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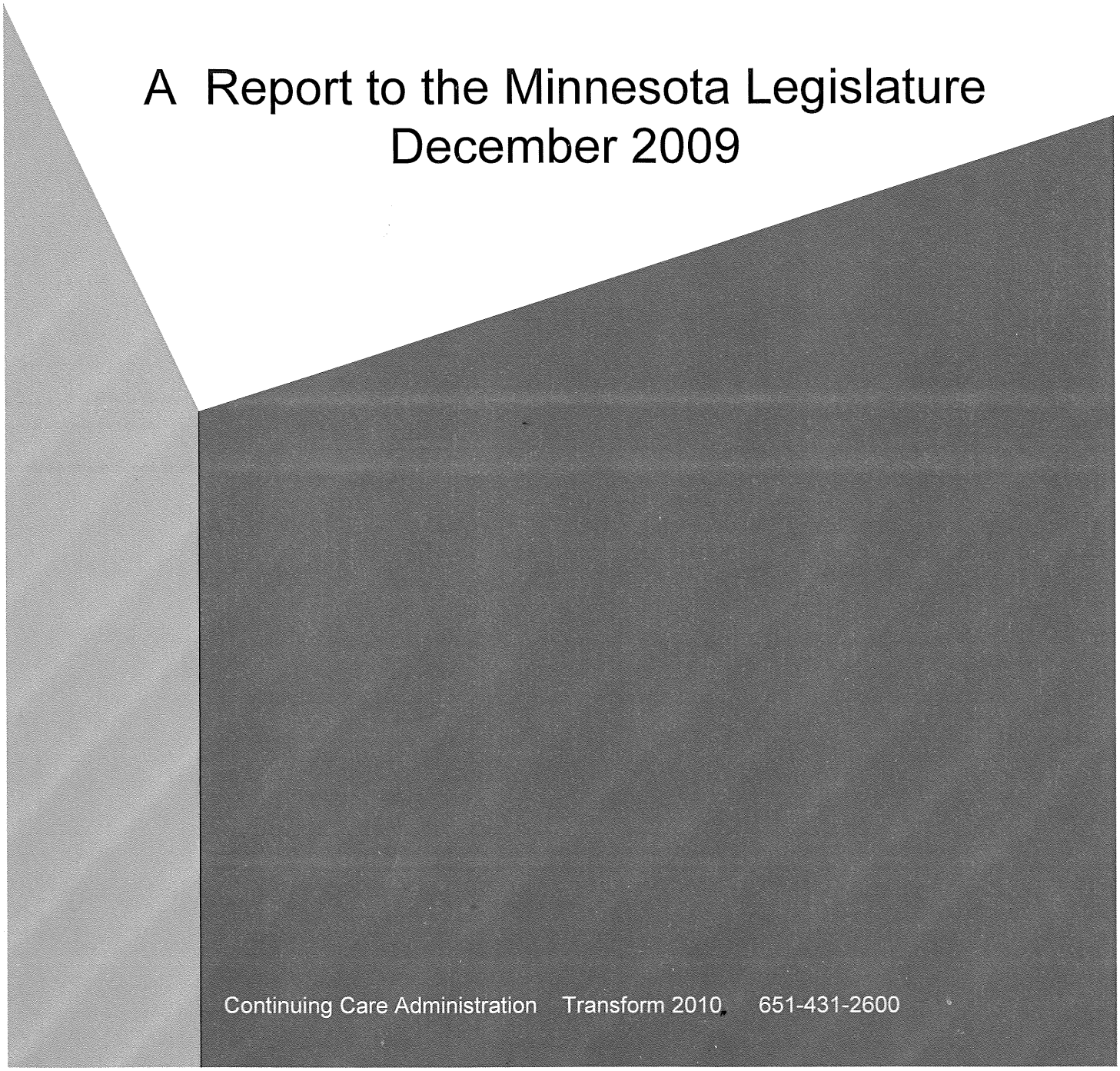
Costs and Options for Insuring Minnesota's Long-Term Care Workforce

A Report to the Minnesota Legislature
December 2009



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Background

A growing number of studies indicate that health coverage plays an important role in recruitment and retention of direct service workers to work in the long-term care field. Given the growing demand for long-term care services and supports and the demand for more workers to provide this support, states need to address the key barriers to long-term retention in these careers. Both workers and providers mention low wages and lack of affordable health insurance as the top two barriers to long-term retention of workers.

To address the insurance issue, in 2008, as part of Minnesota health reform legislation, the Minnesota Legislature directed the Department of Human Services (DHS) to conduct a study including "recommendations for a rate increase to long-term care employers dedicated to the purchase of employee health insurance in the private market." For purposes of the study, a long-term care worker was defined as a person employed by a nursing facility, an intermediate care facility for persons with developmental disabilities, or an agency providing services under the MA waivers. Also included were workers in a number of non-Medicaid reimbursed services, such as elderly nutrition services, mental and chemical health services and several state grant programs.

DHS contracted with The Lewin Group (Lewin) and its sub-contractors Ingenix Consulting (IC) and PHI to conduct the legislatively mandated research. In order to complete the work, the contractor collected data from both employers and employees in the long-term care field and used this data to construct a database on workers and their health insurance status. Lewin prepared actuarial estimates for the take-up rates and costs for six different benefit plans, which included the three called for in the legislation plus three variations. The three identified in the legislation included: 1) the MinnesotaCare program; 2) the state employee health plan (Minnesota Advantage); and 3) a sample commercial health plan with a deductible of $100. Although the legislation required that the health insurance be purchased through the commercial market, in order to provide additional options for the Legislature, Lewin looked at two additional methods for funding the plan: 1) a dedicated risk pool and 2) a plan as part of Minnesota Care.

This executive summary highlights the recommendations made by Lewin, and presents a brief overview of the steps that Lewin completed to develop the required cost estimates. A final report summary, the full final report and the final report appendices provide additional detail on each step of the study, and are available from DHS and online at http://www.dhs.state.mn.us/main/id_005728.

Cost of Providing Health Insurance to Long-Term Care Workers

According to the analysis completed by Lewin, the total cost (excluding the employee contribution) of funding health (medical and dental) insurance for Minnesota long-term care workers expected to sign up for insurance offered through their employer ranges from $17.3 million to $105.1 million per month, depending upon the benefit plan utilized and the assumption made of the number of workers who enroll. The total cost of the insurance for the midpoint estimate of workers (129,000 with 85,140 eligible for coverage) using the plan recommended by Lewin (Minnesota Advantage) with an average of $100 deductible and with dental tied to medical insurance is estimated at $59.5 million per month. The total cost figure includes both state and federal share if funded through Medical Assistance.

Recommendations for Benefit Plan Design and Funding Options

1. A plan modeled after Minnesota Advantage, with the commercial dental plan tied to medical, provides the most cost effective plan with reasonable coverage for this workforce.

- Because individual premiums are $0 for all plans, the main areas where the six plans analyzed differ are in projected costs and projected enrollment in family coverage.
- The MinnesotaCare plans are the most expensive plans, but also result in higher enrollment in family coverage, due to the better benefits. These may not be the most advantageous plans because of the very high cost.
- Lewin recommends the plan modeled after Minnesota Advantage. This plan has a total cost that is about 2.5 percent higher than the $100 deductible plan in the private market, but has a better chance of controlling future cost increases due to its tiering structure. This recommendation assumes that a commercial carrier or third party administrator (TPA)—usually a claims processor— can develop a tiered provider network for the plan.
- For a dental plan, Lewin recommends the commercial plan tied to medical. Tying dental to medical can increase participation in the initiative.
- Montana recently implemented a plan where the state pays the cost of health insurance for workers providing Medicaid-funded personal assistance or private duty nursing services, similar in concept to the Minnesota idea analyzed in this study. Its plan differs in scope from the Minnesota proposal, most closely resembling the $500 sample commercial deductible plan, but Lewin recommends keeping abreast of developments in the Montana plan for lessons learned.

2. Creating a dedicated risk pool could significantly reduce costs.

- Sharing the risk is essential for lowering insurance premiums. That is why it is easier for large companies with multiple facilities that share a single health plan to make insurance affordable. In the employer survey, several employers commented that their small size made it difficult for them to obtain affordable health insurance benefits for their employees.
- In the actuarial analysis, projected costs for commercially purchased insurance were significantly lower when purchased through a new dedicated risk pool. This is primarily due to the lower administrative and other non-benefit costs of a risk pool.
- Lewin recommends that coverage be obtained from carriers in the commercial market for the first five years of the program. After the first five years of operation, the plan would have enough experience on which to base premiums and to build a dedicated risk pool. This is ultimately the better approach, provided that all long-term care employers that accept the rate increase from the state would be required to get their benefit plan from the dedicated risk pool.

3. Providing insurance directly through MinnesotaCare would be a less expensive approach, but low provider reimbursement rates could present a challenge.

- For comparison purposes, the study also projected participation and costs for the approach in which insurance was actually part of MinnesotaCare. This funding option yielded significantly lower projected costs, due to the much lower provider reimbursement rates and non-benefit costs of MinnesotaCare compared with the typical commercial plan. However, this approach may be unrealistic because providers would have to accept very low reimbursement rates. The result could be that many

providers, particularly outside the Twin Cities, would refuse to accept the plan's reimbursement, and members would be left with a very limited provider network.

- This approach would capture federal match as well. Generally, Minnesota's Medicaid match has been 50/50 for both the state Medical Assistance program and the portions of the MinnesotaCare program eligible for federal match. The matching rate has been temporarily increased under the American Recovery and Reinvestment Act of 2009, and could vary in the future.

4. To ensure equitable treatment of providers, make participation voluntary and do not base eligibility on previous expenditures for health insurance.

- Some employers in Minnesota have emphasized health coverage, while others have offered better wages. Hence, the Minnesota Health Care for Long-Term Care Workers working group recommended that the state address fair treatment of providers regardless of prior decisions on the issue of better health insurance benefits versus better wages.
- Lewin recommends that if Minnesota establishes a program, participation should be voluntary and eligibility should not be based upon previous expenditures for health insurance. If providers wanted to continue offering and paying for health insurance through existing mechanisms, they would be able to do so.

5. Consider impacts of the initiative on equity across long-term care workers.

- The legislation directed the study to examine a rate increase for insurance for the entire long-term care workforce. However, given limited state funds, Lewin comments that beginning with one sector of the workforce with the highest rates of uninsurance and expanding to other sectors – as in the Montana plan – may be a viable strategy for Minnesota.

6. Build and maintain accountability systems to ensure that the rate increase is spent for the intended purpose.

- Another key issue identified in the legislation is the importance of developing mechanisms to ensure that rate increases are spent for the intended purpose. Minnesota has already developed an accountability system for previously enacted rate increases (COLAs) for long-term care providers earmarked for employee wage increases and benefits. Within six months after the effective date of each rate adjustment, providers must provide a Provider Statement of Assurance letter to the Department of Human Services Commissioner and those counties with which they have a contract. The letter provides assurances that the provider has developed and implemented a compensation plan that estimates the amounts of money that must be used to meet compensation related and wage requirements and details the distribution plan for the money.
- However, Minnesota officials consulted for this study commented that this has not really worked, as many providers have <u>not</u> returned this statement. In addition, a few survey respondents commented that their employer had not used the COLA for wage increases as required. Research in other states has found that even when accounting mechanisms have been specified, providers have not always passed on rate increases to employees. Hence, Minnesota should ensure a system is in place to track and monitor outcomes of the rate increase on employee health insurance. For example, in Montana's program, payments are advanced to employers monthly, and every quarter the employer must send in reports attesting to their actual costs.

- Research on the experiences of other states suggests several possible approaches to enforcement of a rate increase designated for wages or benefits:
  - Surveying providers after the rate increase to determine whether and how they participated;
  - Requiring providers to submit expanded cost reports;
  - Random audits; and
  - Tracking employer deductions for health insurance on business tax returns.

- It should be noted that, depending upon the approaches chosen, there would be additional costs within DHS to establish and administer this program. The actual cost would depend upon the type and level of reporting and monitoring required to oversee the program.

7. Explore options for making insurance more accessible to part-time workers or ensuring full-time work.

Many long-term care workers, particularly direct service workers, do not qualify for health insurance benefits because they work part-time or irregular hours, particularly those in home care. A third of workers reported working less than 32 or more hours per week. Potential strategies for expanding coverage to part-time workers are suggested below.

- **Ensuring full-time work.** Of the 33 percent of workers who indicated they do not have private health insurance, 33 percent said they would try to work at least 32 hours if that would qualify them for coverage. Another 47 percent said they already work 32 or more hours. This suggests that ensuring full-time work could be a promising strategy for Minnesota. For example, Cooperative Home Care Associations (CHCA) in New York has developed a guaranteed hours program that blends regular hours with replacement hours worked and "on-call" hours not actually worked. The program guarantees participants 30 hours of paid work a week.
- **Design the premium structure to ensure part-time workers are eligible for the full employer contribution.** Under the Minnesota Advantage plan, employees receive the full employer contribution to premium if they work more than 30 hours a week, partial contribution (50% or 75%) if they work 20 to 29 hours, and no contribution if they work less than 20 hours. Based on the results of the worker survey, few workers would be able to afford premiums of over $100 a month for insurance, so it is unlikely that many part-time employees would enroll unless the cost of premiums were fully subsidized or very low.
- **Create an alternative plan for those workers who are working part-time for multiple employers and not eligible for any single employer.** In the worker survey, 15 percent of respondents indicated they work 32 or more hours a week through more than one part-time job. This suggests that another strategy for Minnesota may be to develop a way to count workers as full-time if they work a total of 32 hours through multiple part-time long-term care jobs.

8. Conduct outreach efforts to increase awareness of the health benefit and encourage participation.

- It is important to ensure that long-term care workers are aware of the insurance benefit, the benefits of insurance and how it works, and how to enroll. Minnesota might consider mechanisms to gain direct access to workers, either with the permission of their employers or independently through direct service worker associations or labor unions representing the direct service workforce. Community organizations where many workers are active are another potential way to reach workers.

10. Ensure that the rate increase is adequate to make insurance affordable to employers.

- For the initiative to have significant impact, the payment made to employers would need to be of sufficient size to provide an incentive for employers to participate. In Montana, several of the providers who did not participate said the reason was because the Medicaid rate increase was insufficient to cover the cost of an insurance plan that meets the state's criteria. Maine's experience with a health insurance subsidy for employees also illustrates the difficulty of expanding coverage when the employers have a hard time paying premiums, especially when they are funded primarily with public dollars.

11. To ensure sustainability over time, build in mechanisms to ensure that funding keeps pace with escalating health insurance costs.

- Several of the long-term care worker health insurance initiatives undertaken by other states were short-lived demonstration programs that were unsustainable when the grant period ended, due to lack of a steady financing source. In some cases, rising health care costs led employers to increase costs or reduce benefits for employees.

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Survey Findings and Actuarial Analysis

This section summarizes the data and analysis that Lewin completed in order to develop the required cost estimates.

Surveys of Employers and Employees

Both workers and providers were surveyed to obtain information on the current health insurance picture for long-term care workers in Minnesota. A total of 910 long-term care workers and 772 providers completed at least some portion of the surveys.

Key findings from the employer survey include:

- 72 percent of providers surveyed offer health insurance and 59 percent offer dental insurance.
- 81 percent of employers rated lack of health insurance as a "high" or "medium" challenge in retaining workers, second only to low pay (96 percent).
- Providers generally supported the proposed rate increase for health insurance. Over half (56 percent) of providers said they support or strongly support the initiative, 21 percent neither oppose nor support it, 17 percent were unaware of it, and 8 percent opposed it.

Key findings from the worker survey include:

- 25 percent of all long-term care workers (34% of direct service workers) have been uninsured within the past 12 months.
- Coverage rates vary by employment setting and job type, although facility-based and home and community-based (HCBS) workers reported little difference in the percent uninsured—18 percent of facility-based and 20 percent of HCBS workers.
- Disparities emerged among workers in different occupations. Compared with "professionals" and other long-term care employees, direct service workers were more likely to work part-time, hold more than one long-term care job, have the least longevity on the job, have the lowest incomes, and were more likely to lack private health insurance.

- Many workers— especially in home care— do not qualify for employee benefits because they work less than full-time.
  - A third of workers work less than 32 hours per week, the amount of hours defined as full-time needed to qualify for coverage under this study. Fifteen percent work 32+ hours through more than one part-time long-term care job.
  - Of workers without private health coverage, 33 percent said they would try to work 32+ hours a week so they could get health insurance and 47 percent said they already work 32+ hours a week.
- Nearly one-half (46 percent) of all workers have unpaid medical bills.

Actuarial Analysis of Projected Participation and Costs

Actuarial staff from Ingenix Consulting (IC) projected participation and costs for several plan designs and approaches that could be set up for employers to obtain health insurance for their employees. The process consisted of six steps: 1) Specify the model insurance plans; 2) Determine funding sources; 3) Describe current employee contribution to health plan costs and project change in employee contributions; 4) Describe current participation rates and project increased participation; 5) Project monthly premium rates; and 6) Calculate total projected statewide participation and costs for the various plan design/funding source combinations.

1. Specify the Model Insurance Plans

The legislation specified that the study consider three plan designs, providing the benefit levels of: 1) the MinnesotaCare program for low-income Minnesotans; 2) the state employees' health plan, Minnesota Advantage; and 3) a sample commercial plan with a deductible limited to $100.

The actuarial staff of IC simulated participation rates and costs for six specific model health insurance benefit plan designs. Because MinnesotaCare includes a number of different plans, IC projected outcomes for three MinnesotaCare plans. A higher deductible commercial plan (set at $500), although not called for in the legislative language, was included for comparison purposes because this design is more typical of plans available in the commercial market, as was a third option under MinnesotaCare (Basic Plus One with unlimited inpatient).

IC also projected costs for two dental insurance benefit plan designs: a model dental benefit that provides the benefits of MinnesotaCare dental insurance, and a typical commercial PPO dental plan. The dental plans were modeled for both stand-alone (dental can be chosen separately from medical) and tied to medical dental (requires medical) coverage.

2. Determine Funding Sources

The legislation specified that the study develop estimates assuming the insurance would be purchased in the commercial market. For comparison purposes and at the request of DHS, IC developed costs of plans for two additional purchasing mechanisms: 1) a dedicated risk pool and 2) the plan as part of MinnesotaCare. The main difference between the three options was the proportion of the premium devoted to expenses other than benefits, referred to in this study as "non-benefit costs." In addition, health care provider reimbursement under MinnesotaCare would be at MinnesotaCare levels, which is similar to Medical Assistance reimbursement levels.

3. Describe Current Employee Contribution to Plan Costs and Project Change in Employee Contributions

Based on the results of the employer survey, the current plans offered by long-term care providers require relatively high average employee contributions.

Table RS.3: Current Employee Contribution Levels Based on Employer Survey				
	Small Group (50 or fewer eligible employees)		Large Group (51+ eligible employees)	
	Single EE	Family	Single EE	Family
Medical Coverage				
Average employee monthly contributions	$144.38	$483.95	$109.06	$503.77
as % of total plan cost	27.3%	48.2%	22.8%	39.7%
Dental Coverage				
Average employee monthly contributions	$23.66	$70.57	$16.43	$54.94
as % of total plan cost	43.7%	55.7%	41.2%	54.1%

The proposed plan requires that employee contribution be no higher than that for state employees. Therefore, IC modeled the impact on employee participation of these monthly employee contributions for all plans:

Table RS.5: Proposed Monthly Employee Contribution Rates[1]				
	Small Group (50 or fewer eligible employees)		Large Group (51+ eligible employees)	
	Single Employee	Family	Single Employee	Family
Medical	$0.00	$130.20	$0.00	$130.20
Dental	$5.00	$34.16	$5.00	$34.16

4. Describe Current Participation Rates and Project Increased Participation

Based on the **employer survey**, the **current participation rates in medical and dental plans**, expressed as percentages of employees eligible for coverage, are approximately:

- Small group (50 or fewer eligible employees): 50% for single coverage; 18% for family coverage
- Large group (51 or more eligible employees): 53% for single coverage; 28% for family coverage

Based on the **employee survey**, a significant number of these employees are covered by plans other than the one offered by the surveyed employer. A commercial carrier underwriting a group would consider these employees to have "other valid coverage" and not count them in the minimum participation requirement. IC

[1] While the employee contribution amount is the same for all proposed plans, the employer contribution, and hence the percentage contributions, vary by plan type.

therefore adjusted the current medical plan participation levels to reflect only those employees without other valid coverage, and the **adjusted current medical participation rates** are approximately:

- Small group: 73% for single coverage; 26% for family coverage
- Large group: 77% for single coverage; 41% for family coverage

For dental plans, the current participation rates are approximately:

- Small group: 67% for single coverage; 20% for family coverage
- Large group: 71% for single coverage; 34% for family coverage

It is not necessary to adjust dental participation rates because coverage is less common, individual coverage is rare and COBRA dental is unlikely given its cost.

While participation rates vary by region, the patterns are similar across regions. The proposed single employee contribution is $0. Because this is non-contributory coverage, the projected participation rate for individual coverage in health insurance is always assumed to be 100 percent.

The employee survey indicates a very high level of price sensitivity among these workers. Only 41 percent of surveyed employees said that they are willing to pay $100 per month or more for family medical coverage.

5. Project Monthly Premiums Rates

IC actuarial staff projected the premium rates for each model plan/funding source combination. The table below shows the **projected monthly premium** for each model plan for the year 7/1/2009 through 6/30/2010, for all regions averaged together, with the projected increased employee participation levels.

Table RS.8: 2010 Total Projected Premiums for Health Insurance for LTC Workers: Weighted Average of All Regions with Projected Increased Employee Participation Levels

	Small Group (<51 eligible employees)		Large Group (51+ eligible employees)	
Funding Source & Benefit Plan	Single Employee	Family	Single Employee	Family
A. Coverage from market				
MinnesotaCare Basic+2	$443.89	$1,539.09	$414.70	$1,328.42
MinnesotaCare Basic+1, $10K IP limit	369.94	1,454.31	345.61	1,197.31
MinnesotaCare Basic+1, no IP limit	440.14	1,526.08	411.19	1,317.18
Minnesota Advantage	390.81	1,415.11	365.10	1,212.62
Commercial Plan, $100 deductible	381.38	1,380.99	356.30	1,183.39
Commercial Plan, $500 deductible	363.80	1,348.95	339.88	1,128.83
B. Coverage from dedicated risk pool				

Table RS.8: 2010 Total Projected Premiums for Health Insurance for LTC Workers: Weighted Average of All Regions with Projected Increased Employee Participation Levels				
MinnesotaCare Basic+2	$383.30	$1,327.91	$383.30	$1,227.85
MinnesotaCare Basic+1, $10K IP limit	319.44	1,254.74	319.44	1,106.67
MinnesotaCare Basic+1, no IP limit	380.06	1,316.68	380.06	1,217.47
Minnesota Advantage	337.46	1,220.92	337.46	1,120.82
Commercial Plan, $100 deductible	329.33	1,191.48	329.33	1,093.80
Commercial Plan, $500 deductible	314.15	1,163.86	314.15	1,043.37
C. Coverage directly from MinnesotaCare				
MinnesotaCare Basic+2	$210.51	$729.27	$210.51	$674.32
MinnesotaCare Basic+1, $10K IP limit	189.53	744.45	189.53	656.60
MinnesotaCare Basic+1, no IP limit	208.14	721.06	208.14	666.73

The highest cost plans are the MinnesotaCare Basic+2 and Basic+1 with no in-patient limit purchased in the commercial market. The lowest cost plan in the commercial market is the $500 deductible commercial plan. Providing insurance through a new dedicated risk pool resulted in significantly lower costs. The availability and funding scenario in which the plan is actually part of MinnesotaCare produces lower costs than insurance obtained in the commercial market, due to the low provider reimbursement rates and lower non-benefit costs of MinnesotaCare.

6. Calculate Total Projected Statewide Participation and Costs

Based on the above analysis, the study team projected the total number of participants in each plan/funding source combination to develop an estimate of the cost to cover all long-term care workers. The **total number of LTC employees** was derived from low and high estimates of the number of long-term care workers in the state (71,000 and 181,000), based on the employer surveys and a 2002 report from the Minnesota Department of Health on health insurance among long-term care workers. A medium estimate was added based on the average of the two figures (129,000).

The statewide figures combine projections for single employees and employees with families, in small group (50 or fewer) and large group (51 or more) employers, for each combination of medical plans, dental plans, and funding sources.

The chart below shows the **projected numbers of participants in health insurance** for each funding approach.

Table RS.9: Total Projected Participation in Medical Insurance (Combined Metro & Non-Metro, Small and Large Group)					
Medical Plan		Percent of Eligible Employees Participating	Low Estimate	Med Estimate	High Estimate
MinnesotaCare Basic +2	Individual Coverage	100% of eligible employees not enrolled in family coverage -- for all plans	28,336	47,471	66,607
	Family Coverage	47.5% small group, 58.7% large group	22,484	37,669	52,853
	Total Enrolled	100% of eligible employees -- for all plans	50,820	85,140	119,460
MinnesotaCare Basic +1 $10k In-Patient Limit	Individual Coverage		33,031	55,338	77,645
	Family Coverage	35.8% small group, 46.9% large group	17,789	29,802	41,815
	Total Enrolled		50,820	85,140	119,460
MinnesotaCare Basic +1 No In-Patient Limit	Individual Coverage		28,093	47,065	66,037
	Family Coverage	48.2% small group, 59.3% large group	22,727	38,075	53,423
	Total Enrolled		50,820	85,140	119,460
Minnesota Advantage	Individual Coverage		30,729	51,481	72,233
	Family Coverage	41.6% small group, 52.7% large group	20,091	33,659	47,227
	Total Enrolled		50,820	85,140	119,460
Commercial $100	Individual Coverage		30,741	51,500	72,260
	Family Coverage	41.6% small group, 52.7% large group	20,079	33,640	47,200
	Total Enrolled		50,820	85,140	119,460
Commercial $500	Individual Coverage		31,137	52,164	73,191
	Family Coverage	40.6% small group, 51.7% large group	19,683	32,976	46,269

To estimate total participation, IC added together: 1) the projected number of employees without families who enroll in individual coverage (100 percent for all plans because there is no cost to employees to enroll); 2) the number of employees with families who purchase family coverage (varies by plan depending on the richness of the plan); and 3) the number of employees with families who enroll in individual coverage, i.e., all employees with families who do not purchase family coverage.

The projections of **total costs (excluding employee contribution)** for the plans are the costs of the health and dental plan combination, based on IC's projections for increased participation. The projected total costs for each scenario are included in the following chart.

Table RS.12: Combined Monthly Medical and Dental Insurance Monthly Costs Excluding Employee Contributions						
Medical Plan & Dental Plan	Funding Source	Dental Plan Type	Average Cost per Insured Worker per Month	Estimated Total Monthly Cost (In Millions)		
				Low Estimate # of workers	Med Estimate # of workers	Hi Estimate # of workers
MinnesotaCare +2 / MinnesotaCare Dental	Market	Tied to Medical	$854	$43.4	$72.8	$102.1
		Stand Alone	879	44.7	74.9	105.1
	Dedicated Risk Pool	Tied to Medical	777	39.5	66.2	92.9
		Stand Alone	791	40.2	67.4	94.6
	MinnesotaCare	Tied to Medical	389	19.8	33.2	46.6
		Stand Alone	396	20.1	33.7	47.3
MinnesotaCare Basic +1 10k IP with MinnesotaCare Dental	Market	Tied to Medical	$673	$34.2	$57.3	$80.4
		Stand Alone	716	36.4	60.9	85.5
	Dedicated Risk Pool	Tied to Medical	629	31.9	53.5	75.1
		Stand Alone	642	32.6	54.7	76.7
	MinnesotaCare	Tied to Medical	340	17.3	28.9	40.6
		Stand Alone	346	17.6	29.5	41.4
MinnesotaCare Basic +1, No IP with MinnesotaCare Dental	Market	Tied to Medical	$834	$42.4	$71.0	$99.6
		Stand Alone	877	44.6	74.7	104.7
	Dedicated Risk Pool	Tied to Medical	775	39.4	66.0	92.6
		Stand Alone	789	40.1	67.1	94.2
	MinnesotaCare	Tied to Medical	387	19.6	32.9	46.2
		Stand Alone	393	20.0	33.5	47.0
Commercial Plan, $100 Ded with Commercial Dental	Market	Tied to Medical	$670	$34.1	$57.2	$80.2
		Stand Alone	693	35.3	59.1	83.0
	Dedicated Risk Pool	Tied to Medical	618	31.5	52.7	74.0
		Stand Alone	625	31.8	53.3	74.8
Commercial Plan, $500 Ded with Commercial Dental	Market	Tied to Medical	$634	$32.3	$54.1	$75.9
		Stand Alone	658	33.5	56.1	78.7
	Dedicated Risk Pool	Tied to Medical	586	29.8	49.9	70.1
		Stand Alone	592	30.1	50.5	70.8
MinnesotaAdvantage with Commercial Dental	Market	Tied to Medical	$698	$35.5	$59.5	$83.5
		Stand Alone	711	36.2	60.6	85.0
	Dedicated Risk Pool	Tied to Medical	634	32.3	54.1	75.9
		Stand Alone	641	32.6	54.6	76.7

Total costs for the employer portion of the premium ranged from an average of $340 to $879 per insured worker per month, or a total of $17.3 million to $105.1 million a month, depending on the plan design and the estimate of the total number of LTC workers who enroll. The plan recommended by Lewin is the last one listed on the above table, Minnesota Advantage, through the commercial market and with dental tied to medical insurance.

The total costs include the employer share only. The employer share would be paid through a combination of Federal Medical Assistance match, state funds, and any required employer contributions. The lowest costs were for the option in which the plan is actually part of MinnesotaCare itself. This is because the

average provider reimbursement in MinnesotaCare is assumed to be at the Medical Assistance level, which is far less than provider reimbursement under commercial plans. Also, MinnesotaCare has much lower non-benefit, or administrative, costs than typical commercial plans.

For the options in which insurance is purchased commercially, the lowest cost plan was the $500 deductible commercial plan, purchased through a new dedicated risk pool ($586 per member per month). The $100 deductible plan cost somewhat more, at $618 per member per month if purchased through a dedicated risk pool. The medical plans with the benefits of MinnesotaCare, purchased through the market, were the most expensive options.