OliverWyman

# Memo

To: California Long-Term Care Insurance Task Force

Date: 26 January 2022

From: Oliver Wyman

Subject: **Q&A on Task Force Meeting #6 educational materials**

# Presentation 6.C (Benefits and services)

1. **Question:** Is the benefit maximum data for private insurance on page 6 California-specific?

   **Answer:** No, these data points are based on the Broker World's 2021 LTC Insurance Survey, which is not state-specific.

2. **Question:** Would adult day care be covered under a "home- and community-based services only" design?

   **Answer:** Adult day care is typically considered as a community-based service, so tentatively yes. However, the specifics of this potential design are subject to Task Force member discussion and consensus.

3. **Question:** Not being able to hear is linked to cognitive decline. Under Medi-Cal, do you have to meet spend down requirements to receive hearing aids (page 10)?

   **Answer:** The short answer is no, you do not need to meet spend down requirements to get hearing aids under Medi-Cal today, though there are layers of detail/history associated with this. For LTC beneficiaries and other populations (e.g., pregnant women), hearing aids have been a long-standing benefit (at least 10 years), and the coverage includes screenings. For some other populations, the hearing aid benefit was previously removed, but recently reinstated on January 1, 2020 along with other optional benefits. Also of note is that there is a benefit cap for most populations (see details here: https://www.dhcs.ca.gov/services/Pages/HearingAidCapFAQ.aspx).

4. **Question:** How do the baseline assumptions for covered services and prevention exacerbate potential LTSS workforce supply issues?

   **Answer:** The proposed baseline assumptions may generate more demand for certain services, which could lead to (or compound) workforce strain, supply issues, staffing shortages, etc.

5. **Question:** What preventative services would be the scope?

   **Answer:** The specific preventative services covered under this proposed design will need to be discussed by the Task Force members. For the purpose of the baseline assumption, we did not attempt to compile a list of potential measures/services to be covered but presume that there would be guidelines around the types of measures/services that qualify for this benefit.

6. **Question:** How does a 0-day elimination period works in practice? Assuming that neither private insurance nor a state program would always be able to approve benefits immediately, is it inherent in a 0-day elimination period that reimbursement is retroactive to the day of application? From slide 8 it seems like that is the case in Medi-Cal but not necessarily in the WA program?

**Answer:** In the private industry, general process for a 0-day elimination period claim is as follows:

1. A policyholder notifies their insurer when they believe they are benefit eligible (this may be *after* they have received qualified services)
2. The insurer will adjudicate the claim to confirm that the individual has satisfied eligibility criteria and that the claim is for qualified services (note this latter step does *not* apply if the policy provides cash benefits)
3. Assuming that the claim is approved, the insurer will reimburse the individual for any qualified costs incurred from the date of benefit eligibility

The interpretation of slide 8 is correct—Medi-Cal essentially operates like a 0-day elimination period whereas WA Cares Fund has (up to) an implicit 45-day elimination period since individuals are not reimbursed for any qualified services received between application submission and approval.