OliverWyman

Prepared for the California Department of Insurance

CALIFORNIA DEPARTMENT OF INSURANCE: LONG-TERM CARE INSURANCE PROGRAM

Long-Term Services and Supports ("LTSS") access and regulation questionnaire results

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QUALIFICATIONS, ASSUMPTIONS AND LIMITING CONDITIONS

Oliver Wyman was commissioned by the California Department of Insurance to provide support associated with assessing the feasibility of developing and implementing a culturally competent statewide insurance program for long-term care services and supports (LTSS). The primary audience for this report includes stakeholders from the California Department of Insurance, members of the Long-Term Care Insurance Task Force, and members of the general public within the state of California.

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EXECUTIVE SUMMARY

Task Force Members were asked to complete a questionnaire regarding their **preliminary** views on the **LTSS access and regulation** for a statewide LTC insurance program in California. Task Force Member views may evolve as detailed discussions progress across the seven Work Plan elements. This page summarizes Task Force Member questionnaire results. Subsequent pages contain verbatim responses from Task Force Members and the public (with minor edits for spelling, grammar, and punctuation).

Program element	Key takeaways
Lower-cost program alternatives	The Task Force was asked to specify their preferred alternative lower-cost program design (the feasibility report will include at least one lower-cost design option for the Insurance Commissioner, Governor, and the Legislature to consider). Recommendations included: 1. A program focused on financial support for receiving care at home (either for caregivers or care recipients) 2. A program focused on ancillary LTSS benefits such as caregiver support (respite and education), adult day care, meal delivery, transportation, preventative equipment, home assessment, and minor modifications 3. A leaner version of the current preliminary program recommendation (e.g., lower monthly benefit, lower benefit period) 4. A program that limits care to age 65+
Follow-up working groups	Separate working groups consisting of industry experts should be established to examine: 1. Medicare Advantage coordination 2. Outreach and education planning 3. Private LTC insurance coordination (particularly with respect to wrap-around products)
Initial intergenerational inequity	The program design should mitigate (initial) intergenerational inequity. Potential options included: 1. Grade-in program benefits (i.e., reduced benefits during the earlier years of program rollout) 2. Increased program contributions (i.e., higher "catch-up" contributions during the earlier years of program rollout) 3. Adjust program benefits to mitigate inequity (e.g., lower portability, greater vesting requirement, or longer EP)

The results in this presentation are based on questionnaire responses from **eleven** Task Force members and **four** public respondents; their responses are provided on the subsequent pages

QUESTION 1 (1 OF 2)

The AB 567 Feasibility Report ("Feasibility Report") will include a range of program design options for the Insurance Commissioner, Governor, and the Legislature to consider. This will include at least one lower-cost program alternative that targets a specific population and/or service (e.g., Hawaii's Kupuna Caregivers Program). Please describe your recommended target(s) for this lower-cost program alternative below.

#	Responses – Task Force Members
1	I think it's a great idea to include something like Hawaii's program. [It] would help people who don't quality for Medi-Cal but have family members who work to cover some in-home costs. With the asset test going away, though, I am not sure how large this population will be, but an IHSS-like program seems like a reasonable thought.
2	Those most in need.
3	This is a tough question, and I don't know the option set well. Medi-Cal already helps those that lack financial means—for me, a low-cost alternative shouldn't target the same group. Here is one idea. What if we target stay home individuals that are caring for a parent/family member above 65? We could provide them a stipend to account for them taking care of an individual that meets the 2 of 6 [ADL] trigger. We can also require some basic training. This would allow for some cash plus training, improving their financial situation and that of those being cared for. There could be an income limit on those that could qualify to help keep the cost reasonable.
4	Caregiver respite, support and education, adult day care, meal delivery, transportation to appointments/other key needs, preventative equipment (shower bench, walkers on each level of the house), minor home modifications (ramps), home assessment (rug removal) This would be a good add-on but may not address CA-specific needs or cultural competency holistically. [We] need to evaluate whether this low-cost program alternative is within the charge of AB 567, and if it truly qualifies as an alternative –what pillars does it address in the charter? Alternative to what?
5	I found Presentation 12.B very helpful to [understand] the relative cost associated with different recommendations. My recommendation is to eliminate the partial portability in a lower-cost option as well as consider [a] slightly lower monthly benefit (e.g., $5000/month) and/or a shorter benefit [period] (e.g., 1.5 years). I do not recommend a package limited to home care since individuals with severe cognitive impairment often require memory care in 24-hour RCFEs, assisted living facilities, or nursing homes. I also want to keep [an elimination period] that encourages access to individuals who are lower-income.

QUESTION 1 (2 OF 2)

The AB 567 Feasibility Report ("Feasibility Report") will include a range of program design options for the Insurance Commissioner, Governor, and the Legislature to consider. This will include at least one lower-cost program alternative that targets a specific population and/or service (e.g., Hawaii's Kupuna Caregivers Program). Please describe your recommended target(s) for this lower-cost program alternative below.

#	Responses – Task Force Members
6	65+ only, comprehensive care (i.e., any setting choice that best meets the older adults needs—home [care], assisted living, board and care, or skilled nursing), 2-year benefit period, reimbursement with reduced cash benefits, 2.5% Inflation, partial vesting, partial portability, low income excluded from program, and a 90-day elimination period
7	Not sure—would need more discussion/examples other than the Hawaii program
8	We [must] support the "desirable" plan and support reimbursement over a cash benefit for the capacity to set standards for the services. However, a cash benefit is needed and must be included. We support a broad social insurance program, where everyone pays in. The [Kupuna] program is best described as a supplemental cash program to the social insurance benefit, [so it is] useful as an add-on.
9	Options should have tiered buckets [like] Covered CA Silver, Gold, and Platinum categories. Silver should be low cost but should cover essential benefits—IHSS, community-based services, prevention/wellness, and catastrophic nursing home stay coverages.
10	Adult day care including PACE

QUESTION 2A

Do you recommend establishing a separate working group to examine if the potential statewide LTC insurance program can and should be allowed to pay a portion of the premium for a Medicare Advantage plan that includes LTSS (i.e., this would be one of the eligible program benefits)?

#	Answer – Task Force Members	Percentage	Count
1	Yes	81.8%	9
2	No	18.2%	2

#	Answer – Public	Percentage	Count
1	Yes	66.7%	2
2	No	33.3%	1

QUESTION 2B

Please indicate what types of organizations and individuals you recommend be included in the working group (you may leave this question blank if you are unsure).

#	Responses – Task Force Members
1	Primarily those representing low-income Californians plus others with specific LTC expertise
2	ACHLIC, ACLI, MA plan representatives, academic experts (e.g., Anne Tomlinson), CMS, consumer advocates / patient advocates, regulator agency (CDI?), providers, members of the public
3	Medicare Advantage experts, consumers, actuaries, [the LTSS workforce]
4	Representatives from Centers for Medicare and Medicaid Services to determine feasibility upfront, representatives from institutional SNPs and Medicare consumer groups
5	DHCS, AARP, DOI, Justice in Aging, Rick Kronick (UC San Diego, academic expert on Medicare Advantage)
6	Working group with seniors, people with disabilities who are seniors, and caregivers and their representatives, paid [or] unpaid
7	AARP-CA, PACE program providers

QUESTION 2C

Please explain your response to the question above.

#	Responses for those who chose “Yes”
1	Suggest researching why CHRONIC Care Act landed on the limited scope it did, and not extend into truly long-term supports. Also assess take-up rates and stability of benefits.
2	For all responses that are a yes to forming workgroups on specific topics, I caveat that response by saying no further workgroups should delay the forward progress of moving policy to establish an LTC social insurance program.
3	I answered yes to this questions but feel it will be important to delay the formation of the workgroup until [we learn more] about supplemental benefits and the implementation of CalAIM by commercial managed care plans. Medicare Advantage plans are traditional insurers whose structure and incentives are not aligned with providing services to individuals needing LTSS. Care coordination/management is mostly aimed at utilization management of inpatient services. Supplemental benefits are a positive addition but still need to be evaluated. It would be [interesting] to consider whether a long-term care benefit could be added to a Medicare Advantage Institutional Special Needs Plans since they are focused on the nursing home eligible population and designed to integrate care.
4	It seems pertinent to have a deep-dive discussion around combining services [to] streamline and potentially save costs.
5	Study all the options that expand care.
6	Representation should be inclusive, offer equity and [diverse] perspectives. [Pay] special attention to special populations and culturally diverse stakeholders.

#	Responses for those who chose “No”
1	I don't think a separate workgroup is necessary. It shouldn't be so complex that our group can’t come up with a suggestion as to whether covering part of an MA plan would be advisable. Most of the MA plans have rather low premiums anyway.
2	I don't feel I am an expert on this topic, but hearing those that were more familiar, I got the impression this didn't pass the minimum level of viability. Reading the text that says, ‘individuals enroll when they need LTSS' sounds like it could generate anti-selection. I would like to hear more from those that understand the pricing/design of Medicare Advantage to see if this concept has any legs.

QUESTION 3A

Do you recommend establishing a separate working group to design a plan for outreach and education for a potential statewide LTC insurance program?

#	Answer – Task Force Members	Percentage	Count
1	Yes	100.0%	11
2	No	0.0%	0

#	Answer – Public	Percentage	Count
1	Yes	100.0%	4
2	No	0.0%	0

QUESTION 3B

Please indicate what types of organizations and individuals you recommend be included in the working group (you may leave this question blank if you are unsure).

#	Responses – Task Force Members
1	This will be necessary for promoting equity and getting the word out.
2	This isn't a full list, but some stakeholders to consider are LTC agent representatives, AARP, Medi-Cal Agency, and insurance industry representatives
3	NAIFA, ACHLIC, ACLI, agents, brokers, AARP, aging / consumer advocates, regulatory agency (CDI?), providers, community and cultural organizations (to address culturally competent materials and interests), marketing experts (e.g., Own Your Future), experts on the establishment of statewide programs , and members of the public
4	LTC advocacy organizations, labor unions, consumer groups
5	Working group with seniors, people with disabilities who are seniors, and caregivers and their representatives, paid [or] unpaid
6	AARP-CA, ethnic community groups

QUESTION 3C

Please explain your response to the question above.

#	Responses for those who chose “Yes”
1	My answer is more complex than yes [or] no. I agree it makes sense to have a group that thinks about how we would execute the program and educate. However, does it make sense right after the feasibility report or should it wait until we have more knowledge of what may get approved[?] Isn't the outreach associated with helping people understand the program and benefits? If so, [I] don't believe we need this right after the feasibility report, but near program introduction.
2	It will be critical to design an outreach and education [program] for the LTC insurance program. Most people do not understand that long-term care is not covered by Medicare and need to be educated about the value of such a program.
3	Outreach and education will be integral following the passing of this program. Therefore, it makes sense to hold a group discussion/task force to roll this out correctly should it be passed.
4	It seems important to further specify the goals for this working group—is it to develop a plan for outreach and education before a program is established in statute or after? If after a program is established, is the goal to help people understand their eligibility and how to use benefits once vested? Some of the examples we discussed at the last meeting were about ACA enrollment, but for this program we are mostly talking about mandatory enrollment so it seems like the goal will be different.
6	Outreach/education should represent—look and talk like—the community getting the outreach/educational information.

QUESTION 4

What other recommendations would you like to make regarding an outreach and education program for the potential statewide LTC insurance program?

#	Responses – Task Force Members
1	Website, multiple languages, clarity on what [LTC is], eligibility
2	This is [an] important aspect, and it should be funded to gain broader visibility and access
3	All outreach and education should be culturally competent and information - both verbal and written - should be in language of choice.
4	No additional recommendations. The suggestions by AARP representatives were great.
5	It has to be in many languages—at least the Medicaid Threshold languages—and culturally competent. The outreach must speak to the real experiences of Californians facing the spend down and offer them options they can easily understand. It can also target the share of cost IHSS population.
6	Multi-media and in-person collaboration with community and county agencies doing outreach/education on the ground.

QUESTION 5A

Do you recommend establishing a separate working group to examine how a potential statewide LTC insurance program could coordinate with private LTC insurance, particularly with respect to supplementary ("wrap-around") private LTC insurance products that pay secondary to the state LTSS benefit?

#	Answer – Task Force Members	Percentage	Count
1	Yes	81.8%	9
2	No	18.2%	2

#	Answer – Public	Percentage	Count
1	Yes	100.0%	4
2	No	0.0%	0

QUESTION 5B

Please indicate what types of organizations and individuals you recommend be included in the working group (you may leave this question blank if you are unsure).

#	Responses – Task Force Members
1	This is complex enough to warrant a separate workgroup. Insurance people, actuaries, state budget people, and consumer advocates
2	Insurance industry, DOI product approval team, and LTC agents
3	ACHLIC, ACLI, NAIFA, CDI actuarial and form representatives (to address balance of speed to market and regulatory due diligence), CA Partnership, Parag Shah and Jamala Arland for continuity, academic experts, consumer advocates, providers and caregivers, and members of the public
4	AARP-CA and non-profit organizations offering senior services in the community

QUESTION 5C

Please explain your response to the question above.

#	Responses for those who chose “Yes”
1	To meet our obligation under [AB 567]: (5) Consider the establishment of a joint public and private system to make long-term care accessible to as many individuals within California as possible. and (6) Make recommendations related to key regulatory provisions necessary for the public to access existing long-term care insurance programs and participate in future long-term care insurance programs, whether those programs are recommended by the task force or otherwise. We need to think through the details about how private insurance and this public program will interact. This is a more detailed topic that requires those that are familiar with details associated with insurance products, what can get approved in the state and how it would be sold. Hopefully, [by] allowing the private insurance market to participate, they will be more inclined to support our initiative.
2	It seems like more work is needed to understand the interaction between private LTC insurance and the statewide program.
3	I highly encourage this discussion further. Our program will be most successful by learning how to partner with private LTC and to utilize their current framework. There is also still a [little bit] up in the air when it comes to opt-out and what to do with those who already have LTC. This is a key issue to be ironed out.
4	Many non-profits are already offering services in this space. They offer services such as caregiving, care respite, [and] Meals-on-Wheels. They should have a voice on this question.

#	Responses for those who chose “No”
1	We don't believe private insurance has a role here and is a false solution and a distraction from making progress on a public benefit.

QUESTION 6A

Do you recommend the program include any provisions to mitigate or reduce the initial intergenerational inequity? (recall, upon program inception, older individuals are likely to contribute less to the program over their lifetime relative to younger individuals; this inequity wanes as the program matures)

#	Answer – Task Force Members	Percentage	Count
1	Yes	63.6%	7
2	No	36.4%	4

#	Answer – Public	Percentage	Count
1	No	100.0%	3
2	Yes	0.0%	0

QUESTION 6B

Do you have any recommendations for how this could be addressed?

#	Responses – Task Force Members
1	A few options. We could build a program grade in. During the first 15 years of the program, those that pay in only for 10 years after program launch get 90% of the benefit, those that pay for 15 years get 95%, and those that pay in for the full 15 years get 100%. Alternatively, we could develop a [mechanism] to charge them more. We could potentially limit the amount of annual inflation of [their] benefits. Else we could adjust their benefits (less portability, greater vesting requirement, or longer EP). Nothing will be perfect, but it would help acknowledge this inequality. Do we know if the pricing is materially different if we solve for this inequality? Or is this not material to making the program successful?
2	I am truly not the expert in this area but the ability to utilize current LTC benefits, the ability to contribute more in a “catch-up” framework, and the ability to seek out supplemental insurance makes sense for this group.
3	Universities with Gerontology programs. Academia and students can offer the intergenerational perspective.
4	Equity issue is important—people closer to retirement shouldn’t pay substantially less for the same coverage. Consider increasing the vesting period for older individuals.

QUESTION 6C

Please explain your response to the question above.

#	Responses for those who chose “Yes”
1	I understand the inequality and suggest that we consider options. Any option will add complexity to the program, but if it impacts equality a lot, we should consider it.
2	There is interest in academia [regarding] how their programs and students play a role in policy, advocacy, and practice in this space.

#	Responses for those who chose “No”
1	[I] don't think it requires this level of additional complexity. Set up the program in a way that doesn't require those kinds of age adjustments and [it] will work itself out.
2	There will be some intergenerational inequities to some [extent]. The Japanese program addresses this in some way.
3	In framing the program, it will be important to emphasize that many younger people will value their older family members having access to LTSS (i.e., the advantages of the program are not only for individuals receiving LTSS)


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