Developing a Comprehensive Set of Services to Supplement Medicare: Options for Low-Income Minnesotans

A Report to the Legislature

January 2000

Health Economics Program

Health Policy and Systems Compliance Division
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St. Paul, MN 55164-0975

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INTRODUCTION

The 1999 Minnesota Legislature directed the Commissioner of Health, in consultation with the Commissioners of Human Services and Commerce, to study the extent and type of Medicare supplemental coverage for low-income seniors. This includes studying qualified Medicare beneficiaries in terms of developing a comprehensive set of services to supplement Medicare that these individuals may need to ensure independence and control of their lives. Finally, the Commissioner of Health was asked to make recommendations on the cost-effectiveness of expanding the benefits offered to qualified Medicare beneficiaries including the feasibility of the state providing health care coverage options to low-income seniors that would provide a comprehensive set of services and would build on existing or new Medicare products.

In a separate report, the Commission of Health will report to the Legislature about the fiscal impact of mandating coverage for Medicare supplemental products to include long-term care services, including home health services, homemaker services, and nursing facilities services, and the fiscal implications of the State paying the premiums for this coverage for low-income seniors, including potential savings to the Medical Assistance program.

MEDICARE BASICS

Medicare is a federal health insurance program that serves almost all (99 percent) elderly and some disabled persons. There are two parts to the Medicare program: Part A, the hospital insurance (HI) component, and Part B, the supplemental medical insurance (SMI) component.

Prior to the enactment of Medicare, less than half of all elderly Americans had health insurance (Henry J. Kaiser Family Foundation, 1999[a]). Today, virtually everyone 65 and older is insured by Medicare. Elderly beneficiaries are automatically enrolled in Medicare Part A if they receive Social Security benefits or Railroad Retirement cash benefits and are at least 65 years of age. Other elderly beneficiaries may enroll in Part A if they pay the full actuarial cost of coverage or $301 per month in 2000. Less than 1 percent of part A beneficiaries buy into the program in this way. Part B is an optional program in which participants pay a monthly premium that, in turn, funds 25% of the cost of the program. In 1998, 644,000 Minnesotans were enrolled in Medicare Part A (Health Care Financing Administration, 1999). Almost all of them (96%) were also enrolled in Part B. The elderly make up about 88% of Medicare beneficiaries in Minnesota, the remainder are younger disabled persons.

Medicare covers acute and some post-acute health care services. Part A, the HI components, pays for hospital care, some skilled nursing facility care, limited amounts of skilled home health care, and hospice care. Part B, the SMI component, covers physician services, hospital outpatient services, and a variety of other medical and health services such as laboratory and diagnostic tests.

Medicare Part A is almost entirely financed by a payroll tax that is specifically earmarked for the HI trust fund. Employees and employers are each taxed 1.45% of all wages and this makes up 99% of total Part A revenues. The other 1% comes mostly from the $301 monthly premium paid from people who are not automatically enrolled. Part B, on the hand, has two financing mechanisms–a voluntary premium paid by Medicare beneficiaries with the rest coming from general government tax revenues. The monthly premium ($45.50) generates a little more than one-quarter of the annual revenues for Part B.

In 1997, Medicare expenditures reached $2.3 billion for elderly Minnesotans. Table 1 shows that 48% of all Medicare payments made on behalf of the elderly were for inpatient hospital services. This portion has steadily decreased over the last four years. Physician payments have consistently made up about one-quarter of all Medicare payments. Community and institutional long-term care have seen the largest increase over the past 4 years (growing 17% and 12%, respectively, each year), but these expenditures are still dwarfed by hospital payments–together they comprise about 12% of the total Medicare bill. Later in this report, it will be shown how Medical Assistance spending complements that of the Medicare program.

Table 1: Medicare Spending and Growth by Service Benefit for Elderly in Minnesota, 1997 (Fee-for-service and managed care)

	Medicare Benefit Payments (1997=$2.3B) *in $millions*	Medicare Benefit Payment (as % of total spending)	Average Annual growth ('93-'97)
Inpatient Hospital	$1,105	47.1%	4.2%
Outpatient Hospital	$248	10.5%	8.0%
Physician & other	$681	29.0%	4.4%
Institutional LTC	$177	7.5%	12.2%
Community LTC	$108	4.6%	16.8%
*Pharmacy**	$30	1.3%	17.0%

*Medicare spending through managed care options only.

Gaps in Medicare coverage

Important services are not covered in the Medicare benefit package and fairly high levels of cost-sharing are required by the beneficiary. Medicare covers no outpatient prescription drugs, dental care, eyeglasses, hearing aids, and only minimal mental health and long-term care services. In 1999, cost-sharing (deductibles and coinsurance) for Medicare beneficiaries consisted of:

- $776 per benefit period[1] deductible for each hospital admission
- $194 per day coinsurance for days 61 through 90 of a hospital stay
- $97 per day coinsurance for days 21 through 100 in a skilled nursing facility

[1]A “benefit period” begins when a beneficiary enters the hospital and ends when the beneficiary has not been in a hospital or skilled nursing facility for 60 days.

- $100 annual deductible for Part B
- 20% coinsurance on all medically necessary Part B services

Unlike other insurance plans, Medicare does not limit beneficiaries total spending on cost sharing. Because of the uncovered services and cost-sharing, Medicare paid only about one-half of the health-care goods and services used by the eligible population (Laschober and Olin, 1996).

Future trends and implications for the elderly

Medicare spending is expected to grow rapidly over the next 25 years. This growth is driven by both the number of Medicare beneficiaries–the first wave of the baby boom generation becomes eligible for the program in 2012–and rising per capita expenditures. Fueled by a number of things–technology, utilization, prescription drugs–health care prices tend to grow faster than prices for other goods and services. Nationally, the number of beneficiaries is projected to grow almost 80% in the next 25 years while the per capita expenditures will grow 72% in real dollars. (Moon, 1999).

The effect of this growth on the federal costs of the program have drawn serious concern. However, because Medicare requires substantial cost-sharing on the part of beneficiaries, attention should also be focused on the future financial burden facing the elderly and the implications on state spending for certain low-income elderly.

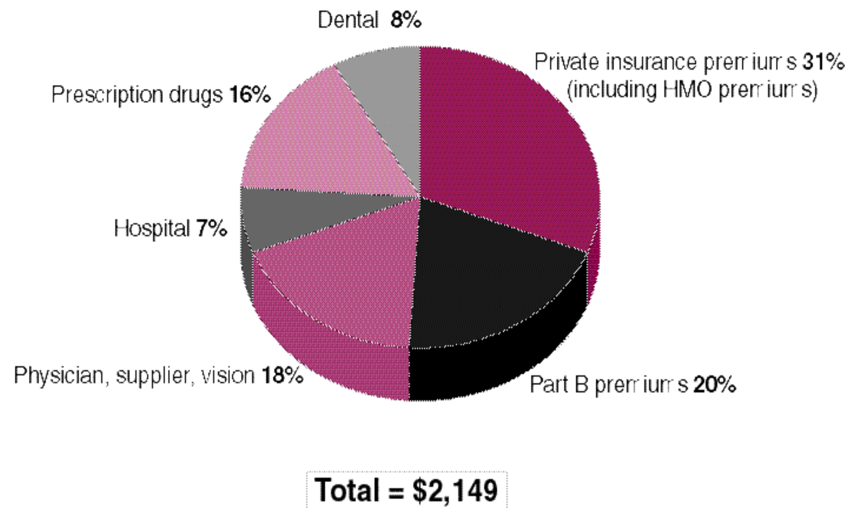
OUT OF POCKET SPENDING FOR MEDICARE BENEFICIARIES

A recent analysis estimates that average out-of-pocket health care spending for Medicare beneficiaries living in the community was $2,149, or 19 percent of their average income in 1997 (Grosss et al.,1999; American Association of Retired Persons and The Lewin Group, 1997).[2] This analysis allowed for total out-of-pocket spending to be divided into health services costs and health insurance costs (i.e. premiums). Half of the average out-of-pocket spending done by Medicare beneficiaries in the community goes toward paying private insurance (including HMO) and Part B premiums (Figure 1).

[2] This total amount includes cost-sharing, out-of-pocket spending for non-covered services and products (e.g. prescription drugs), private health insurance premiums and Part B premiums, and balanced billing charges. It does not include the costs of home health and skilled nursing facility services. Inclusion of these costs, naturally, would increase estimates.

Figure 1

Average Out-of-Pocket Health Costs for Medicare Beneficiaries Living in the Community, 1997



Source: Medicare Benefit Simulation Model; AARP Public Policy Institute and The Lewin Group, 1997.

This financial responsibility is even more burdensome on low income individuals, particularly those who do not qualify for Medical Assistance.

On average, Medicare beneficiaries who have incomes below 100 percent of the federal poverty level (FPL) and are not Medical Assistance eligible spend about half their income on out-of-pocket health care spending (Table 2). Out-of-pocket spending for those between 100 and 200 percent of FPL ranges from 17 to 30 percent. Non-institutionalized Medicare beneficiaries enrolled in managed care but not covered by Medical Assistance spend $679 less, on average, in out-of-pocket spending than those enrolled in fee-for-service. Lower private insurance premiums rather than lower health services costs account for the lower out-of-pocket spending among HMO enrollees. The extent to which this is a reflection of lower HMO cost sharing, greater efficiencies in HMO operations, or better health status among HMO enrollees is unknown.The analysis also reveals out-of-pocket spending pattern differences between those who pay these expenses directly and those who use Medicare supplemental coverage policies to cover the costs. As might be expected, beneficiaries who do not have supplemental coverage spend more on out-of-pocket health services costs ($1,273 vs. $1,121) but less on health insurance costs ($462 vs. $1,489). Although Medicare beneficiaries enrolled in HMOs have the lowest out-of-pocket health services costs, total out-of-pocket spending falls between Medicare only and Medicare supplemental coverage because of premium costs.

Table 2: Out-of-pocket Spending for Medicare Beneficiaries in the Community Not Covered by Medical Assistance, 1997

	Fee for service		HMO
Total out of pocket spending in $1997	$2,452		$1,775
Health services costs	$1,148		$1,103
Health insurance costs	$1,304		$772
Total out of pocket spending as a % of income	21%		16%
Out of pocket spending for low income beneficiaries			
Total dollars (in $1997)			
Poor (below 100% FPL)	$2,299		$1,603
Near Poor (100-125% FPL)	$2,287		$1,406
As a % of income			
Poor (below 100% FPL)	54%		48%
Near Poor (100-125% FPL)	30%		23%
Out of pocket spending by source of supplemental coverage	Medicare Only	Supplemental Coverage	HMO
Total dollars (in $1997)	$1,735	$2,610	$1,775
Health services costs	$1,273	$1,121	$1,103
Health insurance costs	$462	$1,489	$772

Source: Medicare Benefit Simulation Model; AARP and The Lewin Group, 1997

Absent structural changes to the Medicare program, as total Medicare expenditures rise in the future, so too will beneficiary out-of-pocket spending. A recent study projects that, in 2025, out-of-pocket spending among non-institutionalized Medicare beneficiaries will rise to $4,855 (in 1998 dollars)–a 94% increase over 1998. (Moon, 1999). These increased costs will rise faster than incomes of the Medicare beneficiary population; consequently, out-of-pocket spending as a percent of income will grow from 19 to 29 percent (ibid.).

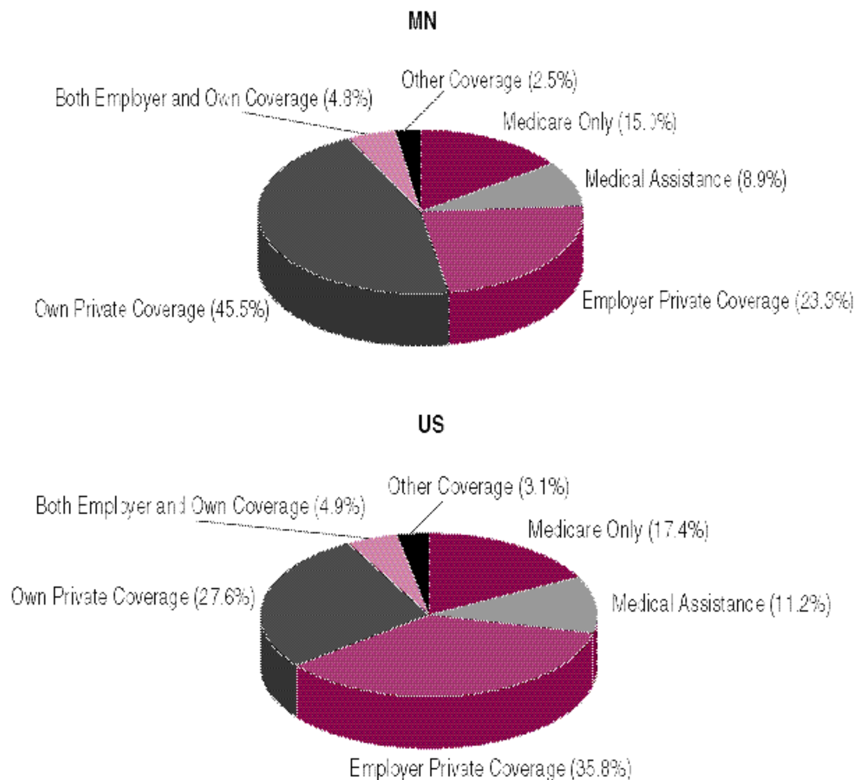
FILLING THE MEDICARE GAPS

The overall picture

Medicare beneficiaries fill in the substantial gaps in coverage by purchasing private supplemental coverage, by enrolling in managed care options or, if they qualify, through public programs. In Minnesota, 74 percent of elderly non-institutionalized Medicare beneficiaries supplement their Medicare coverage with private insurance coverage or “Medigap” insurance; nationally, the proportion is 68 percent of elderly beneficiaries (Figure 2). The rest rely on government programs (Medical Assistance, Veterans’ Administration, etc.) or on Medicare alone.

Figure 2

Medicare Supplemental Coverage



Source: 1997 Current Population Survey.

Compared with national figures, fewer Medicare beneficiaries in Minnesota rely solely on Medicare for coverage and fewer low income beneficiaries turn to Medical Assistance to fill in the Medicare coverage gaps. Approximately 15 percent of elderly Medicare beneficiaries in Minnesota rely solely on Medicare compared to 17 percent nationally. In Minnesota, 9 percent of elderly Medicare beneficiaries also receive assistance through Medical Assistance. Nationally, 11 percent of elderly beneficiaries are also covered by Medical Assistance.

Medicare private supplemental coverage ("Medigap")

Almost since the inception of Medicare, private insurance companies have offered policies that cover the gaps in Medicare such as deductibles, coinsurance, and services not covered by Medicare. Supplemental policies can be obtained in a couple of different ways: through an employer or former employer or by purchasing an individual policy. There appears to be a significant difference between Minnesota and the nation when it comes to the type of private insurance held by beneficiaries. Figure 2 shows that Medicare beneficiaries in Minnesota are more likely to purchase their own supplemental insurance (46 percent) than to have it provided to them by their employer (23 percent). Some (5 percent) have coverage from both sources. This trend is reversed at the national level where beneficiaries are more likely to have insurance provided to them by their employer (36 percent) than to purchase it individually (28 percent). This disparity is likely a result of numerous factors, among them are the relatively large number of self-employed farmers without access to employer-based coverage and the relatively high managed care penetration rates (Atherly, 1998).[3]

The future of employer-provided supplemental health insurance is influenced by the fact that, unlike pensions, virtually all corporations offering post-retirement health benefits have financed them on a pay-as-you go basis rather than prefunding them. Companies are now required to disclose on their balance sheets this future unfunded liability which has resulted in large numbers of employers cutting back on retiree health benefits or dropping coverage (Wiener and Illston, 1995). Indeed, a recent survey of more than 1000 large employers showed that prevalence of retiree health benefits declined from 80 percent in 1991 to 67 percent in 1998 (Hewitt Associates, 1999). These percentages are considerably higher than would be found if smaller employers were included in the survey. In addition, those offering retiree health benefits are more likely, than in the past, to require retirees to contribute towards the cost of this coverage (ibid.).

Since the beginning, Medigap insurance has been plagued with problems (e.g. over-priced policies, unnecessary duplications of coverage, and unethical sales tactics), particularly in the individual market. Minnesota's efforts to curb these problems, standardize choices, and to assist elderly in making informed comparisons between competing products actually preceded national efforts.

The State of Minnesota requires private insurance companies to offer two standardized Medicare supplemental policies: basic policies and extended basic policies,

> ***Basic Policies***, cover 100% of Medicare Part A and B cost-sharing except the $776 Part A and $100 Part B deductibles, 100% of immunization and routine screening procedures for cancer, 80% of emergency foreign travel care, and 50% of most outpatient mental health services. Beneficiaries may add on optional riders to the Basic policy for an additional cost.

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[3] Managed care penetration has always been higher in Minnesota than in the rest of the U.S. At its peak in 1992, the penetration rate was almost 3 times that of the country as a whole. Though the question is not asked directly, it is likely that those with managed care coverage are counted as private purchase in the Current Population Survey.

The optional riders to the Basic policy include:

- payment of the Part A $776 deductible
- payment of the Part B $100 deductible
- payment for the difference between a Part B bill and the Medicare approved reimbursement rate
- payment for at least 50% of the cost of prescription drugs
- payment for preventive health care to include routine physical exams and hearing exams, and
- payment for short-term at-home recovery.

Extended Basic Policies, cover all payments and services provided by the Basic policy and the six optional riders. Extended Basic policies also have a $1,000 annual limit on the amount of money a beneficiary pays for covered medical expenses. Once this limit is reached, the policy will pay for 100% of all covered expenses.

Minnesota beneficiaries may also purchase Medicare Select policies which the state does not require insurance companies to sell:

Medicare Select Policies, are a cross between Medigap insurance and the comprehensive plans described below. They cover the same expenses and co-payments as Basic policies as well as 100% of the Medicare Part A and B deductibles and 100% of physician charges. The major difference with Medicare Select policies is that they pay for these benefits only when the beneficiary obtains them through a limited network of healthcare providers, except in an emergency. In general, Medicare Select plans are not required to pay for any benefits if a preferred provider is not used for non-emergency services. Medicare, however, will still pay its share of approved charges with any Medicare certified provider chosen. In creating Medicare Select in 1990, Congress expected that it would direct beneficiaries to networks of efficient providers established by the supplemental insurers. This would, in turn, reduce fee-for-service Medicare claims and enable Select insurers to offer beneficiaries lower premiums. These expected results have not necessarily been seen in Minnesota (Lee et al., 1997).

In 1999, the average premiums for individually purchased supplemental plans were $65 per month for Basic policies and $317 per month for Extended Basic policies. The cost of optional riders for supplemental plans ranges from $3 to $82 per month. For Medicare Select Policies, average premiums were $100 per month for Medicare Select Basic and $325 for Medicare Select Extended Basic policies.

Table 3: Enrollment and monthly premiums for Medicare Supplemental Plans in Minnesota

Supplemental plan type	Enrollment	Monthly premiums without drugs (range)	Monthly premiums with drugs (range)
Basic	140,108*	$65 *($44-$100)*	$82# *(only one product sold)*
Extended Basic	63,917	n/a	$317 *($148-$451)*
Select Basic	132,255	$100 *($78-$123)*	$169 *($148-$189)*
Select Extended Basic		n/a	$325 *($229-$451)*
	336,280		

Sources: Based on information from the Minnesota Department of Health, the Minnesota Department of Commerce, and the Minnesota Comprehensive Health Association.

*Includes 15,684 non-qualified plans. Non-qualified plans are not included in premium average or range.

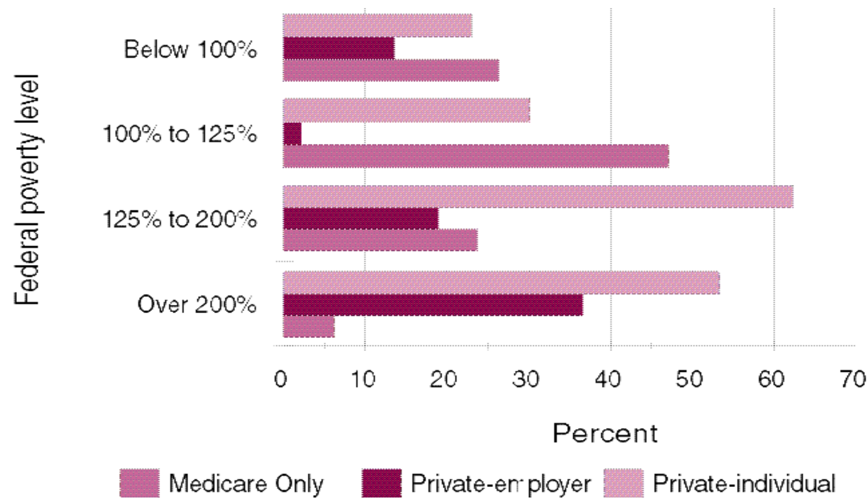
#Basic policy with a prescription drug rider.

Note: enrollment and premium information is for elderly and non-elderly. Enrollment is for 1998 (the most recent data available), premiums 1999.

Coverage through Medicare private supplemental insurance by elderly Medicare beneficiaries varies by income level. As expected, people with higher incomes are more likely than people with lower incomes to have private insurance coverage. Conversely, people with lower incomes are more likely to rely solely on Medicare for their health insurance coverage or, if their incomes are below 100% of the FPL, to receive Medical Assistance. It is interesting to note that a substantial number (23 percent) of people with incomes below 100% of the FPL purchase private supplemental insurance themselves. Presumably, these low income individuals who purchase coverage privately either do not realize they qualify for public coverage under the Qualified Medicare Beneficiary (QMB) program (for a description of this program see page 13), their assets exceed the qualifying level for these programs, or they move on and off QMB eligibility and do not want to lose their private coverage. The cost-sharing piece of the QMB program and coverage available through Medicare supplemental policies are redundant.

Figure 3

Supplemental Coverage by Poverty, Minnesota,1997



Source: 1997 Current Population Survey

Purchase of private supplemental coverage, does not guarantee that a Medicare beneficiary escapes high levels of out-of-pocket spending. Good quality supplemental policies that provide broad coverage ("Extended basic" policies or "Select extended basic") are expensive, more than $300 per month, and less expensive policies ("Basic" policies) still leave important gaps unfilled.

Comprehensive plans

Under Medicare comprehensive plans, health plans or HMOs are responsible for providing all Medicare-covered benefits for primary and acute services. Sometimes this is done for a fixed capitated rate each month previously called the Adjusted Average Per Capita Costs (AAPCC); other times, at actual costs. Health plans must also cover the Medicare deductibles and coinsurance for which the beneficiary is responsible, and health plans can charge a "fair" premium.[4] Occasionally, benefits not normally covered by Medicare (e.g. prescriptions drugs, eyeglasses, dental exams, routine physicals) are also included in the benefit set. Except for prescription drugs, these are offered at little or no extra charge. In Minnesota, coverage of prescription drugs requires a substantially higher premium. The health plan must provide or arrange for all the care.

There are three types of comprehensive plans currently available in Minnesota:

> ***Medicare+Choice Plans***, were created in 1997 under the Balanced Budget Act to replace earlier "risk contracts." Medicare makes monthly capitated payments to participating health plans for each enrolled beneficiary and health plans are at risk for all spending above that capitated payment.

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[4]Premiums and copayments charged to beneficiaries under comprehensive plans are restricted to the actuarial value of Medicare deductibles and coinsurance calculated by HCFA.

The capitated payments are partly based on historical Medicare fee-for-service payments at the county level. These payment rates are risk adjusted to reflect the demographic characteristics of enrollees.

Cost-Based Plans, were created in 1982 under the Tax Equity and Fiscal Responsibility Act (TEFRA) as an intermediate step towards HCFA entering into contracts with providers on a full risk basis. Unlike Medicare+Choice plans, Medicare pays the actual cost that a Cost-Based plan incurs in providing Medicare covered services to beneficiaries. With the passage of the Balanced Budget Act of 1997, Cost-Based plans are scheduled to be phased out or converted to Medicare+Choice plans by 2004.

Minnesota Senior Health Options (MSHO), is a demonstration project operating in the metro area. Minnesota has received federal waivers that allow the State to purchase both Medicare and Medical Assistance services in a combined package. The purpose of the demonstration project is to decrease the service fragmentation experienced by seniors who are eligible for both Medicare and Medical Assistance. Under MSHO, the state contracts with health plans on a capitated risk-basis.

Table 4: Enrollment and monthly premiums for Medicare Comprehensive Plans, 1999

Comprehensive plan type	Enrollment	Average monthly premiums without drugs (range)	Average monthly perm iums with drugs (range)
Medicare+Choice	48,588	$71 *$50-$85)*	$223 *$200-$250)*
Cost -based	37,050	$114 *$89-$142)*	$225 *$160-$275)*
MSHO	3,348	- -	- -
Total	**88,299**		

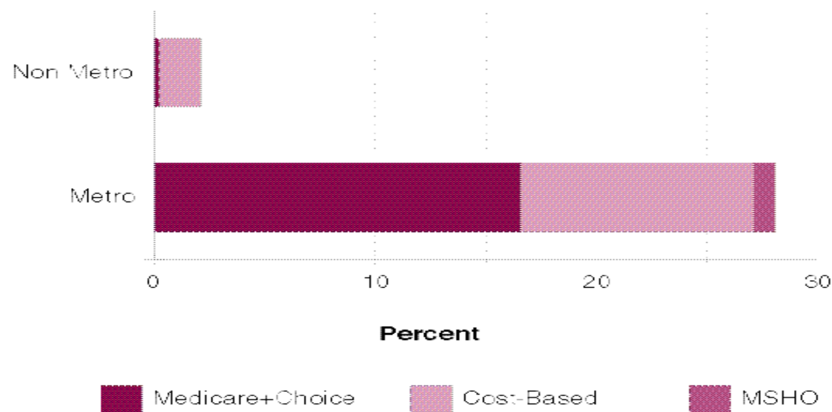
Source: Health Care Financing Administration, Minnesota Department of Commerce

Over 88,000, or approximately 14%, of Medicare beneficiaries are enrolled in comprehensive plans (Table 4). This percentage is dropping and has been since a peak in 1992 (Minnesota Department of Health, 1999). Participation in comprehensive plans varies greatly throughout Minnesota. About 91% of comprehensive plan enrollees reside in the seven county metro area (Figure 4). In the metro area, 28% of Medicare beneficiaries are enrolled in comprehensive plans. Outside the metro area, 2% of beneficiaries are enrolled in comprehensive plans. The primary reason for this difference is that comprehensive plans are not generally available outside the metro area.

Many comprehensive plans have decided not to offer their services outside the metro area because the Medicare payment rates in rural Minnesota are lower than the payment rates in the seven county metro area. For example, in 2000, the Medicare monthly payment rate per enrollee in Ramsey county $472 and the average payment rate outside of the metro area is $402.

Figure 4

Comprehensive Plan Enrollment: Percent and Distribution between Plan Type



Source: Health Care Financing Adminsitration

Of the beneficiaries enrolled in comprehensive plans, 55% are enrolled in Medicare+Choice plans, 42% are enrolled in Cost-Based plans, and 3% are enrolled in MSHO. Cost-Based plans will be phased out by 2004.

Comprehensive plans offer a variety of different benefit packages. The major differences between them are whether or not prescription drugs are covered, and whether and in what amount there are copayments required for covered services. In 1999, the average monthly premium for a Medicare+Choice plan without prescription drug coverage is $71, while the average monthly premium for a Medicare+Choice plan that offers prescription drug coverage is $223. The average monthly premium for a Cost-Based plan that does not offer prescription drug coverage is $114, while the average monthly premium for a Cost-Based plan that offers prescription drug coverage is $225. See Table 4 for average monthly premiums for comprehensive plans.

It is interesting to note that, nationally, most (64 percent) Medicare comprehensive plan enrollees are not charged a premium and an additional 2 percent pay $10 or less per month. Only 11 percent of enrollees are in health plans that charge more than $45 per month. The average premium is $15.50 per month. (The Henry J. Kaiser Family Foundation, 1999[b].) Premiums for Medicare+Choice plans are directly related to the capitated payment Medicare pays health plans for beneficiaries choosing this managed care option. Generally, the higher the capitation rate, the lower the premium. As mentioned earlier, these payments are partly based on historical Medicare fee-for-service payments in the county where the beneficiary lives and historical spending in Minnesota has been low relative to other parts in the country. The result of this is that, not only do many managed care plans around the country offer zero premiums, but they also offer, at no extra cost, benefits not normally covered under the Medicare benefit set–e.g. prescription drugs, eyeglasses, and hearing aids. Although some improvements have been made to the payment methodology for managed care plans—for example, the 1997 Balanced Budget Act set a payment floor—the discrepancy between what health plans can offer Medicare beneficiaries in Minnesota and in other parts of the country remains.

Public coverage of the gaps in Medicare

Medical Assistance programs and state-specific programs are available to low-income Medicare beneficiaries to help reduce the financial burden imposed by Medicare.

Medical Assistance

Under the Medical Assistance program, low-income beneficiaries may be eligible for a range of options from obtaining full Medical Assistance benefits to getting assistance paying Medicare part B premiums. In Minnesota, beneficiaries may also be eligible for the Senior Drug Program or the Alternative Care program. Table 5 shows that Medical Assistance spending complements that of Medicare. For instance, long-term care represents the largest benefit gap in Medicare coverage and institutional long term care is the largest single expenditure for the elderly under the Medical Assistance program. Also, Medicare buy-in payments illustrate the complementary nature of Medical Assistance and Medicare.

Table 5: Medical Assistance Spending and Growth for the Elderly by Service Benefit

	Medicaid Benefit Payments (FY '99 = $1.04B) *in $millions*	Medical Assistance Benefit Payment (as % of total spending)	Annual growth ('96-'99)
Inpatient Hospital	9.3	0.9%	-11.7%
Outpatient Hospital	1.6	0.2%	-1.7%
Institutional LTC	759.9	72.9%	-0.3%
Community LTC	64.8	6.2%	9.5%
Physician/Therapy	8	0.8%	-21.0%
Pharmacy	36.3	3.5%	-4.1%
Other	9.7	0.9%	-34.4%
Medicare Buy-in	34.5	3.3%	7.8%
HMO Premium	117.3	11.3%	21.3%
Total	1041.9	100.0%	0.7%

Source: Minnesota Department of Humans Services

Dual eligibles. The Medical Assistance Program pays the Medicare premiums and cost sharing for Medicare beneficiaries who are eligible for full Medical Assistance benefits. These individuals who are eligible for both Medical Assistance and Medicare are referred to as "dual eligibles." Dual eligibles also receive coverage for long-term care in skilled nursing facilities, in the community (through the Elderly Waiver program) and at home, prescription drugs, physical exams, dental care, eye glasses, hearing exams, and hearing aids, all of which are not covered by Medicare. To be eligible for full Medical Assistance benefits, a Medicare beneficiary must meet the income ($5604 annually for individuals in 1999) and asset ($3,000 for individuals) requirements.[5] In 1999, there were approximately 47,100 elderly dual eligibles in Minnesota.

[5] Medical Assistance eligibility is extremely complicated and depends on a variety of factors–whether you are in an institution or not, whether you are married or not, etc. The details of Medical Assistance eligibility are beyond the scope of this report. See Appendix A for a brief description.

The dual eligibles are a focus of policy makers because their health care costs are dramatically higher than those of other Medicare beneficiaries. Table 6 gives an analysis from linked Medicare/Medical Assistance data files for (Saucier et al., 1998) Minnesota. It shows that dually eligible beneficiaries use a disproportionate amount of both Medicare and Medical Assistance resources (Minnesota Department of Human Services, 1999). In 1997, total combined spending from these two programs for the dually eligible was almost $2 billion, compared with $1.7 billion for Medicare only beneficiaries. There are eight times as many Medicare-only beneficiaries; consequently, the average monthly per capita spending on the dual eligibles is nearly eight times that of the Medicare-only. The disproportionate spending is driven largely by the significant subset of the population that uses institutional care.

A recent national study confirmed these higher health care expenditures among the dual eligibles and found that the differences were largely explained by health and function-status differences (Liu, Long and Aragon, 1998). However, the authors also concluded that some of the remaining differences might be attributable to inefficiencies in how health services are delivered.

QMBs and SLMBs. Recognizing both the strict income and asset requirements for full Medical Assistance participation and the significant financial burden Medicare premiums and cost-sharing represent for other low income elderly, the Qualified Medicare Beneficiary (QMB) and Service Limited Medicare Beneficiary (SLMB) programs were created. The QMB program pays for part B premiums and cost- sharing. To be eligible for the QMB program, beneficiaries must have income below 100% of FPL ($8,244 per year in 1999 for individuals) and meet the asset ($4,000 for individuals) requirement. In 1999, there were approximately 2,100 elderly Medicare beneficiaries enrolled in the QMB program The SLMB program pays for Medicare Part B premiums only. To be eligible for the SLMB program, beneficiaries must have income below 120% of FPL ($9,888 per year in 1999 for individuals) and meet the asset ($4,000 for individuals) requirement. Currently, about 2,300 elderly Medicare beneficiaries are enrolled in the SLMB program.

Table 6: Medical Assistance and Medicare Beneficiaries and Spending, Minnesota, 1997
Aged and Disabled

	Medicare-Only		Dual Eligibles		QMB/SLMB	
	Total	Percent	Total	Percent	Total	Percent
Beneficiaries	557,290	100%	71,819	100%	5,029	100%
Elderly	519,300	93%	45,679	64%	3,485	69%
Disabled	38,012	7%	26,141	36%	1,544	31%
Beneficiary care setting						
Nursing homes	14,930	3%	29,605	41%	78	2%
Community with services	10,170	2%	11,718	16%	400	8%
Community without services	532,190	95%	30,496	42%	4,546	90%
Total Spending in millions	$1,713	100%	$1,955	100%	$19	100%
Medicare	$1,713	100%	$440.0	23%	$13	68%
Medicaid			$1,515.0	77%	$6	32%
Payment per eligible month						
Total	$278		$2208*		$319.0	
Payment per eligible month by care setting						
Nursing homes			$3,434			
Community with services			$6,073			
Community without services			$898			

Source: Medicare/Medical Assistance Database Project, Department of Human Services, unpublished data.

Note: Per capita spending for the disabled is higher across-the-board than it is for the elderly; depending on category, sometimes as much as 77% higher. This skews the estimates, particularly for beneficiaries living in the community and receiving services.

*These estimates are for dual-eligibles in the fee-for-service sector only. 20,131 dual eligibles are in managed care. The effects of this spending are unknown.

The Medicare/Medical Assistance Database shows 5029 elderly participating in the QMB and SLMB programs in 1997. The large majority (98%) of this population is found in the community and resemble the characteristics of the Medicare-only population more than the dual eligible population.

QI-1s and QI-2s. Under the Balanced Budget Act of 1997, Congress created a five-year block grant providing funds for states to pay all or part of the Part B premiums for two additional groups of qualifying individuals. Medical Assistance pays the full premium for those with incomes up to 135 percent of the FPL (known as QI-1s); and a small portion–about $1.00–of the premium for those up to 175 percent of the FPL (QI-2s). As of November 1999,k there were 618 QI-1's and 117 QI-2's.

The Senior Drug Program

In the earlier discussion of out-of-pocket spending, it was noted that, on average, prescription drugs represent 16 percent of the total $2,149 annual out-of-pocket bill for Medicare beneficiaries living in the community. Indeed, prescription drugs represent the single largest share of non-premium

out-of-pocket health care costs for these Medicare beneficiaries. Minnesota-specific estimates indicate that the average older person in Minnesotan without drug coverage spends about $550 per year for prescription drugs; and 21 percent of the poorest elderly (less than 100 percent of the federal poverty level) report annual drugs expenses in excess of $1000 (Nystrom and Muse, 1997). Minnesota's Senior Drug Program helps low-income elderly pay for their prescription drugs. The Minnesota Department of Human Services estimates that 124,600 low-income seniors in Minnesota do not have prescription drug coverage.

The Senior Drug program pays for necessary prescription drugs after an enrollee pays a $35 monthly deductible. To be eligible for the Senior Drug program seniors must have income below 120% FPL ($9,888 per year in 1999 for individuals), meet the asset ($4,000 for individuals) requirement, be enrolled in the QMB or SLMB program, and not have had any prescription drug coverage (including through a Medigap policy) within four months of application. There are approximately 1,300 people enrolled in the Senior Drug program. State spending for this program averages $98 per beneficiary per month.

The Alternative Care Program

The Alternative Care Program generally covers the same kind of home- and community-based services that the Medical Assistance program covers through the Elderly Waiver Program for elderly who do not yet qualify for Medical Assistance. These include adult day care, adult foster care, homemaker services, home health aides, personal care assistance, case management, respite care, assisted living, care-related supplies and equipment, home delivered meals, transportation, skilled nursing, chore services, companion services, nutrition services, residential care services, training for direct informal caregivers, and telemedicine devices. To be eligible, a person must be in need of nursing home care and, if they had entered a nursing home, within 180 days, these elderly would have used enough of their resources that they would qualify for Medical Assistance. The program is funded entirely with state money and its purpose is to help elderly Minnesotans avoid or delay admission to skilled nursing facilities and reduce Medical Assistance costs. Because the program serves people with more resources than those on Medical Assistance, the Alternative Care Program was designed so that monthly payments are capped at no more than 75 percent of the average Medical Assistance payment made for the same person had they entered a nursing home. Premium payments equal to 25 percent of the monthly service costs are then paid by some enrollees. The average state spending per month of service is $526.

Table 7: Minnesota Government Programs for the Elderly

Program	Benefits	Eligibility Standards (Single, Couple)	Enrollment	Monthly Spending (per enrollee)
Medical Assistance (dual eligible)	Medicare premiums and cost sharing and full set of Medicaid benefits.	*Income* : 133 1/3% AFDC (or 68% FPL) $5,604; $6,996 *Assets:* $3,000; $6,000	421,723	$2,174
QMB only	Medicare premium and cost sharing.	*Income:* 100% FPL $8,240;$11,060 *Assets:* $4,000; $6,000	2,058	$86
SLMB only	Medicare Part B premium	*Income:* 120% FPL $9,888; $13,272 *Assets:* $4,000; $6,000	2,258	$46
QI-1	Medicate Part B premium	*Income:* 135% FPL $11,124; $13,931 *Assets:* $4,000; $6,000	618	$46
QI-2	$1 of Medicare Part B premium	*Income:* 175% FPL $14,420; $19,355 *Assets:* $4,000; $6,000	117	$1
Senior Drug	All necessary prescription drugs after $35 monthly deductible	*Income:* 120% FPL $9,888; $13,272 *Assets:* $4,000; $6,000 *Other:* enrolled QMB or SLMB	1,272	$98
Alternative Care	Home and community based services.	*Income and Assets:* 180-day spenddown* *Other:* Nursing home certifiable	7,690	$526

Per enrollee spending for dual eligible, QMB, and Alternative Care are 1997 figures; all others are for 1999.

Source: 1999 Data from the Minnesota Department of Human Services, Reports and Forecasts Division; Medicare/Medical Assistance Database. Note: 180-day spenddown means that a person would spenddown to Medical Assistance within 6 months of entering a Skilled Nursing Facility.

THE SPENDDOWN PHENOMENON

Despite the State's existing efforts to offer strategic coverage to certain low-income people to help prevent them from becoming impoverished from high health and health-related expenditures, there is still some concern among lawmakers and other stakeholders that more should done to target those expenditures for greater efficiency and effectiveness. This impoverishment is commonly referred to as "spending down" and results in people eventually becoming poor enough to qualify for full Medical Assistance coverage.[6] To target expenditures more effectively, we first need a better understanding of exactly who is at risk of spending down. The extensive literature on the spend-down population can provide much insight into how this might be done.

Health and long-term care services use

From the academic literature, we know that the use of health care services is strongly correlated with the spenddown phenomenon. The spenddown population who remain in the community use 5.26 hospital days per year compared with 1.93 for those who did not spenddown. Those who spenddown and wind up in nursing homes use 9.06 days. Also, nearly half of all low-income persons who spent down were hospitalized (Gruenberg and Silva, 1998a).

People are five times more likely to spenddown if they have spent some time in a nursing home (Liu, Doty, and Manton, 1990), but this only holds true for people with long nursing home stays (Liu and Manton 1989). While the rate of spenddown is much higher, the absolute number of people who spenddown and remain in the community is larger than the number who entered nursing homes. People with no home care use are three times more likely to spenddown that those with some spending.

The patterns of prescription drug spending are less clear; however, it is clear that drug spending is an important component of the spenddown problem for a portion of the population (Gruenberg and Silva, 1998a).

Functional status

An individual's functional status (as measured by Activities of Daily Living limitations) is not a particularly strong predictor of who will spenddown and a large part of the difference that does exist can be accounted for by nursing home use among those with more functional disability. Indeed, the kind of severe functional impairment usually associated with "nursing home certifiable" status and Medical Assistance eligibility for waivered long-term care services does not appear to be a significant risk factor for spenddown, or at least not in a large number of cases.

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[6]The term "spend down" is actually used in two circumstances. The first is in the situation described above. The second is when a nursing home resident has medical expenses that exceed their ability to pay, they must contribute all of their income (minus a small personal needs allowance) towards the cost of their care before Medical Assistance will help pay the bills.

Medical vulnerability

Medical vulnerability is a measure of both high medical costs and frailty. Taken together, these two dimensions have a strong relationship with the risk of spending down. A detailed profile has been developed that allows an index or score to be developed that places a person at high risk (upper 10% of persons with regard to their probability) of spending down(ibid.). It is possible with this medical vulnerability index to identify and describe a subgroup of persons in the community whose expected Medicare costs (in the next year) are predictable, and can be quantified. Although many of these individuals have functional impairments, the majority are not nursing home certifiable.

Cost-sharing and Medigap insurance.

Not surprisingly, copayments and deductibles for inpatient care were much higher for persons who spenddown. Copayments and deductibles were $313 per month in the year of spenddown for persons who remained in the community and somewhat higher for persons who ended up in nursing homes. For persons who did not spenddown their monthly spending was $59. Over a third of one spenddown group did not have Medigap insurance (Gruenberg and Silva, 1998a). The majority of persons who had Medigap insurance also spent down indicating the limitation of Medigap coverage and the high cost of Medigap premiums (Leutz et al., 1992).

Demographics

Using both spenddown rates and relative risk of spenddown ("risk ratios"), persons with incomes of $10,000 or less are two to five times more likely than the population at large of spending down (Gruenberg & Silva, 1998b).

DISCUSSION

One can draw several conclusions about the elderly, their health care coverage, and the circumstances under which they remain vulnerable and at risk of losing their independence.

First, although Medicare has made significant progress in providing the elderly with health insurance–virtually all elderly now have Medicare coverage–considerable gaps remain. These gaps include high levels of cost-sharing and several important uncovered services such as prescription drugs and long-term care. Essentially, the elderly, as a group, are "underinsured" as evidenced by the fact that the average Medicare beneficiary in the community still spends about one-fifth of their income on health and health-related expenses.

Second, elderly at both ends of the income spectrum enjoy greater certainty about how they will fill the Medicare gaps. The very rich can afford to purchase adequate supplemental or comprehensive coverage through the private market. The very poor qualify for Medical Assistance and have comprehensive coverage through that program. Many elderly in between, particularly those who live below the poverty level but are not poor enough for Medical Assistance, remain vulnerable and at risk of losing their independence. More than 73,000 elderly Minnesotans live below the poverty level though only 47,000 are eligible for full Medical Assistance benefits. The available data do not allow for a determination of whether these low-income Medicare beneficiaries are delaying or foregoing needed care due to an inability to pay, but low levels of certain kinds of spending (e.g. prescription drug and dental) indicate that such problems may indeed be occurring. It is likely that these behaviors lead to higher health care costs down the road.

Third, a number of different public programs are already available for these low-income elderly. Yet, it is difficult for the elderly and their families to put together the disparate pieces in order to protect themselves from high health care expenses and, ultimately, from complete impoverishment. Indeed, large numbers of poor elderly are unaware that these programs even exist for their protection or fall just outside the eligibility criteria--especially with regard to assets.

Fourth, enough is now known about spenddown or this impoverishment process that it is possible to construct additional, targeted programs to prevent or delay much of the impoverishment resulting from the existing gaps in Medicare coverage.

OPTIONS

Minnesota has already made great strides in providing a comprehensive set of services to low-income seniors who do not qualify for full Medical Assistance benefits. Both the Alternative Care (AC) program and the Senior Drug Program fill two of the most critical service coverage gaps in Medicare for Minnesotans. Combined with the federally-mandated QMB and SLMB programs, which provide critical assistance with out-of-pocket expenditures, and outreach efforts to bring more people into the QMB and SLMB programs, many more Minnesotans now live independently.

Yet, many low-income elderly Minnesotans every year find themselves with large out-of-pocket health spending and ultimately lose their independence because they either have chronic medical needs that are not well managed, they fall through the housing and services safety net in the community, or they are just outside the eligibility requirements for important public supports. In many instances, the result of these persistent gaps is that certain elderly continue to resort unnecessarily to nursing facility care. The question arises: what else can be done to ensure them independence and control over their lives?

Below, four broad strategies are discussed: expanding coverage options, developing managed care options for certain low-income elderly, developing targeted medical management programs, and providing better housing support for community long-term care. Many of the options can be taken together or they may be considered separately.

Expanding coverage options

Medical Assistance coverage options are powerful tools available to Minnesota to fill gaps in insurance for low-income aged who often have considerable unmet health needs (Bruen et al., 1999). At one extreme, the State may extend full Medical Assistance eligibility to the fullest extent available under current law. At the other, it may simply enhance outreach efforts to get eligible persons into programs where partial to full protection is available.

> ***Option 1**. Expanding full Medical Assistance eligibility up to 100 percent of the federal poverty level.* States are permitted to provide full Medical Assistance benefits up to the federal poverty level. Currently, Minnesota uses 133 1/3 percent of the AFDC level which is approximately 68% of the federal poverty level. If made eligible for full Medical Assistance benefits, those between 68% and 100% of poverty will not only have greater access to needed services but they may also be included in Minnesota's existing Medical Assistance managed care programs–the Minnesota Senior Health Options (MSHO) program and the Prepaid Medical Assistance Program (PMAP). Low income individuals tend to have more severe health needs and Minnesota has already acknowledged the efficiencies inherent in serving people's health care needs through a managed care system.
>
> ***Option 2**. QMB buy-in and asset liberalization.* As was noted earlier, 23 percent of people with low incomes–below 100% of the FPL–are purchasing private supplemental insurance themselves. One reason this may be happening is that some people may have incomes that

fall within QMB qualifying levels, but assets that exceed the $4,000 for single persons and $6,000 for couples limit set for the program. A small liberalization of asset limits could be implemented with an avenue for having these low-income people contribute towards the costs of the QMB program. The buy-in would be viewed as a financial maintenance of effort strategy. The more than $110[7] that individuals would save monthly from having the State pick up the Part B and not having to pay Medigap premiums could be used to offset part of the cost of the program.

Option 3. *Enhanced outreach efforts for buy-in and cost-sharing protection.* Another reason for relatively high purchase rates of private supplemental insurance among low-income elderly is that these people might not realize they qualify for public coverage under the QMB, SLMB or QI programs. Numerous reports have indicated that the buy-in and cost-sharing protections from the QMB and other programs are not reaching all or even a sizable fraction of those who are eligible and could benefit from coverage. Recent national estimates suggest that participation rates for QMBs and SLMBs have improved but there are still a significant portion of eligibles–22 percent of QMBs and 84 percent of SLMBs– not receiving the benefits to which they are entitled (Moon et al., 1998). In Minnesota, participation rates may be as low as 19 percent (Rosenbach and Lamphere, 1999). Recognizing the critical role that these programs play in assisting elderly with out-of-pocket health care expenditures, Minnesota already has significant outreach efforts in place for this population. These efforts should be continued and/or enhanced. Moreover, the less-than-expected enrollment in the Senior Drug Program, which is linked to QMB/SLMB eligibility, indicates the need for coordinated outreach efforts across the various programs.

Managed care strategies for certain low-income beneficiaries

Much has been written about the fragmentation that arises from people having different coverage, payment, and provider certification requirements from different programs and how this leads to cost-shifting and movement of patients to satisfy revenue needs rather than patient care needs. Minnesota has long considered the role managed care may play in reducing the inefficiencies in how health services are provided to Medicare beneficiaries who qualify for full Medical Assistance benefits (the dual eligibles). Both Minnesota Senior Health Options and the Prepaid Medical Assistance Program use managed care models. It seems logical, then, that the state should look at providing some assistance for persons using other state-only funded programs or at high risk of becoming eligible for full Medical Assistance benefits to move into managed care programs as well.

Why target low income beneficiaries? The QMB population is a logical target group for such efforts because income is a significant factor in spending down and becoming eligible for Medical Assistance. Persons with incomes of $10,000 or less are 2 to 5 times more at risk than the population at large of spending down. QMBs' annual incomes cannot exceed 100 percent of the FPL or $8,240. In addition to Part A and Part B premiums and cost-sharing being paid, QMBs are eligible for reimbursement of premiums for enrollment with a health maintenance organization or a competitive medical plan if the premiums are *cost-effective*. Cost-effective means that the reduction

[7]The $110 savings represents $45.50 (Part B premiums) plus $65 (the average cost of a basic medicare supplemental policy).

in expenditures for individuals enrolled in an HMO are likely to be greater than the additional expenditures for premiums and cost-sharing required.

Cost effectiveness in Minnesota. Meeting the cost-effective standard in Minnesota is more difficult than in other parts of the country because HMOs in Minnesota must charge relatively large monthly premiums to offset the low capitation rates paid by the Medicare program to HMOs under managed care arrangements. In Minnesota, the average monthly premium for a Medicare+Choice plan without drug coverage is $71; plans with drug coverage run, on average, $150 more. State Medical Assistance programs in other parts of the country can more easily take advantage of the provision that allows for payment of cost-effective premiums under managed care option because most (64 percent) Medicare+Choice enrollees are not charged a premium. In addition, internal state protocols for determining cost-effectiveness use a 2 to 1 savings ratio. That is, a $2 savings needs to be shown for every $1 in premium paid.

The task of developing a monthly expenditure (per member per month or "PMPM") against which premiums can be compared in order to analyze the cost-effectiveness of a strategy is also a challenge. This is due to the complex and varying eligibility rules for different public programs and the fact that low income seniors are a very dynamic population that regularly move between public programs and in/out of eligibility. Consequently, at any one time, very few people are concurrently enrolled in all the potential programs–QMB, Alternative Care, Senior Drug–that might be rolled together for a managed care program and for which a "composite" PMPM could be developed. For example, in September 1999, while there were over 2000 QMBs, only 56 QMBs received AC benefits and were also enrolled in the Senior Drug Program; about 150 QMBs are AC recipients. Moreover, it is expected that the loosening of the Medical Assistance home and community-based "Elderly Waiver" eligibility criteria will move a number of clients from Alternative Care to the Elderly Waiver bringing these numbers down even further. [Recall, the Alternative Care and Elderly Waiver programs offer the same services, but for people meeting slightly different criteria. The Elderly Waiver program is a Medical Assistance program and Alternative Care is a state-funded only program for people who do not qualify for Medical Assistance.]

Table 8: Potential target population and PMPMs

Programs	QMB only	QMB + AC	QMB + Sr. Drug	QMB + AC + Sr. Drug
Target Population	2058	150	451	56
PMPM	$43*	$43* + $526**	$43* + $98	$43* + $526** + $98

*$43 represents the cost-saving portion of QMB spending. The other half goes directly to the federal government for Part B premiums.

** Although the average expenditure is $526 per month of service, recipients often get less than 12 months of service in a year. Consequently, $526 overstates the money available for a PMPM for AC recipients if calculated on an annual basis.

The end result of these cost effectiveness barriers is that elderly living below the poverty line but not eligible for full Medical Assistance benefits, who are already enrolled in a Medicare managed care option, have two options. They must either drop out of the plan in order to secure the full QMB benefits (i.e. both Medicare premium payment and cost-sharing) to which they are entitled or they must forego the cost-sharing part of their entitlement because there is no mechanism for having the state pay these costs to the health plan.

Given the discussion above, a number of options are available to state policy makers:

Option 4: *Work towards lowering Medicare managed care premiums.* The State should continue to push for higher, more equitable payments for Medicare+Choice plans in Minnesota. This includes both the base rate and any risk adjustment system applied to the base rate. This would likely result in lower premiums being charged by health plans and the ability to more easily structure cost-effective programs. This would benefit all current and future Medicare managed care enrollees.

Option 5: *Include AC and/or Senior drug programs in cost effectiveness calculations.* The State could try to bring more QMBs into the AC and Senior drugs programs and then craft a managed care product around the larger composite PMPM amount (QMB + AC + Senior Drug) and a larger pool of recipients. There are at least two drawbacks to this strategy. First, if, by design, the State does anything to increase the AC caseload, it will alter a program already judged effective. Currently, the impact of the AC program is considered statistically significant for purposes of the state budget forecast. For every 100 AC recipients, the demand for nursing homes beds is reduced by 33. As a non-entitlement program whose benefits are well-targeted, the "performance" of AC exceeds that of its Medical Assistance counterpart EW. Second, the average monthly spending on the Senior Drug Program is currently $98 per recipient. This is $22 *less* than the average marginal cost of adding prescription drug coverage to a Medicare+Choice product. Including senior drugs in the QMB + calculation will diminish its cost effectiveness.

Option 6: *QMB partial buy-in into managed care.* Another way of getting around the existing cost-effectiveness barrier to helping low-income Medicare beneficiaries enroll or remain enrolled in managed care is to split QMBs into subsets based on their spending patterns. For those with high spending, the cost effectiveness test would be met and the State could buy them into a managed care plan. For the subset of QMBs with lower average expenditures the State could have beneficiaries make up the difference between premiums and average monthly spending for this subset.

Option 7: *Develop a better picture of QMB spending and potential savings.* Given what we currently know about spending on QMBs, cost effectiveness criteria prevent the State from going to the market with the $43 PMPM (1997 spending) for the QMB only population. (Note: $43 represents the cost-sharing portion of average monthly QMB expenditures; the remaining dollars must go directly to the federal government to pay for Part B premiums.) For comparison purposes, the average monthly premium for a Medicare+Choice policy without drug coverage is $71. More analysis has to be done on this dynamic, complex population. For example, we need to understand what savings might be derived from preventing QMBs from moving on/off full Medical Assistance eligibility if only on a temporary basis. The State could create profiles of low-income elderly and all the different programs (Medical Assistance and state-only) they qualify for and use. We also need to understand what other offsetting savings might be derived from enrollment in managed care such as from the 100 days of covered Skilled Nursing Facility care under Medicare+Choice products. With the existing resources, the Department of Human Services can not yet answer

these questions. However, new information from the dual Medicare/Medical Assistance data base, as well as data on current Medicare managed care enrollment from HCFA that can be added to existing Medical Assistance recipient profiles, will provide insight into these and other questions, and support for these activities will likely yield valuable information on this population.

***Option 8**: Medicare beneficiaries enrollment in MinnesotaCare.* MinnesotaCare could be used as a vehicle for developing a managed care program for low-income elderly who may or may not necessarily be eligible for QMB benefits. To do this, the State would need to alter certain existing barriers in MinnesotaCare. For example, the language that specifically denies eligibility to anyone with Medicare coverage would have to be changed. The advantages of using MinnesotaCare is that the asset test can be liberalized, a sliding scale fee can be used and, with voluntary enrollment, the State can require that services be received in a managed care model. The sliding scale fee can be income-related and/or related to the past or expected expenditures of the beneficiary.

Targeting the medically vulnerable

As with any program, careful targeting should lead to greater cost effectiveness, at least in the long run. Recall from the earlier spenddown discussion (pages 18-20), the highest risk of spend down is found among persons with significant health risks. Indeed, a group of researchers have found it possible to identify and describe a subgroup of persons in the community whose expected Medicare costs (in the next year) are predictably high and can be quantified. This “medical vulnerability” index is a measure not just of high medical costs but also of frailty. Taken together, these two dimensions have a strong relationship to the risk of spend down. Other research findings support this population as one that should be targeted for spenddown efforts. Although many of the medically vulnerable individuals had functional impairments, the majority are not nursing home certifiable (a population for whom Medical Assistance community spending is often targeted). Instead, medical vulnerability suggests another population who require special attention to help them remain independent.

***Option 9:** Develop a medically vulnerable program for QMBs.* If the State could identify a subset of QMBs who were medically vulnerable and quantify spending on this subset, a targeted medical management program could be developed. It will likely be easier to meet the cost effectiveness criteria for a targeted high-cost subset of the QMB population than for QMBs as a whole. Because of the large expenditures associated with a targeted population, the potential for a good care management program to reduce total medical care costs is great. On the other hand, they are an expensive population to serve and the premium costs charged by health plans will likely reflect this. The cost-effectiveness would depend on the size of the premiums.

Targeting housing support needs in the community

In order to remain living independently in the community, low income seniors with supportive and health care service needs must often piece together a number of different public programs. These include programs for health and supportive services (Medicare, Medical Assistance especially the Elderly Waiver, and the Alternative Care program), for lodging/rental costs, food and related living expenses (federal HUD rent subsidies and housing programs, Minnesota's Group Residential Housing program, senior nutrition programs, food stamps, and utility assistance) and income support (the federal Supplemental Security Income program and Minnesota Supplemental Aid).

The most commonly used state funding programs in elderly housing with services settings are the Elderly Waiver (EW) program, the Alternative Care (AC) program, and the Group Residential Housing (GRH) program, though elderly recipients account for only about 5 percent of GRH spending. To be eligible for the GRH program, a single person's countable monthly income must fall below the GRH rate which was $621 in July 1999.[8] GRH then makes up the difference. In this way, the program effectively leverages private dollars to support independent living in the community. GRH differs from most other income-based programs because it requires residence in a licensed and/or registered setting and more than simple financial eligibility on the part of the individual. A county human service agency must also approve placement in the GRH setting. Between 800 and 900 elderly receive GRH payments each month; about half of those also receive EW services.

The $621 GRH rate must cover lodging, raw food costs (for three meals per day), cleaning common spaces, laundry of lines and towels, provision of basic furnishings for the resident, and utilities. Although hard evidence is lacking, it has been suggested that GRH payments sometimes fall short of what is needed. Consequently, providers and their private pay clients must sometimes "cross subsidize" the costs of publicly-funded clients when the GRH payments are inadequate. In the absence of this cross-subsidy, publicly-funded clients may wind up in more expensive nursing home settings. Indeed, the 1999 Legislature strengthened the relationship between GRH payments and nursing home use by creating a GRH "conversion" rate for persons who have lived in a nursing home for at least 6 months. The higher rate would enable some persons to move out of the nursing homes and into housing-with-services settings.

> ***Option 10:*** *Develop a supplement housing fund.* The state could ensure the continued effectiveness of the GRH investment and private dollar leverage by creating a more targeted strategy to get additional supplemental funds to certain individuals with high housing costs. The Department of Human Services has developed the idea of a "special needs allowance" which identifies EW recipients who spend more than 40% of their incomes on shelter costs which is entirely consistent with this option.

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[8]GRH rate = Minnesota Supplemental Aid housing rate ($561) plus individual food stamp allotment ($125) minus personal needs allowance ($65). Both MSA and food stamp allotments are adjusted for inflation annually.

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Appendix A:

Medical Assistance Eligibility

Categorical eligibility. Minnesota extends Medical Assistance eligibility to the poor aged in a number of different ways. Federal law requires certain categories of individuals be covered. The largest category is recipients of Supplemental Security Income(SSI). For determining Medical Assistance eligibility, eleven states–the so-called 209(b) states–are allowed to use state-specific eligibility that are different from the federal SSI standards. Minnesota has elected to use income standards that are stricter than federal SSI standards, but asset standards that are somewhat higher.

At state option, Medical Assistance eligibility may also be extended to recipients of state-only supplemental income programs. In Minnesota, Minnesota Supplemental Aid (MSA) recipients can have incomes (after disregards) up to $561 for an individual and $842 for a couple. To receive MSA, however, the lower federal SSI asset standards must be met.

Spend-down program. People whose incomes or resources initially exceed the limits for the groups mentioned above may still be able to obtain Medical Assistance coverage. Elderly are allowed to deduct incurred medical expenses from their income when determining eligibility for Medical Assistance. The income and asset levels that these people must "spend down" to are the same as for Medical Assistance eligibility for SSI recipients.

Eligibility type	Income Standards		Asset Standards		Comments
	Individual	Couple	Individual	Couple	
SSI Recipients	$467 68% FPL	$583 64% FPL	$3,000	$6,000	Mandatory. As a 209(b) state, allowed to have different standards. Income is more restrictive; asset less restrictive.
MSA Recipients	$561 82% FPL	$842 91% FPL	$2,000	$3,000	Lower federal SSI asset standards used.
Spenddown Option	$467 68% FPL	$583 64% FPL	$3,000	$6,000	The Spenddown standards are the same as for SSI.

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