



Dan Lindh, President and CEO of Presbyterian Homes & Services

Civic Caucus, 8301 Creekside Circle #920, Bloomington, MN 55437

March 5, 2010

Present: Verne Johnson (Chair); David Broden, Janis Clay, Marianne Curry, Paul Gilje, Jim Hetland (phone), Jan Hively, Tim McDonald, Jim Olson (phone), Wayne Popham (phone), Clarence Shallbetter (phone), Bob White

A. Context of the meeting - Medical and hospital services are one of the principal sources of pressure on the state budget today, and will be a main cost driver over the coming years with the potential to overshadow all other areas of spending. As Minnesota's population grows older, lives longer, and tries to make do on less savings, the state is faced with a basic choice: continue delivering long-term care and services for seniors as it is now, and see the financial health of the state traverse a long, debilitating decline that decreases its quality and limits options.

Or, state leaders in cooperation with businesses, insurance companies, and non-profit service providers can re-examine how the state delivers and finances services associated with health and long-term care.

Dan Lindh, a near 35-year veteran of the industry and an executive with a mind toward innovation, will visit with the Civic Caucus today on what he calls a "paradigm shift in long-term care."

B. Welcome and introductions - Lindh has served at Presbyterian Homes and Services for 34 years, the last 14 as President. Presbyterian Homes is a faith-based not-for-profit organization headquartered in Roseville, MN, that serves nearly 17,000 older adults each year. Approximately two-thirds of those are served at 36 community locations and one-third through home & community-based services. Presbyterian Homes partners with nearly 5,400 employees and 3,200 volunteers to provide care and services for older adults as a ministry and mission.

Lindh grew up as a "preacher's kid" which among other things allowed him to learn more about different parts of Minnesota including Russell (near Marshall), Paynesville, St. Paul, Cottage Grove and Cambridge. Dan graduated from St. Paul Park High School in 1971 and Bethel College in 1975. This was followed by Long Term Care Administration at the University of Minnesota and an MBA in Healthcare and Not-For-Profit Management at St. Thomas University. Lindh is married to Jeannie and they have three sons ages 20 to 27.

Lindh is the immediate past chair of Aging Services of Minnesota, current Chair of Bethel University, has been active in leadership roles at Calvary Church of Roseville, and serves on several other not-for-profit boards. Dan is a member of the House of Delegates of the American Association of Homes and Services for the Aging (AAHSA) and had the opportunity to serve on the AAHSA Finance Cabinet that developed "the framework for financing long term care" which became part of the framework for the Class Act legislation.

C. Comments and discussion - During Lindh's visit with the Civic Caucus, the following points were raised:

1. Online and e-learning are going to become core components to higher education —

As the group gathered a member remarked that in addition to his role with Presbyterian Homes, Lindh chairs the board of trustees at Bethel University. He asked Mr. Lindh about conversations the Caucus has had recently about online education, and its role in colleges and universities.

"Within a time of 10 years or so," Lindh said, with firmness, "if you're not proficient with online learning it will no longer be a matter of foregoing a tactical advantage-but instead you will be behind, missing a core offering."

The university world is still in the early stages of the uptake of what's now being called e-learning-a term that accounts for IT-enabled learning that is not exclusively online. Soon its quick pace of adoption will become more apparent, "flipping upward." This will be driven as much by changes in culture as by new technologies. "The flip will be when the young people start taking over."

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The remainder of Lindh's visit with the Caucus covered long-term care.

2. Dan provided an overview and context for the challenge Minnesota has in providing older adult services longer term—

- The next 25 years will see a doubling of Minnesota's population of people over 65 and a tripling for those over 85. Slightly over 12.6% of our population is presently over the age of 65, which will likely increase to 25% by 2035.
- Today, Minnesota spends approximately \$1.0 billion on older adult services each biennium. HHS is about 29% of overall general fund budget for FY2010-2011. \$1 billion represents 11% of that 29% or 3.2% of state only general fund amounts (no federal or Non-GF spending included).
- At our current projected rate of growth, Minnesota will spend \$20 billion per biennium by 2050, which will amount to an estimated 20%+ of total state only general fund amounts, i.e., we have an approximate 3% structural gap for this segment.
- 91% of long-term care is provided by informal caregivers, which is down from 97% as recently as 1990. Each 1% decline in elder care provided by informal networks costs Minnesota an additional \$30+ million per year.
- Soon one-half of all workers in Minnesota will be caring or relating to an older adult in need.
- Within 10 years we will have more seniors than children, a Minnesota first. Approximately 30% of Baby Boomers do not have children.

- 35% to 40% of Minnesotans between age 50 and 70 are at "high risk" of having inadequate retirement income and may be unable to afford long term care costs.

3. Changing our financing paradigm for older adult services for our state and country from a welfare model to an insurance model:

A. The current Medicaid model will continue to exert significant financial pressure on Minnesota and most states, and our Medicaid model in Minnesota is simply not sustainable.

- "Every state has a challenging Medicaid budget which can only get worse" - OMB
- Dan quoted the recent Civic Caucus notes of John James and Senator Pogemiller who discussed the structural imbalance of in the state budget and the rising costs of medical and hospital services, respectively. "We need to look at alternatives."
- Demographic shifts resulting in fewer workers supporting more older adults will exacerbate the problem.
- Minnesota's current financing structure is a current biennium allocation from general funds that attempts to optimize federal match.
 - "Things that can't go on forever, don't" - Herbert Stein

B. Minnesota has the opportunity to take a leadership position in helping our state and country move from a welfare model to an insurance model and to a financing paradigm that is actuarially sound and sustainable. The current economic climate creates a glimpse of what the future may be and a window of opportunity for change.

C. Minnesota can become a leader in the financing paradigm for older adults two ways:

1. Implement a state specific comprehensive LTC insurance program. (Perhaps modeled loosely after Hawaii's attempts.)
2. Provide leadership at the federal level to establish a mandatory national long term care insurance model.

D. Begin changing public expectations for care from welfare to insurance—Outlined in his proposal below; Lindh argued that all people should be required to buy long-term care insurance from a "quasi-governmental" program. This is not that radical, he argues, because it actually has a larger degree of self-determination than Medicare and Medicaid, which are welfare-style programs and cover the largest portion of medical and hospital costs paid out for seniors.

"The entitlement programs we use only kick in once personal assets have been exhausted and benefits typically follow program and licensure type. People will prefer choice and personal direction, which insurance provides," Lindh stated, confidently.

He cited a German model that takes a list of Activities of Daily Living (ADL)-basic functions such as bathing, dressing, feeding, medication, mobility-and uses them as a standard to determine when an individual's benefits kick in. "When a physician determines an individual to have 3+ ADL needs, they can begin drawing on their benefits."

E. Alignment " cash and carry and similar programs that put the dollars in the consumer hands have proven to work well. Older adults' motivation, preferences and spending tendencies are aligned with societal priorities. That is, older adults are highly motivated to avoid institutionalization and will leverage the informal caregiver network and spend wisely to remain at home for as long as possible when given the opportunity. "What is it about the model that cuts the cost?" a member asked. Lindh responded that, "When you put the money in the hand of consumers, there is a remarkable alignment of needs and purchases."

Once payment is initiated does it go to an individual, or to the medial service organization? "Once you show that you are eligible you may choose cash payment or direct pay to the provider."

F. Personal responsibility is often touted as the longer term solution for paying for LTC. What does that mean? How does that happen? Mandatory LTC insurance with appropriate opt out provisions if individuals have demonstrated that they have taken personally responsible steps is a reasonable alternative. Social security has become an essentially required program as a safety net for retirement. Automobile insurance is required if we drive. Property and liability insurance is often required if we own a home.

G. The need for care and services is predictable and insurable. LTC is as "an insurable event" as auto, health, property or other but is not financed that way.

- Risk is relatively predictable in the aggregate, but not on an individual basis. For those turning 65 today: 31% will not use LTC; 17% will use less than 1 year; 32% will use 1 to 5 years; 20% need care for more than 5 years.

- The risk for using LTC increases with age, but 40% of those needing LTC are under age 65.

- Costs for those with lengthy and/or extensive needs can be catastrophic.

- Our welfare system approach does not fit all LTC needs.

H. Optional Long Term Care insurance will simply not be sufficient, primarily because of its affordability, those that need it the most often don't qualify given current underwriting standards and because of psychographic perspectives. Lindh commented on a "psychographic block" that he has identified among the public, when they are planning for their post-retirement lives. "When we look at long-term care insurance," he said, "people take where they are now in health and vitality, and project that out 30 years figuring they'll be the same person, only with a higher number of birthdays. So they don't feel that they need it," they feel that they'll be able to take care of themselves. They under-plan.

I. "The United States can learn a lot from counties who have 18% or more of their population over the age of 65," Dan said. Germany, for example, faced a similar but more advanced demographic predicament (18%) and a Medicaid economic paradigm near collapse, state government, in particular

the governors, banded together and ignited the national agenda for change. Once instituted in Germany, the state Medicaid budget was cut in half within just a few years and has stayed at lower levels. Other "longer term oriented countries" including the Netherlands, Luxembourg, and Japan (voucher blend) have implemented mandatory long term care schemes.

J. The sooner a mandatory long term care insurance policy is implemented the more affordable it will be and the sooner state government will benefit.

K. At the national level, legislation has been introduced in the Barton and Kennedy CLASS Act. It was initially authored on a bi-partisan basis, but is only about 60% of what we advocated for in our "framework for financing long term care" initiative.

L. Don't use the Social Security model— A member asked if Lindh believes the idea is applicable at the state level. "I do. We'd need to do serious actuarial work" to implement it. "Flat premium; does not vary with age." Again, he held that this was a better approach in the public interest than the model of Medicaid. This could be seen, a member observed, as something in addition to - on top of - Social Security. "I don't want it to be part of Social Security," he said. "Germany holds it semi-autonomous from government. It can't be raided like Social Security, which really is a pyramid scheme."

A member asked: Are we moving toward an age-neutral arrangement, targeting money at needs, not age? "Yes, in a way-the new paradigm does end up working out that way."

M. Informal support networks are key to controlling costs—"Informal support-networks of families, friends, neighborhood capacity-is key. For every dollar spent on providing long term care, seven times that amount is provided through informal networks.

91 percent of long term care is provided by informal caregivers, which is down from 97 percent as recently as 1990." The impact of that decline in informal care on state finances is significant. "For each 1 percent decline in elder care provided by informal networks, the costs to the state rise \$30 million."

Families shoulder the large majority of responsibility. "Approximately 10 percent of Minnesotans have private long-term care insurance," which compares to 7 percent annually. "The average cost of care for older adults is \$5,531. Families and unpaid caregivers absorb 68 percent of long-term care costs. Public funding pays 28 percent and private insurance only pays 4 percent."

N. A large portion of Minnesotans will not be able to support themselves—"35 to 40 percent of Minnesotans between 50 and 70 are at high risk of having inadequate retirement income and may be unable to afford" the costs associated with their long-term care.

O. Informal care will affect the productivity of Minnesota's workforce—"Soon one-half of all workers in Minnesota will be caring or relating to an older adult in need. It is estimated that lost productivity due to employees having to miss work to provide care and services for older adults' amounts to \$800 million per year in this state."

4. Restructure government to improve effectiveness and efficiency — "We should consider a new state department dedicated to older adult services," Lindh submitted, "that represents Minnesota's interests in older adult services in a comprehensive manner." Concentration of

administration is essential for efficiency. Older adult issues are currently managed in several different areas of state government.

"There needs to be more coordination and less redundancy," and there is opportunity to address this. He provided an example in the potential to streamline the use of the 'Elderly Waiver,' a Medicaid device that provides funding for home-based services. "We currently have 87 counties and nearly as many policy and contractual approaches to how Elderly Waiver is administered and contracted for. This is confusing to customers and providers, administratively cumbersome, and less efficient than it could be.

Improve and align the regulatory process—"Our regulatory process is uneven and there is an opportunity to improve it substantially. The Minnesota contract system in assisted living is productive and effective. Regulatory oversight of our care center system (Presbyterian Homes) is uneven and has negative unintended consequences because it is punitive. The current regulatory system adversely impacts delivery and quality of care."

Need for a policy framework—A member asked Lindh how he would pull this all together into a policy framework. First, "Support the notion of 'older adult affairs' in government," he reiterated. "Right now there are many different competing voices."

But isn't that a contradiction, if a larger number of young people are to be involved as well with insurance?

"There are two separate pieces here," Lindh said. "One is restructuring the executive branch, so that it concentrates its efforts in dealing with long-term care and services for the aging. The other is this new insurance scheme," which would encompass all of society.

5. Enact workforce initiatives to improve quality and staffing availability — "Conceptually, the state can help position infrastructure and workforce to align with future demand. One potential solution is some restructuring with the introduction of an 'older adult social worker.'" Sweden and Norway do this. "Their role is tailored to the chronic care world," and varies from that of an RN in an institutionalized setting.

The older adult social worker model is lower-cost, both for the salary of the professional and because the client remains in his home. "A structured redesign" that moves care more toward assistance in the home "could result in a win-win outcome and improve quality."

MCTC is offering a program like this now, called Personally Designed Living. "They are now an accepted apprenticeship option," Lindh said, but needs to be further developed and expanded.

Over the long term there is risk of a significant shortage of RN's and other medical professionals. Combined with cost pressures on states and families, this model could be emerging at just the right time.

6. Make strategic investments for innovation and policy change — "Strategic intentionality may have profound impact," Linda said, "but must be intentionally leveraged.

"Minnesota does a great job of prioritizing Home and Community Based Services (HCBS). With those investments comes an opportunity for strategic initiatives and development of innovative models of care.

"Recent legislation by Representatives Tom Thissen (DFL) and Laura Brod (R) enabled 'consortium grants' that provide incubators for innovation and community involvement.

"Perhaps the largest short term implementation effectiveness can be focusing on case management utilizing open and integrated care plans that include the physician and individuals."

In addition "policies that draw in families and older adults and support groups into the process will personally and financially have an opportunity to make a difference." There is a program at work in 31 states called Person Centered All-inclusive Care for the Elderly (PACE) that is not available in Minnesota. It is more "relational and informal," providing better care at a lower cost.

"We had a bill for it in 2005, and could have had it in Minnesota. We would have been the 5th state. Now, by the time we get it, we'll be something like the 35th."

7. Proposal is still in its early stages — After hearing his vision for policy, a member asked Lindh if he had a political plan. "Not really-not right now-but I have been visiting with people at Health and Human Services." Visiting with many people, not just sitting complacent. He asked, rhetorically, "At what point are we ready for this as a society? I don't think that the pain at the state is severe enough yet for a paradigm shift." Internationally, most changes have occurred when the percent of population over 65 - who vote - is over 18%. Minnesota is a decade away on that basis.

He added a caveat. "This does not address the tidal wave that is coming," in terms of demographics- or even get to the roots of the uneconomic nature of the medical-hospital services market. "It can't change that."

8. Faith-based and philanthropic organizations can innovate in delivery of services —

"Historically informal care, philanthropy, and innovative programming have helped align and influence older adult services. Major philanthropic and community investments are being made nationally but appear to be more limited, locally."

As needs rise, Minnesota will need philanthropies more than ever-particularly their ability to fund and pilot alternative ways of delivering public services. "Minnesota Senior Health Options (MnSHO), a Minnesota program that is known nationally was made possible by a grant from the Robert Wood Johnson foundation." He also cited the significant effect Alt-Care has had leading the nation on the innovation and implementation of assisted living facilities.

"Where is the Minnesota philanthropic community," Lindh asked, "on the important topics of older adult services? What can Minnesota do to engage them in a more meaningful way?"

9. Change long-term care financing — Lindh closed by stating that, "Our long-term care system of financing is ready for and needs change to be relevant in the future." Changes should promote consumer choice, informed by awareness of quality and service; promote personal financial responsibility and wise stewardship of public resources; and promote equitable availability of benefits.

"Changing our financing paradigm to an insurance model may be a productive alternative," he re-emphasized, and believes that it has the potential for broad appeal.

The chair thanked Mr. Lindh for a productive and engaging visit, and thanked him especially for his thorough preparation and presentation of such thoughtful policy proposals.