPs with up to 2,500 enrollees per site across diverse geographies and demographic profiles. They also pointed to the tenuous nature of dual status, with some individuals fluctuating between dual-eligible and not. It was suggested that CBI-SNP enrollees remain part of the program if they do end up in dual status.

**Figure 7: New CBI-SNP Program Adapted from HR 3461**

This updated Community-Based Institutional Special Needs Plan (CBI-SNP) provides low-income, Medicare-only beneficiaries with additional LTC to help them avoid institutionalization and remain in their homes.

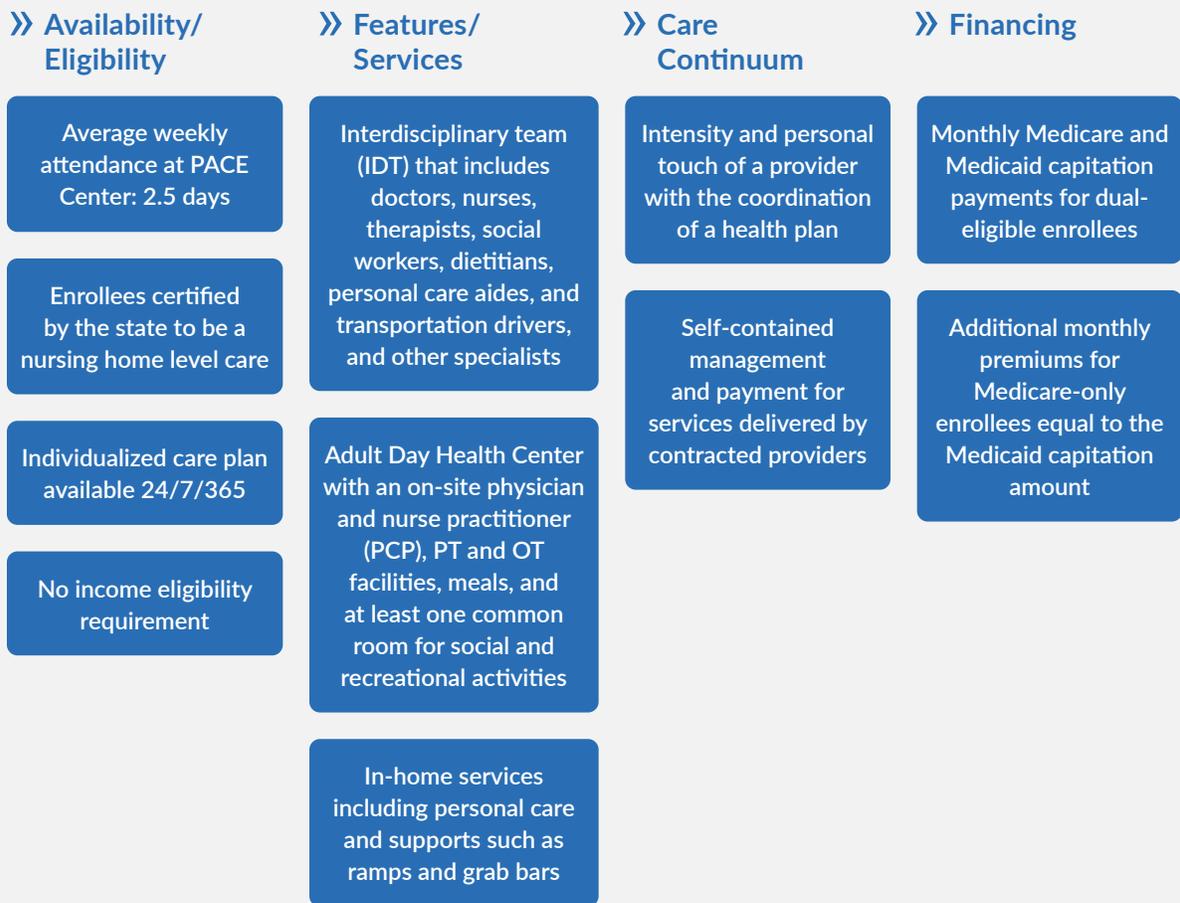


Source: Milken Institute (2021)

## PACE Expansion for Medicare-Only Enrollees

While the gap in access to PACE programs for middle-income older adults persists, many Lab participants identified several key adjustments that could make the program more accessible and financially sustainable. The table below summarizes the current critical components of the PACE program.

**Figure 8: PACE Program: Current Design**

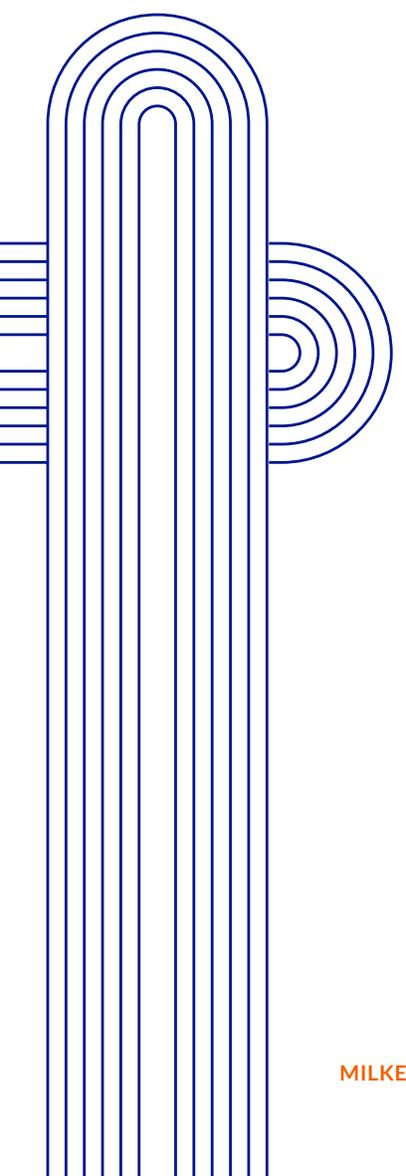


Sources: CMS, National PACE Association (2021)



## Adaptive Program Design

Central to PACE and its unique value proposition is the interdisciplinary team caring for each patient and the wraparound services provided at a centrally located PACE center. Currently, no alternative need-based menu of services or tiers of services is available. Many saw tiers of bundled services as an opportunity to boost enrollment and help address the obvious financial barrier to entry for Medicare-only enrollees. In effect, a Medicare-only beneficiary could enter the program at Tier 1 and purchase a core set of services, similar to a flexible subscription model. As needs adjust, the enrollees could move up two, three, or four tiers until they require the full PACE benefit. A broader population of PACE-eligible Medicare-only enrollees who buy in at different need levels would bring a much higher chance of solvency to PACE centers (and, especially, the participating nonprofit programs) by broadening the risk pool and reducing average costs per participant. Some participants questioned whether segmenting core benefits and services would be possible without diluting the essential value of the program. An alternative, they argued, would be to keep core services intact for all participants but allow for tiered premiums that could be adjusted periodically based on health assessments with reasonable protections for how often this premium adjustment could happen.



Other program adjustments that would promote PACE expansion would require addressing specific regulatory and governance barriers. For instance, a PACE plan can offer wraparound services to non-PACE enrollees, but those people cannot reflect more than 49 percent of the plan's business. Lab participants also cited state enrollment caps as one of the biggest barriers to scale; as a result, PACE centers are located predominantly in lower-income areas with high concentrations of dual-eligible enrollees. Medicare-only enrollees may not have centers nearby and may not even have much familiarity with PACE services in the first place.

Lab participants cited two policy adjustments. The first involves a cost waiver. All PACE participants must enroll in the Medicare Part D prescription plan offered by their PACE plan, even if an alternative standalone plan is more affordable. Medicare-only enrollees must pay these premiums out of pocket, which can be extremely expensive, in excess of \$1,000 per month (on top of the up to \$4,000 monthly out-of-pocket program cost). By comparison, their own regular monthly Medicare Part D premiums would normally be \$200–\$300. Recognizing this cost barrier, participants representing PACE programs have developed a Part D waiver application, which CMS so far has denied. However, under a new administration, using PACE's [waiver authority](#), this proposal may be reconsidered. An alternative approach may be to test a demonstration through CMMI authority that allows PACE participants to utilize standalone Part D plans.

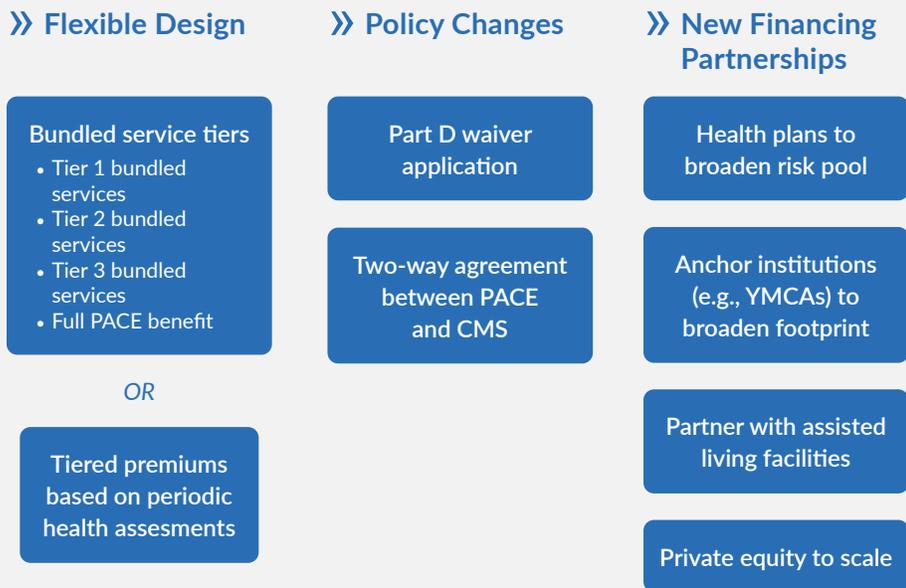
The second policy adjustment would bring a statutory change to the process of establishing new PACE programs. These programs currently require a three-way agreement among PACE, the individual states, and CMS. Instead, the Lab



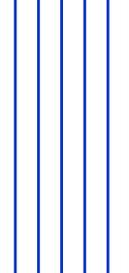
participants recommended a two-way agreement whereby a prospective PACE program, much like Medicare Advantage or an SNP, could go into a state without the required contractual relationship with Medicaid. This new PACE program would enroll Medicare-only beneficiaries. Because they could pay premiums based on their assessed health status, the program would be equipped to tackle barriers to financial stability and to assist in financing program expansion. By partnering with private insurers and using tiered care, the programs could serve a broader risk pool and reduce the per-beneficiary cost.

Participants agreed that any growth strategy for PACE must also incorporate a digital/virtual care component as a cost-saver in cases where on-site care is not needed, as well as an alternative source of revenue. The COVID-19 pandemic could serve as an important test case in this regard. Finally, some suggested using shared site models instead of standalone PACE centers, whose startup and fixed costs are high. PACE programs could partner with trusted anchor institutions like YMCAs that have large physical footprints across diverse geographies and markets as a cost-sharing option. Or PACE could be offered in assisting living facilities, continuing care retirement communities, or other senior living environments for those who need more complex care. Finally, private equity capital could continue to play a role in the rapid scaling of for-profit PACE models.

**Figure 9: Priorities for Expanding Medicare-Only Enrollment in PACE**

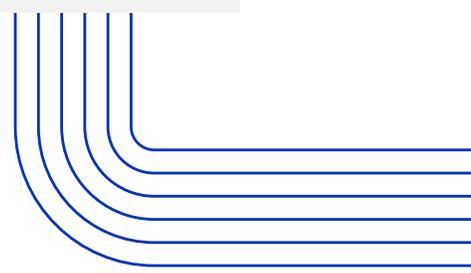


Source: Milken Institute (2021)



## Next Steps

- » Evaluate the feasibility of channeling a revised CBI-SNP demonstration under the VBID authority.
- » Conduct economic modeling to evaluate a potential tiered PACE model.
- » Resubmit a PACE Part D waiver to CMS under the new administration or engage CMMI to evaluate the feasibility of a PACE Part D waiver to better align with the costs of traditional Part D premiums (i.e., applying for a PACE demonstration for Medicare-only beneficiaries).



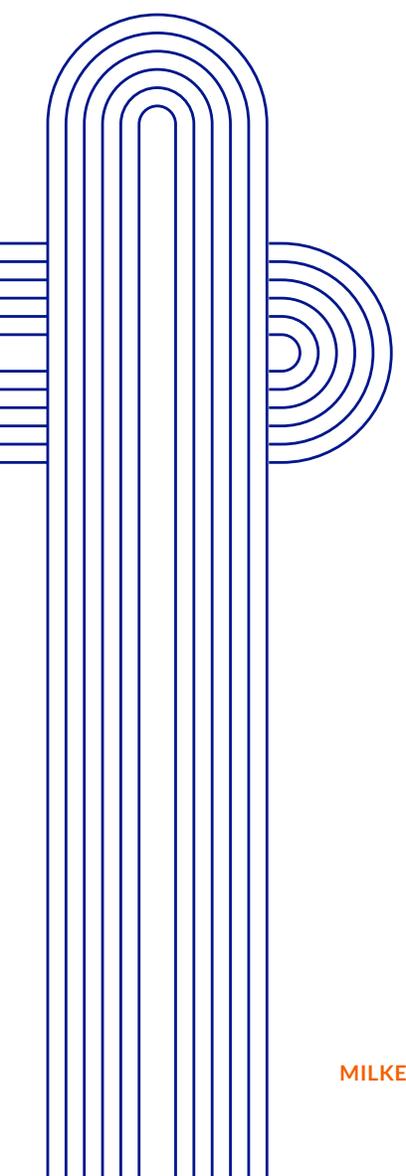
### 3) *Develop Complementary Public-Private LTC Insurance Solutions*

LTC insurance options are currently quite limited. As mentioned earlier, the CLASS Act's repeal eliminated a federal-level program designed to provide targeted LTC coverage on a voluntary basis. State-based LTCI programs are only in the early stages of development. And the private LTC insurance market has shrunk in recent years. Also, participants noted that before 2015, some private LTCI policies offered the option of unlimited, or lifetime, benefits that effectively provided full coverage of LTC risk.<sup>53</sup> But over the last decade or so, due to unmanageable costs, insurers have stopped offering these uncapped benefits, which encompassed the tail end or highest risk level. Still, insurance solutions could provide an important opportunity to spread the risk and guard against financial hardship for older adults and their families. Lab participants were in remarkable agreement that the public and private sectors should work together to design complementary insurance programs and products to provide coverage that would offer financial protection and reduce reliance on Medicaid. There was a clear sense that one sector's efforts alone could not adequately address the magnitude of the challenge.



Participants suggested that there could be a growing appetite among lawmakers to pursue a federal-level insurance solution, despite the CLASS Act repeal and the challenges it created for developing an alternative federal LTCI program. In January 2021, for example, Rep. Thomas R. Suozzi of New York issued a discussion draft for the Well-Being Insurance for Seniors to be at Home (WISH) Act that outlines a possible federal catastrophic (back-end) program.<sup>54</sup> Even in its current early draft form, this proposal offers a valuable opening to discuss LTC issues at a national level. The WISH Act further illustrates that the public and private sectors must work together; it specifically seeks to reinvigorate the private LTCI market so that affordable private policies can fill the first one to five years of need.

Alternatively, some participants proposed that public support could take the form of a state subsidy that helps people purchase a front-end *private* LTCI product. In this scenario, a state could establish a web-based LTCI exchange or marketplace, similar to the ACA health insurance exchanges. In addition, stakeholders reiterated that expanding Medicare to include LTC benefits could be a viable and efficient path forward. Ultimately, the Lab discussion focused mainly on how states could design their own front-end programs and how the LTCI industry could create affordable products to enhance that coverage. The more nuanced approach to risk segmentation described earlier, with a front-middle-back architecture, would allow each sector to address discrete tranches of risk.



During our discussion about feasible public-private divisions of risk, agreement coalesced around the idea of using public programs and funding to help cover the initial “front-end” LTC costs, addressing the first year or two of need. Participants saw the initial portion of risk as the most appealing for the public sector to address through a new program because it would benefit the most people, which could help garner public support and improve political feasibility. The private LTCI industry could then design complementary products for the “middle” tranche of risk, picking up where public programs end by offering policies with capped benefits that extend coverage for an additional year or two. If this combined approach were adopted across all states and resulted in total combined coverage of perhaps \$200,000 per person, it would adequately cover the LTC needs of roughly 83 percent of older adults.<sup>55</sup> The remaining 17 percent of individuals who incur expenditure levels greater than \$200,000 represent the “back end” tranche of risk. Medicaid could act as a safety net for those people if personal assets were insufficient. The discussions and recommendations outlined here centered around state-based public programs, but the same ideas could apply to a federal program.

LTCI industry participants said they were optimistic that insurers could design products to wrap around and complement state-level public programs. They added a caveat, however: If 50 states offer 50 vastly different public programs, insurers will have a greater challenge creating products that complement the nuances of each state’s program. This would be particularly true regarding benefit eligibility

criteria; multiple triggers would make it difficult for the private sector to offer solutions across multiple states. Many agreed that it would be ideal to have a basic level of uniformity in programs across states. The National Association of Insurance Commissioners (NAIC) could develop guidelines for this purpose.

## Design Elements

The following addresses some of the essential design features that Lab participants recommended for a state-level public LTCI program and the related policy questions. The points described here can help state policymakers evaluate how to develop programs that work for their residents. The Washington state program provided a good starting point for the discussion of plan elements. Still, participants recognized that the Washington model is not perfect, and alternative approaches to some design features could yield better results. Figure 10 outlines what this model might look like, incorporating some contours of Washington's program. Individual states would need to determine the design details that best fit their particular circumstance.

**Figure 10: Complementary Public-Private Insurance Solution Model**

**Goal:** The public and private sectors develop complementary insurance programs and products that, when combined, provide a level of coverage that financially protects a majority of citizens and helps reduce reliance on Medicaid for LTC

## Public Sector

### » Public front-end LTCI program

**Risk covered:** Front end, first one to two years of LTC

**Design features:**

- Mandatory program participation
- Eligibility limited to vested adults
- Benefit level totaling \$36,500, or higher (based on funding capacity)
- Benefit level based on need and funding capacity (e.g., Washington state's \$36,500 benefit, but preferably higher)
- Funding via a specified taxing mechanism (state specific)

### » Medicaid

**Risk covered:** Back end

Medicaid acts as a backstop for individuals who exhaust the public front-end program benefits, private LTCI policy benefits, and personal financial resources

## Private Sector

### » Private LTCI

**Risk covered:**

Middle, capped benefit providing one or more years of coverage beyond the public front-end program

**Design features:**

- Simplified products with tiered benefit architecture that accommodates various consumer budgets
- Waiting periods that align with exhaustion of public program benefits
- Additional design features align with public front-end program, ensuring easy transition: benefit trigger, benefit levels, etc.

Source: Milken Institute (2021)



## Mandatory Participation

Lab participants widely agreed that participation in any public LTC insurance program must be mandatory to be successful. Optional participation could lead to “adverse selection,” an industry term that refers to the imbalance of risk pools, with higher enrollment rates for higher-cost beneficiaries, ultimately raising average premiums and causing lower-cost, healthier individuals to drop out of the market. Policymakers could explore specific opt-out allowances (e.g., for individuals who already own private LTCL policies covering the same front-end risk). Participants acknowledged that mandating program participation may present political challenges but argued that a voluntary program is financially unviable.

## Eligibility

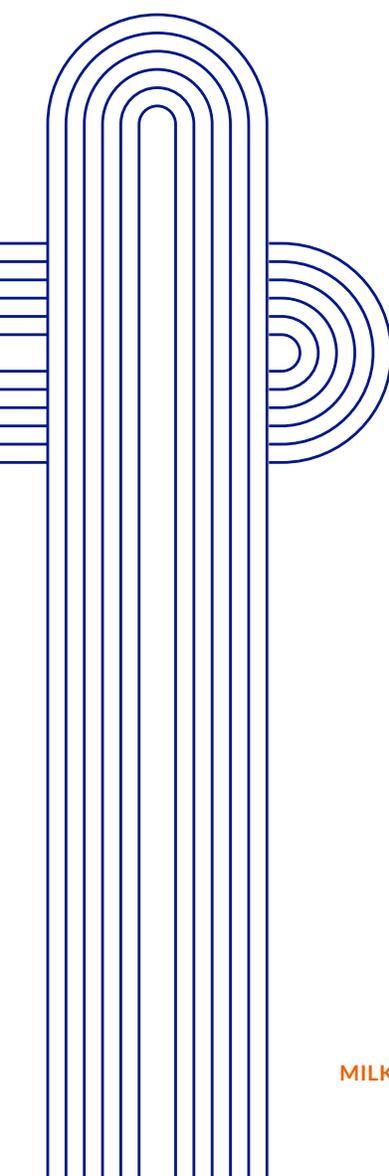
Policymakers must find an appropriate balance when determining program eligibility, and this may vary across states. They will need to keep eligibility narrow enough to ensure financial solvency but broad enough to ensure access for a significant portion of the population. Such programs must also prioritize solutions for older and middle-income populations. Public support and political buy-in become more challenging when social programs benefit only a narrow population segment.

The Washington state program can offer some guidance. It is available only to residents of the state 18 and older who have paid into the program for a specified period through a 0.58 percent payroll tax. It excludes retirees who have not paid into the program. The decision to tie eligibility to a vesting period funded via a mandatory payroll tax may help build support for the program because people will see it as an earned benefit. However, the program excludes people “disabled before the age of eighteen,”<sup>58</sup> a population that would benefit from access to LTC. Exclusions like this present significant political challenges but may help make a program financially viable.

## Benefit Level

As with eligibility, and depending on their fiscal health, states may develop different determinations of benefit levels. The Lab recommends that policymakers first select their funding mechanisms and set funding levels, and then build out a benefits package to fit that budget. This approach will help inform the eligibility decisions as well.

Washington’s program provides benefit units of \$100 per unit and a maximum of 365 units for a total benefit value of \$36,500 (indexed to inflation) per qualifying individual. The units are “stackable,” meaning a beneficiary can spend more than \$100 per day, but the total benefit value is fixed.<sup>59</sup> Lab participants saw this benefit level as a fair starting point and better than no benefit at all but acknowledged that it might be insufficient, depending on the type and duration of care required.

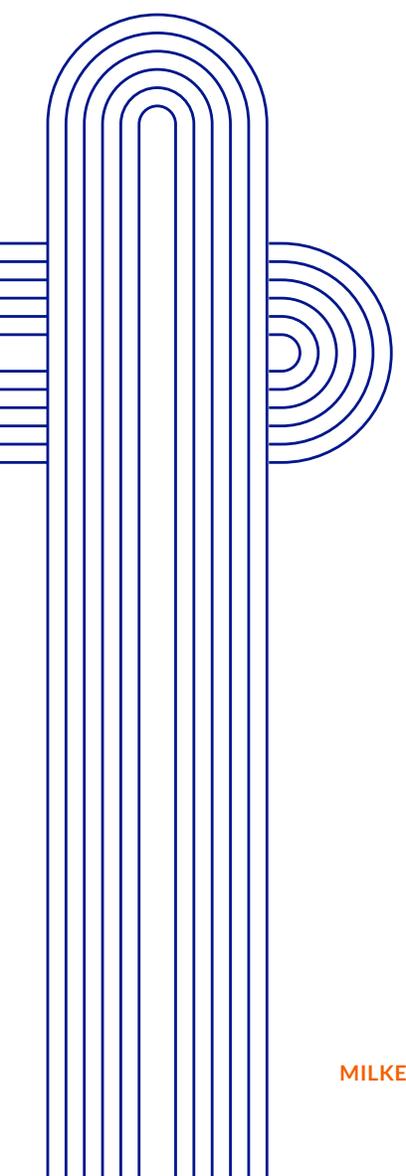




For context, Genworth's 2020 cost of care survey finds that the national average price of a private room in a nursing home facility is \$8,821 per month; at this rate, an individual would deplete the \$36,500 benefit in just over four months. The benefit would last significantly longer, almost two years, if used to pay for adult day care, which is estimated to cost \$1,603 per month.<sup>60</sup> In an ideal world, states would offer a more robust benefit that covers a reasonable percentage of the cost for all levels of care and across various settings for an extended period, but this may not be financially feasible.

Policymakers must also decide what kind of spending flexibility to offer. They can choose to limit allowable expenditures to a small list of approved services and care settings or take a broader approach that covers a greater variety of services, including home health aides, home modifications, family caregivers, meal delivery, assisted living facilities, and so on. This depends in large part on whether a program is designed to reimburse the cost of allowable services or provide a cash benefit that the individual can use to purchase whatever services he/she chooses.

### **Benefit Triggers**



As mentioned, a standardized trigger would bring public programs and private LTCI policies into alignment. For state programs, the benefit trigger (i.e., the set of conditions a policyholder must meet to begin receiving benefits) should align with the benefit trigger as defined in HIPAA, the Health Insurance Portability and Accountability Act of 1996.<sup>61</sup> HIPAA defines the benefit trigger as the point when an individual is certified to be either lacking the ability to perform two out of six ADLs or living with severe cognitive impairment. In both cases, the impairment must be expected to last at least 90 days.

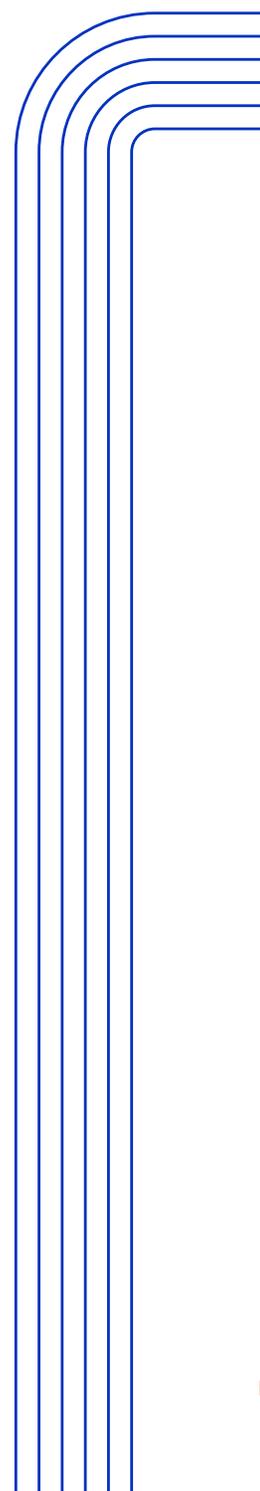
Most private LTC insurers already adhere to the HIPAA standard in exchange for preferential tax treatment on these policies, and it would be difficult for them to deviate from the HIPAA benefit trigger when designing products to complement the public program. Notably, Washington state does not adhere to the HIPAA standard; it instead requires the qualifying beneficiary to lack the ability to perform three ADLs. This will make it more challenging to ensure a continuity of private and public coverage for those who choose to purchase private long-term care insurance to supplement their public coverage.

### **Funding and Governance**

States will, of course, vary in their determination of the most appropriate funding sources for their own public LTCI programs. Possibilities include payroll, Medicare, and income tax surcharges, but each state's circumstances will be unique; some states, for example, collect no income tax.



Broader-based taxes, like the payroll tax, can help keep down the rates paid by individuals. Again, a broad-based tax may gain support over time as people feel they've earned the benefit through their tax contributions. Alternatively, states could consider more progressive funding approaches like a millionaire tax or a payroll tax above the Social Security cap. States will have to assess political feasibility and model out various funding mechanisms.



## Policymakers must also consider:

- » how to ensure their program's financial solvency,
- » how best to make the program equitable, and
- » how the program could affect Medicare and Medicaid spending.

In terms of financial solvency, policymakers must first determine if the program is prefunded or pay-as-you-go. They will have to create a trust fund and ringfence those dollars. Beyond identifying how to capitalize the trust fund, they must develop an investment strategy that allows the fund to generate sufficient returns to become self-sustaining. This will require additional modeling to project the combined estimated tax revenue and potential investment returns, and then compare those figures to estimated claim amounts. As noted, Washington voters turned down a referendum in late 2020 that would have expanded investment options for the state's LTC trust fund. Projections now show a major shortfall in the state's future fund balances that state lawmakers will have to address in the coming years by increasing the payroll tax, reducing benefit levels, or putting the issue to voters again.<sup>62</sup>

Equity issues came up repeatedly during the Lab. Participants wanted to find ways to correlate the level of aid an individual receives or the amount of premium they pay to their income level. A recent study by Richard Frank of Harvard Medical School and Meg Wiehe of the Institute on Taxation and Economic Policy applied this approach to two models that provide subsidies to moderate- and middle-income households to purchase a basic level of front-end private LTCI. They looked at two scenarios where the purchase of LTCI is mandatory and a sliding scale of subsidies is available to households within the 30th to 60th percentile of the income distribution, \$35,000 to \$75,000 (2017 dollars). Their analyses showed the benefits of an approach that targets the most assistance to individuals with more modest income levels and less assistance for those further up the income ladder. Some key benefits to this design include its progressivity and the resulting reduction of on-budget taxpayer costs.<sup>63</sup>

Participants raised the idea of adding a surcharge to program premiums paid by residents whose incomes exceed a certain amount, an approach similar to the Income Related Monthly Adjustment Amount (IRMAA) paid for Medicare Part B coverage by individuals with incomes over \$87,000 and couples over \$174,000. In this tiered system, the surcharge increases as income increases.<sup>64</sup>

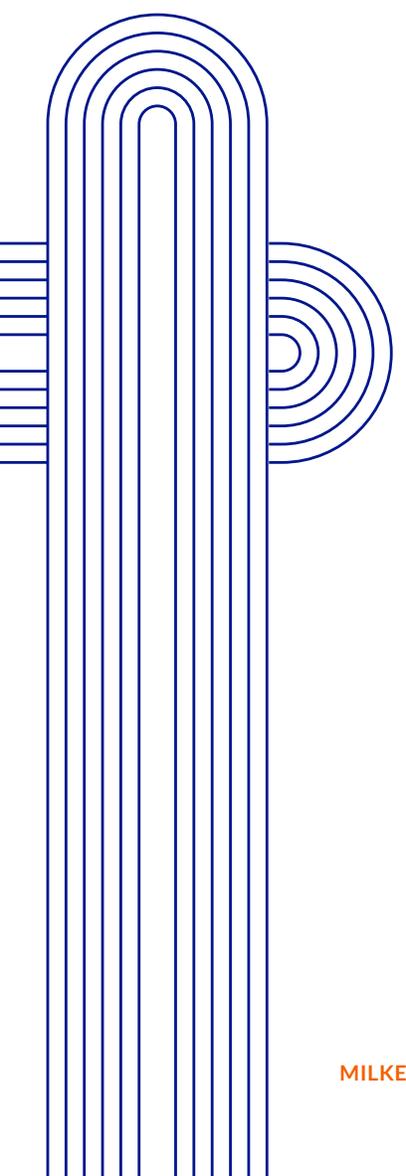


Policymakers must also analyze the potential impact a public LTCI program will have on their Medicare and Medicaid spending. In particular, participants discussed the opportunity for reduced Medicaid expenditures and the possibility of using those savings to help fund the LTCI program.

### **Complementary Private LTCI Design**

As policymakers explore the concept of public front-end programs, they must keep in mind how important it will be to foster collaboration with the private LTC insurance industry. This will ensure a seamless transition of care that leaves no gaps in coverage. Alignment is particularly important in the areas of eligibility criteria, approved services and supports, and daily expenditure limits. Policymakers should avoid scenarios whereby an individual eligible for benefits under the public program begins to receive care in a certain setting, only for those services to be denied later under his or her private LTCI policy. For their part, insurers can help avoid gaps in coverage if they treat the public program's depletion of benefits as the elimination period, also known as the qualifying, or waiting period, of their policies. For example, if the public program has a maximum lifetime benefit of \$36,500, the private LTCI's elimination period would be satisfied when the beneficiary's allowable LTC expenditures exhaust that amount. But again, if benefit levels are not standardized across states, some of them will no doubt have gaps in coverage. The NAIC can play a role here, too, in developing state guidelines that ensure public programs and private policies complement each other.

During the Lab, in addition to affordability concerns, participants expressed the need to simplify LTCI products to make them easier for consumers to understand and ultimately increase uptake. Current products offer extensive options, which can make product comparisons difficult. With this in mind, insurers might adopt a simple, standardized, three-tier policy option that builds off the coverage of the public program. The first tier might offer a modest amount of coverage with broadly affordable premiums (e.g., a \$50,000 policy). The benefit level would increase in subsequent tiers, creating a good-better-best architecture. Lab participants expressed optimism on the affordability of private LTCI products in this scenario, given that the public program would cover the initial risk and the private benefit option is capped.



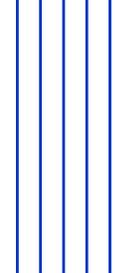
## Reinsurance Model

Throughout the Lab discussions, stakeholders made clear that affordable premiums are a primary barrier for middle-income households wishing to use private LTCI products. One innovative approach to lowering premium levels and boosting uptake could be through the utilization of reinsurance. Often referred to as “insurance for insurers,” reinsurance helps spread claim risk away from the insurer who holds the policy. It takes effect when specific conditions are met on a policy or block of policies, for example, if a claim exceeds a predefined threshold or duration. Reinsurance thus helps spread the risk by covering the claim costs above the threshold. This type of reinsurance is referred to as a catastrophic model. Reinsurance is already used to help manage the costs of some legacy blocks of in-force LTCI policies, meaning older policies that were issued some time ago and are still active even if the insurer who originated the policies exited the LTCI market. It is not widely used in the design and management of LTCI products currently available for purchase. Notably, many reinsurers left the LTC insurance market because of significant past losses. Lab participants highlighted that accurately priced products are key to the success of any future reinsurance programs.

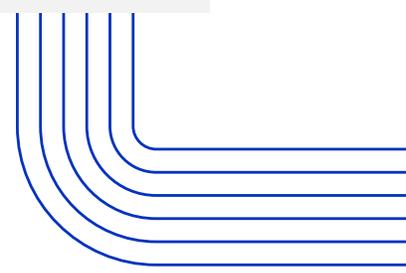
Reinsurance may make it possible for insurers to design policies with lower premiums than would normally accompany this kind of coverage. The question is, who pays for the reinsurance policy? Washington state explored two reinsurance models during a feasibility study conducted prior to moving forward with its current LTCI program. The study found that without subsidies from an

outside funding source, the costs associated with the reinsurance would be passed back to the consumer, ultimately leaving the amount paid by the consumer unchanged relative to policies lacking reinsurance. The study also indicated that without significant premium reduction, uptake would remain at current low levels.<sup>56</sup> Lab participants raised the idea of identifying a state or federal funding source that could satisfy the cost of the reinsurance, thus bringing down the premium for consumers and in turn increasing demand for private LTCI.

During the early years of the Affordable Care Act, a similar approach was used to help stabilize health insurance premiums. In the years since, some state governments have created their own reinsurance programs. The states fund their programs through ACA Section 1332 State Innovation Waivers that allow for the “pass-through” of federal funds. Put simply, state reinsurance programs result in lower health insurance premiums. Under the ACA, the federal government provides subsidies that enable eligible individuals to purchase health insurance. If the premiums are lower, the federal government spends less on the subsidies.<sup>57</sup> It may be possible to apply a similar “pass-through” funding model to an LTCI reinsurance program using Medicare and Medicaid savings. This concept would require modeling to understand how much participation might expand under this scenario, the cost to fund the reinsurance pool, and the level of potential Medicare and Medicaid savings. There would also be questions about equity and if the purchase of private LTCI products should be compulsory.



## Next Steps

- » Encourage states and private LTCI providers to work together to create complementary benefit designs, ensuring consumers have access to affordable private products that build off any newly created public front-end LTCI programs. The NAIC could help facilitate this process. Greater affordability in private policies is assumed due to the public-sector shouldering of initial risk. Additional research and modeling are needed to determine the exact cost-saving potential for insurers who tailor products to this middle tranche of risk and how those savings could translate to lower premiums.
  - » Conduct economic modeling to evaluate funding mechanisms and the estimated funding amount available to capitalize a trust fund. This modeling should include investment scenarios for the trust fund (accounting for limitations within states), using technical assistance from philanthropic and private capital. States should also model the potential cost savings from reduced Medicaid spending. Clearly demonstrating the potential for long-term government savings will be instrumental to lawmaker adoption of a mandatory program.
  - » Develop a policy brief, using the Washington state program as a case study, which outlines what a complementary tiered private policy option might look like including potential variables that could affect policy premiums.
- 



# CONCLUSION

As the US population ages, the need for long-term care rises proportionally. Of particular concern is the risk of a catastrophic health event that necessitates a high level of expensive care over an extended period. This looming risk is front and center for most middle-income Americans, who have been priced out of private care and cannot qualify for public aid. Meanwhile, the private long-term care insurance industry itself has shrunk under cost burdens, and federal and state budgets have been hit hard by COVID-19. Urgent action is needed, and effective solutions to these challenges will require public-private cooperation and collaboration.

The Financial Innovations Lab has resulted in this plan for a technology-focused Medicare Advantage demonstration project to show improved care delivery and lower costs. We also offer ideas to scale and hone two of the most promising integrated care programs, PACE and SNPs. Perhaps most important is an initial roadmap to coordinate public and private efforts to develop complementary LTCI programs and products that ensure seamless coverage and shared financial risk. The Milken Institute encourages stakeholders from across the LTC ecosystem to utilize the recommendations laid out in this report to take action on this critical issue. The Institute will continue to leverage our network and platform to advance these and other solutions to ensure access to quality long-term care for Americans across the socioeconomic spectrum.



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Randy	Hardock	Partner	Davis & Harman LLP



First Name	Last Name	Title	Organization
Robert	Herbolsheimer	Chief Legal and Compliance Officer	Meals on Wheels America
Maureen	Hewitt	President and CEO	InnovAge
Jhamirah	Howard	Social Science Analyst	Office of the Assistant Secretary for Planning and Evaluation, HHS
Jeff	Huber	CEO	Home Instead Senior Care
Lynne	Katzmann	Founder and CEO	Juniper Communities
Gavin	Kennedy	Associate Deputy Assistant Secretary	Office of the Assistant Secretary for Planning and Evaluation, HHS
Keavney	Klein	Senior Counsel, Government Relations	Kaiser Foundation Health Plan
Christopher	Koller	President	Milbank Memorial Fund
Robert	Kramer	Founder & Strategic Advisor	National Investment Center for Seniors Housing & Care
Corinne	Lewis	Program Officer, Delivery System Reform	The Commonwealth Fund
Jim	Lydiard	General Manager	CareMore Health
William	Marton	Director, Division of Disability and Aging Policy	Office of the Assistant Secretary for Planning and Evaluation, HHS
Neel	Mehta	Senior Vice President, Corporate and Business Development	Honor
Arielle	Mir	Vice President of Health Care, Complex Care	Arnold Ventures
Debapriya	Mitra	Vice President—Business Strategy & New Ventures, Genworth US Life Division	Genworth
Anne	Montgomery	Co-Director, Program to Improve Eldercare	Center for Appropriate Care, ALTARUM
Tom	Moriarty	EVP, Chief Policy and External Affairs Officer, and General Counsel	CVS Health
Robert	Morse	Partner & Executive Chairman	Bridge Investment Group
David	O'Leary	President and CEO, US Life Insurance Companies	Genworth
Kali	Peterson	Program Officer	The SCAN Foundation
Cheryl	Phillips	President and CEO	SNP Alliance
Gabriela	Prudencio	Research Director	National Alliance for Caregiving
Susan	Reinhard	Senior Vice President and Director	AARP Public Policy Institute
Allison	Rizer	Principal	ATI Advisory
Bruce	Saul	Senior Regulatory Analyst (retired)	Federal Insurance Office, US Department of the Treasury
Rob	Schreiber	Vice President and Medical Director	Summit ElderCare, Fallon Health
Katie	Sloan	President & CEO	LeadingAge



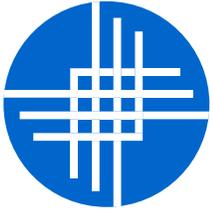
<b>First Name</b>	<b>Last Name</b>	<b>Title</b>	<b>Organization</b>
Jesse	Slome	Executive Director	American Association for Long-Term Care Insurance
David	Smith	Senior Vice President, Operations	Genworth
Sandy	Spitale	Director, Home Health Transformation	Humana
John	Squire	Chief Growth Officer	Philips
Bonnie	Washington	Vice President, Head of Public Policy	CVS Health/Aetna
Kevin	Waterman	Vice President & Actuary	Genworth
Lynn	White	Senior Vice President and Chief of Staff	Genworth
C. Grace	Whiting	President & CEO	National Alliance for Caregiving



## About the Authors

**Jason Davis** is a senior associate of innovative finance at the Milken Institute. He contributes to the research, development, execution, and follow-up of our Financial Innovations Labs, which address market failures and funding gaps within social or environmental issues. During his time at the Institute, Davis has addressed financing large-scale coastal resiliency infrastructure projects in New York City. He has also explored how Los Angeles can facilitate a “green recovery” during the COVID-19-induced economic downturn. Before joining the Milken Institute, Davis held several positions in the media industry in New York and Los Angeles. Davis graduated with a BFA from Syracuse University and recently earned his MBA from Loyola Marymount University.

**Caroline Servat** is an associate director at the Milken Institute Center for the Future of Aging. Her work focuses on developing collaborative partnerships and analyzing best practices for long-term care and next-generation senior housing solutions. Recently, she co-authored a working paper for the Wharton Pension Research Council on innovative public/private strategies to finance and deliver long-term care. She also developed and launched an initiative, Age-Forward 2030, which aims to help cities prepare for a diverse older population by integrating population aging into strategies for economic growth, inclusion, and resiliency. In 2018 and 2019, she was selected to speak on aging and the future of cities at the SXSW Conference. Servat studied political science and theater at Bates College and completed her master’s degree in public policy at the University of Southern California. She also serves as a member of the public policy committee for the American Society on Aging.



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