OliverWyman

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Presentation #4.C.

COORDINATION AND INTERACTION: MEDI-CAL

Considerations for designing a statewide long-term care (LTC) insurance program in California

October 8, 2021

QUALIFICATIONS, ASSUMPTIONS AND LIMITING CONDITIONS

Oliver Wyman was commissioned by the California Department of Insurance (CDI) 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. 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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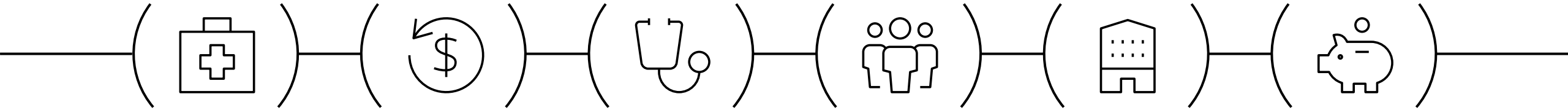
MEDI-CAL IS CALIFORNIA'S MEDICAID PROGRAM

For a detailed overview of Medi-Cal refer to the corresponding presentation by the California Department of Health Care Services

Medi-Cal is free or low-cost health coverage for children and adults with limited income

Medi-Cal eligibility is based on income, assets, physician approval, and medical necessity

Two thirds of California's nursing facility residents rely on Medi-Cal to pay for their care in a skilled nursing facility



Medi-Cal is authorized and funded through a federal-state partnership

Medi-Cal covers 14 million Californians, including:

- 5.0 million children up to age 18
- 7.7 million adults aged 19-64
- 1.3 million adults aged 65+

By federal law, Medicaid (Medi-Cal) is the payer of last resort

COORDINATION BETWEEN MEDI-CAL AND A NEW STATEWIDE LTC INSURANCE PROGRAM

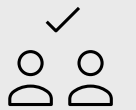
How should individuals eligible for BOTH programs be handled?

Including Medi-Cal eligible population will impact expenditures

- Per Milliman's 2020 feasibility analysis, a new statewide LTC insurance program may not be the most cost-effective way to provide LTSS benefits to Medicaid eligible individuals due to the absence of a federal match
- If a new statewide LTC insurance program diverts cost from Medi-Cal, federal financial participation will be reduced
  - Based on the LTSS program design in Milliman's report, Medicaid savings of $42 billion expected by 2070[1] (inclusive of both state and federal spending)
- California could pursue a CMS Waiver to retain federal savings from a new statewide LTC insurance program
  - Approach taken by Washington State

Excluding Medi-Cal eligible population may not be feasible or equitable

- Medi-Cal eligibility may change for individuals over time due to shifts in their family size and/or income/assets
- Public commentary from prior Task Force Meetings suggests that individuals may prefer to be part of a social insurance program (vs. relying on public assistance)
- Carving out Medi-Cal eligible individuals from a new statewide LTC insurance program may mean they do not have access to the same range of facilities or services if coverage under the new statewide LTC insurance program is broader than that under Medi-Cal



Certain Medi-Cal eligible cohorts may require careful consideration

- A group of persons may all be eligible for Medi-Cal through satisfaction of the same eligibility criteria, but differences in their individual circumstances could impact the interaction between Medi-Cal and a new statewide LTC insurance program (depending on design)
- Examples (non-exhaustive):
  - Those who qualify for Medi-Cal due to developmental disabilities
    - Potential challenge if payroll tax is used for financing as many of these individuals may not be employed
  - Those receiving benefits under Medi-Cal's In-Home Supportive Services (IHSS) Program
    - Potential challenge due to significant size of IHSS Program
- It is important to be aware of these groups of individuals and keep them in mind for our eligibility discussion at Task Force Meeting 5

[1] Assumes 3% healthcare trend; https://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Long-Term-Services-and-Supports-Feasibility-Study-Final-Report.pdf

HOW WOULD A NEW STATEWIDE LTC INSURANCE PROGRAM INTERACT WITH MEDI-CAL?

Coordination of benefits with Medi-Cal is possible with well-defined guidelines, as demonstrated by the existing coordination with Medicare

Coordination considerations

- When two programs cover the same services, it is pertinent to establish rules that define how programs coordinate with each other, including:
  - What services are covered by each program?
  - Which program pays first? How much does the second program pay?
- Medi-Cal is considered the "payer of last resort", so benefits under a state LTC insurance program would need to be paid *before* or *concurrent* with Medi-Cal
  - "Before" means that state-level benefits must be fully exhausted before costs will be covered by Medi-Cal for eligible individuals
  - "Concurrent" means that excess LTSS costs beyond state-level benefits may be covered by Medi-Cal for eligible individuals (with Medi-Cal costs directly offset by all other coverages)
    - Examples of "concurrent" payors with Medi-Cal: Medicare and private LTC insurance
- Would benefits paid by a new statewide LTC insurance program be considered income or impact the level of income/assets used to determine Medi-Cal eligibility?

Illustrative example: concurrent benefit payments between Medicare and Medi-Cal

	(A)	(B)	(C)	(D)	(E) = (B) – (C) – (D)	(F)	(G) = (F) – (E)	(H) = (E) + (G)
Service Type	Provider Billed Amount	Medicare Allowed Amount	Medicare Deductible[1]	Medicare Coinsurance[3]	Medicare Payment	Medi-Cal Allowed Amount	Medi-Cal Payment[4]	Total Payment to Provider
Inpatient Hospital Stay (4 days)	$16,000	$14,000	$1,484	$0	**$12,516**	$11,200	**$0**	$12,516
Outpatient Surgery (first claim of the year)	$710	$650	$203	$89.40	**$357.60**	$450	**$92.40**	$450
Long-Term Care - Skilled Nursing (30 days)	$12,000	$10,500	$1,855[2]	$0	**$8,645**	$9,000	**$1,855**	$10,500
Long-Term Care - Custodial (30 days)[5]	$4,500	$0	N/A	N/A	**$0**	$3,000	**$3,000**	$3,000

1. Medicare deductibles are for 2021 and represent per-benefit period requirements for inpatient services and annual requirements for outpatient services
2. Skilled nursing facility (SNF) example assumes Medicare fully covers first 20 days followed by a $185.50 daily deductible for days 21-30 (i.e., 10 x $185.50 = $1,855)
3. Medicare coinsurance is $0 for Part A services (e.g., inpatient services) within first 60 days and 20% of Medicare allowed amount less deductible for Part B services (e.g., outpatient services); there is no coinsurance for SNF services
4. Medi-Cal pays full deductible for SNF services regardless of Medi-Cal allowed amount, with total payment to provider exceeding Medi-Cal allowed amount
5. Most long-term custodial care services and scenarios (including above example) are not covered by Medicare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