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CALIFORNIA ASSEMBLY BILL 567: OLIVER WYMAN FEASIBILITY REPORT

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Overview

This report summarizes the recommendations by the Assembly Bill ("**AB**") 567 Long Term Care Insurance Task Force ("**Task Force**") for establishing a culturally competent statewide long-term care ("**LTC**") insurance program in California ("**Program**"). In addition, the respective degrees of feasibility for each recommended design are explored, and the process by which the Task Force arrived at its recommendations is outlined.

A team from Oliver Wyman Actuarial Consulting, Inc. ("Oliver Wyman" or "we") facilitated Task Force discussions and authored this Feasibility Report based on Task Force recommendations. However, we are neither members of the Task Force nor allowed to vote on issues associated with AB 567.

This report is organized into five sections that overview key considerations and outcomes of the Task Force's feasibility analysis, as follows:

1. **AB 567 background**: This section provides an overview of the Task Force and scope of AB 567
2. **Overview of Program design recommendations**: This section summarizes five Program designs recommended by the Task Force and identifies which design is preferred by each Task Force member
3. **Overview of recommended next steps**: This section outlines the Task Force's recommended next steps following the publication of this Feasibility Report
4. **Feasibility analysis**: This section details the feasibility analysis and provides considerations and recommendations for each Program design element discussed by the Task Force
5. **Interaction with California's Master Plan for Aging**: This section identifies how the Program aligns with the goals and strategies set forth by California's Master Plan for Aging

To ensure the Program offers both an adequate benefit while remaining solvent, a separate Actuarial Report that assesses the cost and viability of each recommended Program design will be completed in 2023.

Terminology throughout the Report is bolded the first time it appears and is defined in the glossary of terms in Appendix A.

This report is not considered a Statement of Actuarial Opinion under the guidelines promulgated by the American Academy of Actuaries, as it does not contain actuarial advice or actuarial opinions by the report's authors. The recommendations contained in this report are those of the AB 567 Task Force.

1. AB 567 background

In recognition of California's aging population, AB 567 (Calderon) was passed by California's Legislative Assembly and Senate, and approved by Governor Newsom in October 2019. AB 567 established the Task Force in the California Department of Insurance ("**CDI**") to explore the feasibility of developing and implementing a culturally competent statewide insurance program for long-term care services and supports ("**LTSS**")[1].

1.1. Task Force

The Task Force is comprised of 15 members (volunteers and government agency representatives) with expertise spanning many facets of the LTC industry. The Task Force includes representation from a health policy expert, LTC providers, family caregivers, health professionals, a senior/consumer organization, actuaries, the LTC insurance industry, an LTC workers organization, and California government agencies (Department of Aging, Department of Health Care Services ("**DHCS**"), and Department of Insurance). Task Force members were appointed by various California authorities, including the Insurance Commissioner, the Governor, the Speaker of the Assembly, and the Senate Committee on Rules.

The individuals from Oliver Wyman that facilitated the Task Force discussions are not members of the Task Force, nor are they permitted to vote on the issues associated with AB 567.

Task Force members, as of the publication of this report, and their roles are presented in Exhibit 1.1.

Exhibit 1.1: AB 567 Task Force members and roles

Task Force member	Task Force role
Aron Alexander	Representative of residential care facilities for the elderly
Jamala Arland	Representative from the LTC insurance industry
Susan Bernard (chair)	California Insurance Commissioner Ricardo Lara designee
Dean Chalios	Representative of hospice and palliative care providers
Anastasia Dodson	California Department of Health Care Services Director Michelle Baass designee
Becky Duffey	Representative of adult day services providers
Joe Garbanzos	Representative of a senior/consumer organization
Eileen Kunz	Representative of an LTC provider association
Laurel Lucia	Representative of a nongovernment health policy expert

[1] LTC (long-term care) is typically used in the context of private insurance (i.e., LTC insurance), whereas LTSS (long-term services and supports) is typically used in the context of academia and government programs. These terms are used interchangeably in this report.

Task Force member	Task Force role
Doug Moore	Representative of independent providers of in-home personal care services
Parag Shah	Certified actuary with expertise in LTC insurance
Sarah Steenhausen	California Department of Aging Director Susan DeMarois designee
Dr. Karl Steinberg	Representative of LTC health professionals
Tiffany Whiten	Representative of family caregivers
Brandi Wolf	Representative of an employee organization that represents LTC workers

The Task Force's mandate, as outlined in AB 567, included the following activities:

1. Explore how a Program could be designed and implemented to expand the options for people who are interested in insuring themselves against the risk of costs associated with functional or cognitive disability, and require LTSS.
2. Explore options for the design of the Program, including eligibility, enrollment, benefits, financing, administration, and interaction with the Medi-Cal program and other publicly funded resources. In exploring these options, the Task Force shall consider all of the following:
    a. Whether and how a Program could be included as a benefit in the state disability insurance program structure, possibly through a nominal increase in the payroll tax, and whether the Program could be structured in the same manner as Paid Family Leave ("**PFL**") benefits.
    b. Allowing for enrollment in the Program of working adults who would make voluntary premium contributions either directly or through payroll deductions through their employer.
    c. To the extent feasible, requiring a mandatory enrollment with a voluntary opt-out option.
    d. Giving working adults the opportunity to plan for future LTC needs by providing a basic insurance benefit to those who meet work requirements and have developed functional or equivalent cognitive limitations.
    e. Helping individuals with functional or cognitive limitations remain in their communities by purchasing nonmedical services and supports, including home health care and adult daycare.
    f. Helping offset the costs incurred by adults with chronic and disabling conditions. The Program need not be designed to cover the entire cost associated with an individual's LTC needs.
3. Evaluate how benefits under the Program would be coordinated with existing private health care coverage benefits.

4. Evaluate the demands on the LTC workforce as the need for LTC in California grows, and how the LTC workforce can be prepared to meet those demands.
5. Consider the establishment of a joint public and private system to make LTC accessible to as many individuals within California as possible.
6. Make recommendations related to key regulatory provisions necessary for the public to access existing LTC insurance programs and participate in future LTC insurance programs, whether those programs are recommended by the Task Force or otherwise.

The Task Force's recommended Program designs associated with the above mandate, along with analysis on the respective degrees of feasibility, are described in this Feasibility Report. In addition, to ensure an adequate benefit within a solvent Program, a separate Actuarial Report will be submitted by Oliver Wyman to the Task Force for approval and, subsequently, to the Legislature on or before January 1, 2024. The Actuarial Report will include an actuarial analysis of the Task Force's recommended Program designs.

1.2. Plan of Action

During the inaugural Task Force meeting in March 2021, seven key Program design elements were identified for consideration and discussion, which became the Task Force Work Plan. The seven elements are as follows:

1. Structure options
2. Financing
3. Administrative considerations
4. Workforce
5. Services
6. Coordination and interaction
7. Access

Using the Task Force Work Plan as a guide, we followed a three-step process involving Task Force member education, discussion, and consensus to converge on the Program designs included in this report. A total of 15 Task Force meetings were held through August 2022, with many iterations of this three-step process, to cover each of the Work Plan elements as well as Program interdependency considerations. Task Force meetings were subject to the Bagley-Keene Open Meeting Act and as such were open to, and encouraged, public observation and participation.

To ensure a common baseline of knowledge and information among Task Force members, the first step of this process included sharing educational presentations spanning the seven elements of the Task Force Work Plan during Task Force meetings. We then commissioned questionnaires (i.e., surveys) related to each Work Plan element to independently collect Task Force and public recommendations. The questionnaires were followed by group discussions between the Task Force and public to align on preliminary results, recommendations, and next steps.

Task Force discussions primarily focused on comparing and contrasting different Program design provisions (generally, evaluating the pros and cons of various options). However, we provided quantitative support, including relative cost impacts and benchmarks, to facilitate Task Force decision-making. The comprehensive pricing and analysis of the Program designs included in this report will be completed in 2023 as part of the Actuarial Report. Recognizing that we asked the Task Force to make Program recommendations without knowing their full financial implications, we guided the Task Force towards developing a set of Program design options that span a range of anticipated costs.

The Program designs included in this report are based on the Task Force's most prevalent views, but it is important to note that unanimous consensus was not achieved for all Program design elements—that is, more than one view often received strong support from the Task Force.

2. Overview of Program design recommendations

Seventeen Task Force meetings were held throughout 2021 and 2022, during which Program design elements and views were deliberated by the Task Force and the general public. The views shared at the Task Force meetings, coupled with discussions related to establishing priorities and design trade-offs, formed the foundation of a Program design "straw man". The "straw man" outlined several Program designs for consideration by the Task Force and was narrowed down to the five design recommendations described in this report.

In addition, the Task Force recommended exploring several alternative scenarios (i.e., financial sensitivities) to understand the financial impact of certain design choices. Upon completion of the Actuarial Report in 2023, the alternative scenarios may inform targeted refinements to the Task Force's recommended designs with Program affordability and sustainability in mind.

Exhibit 2.1 summarizes the five recommended Program designs, ordered from lowest anticipated cost (Design 1) to highest anticipated cost (Design 5). These five designs reflect the Task Force's submission to the Insurance Commissioner, Governor, and Legislative Assembly for consideration in response to AB 567.

Exhibit 2.1: Description and overview of the recommended Program designs

Design	Description	Overview
1	Supportive LTSS benefits	• Targeted benefits for California's adult population (ages 18+)
2	Home care benefits for seniors	• Targeted benefits for California's senior population (ages 65+) • Excludes lower-income individuals
3	Low-range comprehensive LTSS benefits	• Low-range comprehensive benefits for California's adult population (ages 18+) • Inspired by the WA Cares Fund design with select updates
4	Mid-range comprehensive LTSS benefits	• Mid-range comprehensive benefits for California's adult population (ages 18+)
5	High-range comprehensive LTSS benefits	• High-range comprehensive benefits for California's adult population (ages 18+)

The remainder of this section expands on each design and lists the preferred and supported design(s) for each Task Force member.

2.1. Key Program design features

Several Program design elements received broad support from the Task Force and were thus reflected in all five Program designs. These elements are summarized in Exhibit 2.2.

Exhibit 2.2: Common Program design elements

Design element	Common design recommendations
Program structure	• Front-end coverage (i.e., benefits payable near the beginning of LTSS need) • Vested social insurance with pro-rated benefits (with variation by option)
Benefit eligibility criteria	• 2 of 6 activities of daily living ("**ADLs**") or severe cognitive impairment
Portability	• Benefits available outside of California (with variation by option)
Benefit type	• Reimbursement benefits (two options include a reduced cash benefit alternative)
Family caregiver support	• Reimbursement to informal or family caregivers subject to completion of certified caregiver training[2]
Contribution rate structure	• Level payroll tax split between employees and employers • Income tax for self-employed individuals • Contributions begin at age 18, with no maximum age
Benefit inflation	• Benefit increases based on Consumer Price Index ("**CPI**") • Benefit increases evaluated annually but not automatically applied (except for Design 5)
Investment strategy	• Invest Program revenue in U.S. treasuries, bonds, stocks, and other equities (state constitution currently only allows for investment in U.S. treasuries so a constitutional amendment would be required to facilitate this recommendation)

[2] Minimum training requirements that do not discourage benefit utilization will need to be defined in a culturally competent manner.

Design element	Common design recommendations
Coordination and interaction	• Private LTC insurance[3] pays before the Program • Considerations for individuals with (eligible) private insurance: – Opt-out provision if purchased before Program's legislative enactment – Reduced Program contributions if purchased after Program's legislative enactment • Program pays before Medi-Cal and should not influence Medi-Cal eligibility

Aside from the common elements outlined above, the five Program designs vary considerably. Exhibit 2.3 summarizes the eligibility, enrollment, benefits, services, and financing elements of each Program design. In addition, the comprehensive Program design "straw man" is provided in Appendix B.

[3] Supplemental private LTC insurance products developed after the Program's legislative enactment would not be eligible for reduced Program contributions and may be subject to different interaction criteria than private LTC insurance products designed before the Program's legislative enactment. The Task Force recommended establishing a separate working group to explore Program coordination and interaction with supplemental private LTC insurance in more detail.

Exhibit 2.3: Summary of Program designs

Design element	1: Supportive LTSS benefits	2: Home care benefits for seniors	3: Low-range comprehensive LTSS benefits	4: Mid-range comprehensive LTSS benefits	5: High-range comprehensive LTSS benefits
Benefits	• Maximum $36,000 ($1,500 per month for two years) • No elimination period ("**EP**") • Individual coverage	• Maximum $110,400 ($4,600 per month for two years) • 50% cash benefit alternative • 90-day EP • Individual coverage	• Maximum $36,000 ($3,000 per month for one year) • 30-day EP • Individual coverage	• Maximum $81,000 ($4,500 per month for 18 months) • No EP • Shared benefit pool with spouses or domestic partners	• Maximum $144,000 ($6,000 per month for 2 years) • 50% cash benefit alternative • No EP • Shared benefit pool with spouses or domestic partners
Services	• Supportive LTSS benefits, including: – Caregiver support (training, respite care, financial support, etc.) – Adult day care ("**ADC**") – Meal delivery – Transportation – Preventative equipment – Home assessments and minor home modifications	• Home and community-based services ("**HCBS**") • Limited preventative benefits	• HCBS and select institutional care • Limited preventative benefits • Coverage for California's Program for All-Inclusive Care for the Elderly ("**PACE**")	• HCBS and institutional care • Preventative benefits before satisfying benefit eligibility criteria • Coverage for PACE	• HCBS and institutional care • Preventative benefits before satisfying benefit eligibility criteria • Coverage for PACE

Design element	1: Supportive LTSS benefits	2: Home care benefits for seniors	3: Low-range comprehensive LTSS benefits	4: Mid-range comprehensive LTSS benefits	5: High-range comprehensive LTSS benefits
Eligibility and enrollment	• Benefits available at ages 18+ • 5-year vesting period with pro-rating of benefits • Full domestic portability	• Benefits available at ages 65+ • 5-year vesting period with pro-rating of benefits • Partial portability (grade to 50% over 5 years within U.S.) • Grade-up benefits over the first 20 years for intergenerational equity	• Benefits available at ages 18+ • 10-year vesting period with pro-rating of benefits • Partial portability (grade to 50% over 5 years within U.S.) • Grade-up benefits over the first 20 years for intergenerational equity	• Benefits available at ages 18+ • 10-year vesting period with pro-rating of benefits • Full domestic portability • Grade-up benefits over the first 20 years for intergenerational equity	• Benefits available at ages 18+ • 5-year vesting period with pro-rating of benefit and a voluntary option to top-up benefits if unable to fully vest • Full international portability • Grade-up benefits over the first 20 years for intergenerational equity
Financing	• Contribution cap • Consider alternative funding beyond payroll tax and income tax • Contribution waiver for lower-income individuals	• Contribution cap • Individuals below a specified poverty level will not contribute or receive vesting credits • Consider alternative funding beyond payroll tax and income tax	• Contribution cap • Contribution waiver for lower-income individuals	• No maximum contribution cap • Contribution waiver for lower-income individuals	• Contribution cap • Contribution waiver for lower-income individuals

2.2. Program design recommendations

After considering all relevant Program design elements and compiling a "straw man" of five design options, we asked the Task Force to select their most preferred Program design and other designs they support. The results are summarized in Exhibits 2.4.

Exhibit 2.4: Task Force member Program design recommendations[4]

Design	Description	Preferred design		Supported design	
		Vote count	**Voting Task Force member**	**Vote count**[5]	**Voting Task Force member**
1	Supportive LTSS benefits	**0**	N/A	**4**	1. Aron Alexander 2. Jamala Arland 3. Dean Chalios 4. Parag Shah
2	Home care benefits for seniors	**2**	1. Jamala Arland 2. Parag Shah	**1**	1. Dean Chalios
3	Low-range comprehensive LTSS benefits	**2**	1. Aron Alexander 2. Dr. Karl Steinberg	**4**	1. Dean Chalios 2. Joe Garbanzos 3. Eileen Kunz 4. Parag Shah
4	Mid-range comprehensive LTSS benefits	**5**	1. Dean Chalios 2. Eileen Kunz 3. Laurel Lucia 4. Tiffany Whiten 5. Brandi Wolf	**3**	1. Becky Duffey 2. Joe Garbanzos 3. Dr. Karl Steinberg
5	High-range comprehensive LTSS benefits	**3**	1. Becky Duffey 2. Joe Garbanzos 3. Doug Moore	**6**	1. Dean Chalios 2. Eileen Kunz 3. Laurel Lucia 4. Dr. Karl Steinberg 5. Tiffany Whiten 6. Brandi Wolf

[4] Counts do not add up to 15 because Task Force members from the California Department of Aging ("**CDA**"), CDI, and DHCS were absolved from providing a recommendation.

[5] The "supported design" count does not include Task Force members who selected the design as their preferred option.

In addition, we asked Task Force members to propose modifications to any designs they did not support to improve their opinion of those designs. The proposed modifications are summarized in Exhibit 2.5.

Exhibit 2.5: Program design modifications recommended by Task Force members that did not support the design

Design	Description	Recommended modifications by non-supporting Task Force members
1	Supportive LTSS benefits	• Provide a more generous benefit • Provide comprehensive coverage • More flexibility in available care settings
2	Home care benefits for seniors	• Provide a more generous benefit • Provide comprehensive coverage • Ease eligibility requirements
3	Low-range comprehensive LTSS benefits	• Remove EP • Higher benefit maximum and benefit period • Do not limit coverage to select institutional care • Ease eligibility requirements • Reassess if current similarities to Washington State's WA Cares Fund are appropriate for California
4	Mid-range comprehensive LTSS benefits	• Ease eligibility requirements • Restrict eligible population to retirement age adults (e.g., age 65+) • Reduce domestic portability divesting mechanism to 75% • Add a contribution cap • Remove family and spousal coverage extension option
5	High-range comprehensive LTSS benefits	• Reduce richness of benefits or make alternative adjustment(s) to reduce cost • Restrict eligible population to retirement age adults (e.g., age 65+) • Reduce international portability divesting mechanism to 75% • Increase vesting period to ten years • Add a 30-day EP

In addition to the Task Force, numerous members of the public participated in the feasibility process by sharing their perspectives at Task Force meetings, responding to the Program design questionnaires, and providing written commentary to the CDI and Task Force.

As acknowledgment and appreciation for the public's participation, we asked members of the public to select their most preferred and supported Program designs, similar to our ask of the Task Force. We received 12 responses from the public, which are summarized in Exhibit 2.6 below.

Exhibit 2.6: General public Program design recommendations

Design	Description	Preferred design count (vote count)	Supported design count (vote count)[6]
1	Supportive LTSS benefits	**0**	**0**
2	Home care benefits for seniors	**0**	**0**
3	Low-range comprehensive LTSS benefits	**1**	**0**
4	Mid-range comprehensive LTSS benefits	**0**	**12**
5	High-range comprehensive LTSS benefits	**11**	**0**

2.3. Design benefits and trade-offs

Designing a Program that is affordable, widely accessible, and inclusive of comprehensive benefits may not be practicable. Further, the relative importance of these attributes could vary among the range of stakeholders that may be affected by the Program (e.g., public opinion, political opinion, LTSS providers, LTSS workforce, associations, corporations, and other organizations and individuals).

Through AB 567, California's Legislative Assembly and Senate requested that the Task Force make design decisions that required trade-offs between affordability, accessibility, and comprehensiveness of benefits to arrive at the five designs included in this report. A summary of the key trade-offs associated with each design is provided below.

- **Design 1** (supportive LTSS benefits) emphasizes affordability and accessibility while offering a more limited selection of benefits relative to the other designs.
- **Design 2** (home care benefits for seniors) emphasizes affordability and offers more comprehensive benefits relative to Design 1 but restricts access to California's senior population and excludes lower-income individuals.
- **Designs 3, 4, and 5** offer benefits that are widely accessible, but each design incrementally trades affordability for more comprehensive benefits, ratcheting up from Design 3 (low-range

[6] The "supported design count" does not include any public members who selected the design as their preferred option.

comprehensive LTSS benefits) to Design 4 (mid-range comprehensive LTSS benefits) and ultimately to Design 5 (high-range comprehensive benefits).

3. Overview of recommended next steps

In conjunction with the recommended Program designs, the Task Force recommended several additional next steps. This section summarizes the open items to be addressed following the publication of this Feasibility Report (e.g., as part of the forthcoming Actuarial Report).

1. **Financial analysis**. The Task Force expressed particular interest in exploring several alternative scenarios (i.e., financial sensitivities) for the following aspects of Program financing to inform potential changes to the recommended Program designs:
    a. **Benefit eligibility age**. Assess the financial impact of a range of Program benefit eligibility ages (e.g., no minimum age, 18+, 30+, 40+, 50+, 65+).
    b. **Vesting criteria**. Assess the financial impact of increasing the Design 5 vesting criteria from 5 years to 10 years.
    c. **Portability and divesting criteria**. Assess the financial impact of including full or partial international portability for all Program designs.
    d. **Benefit maximum**. Assess the financial impact of reducing the Design 1 benefit maximum from $1,500 to $1,000 per month.
    e. **Revenue source(s)**. Assess the financial impact of a range for the employer-paid portion of the Program contribution rate (e.g., 0% employer paid or fully employee paid, 25% employer paid, 50% employer paid).
    f. **Contribution limits**. Assess the financial impact of a range of contribution limits (e.g., various multiples of the Social Security contribution limit).
    g. **Investment strategy**. Assess the financial impact of an investment strategy that includes bonds, stocks, and other equities versus one that only includes U.S. Treasuries (i.e., if an amendment to Article XVI, Section 17 of the California Constitution is not obtained).
2. **Separate working groups**. The Task Force recommended the establishment of six separate working groups to examine a range of topics that could influence certain aspects of the Program. These working groups would be comprised of individuals with expertise pertaining to the specific topic and should include a diverse range of perspectives. Given potential resource constraints and competing priorities, the Task Force recommends prioritizing the working groups as follows:
    a. **Working group 1**: Program outreach and education, including outreach to sovereign tribal communities to ensure they are aware of the Program and their choice of opting into the Program.
    b. **Working group 2**: Program coordination with supplemental (or wrap-around) private LTC insurance.
    c. **Working group 3**: Assessment of LTSS needs for individuals with developmental and acquired disabilities in early adulthood.

d. **Working group 4**: Program coordination with PACE

e. **Working group 5**: Program coordination with existing LTSS programs and resources in California (beyond Medi-Cal and Medicare), including potential integration with existing outreach, care coordination, and care access programs, such as Aging and Disability Resource Centers ("**ADRCs**"), the Health Insurance Counseling and Advocacy Program ("**HICAP**"), and the No Wrong Door System administered by the CDA.

f. **Working group 6**: Program coordination with Medicare Advantage plans.

3. **Coordination and interaction**. The Task Force identified several aspects of the Program coordination and interaction that require additional exploration subsequent to this Feasibility Report.

    a. A federal demonstration waiver from the Centers for Medicare and Medicaid Services ("**CMS**") should be pursued to allow the state to retain federal Medicaid savings attributable to the Program. If approved, any funds received from the waiver should be held in a trust fund to benefit the Program's members.

    b. The Program's coordination and interaction with LTSS benefits provided by the United States Department of Veterans Affairs ("**VA**") should be further explored. Program provisions should be refined, as needed, based on new findings.

    c. Further assessments need to be performed to determine how best the Program can coordinate with (i) Medicare's LTSS benefits and (ii) California's In-Home Supportive Services ("**IHSS**") program.

    d. For the proposed Program opt-out provisions, a definition of the LTC insurance products eligible for either opt-out or reduced Program contributions (e.g., type of insurance, minimum benefits, etc.) is yet to be determined. Further, a recurring recertification process needs to be established for individuals that opt out of the Program or qualify for reduced contributions, including defining the frequency at which individuals will be required to demonstrate that they continue to be covered by an eligible private LTC insurance.

    e. Developments in other states related to public LTSS financing should be monitored, particularly in relation to the development of any supplemental private LTC insurance products, to ensure uniformity across states to the extent practicable.

    f. Encourage and support the exploration of a federal LTSS program.

4. **Eligibility and enrollment**. Further exploration is required regarding potential Program variances for sovereign tribal communities that opt into the Program (e.g., allowing Program contributions for tribal communities to be covered by alternative revenue sources that are only available to tribes).

5. **Benefits and services**. The Task Force recommended that the Program offer preventative measures, but the specific preventative benefits and services that the Program will cover have

yet to be defined. Additionally, the Task Force has not yet aligned on whether preventative measures will be covered under a separate (limited) benefit (e.g., $5,000) or deducted from the same benefit pool as other Program services.

6. **Administration**. Based on the ultimate Program design, confirm the administrative functions needed, identify staff and resource needs, determine whether existing infrastructure in California could be expanded upon to support the Program, and decide if a new board, department, or agency is required to administer the Program. Expanding current infrastructure or creating a new board, department, or agency would require legislation. As part of this effort, determine whether there are opportunities to leverage the administrative framework in the private LTC insurance industry to execute certain administrative functions required for the Program.

7. **Financing**. To allow Program funds to be invested in bonds, stocks, and other equities, an amendment to the California Constitution is required (specifically Article XVI, Section 17 of the California Constitution). Exploration of the potential avenues by which this constitutional amendment could be achieved is required. Additionally, the Task Force recommended that the Program waive contributions for lower-income individuals, but the specifics of the contribution waiver have yet to be defined.

8. **LTSS Workforce**. The Task Force recommended that the Program establish minimum training requirements for informal or family caregivers to become certified caregivers. While the specifics of the training requirements have yet to be defined, the Task Force recommended that the minimum standards be established in a culturally competent manner that does not discourage benefit utilization. The Task Force also made several recommendations related to the LTSS workforce that are tangential to the core Program design but paramount to the Program's successful rollout and viability.

    a. Identify ways the Program could positively influence or improve caregiver wages and benefits, invest in caregiver training programs, support caregiver career progression, promote career opportunities for younger individuals (e.g., community college programs), and expand the LTSS workforce. Further, the Program should explore opportunities to leverage automation and technology to supplement the workforce.

    b. As part of the Program's administration, establish LTSS workforce governance and oversight processes, and ensure caregivers have access to unions and other forms of workforce representation.

4. Feasibility analysis

4.1. Overview

In assessing the feasibility of implementing a statewide LTC program in California, we followed a three-step process involving Task Force member education, discussion, and consensus[7]. To facilitate holistic discussions and provide the Task Force with relevant data points for each Program design element, we analyzed existing programs and frameworks in California, the United States, and abroad, including:

1. Private LTC insurance
2. California's Medicaid program, Medi-Cal (including the IHSS program)
3. California's State Disability Insurance ("**SDI**") and PFL programs
4. Hawaii's Kapuna Caregivers Program
5. Washington State's LTSS program (WA Cares Fund)
6. Germany's LTSS program
7. France's LTSS program

In particular, considering the public LTSS programs in Washington State, France, and Germany allowed us to draw inspiration and insights while being mindful of political, economic, and social differences relative to California.

Program design elements have significant interdependence, which we addressed by continuously revisiting certain design elements and recommendations throughout the Task Force meeting process. Program interdependencies were also the focus of the Task Force Meeting #14 discussion in July 2022.

The remainder of Section 4 details the recommendations and considerations for each design element outlined in the Task Force Work Plan.

4.2. Structure

There are two primary components to Program structure—Program design and Program coverage. The following overarching structure options were discussed with the Task Force:

1. **Program design**: Public benefits, public support for private benefits, and hybrid public-private benefits

[7] The Program designs included in this report are based on the Task Force's most prevalent views, but it is important to note that unanimous consensus was not achieved for all Program design elements—that is, more than one view often received strong support from the Task Force.

2. **Program coverage**: Front-end coverage, back-end (or catastrophic) coverage, and comprehensive coverage

4.2.1. Structure recommendations

The Task Force recommended a Program that provides front-end public benefits for Californians and viewed a vested social insurance program as the most feasible design for the Program. Key considerations for this recommendation include:

- A front-end design provides individuals access to benefits earlier in their need for LTSS, which might result in improved health outcomes
- A front-end design might address the needs of those who do not immediately qualify for Medi-Cal
- A front-end design is perceived as the best fit for the state government (as opposed to the federal government)
- A vesting requirement is anticipated to increase Program sustainability
- Social insurance could benefit the middle class (as opposed to means-tested public assistance)

The Task Force also expressed support for a lower-cost targeted Program design, for which the target could be specific services (e.g., supportive services, home and community-based care) and populations (e.g., seniors, family caregivers). Some Task Force members felt a lower-cost targeted design might be more feasible to implement.

Additional recommendations and next steps outlined by the Task Force include:

1. The vesting requirements should be designed with cultural competence in mind while remaining financially viable
2. A working group should be established to explore coordination between the Program and supplemental private LTC insurance

4.2.2. Structure considerations

Design considerations for the Program's structure were discussed with the Task Force at Task Force Meeting #3 in August 2021.

Relevant educational materials on this topic included:

- Program design and program coverage concepts
- Social insurance versus public assistance overview

Key concepts and takeaways from this discussion are summarized below.

4.2.2.1. Program design

4.2.2.1.1. Public benefits

Programs that provide public benefits are typically constructed as social insurance or public assistance. Social insurance programs generally involve pooling risks among participants, while public assistance programs generally aim to provide basic economic security (e.g., health care, housing, etc.) to the needy. Both social insurance and public assistance could vary in comprehensiveness—from universal to targeted coverage.

The pros and cons of three public benefit constructs were assessed, as summarized in Exhibit 4.1.

Exhibit 4.1: Public benefits – design considerations

Design option	Pros	Cons
Universal social insurance (e.g., Germany's LTSS program)	• All Californians would be covered • May be able to negotiate and/or regulate LTSS costs • Potentially lower administrative costs per Program participant • Mechanism(s) established for SDI may be leverageable for employee payroll tax collection	• High cost • Potential loss of federal Medi-Cal funding • Benefit modification for social insurance programs could be challenging post-Program implementation
Vested social insurance (e.g., Washington State's WA Cares Fund)	• Less costly than universal coverage • Less overlap with Medi-Cal (e.g., vested workers may not qualify for Medi-Cal) • Mechanism(s) established for SDI may be leverageable for employee payroll tax collection	• Only covers vested workers (and potentially their family members) • Costly • Potential loss of federal Medi-Cal funding • Benefit modification for social insurance programs could be challenging post-Program implementation

Design option	Pros	Cons
Targeted social assistance (e.g., Hawaii's Kapuna Caregivers Program)	• Less costly than either of the above designs • Coverage could be designed to limit overlap with Medi-Cal • May be easier to design and implement • May be easier to reduce benefit levels (compared to a social insurance program), if necessary, for financial viability	• Will not solve larger LTSS needs (demographic and funding) • A new eligibility record system may need to be constructed and maintained

4.2.2.1.2. Public support for private benefits

Programs that provide public support for private market solutions often involve government actions to support or incentivize the purchase of private insurance.

The pros and cons of four such design constructs were assessed, as summarized in Exhibit 4.2.

Exhibit 4.2: Public support for private benefits – design considerations

Design option	Pros	Cons
Public-private reinsurance or risk-sharing for private LTC insurance (e.g., public financial support to reimburse private insurer costs for catastrophic LTC claims)	• Not disruptive—largely maintains status quo • Would provide insurers more certainty when estimating insurance premiums • Could be relatively low cost • Comparatively simple	• May not materially reduce private LTC premiums • May not improve private LTC insurance sales or motivate new market entrants • Any insurer costs associated with the Program may be passed on to consumers • May not receive public support (e.g., it could be viewed as a subsidy) • Potential for individuals who do not have private LTC to indirectly subsidize individuals who do have private LTC (e.g., if the reinsurance solution draws down assets from the state's general fund)

Design option	Pros	Cons
Promote and incentivize new LTC products (e.g., Minnesota's support of a LifeStages product)	• Not disruptive—largely maintains status quo • Very low cost • Comparatively simple	• New products may not be more affordable • May not improve private LTC insurance sales or motivate new market entrants • Will not solve larger LTSS needs (demographic and funding)
Require Medicare Supplement health plans to include limited LTSS benefits (e.g., proposal in Minnesota)	• Not disruptive—largely maintains status quo • Very low cost • Comparatively simple	• Any material benefit will likely increase plan costs • May drive insurers from the market • May not be actuarially viable • Will not solve larger LTSS needs (demographic and funding)
Expand California's LTC Partnership Program (e.g., more affordable policies and/or higher program participation)	• Not disruptive—largely maintains status quo • Very low cost • Comparatively simple	• May not materially reduce private LTC premiums • May not improve private LTC insurance sales or motivate new market entrants • Will not solve larger LTSS needs (demographic and funding)

4.2.2.1.3. Hybrid public/private solution

Programs that offer hybrid public/private solutions often provide some public benefits supplemented by private coverage. Private benefits may be supplemental (e.g., additional coverage or services above those offered by public benefit) or complementary (e.g., covering any copays, deductibles, or share-of-cost required for the public benefit). Supplemental and complementary private insurance options exist in most countries with social LTC insurance programs.

Some pros associated with a hybrid Program design are that the private options could help fill gaps in public benefits and may allow for lower public costs. Additionally, this Program design would give consumers more freedom of choice in terms of the level of coverage they prefer. However, two key cons associated with this design are that private options may not be affordable and private insurers would need to enter and adapt to a new market.

4.2.2.2. Program coverage

There are three primary program coverage types, as follows:

1. **Front-end coverage**: Provides benefits at or near the beginning of an individual's eligibility for LTSS
2. **Back-end (or catastrophic) coverage**: Provides benefits after an individual with LTSS needs has waited for a specified period (e.g., two years) or paid a specified dollar amount (deductible) for LTSS (e.g., $50,000)
3. **Comprehensive coverage**: Provides benefits throughout an individual's eligibility for LTSS, though benefits may still be subject to an individual satisfying a specified waiting period

The pros and cons associated with these three coverage types were assessed, as summarized in Exhibit 4.3.

Exhibit 4.3: Program coverage– design considerations

Design option	Pros	Cons
Front-end coverage (e.g., Washington State's WA Cares Fund)	• Will likely benefit a broader facet of the Californian population (relative to back-end coverage) as all individuals who have met the Program's qualification requirements (e.g., vesting period) will receive benefits • Front-end coverage is typically less costly than back-end and comprehensive coverage • Comparatively more predictable program costs • Less overlap with existing public coverage options (e.g., Medi-Cal)	• Could pay far less per claim than back-end or comprehensive coverage • Benefits may be inadequate to cover all costs associated with an individual's LTSS needs • Individuals may still require support from Medi-Cal if their LTSS needs exceed the public benefit • Increased coordination and interaction complexity with private LTC insurance
Back-end coverage (e.g., federally proposed WISH Act)	• Coverage could pay more per claim than front-end coverage • For those with significant LTSS needs, back-end coverage is likely more beneficial than front-end	• Back-end coverage is typically more costly than front-end coverage • Provides benefits to fewer individuals

Design option	Pros	Cons
	• More likely to reduce Medi-Cal spending relative to front-end coverage • May allow for easier coordination and interaction with private LTC insurance	• Comparatively less predictable program costs relative to front-end coverage • Significant overlap with Medi-Cal—may reduce federal match funds • Individuals may be impoverished during the waiting period
Comprehensive coverage (e.g., Germany's LTSS program, private LTC insurance)	• Will likely benefit a broader facet of Californians (relative to back-end coverage) as all individuals who have met the Program's qualification requirements (e.g., vesting period) will receive benefits • Potential for cost control through the ability to negotiate and regulate service prices as the state would be a primary financer of LTSS • Potentially lower administrative complexity and costs (e.g., simplified coordination and interaction with other public programs and private LTC insurance)	• Highest program cost • Significant overlap with Medi-Cal—may reduce federal match funds • Comparatively less predictable program costs relative to front-end coverage

4.3. Coordination and interaction

Coordination of payers could have significant financial implications. Therefore, an assessment of how the Program could interact and coordinate with private LTC insurance and existing public programs is necessary to delineate the order of payers and avoid duplication of coverage across financing sources.

Task Force recommendations focused on the Program's coordination and interaction with the following LTSS financing sources:

1. Private LTC insurance
2. Medi-Cal (California's state Medicaid program)

3. Medicare (National health insurance program)
4. Other LTSS programs and services (e.g., supportive LTSS benefits administered by the CDA

A brief primer on the LTSS programs and services administered by the CDA is included in Appendix C. In addition, an assessment of the Program's impact on existing state LTSS programs, including Medi-Cal, IHSS, and Medicare, will be included in the Actuarial Report.

Additionally, the Task Force received a briefing on several LTSS-related programs and initiatives proposed at the federal level (e.g., the Well-Being Insurance for Seniors to be at Home ("**WISH**") Act). As these programs and initiatives remain under review by the United States Congress, they are subject to change or may fail to pass. As such, we did not ask the Task Force to provide recommendations related to the Program's coordination and interaction with federal programs that have yet to be enacted.

4.3.1. Coordination and interaction recommendations

The Task Force recommended that substitutive private LTC insurance should pay benefits before the Program pays benefits because the premiums paid by policyholders were determined in the absence of the Program. Further, if substitutive private LTC insurance were to pay benefits after the Program, California Insurance Code 10235.91[8] would likely apply, which the Task Force deemed administratively challenging. This recommendation is interdependent with the Task Force's private LTC insurance exemption recommendation, which is discussed in more detail below.

The Task Force also recommended establishing a separate working group to examine how the Program could best coordinate with supplemental (or "wrap-around") private LTC insurance products developed after the Program's legislative enactment. These supplemental insurance products would pay for an individual's LTSS costs after an individual has exhausted their Program benefits. The California Insurance Code would need to be updated to include standards for supplemental LTC insurance products, including product labeling, suitability criteria, benefits triggers, and interaction with Program benefits.

The Task Force recommended that the Program should pay before Medi-Cal, because Medi-Cal is typically the payer of last resort by federal law.

Additional recommendations and next steps outlined by the Task Force with regard to the Program's coordination and interaction are summarized below.

[8] California Insurance Code 10235.91 stipulates that "in the event a non-Medicaid national or state long-term care program is created through public funding that substantially duplicates benefits covered by the policy or certificate, the policyholder or certificate holder will be entitled to select either a reduction in future premiums or an increase in future benefits An actuarial method for determining the premium reductions and increases in future benefits will be mutually agreed upon by the department and insurers. The amount of the premium reductions and future benefit increases to be made by each insurer will be based on the extent of the duplication of covered benefits, the amount of past premium payments, and claims experience. Each insurer's premium reduction and benefit increase plans shall be filed and approved by the department."

Private LTC insurance:

1. Coordination of benefits between the Program and private LTC insurance should allow for concurrent benefits if they are non-duplicative. That is, if an individual's LTSS costs exceed their maximum private LTC insurance benefits, an individual should be permitted to claim the excess portion of the costs through the Program, subject to Program eligibility requirements. There may also be situations where certain services are covered by the Program but not by an individual's private LTC insurance, in which case an individual should be permitted to claim these costs through the Program.
2. Individuals who own eligible substitutive private LTC insurance before the Program's legislative enactment (e.g., the date that the legislation is signed by the Governor) should be permitted to opt out of the Program. Any new private LTC insurance policies sold after this deadline (which should be explicitly established in the enacting legislation) would be ineligible for Program opt-out. Further, these individuals should be permitted to opt back into the Program under select circumstances, which have yet to be defined.
3. Individuals who purchase eligible substitutive private LTC insurance after the Program's legislative enactment should qualify for reduced Program contributions. These individuals would still be able to receive LTSS benefits under the Program as a second payer. Offering reduced Program contributions to individuals that purchase substitutive private LTC insurance incentivizes individuals to plan for their future LTC needs holistically. This allowance is beneficial to the individual because private LTC insurance may provide more comprehensive coverage than the Program. It is also beneficial to the Program, as substitutive insurance would be the first payer, thus reducing the costs borne by the Program. The determination of the reduced contribution would be subject to an actuarial evaluation.
4. A recurring recertification process should be established for individuals that opted out of the Program or qualified for reduced contributions to demonstrate that they continue to own eligible private LTC insurance. The frequency of this recertification has yet to be determined. If the individual no longer owns an eligible policy, due to cancellation or lapse, the individual would be required to participate in the Program and begin payment of Program contributions.
5. The definition of eligible LTC insurance products that qualify for either opt-out or reduced Program contributions has not yet been determined. A proposed definition should be determined by the CDI and should incorporate input from the LTC industry.
6. The Task Force recognized the importance of having uniformity in public LTC program designs among states to promote a viable supplemental private LTC insurance market (i.e., designing and filing unique supplemental LTC insurance products for each state with a public LTC program might not be practicable). However, the only immediate actionable step is to monitor developments in other states.

Medi-Cal:

1. Coordination of benefits between the Program and Medi-Cal should allow for concurrent benefits if they are non-duplicative. That is, if an individual's LTSS costs exceed the Program's maximum benefit, an individual should be permitted to claim the excess portion of the cost through Medi-Cal, subject to Medi-Cal eligibility and reimbursement requirements. There may also be situations where certain services are covered by Medi-Cal but not by the Program, or where the individual is eligible to receive benefits under Medi-Cal but not the Program, in which case the individual should be permitted to claim these costs through Medi-Cal.
2. The Program should not influence the Medi-Cal eligibility determination process (e.g., benefits received from the Program should not be deemed income when determining Medi-Cal eligibility).
3. The Program should not exclude individuals on the basis that they are eligible for Medi-Cal (whether in the past, present, or future). Said differently, the Program should not be designed with the intent of carving out individuals who may be eligible for Medi-Cal. Design 2 is an exception to this principle because it targets individuals less likely to qualify for Medi-Cal.
4. A CMS federal demonstration waiver should be pursued to retain federal Medicaid savings attributable to the Program. If approved, funds received from the waiver should be held in a trust fund to benefit the Program's members.
5. Further analysis is needed to understand how the Program could best coordinate with IHSS.

Medicare:

1. Medicare LTSS benefits are generally narrow in scope, including short stays in a nursing facility and some home health care services. Thus, it is anticipated to be more practical for Californians and more cost-effective for the Program if Medicare pays before the Program when overlapping coverage exists. This order of payers would also negate the potential need to pursue a CMS federal demonstration waiver to retain federal Medicare savings attributable to the Program. However, further analysis and stakeholder interviews are needed to assess the feasibility of having the Program pay second to Medicare.

Other LTSS programs or services:

1. To the extent feasible, the Task Force recommended that the Program integrate with existing outreach, care coordination, and care access programs available in California, such as ADRCs, HICAP, and the No Wrong Door system administered by the CDA.
2. Due to the complex nature of the existing LTSS programs and services available in California, the Task Force recommended establishing a separate working group to assess how the Program could best coordinate with all available LTSS resources in the state (beyond Medi-Cal and Medicare). Relatedly, the Task Force recommended establishing working groups to assess how the Program could coordinate with PACE and Medicare Advantage plans.

3. California's veteran population has access to certain LTSS benefits through the VA. Further exploration of the Program's coordination and interaction with the VA is needed.
4. While further exploration of the Program's coordination and interaction with private medical insurance (i.e., distinct from private LTC insurance) is needed, it is anticipated to be more practical for Californians and more cost-effective for the Program if private medical insurance pays before the Program when overlapping coverage exists given that private medical insurance coverage for LTSS is similar to Medicare.

4.3.2. Coordination and interaction considerations

Design considerations for the Program's coordination and interaction with other public LTSS programs and private LTC insurance were primarily discussed with the Task Force at Task Force Meeting #4 in October 2021 and Task Force Meeting #6 in January 2022.

Relevant educational materials on this topic included:

- California Department of Aging long-term services and supports
- California's No Wrong Door System infrastructure and planning
- California Department of Health Care Services Medi-Cal and Medicare programs
- Coordination and interaction with Medi-Cal
- Medicaid and related federal waivers for LTSS
- Potential integration with Medicare Advantage
- Overview of PACE
- Coordination and interaction with private LTC insurance
- Partnering a statewide LTC program with private LTC insurance
- Actuarial considerations of program design
- Private LTC insurance and PACE coordination illustrative examples
- Coordination and interaction with current federal proposals

Key concepts and takeaways from these discussions are summarized below.

4.3.2.1. Coordination with private LTC insurance

4.3.2.1.1. Partnering with private LTC insurance

An overarching objective of AB 567 is to cover LTSS needs of as many Californians as possible. To achieve this goal, the Program must coordinate with the private LTC insurance market. Key considerations regarding how the Program could optimally partner with private LTC insurance include:

1. Public programs that provide some level of LTSS coverage may be able to build on the existing framework in the private LTC market instead of seeking to replace it. For example:
    a. It may be possible to utilize administrative capabilities in the private sector to readily and efficiently deliver LTC services under public programs.
    b. Insurance agents could be leveraged to support and execute public education initiatives (e.g., in conjunction with the sale of supplemental LTC insurance products).
2. A public program that integrates with a variety of LTC insurance options would result in more consumers having access to the coverage they need and would promote overall Medi-Cal savings. To that end, it may be beneficial to consider ways to build on and enhance existing programs like the Partnership program.
3. The private LTC insurance market could develop and offer innovative supplemental insurance products, likely at more widely affordable price points, which could potentially lessen the financial burden on other public programs such as Medi-Cal. It is crucial for states to work collaboratively with the private industry to set standards for supplemental insurance products prior to Program implementation and ensure that such private insurance options can reach the marketplace in a timely manner.

4.3.2.1.2. Private LTC insurance opt-out considerations

An opt-out provision would allow individuals with eligible private LTC insurance to be exempt from the Program—they would not be required to contribute, nor would they have access to Program benefits. However, care must be taken to minimize opt-out anti-selection, as any anti-selection could jeopardize the Program's sustainability. An example of how anti-selection may arise is if the value proposition (benefits relative to premiums) of private LTC insurance far outweighs the value proposition under the Program for higher-income individuals, which may incentivize these individuals to opt out of the Program, thereby significantly reducing Program revenues.

The pros and cons associated with the three primary opt-out provisions discussed by the Task Force are summarized in Exhibit 4.4.

Exhibit 4.4: Private LTC insurance opt-out considerations

Design option	Pros	Cons
Opt-out (unrestricted or time-limited)	• More equitable for individuals who purchased private LTC insurance before the enactment of the Program • Provides individuals with more choice	• May negatively impact Program viability as wealthier individuals are more likely to opt out • May receive limited public support (particularly in light of circumstances leading up to the WA Cares opt-out deadline)

Design option	Pros	Cons
Reduced Program contributions	• Rewards individuals for purchasing private LTC insurance, which may provide more comprehensive LTSS protection while enhancing Program sustainability	• May negatively impact Program viability as wealthier individuals are more likely to purchase private LTC insurance
No opt-out	• May positively impact Program viability as more individuals will participate in the Program	• Takes choices away from the individual • Less equitable for individuals who have already purchased private LTC insurance • May receive less public support, particularly from those with existing LTC insurance policies

Additional considerations related to opt-out provisions include:

1. The circumstances and motivations underlying an individual's decision to purchase private LTC insurance likely differ depending on whether the insurance is issued before or after the legislative enactment of the Program. The potential for anti-selection substantially increases if an opt-out provision is extended post-Program enactment. If an opt-out provision is included, the least risky provision would be to allow only individuals with legacied private LTC insurance policies the ability to opt out. For this provision, a legacied policy would be defined as an LTC insurance policy issued before a specified date preceding Program enactment (e.g., January 2022). Capturing only legacied policies in the opt-out provision significantly reduces the risk of anti-selection as it generally encompasses a smaller cohort of individuals who were not motivated to purchase private LTC insurance as a result of the Program.
2. While including a time-limited opt-out window would increase flexibility for prospective private LTC insurance consumers, a surge in private LTC insurance applications would likely occur in the months leading up to the deadline, similar to what happened with the WA Cares Fund. To avoid this outcome, legislation enacting the Program should set a deadline (e.g., the date the Governor signs the legislation), which would make any new LTC policy sales ineligible for Program opt-out after the deadline.
3. A clear definition of what constitutes "eligible" private LTC insurance for the purposes of an opt-out provision must be established. The definition should be broad-based to cover a range of insurance products that provide LTSS coverage (e.g., inclusive of both standalone LTC insurance and life or annuity insurance products with LTC riders). The definition may also

consider establishing a minimum level of benefits requirement. Further discussion is required on this topic, as noted above.

4. Periodic verification that an individual has maintained their private LTC insurance coverage post opt-out is essential. While a one-time certification would be simpler to administer than a recurring recertification process, allowing a one-time certification could be fraught with misuse (e.g., individuals opt out of the Program and subsequently lapse their private LTC insurance coverage).
5. Outreach and education could support individuals in holistically planning for, and financing, their future LTSS needs.

4.3.2.2. Coordination with Medi-Cal

California's Medi-Cal program provides health coverage for children and adults with limited income at no cost (or low cost) to the covered individual. Regarding LTSS coverage, the program offers a broad array of HCBS (such as care coordination, medical services, chore services, protective supervision, and respite care), and two-thirds of California's nursing facility residents rely on Medi-Cal to pay for their care.

In addition, IHSS, which also uses state Medicaid funds, provides personal care services to individuals who otherwise would not be able to remain in their homes.

Key considerations for how the Program could coordinate and interact with Medi-Cal and IHSS include:

1. **Medi-Cal savings**: Medi-Cal is authorized and funded through a federal-state partnership. Including the Medi-Cal eligible population in the Program will affect Medi-Cal expenditures. If the Program diverts costs from Medi-Cal, federal financial participation will be reduced unless a federal CMS waiver is obtained to retain federal savings within the Program. Washington State is seeking a CMS waiver for anticipated savings generated by the WA Cares Fund. The estimated Program savings to Medi-Cal will be assessed as part of the Actuarial Report to be released on or before January 1, 2024.

B. **Medi-Cal eligibility**: Medi-Cal eligibility is currently based on income, assets, physician approval, and medical necessity, though the Medi-Cal eligibility asset limit will be eliminated in 2024, which is expected to slightly increase enrollment. Excluding the Medi-Cal eligible population from the Program may not be feasible or equitable. It would also be an administrative challenge, given that Medi-Cal eligibility may change for individuals over time due to shifts in their family size or income.

C. **Coordination of benefits**: Coordination of benefits between the Program and Medi-Cal is possible with well-defined guidelines, as demonstrated by the existing coordination with Medicare and other health coverages. By federal law, Medi-Cal is typically the payer of last resort, so Program benefits need to be paid before or concurrent with Medi-Cal (so long as benefits are not duplicative).

D. **Coordination with IHSS and lessons learned from Cal MediConnect**: Cal MediConnect is a voluntary program that coordinates all Medicare and Medi-Cal benefits under a single health plan for the dual eligible population (i.e., individuals who qualify for both Medicare and Medi-Cal). When Cal MediConnect was being developed, it was also intended to encompass the IHSS program. However, that coordination could not happen due to several complexities (details of which are beyond the scope of this Feasibility Report), and IHSS remains excluded from Cal MediConnect. This highlights an important lesson that could be learned from Cal MediConnect—it may be particularly challenging to coordinate benefits between the Program and IHSS. Further analysis would be needed to understand how the Program could best coordinate with IHSS.

4.3.2.3. Coordination with Medicare

Medicare is a federal health care program for individuals age 65 and older, younger individuals with qualifying disabilities, and individuals with End Stage Renal Disease. Medicare helps cover a variety of services, such as hospital stays, doctor visits, medical supplies, and prescription drug coverage.

While Medicare covers select LTSS benefits, including home health services (such as part-time skilled nursing care, physical therapy, occupational therapy, medical social services, part-time home health aide, and durable medical equipment), more comprehensive LTSS benefits, such as those offered by private LTC insurance or Medi-Cal, are not covered. For example, Medicare generally only covers HCBS specific to an individual's medical care (e.g., part-time or intermittent skilled nursing care is covered, but personal care services are not covered when that is the only care needed). While Medicare covers custodial care in nursing facilities under certain conditions, such care is only covered for up to 100 days and only if the nursing facility stay is immediately following a hospital-related medical condition (i.e., Medicare does not cover long-term custodial care).

Given that the scope of Medicare's LTSS benefits is generally narrower (e.g., custodial care is only covered for a short duration and only under certain circumstances), it is anticipated to be more practical for Californians and more cost-effective for the Program if Medicare pays before the Program when duplicative coverage exists.

If the Program were to pay before Medicare, members eligible for both programs might forfeit some or all of the nursing facility benefits available under Medicare, as Medicare only covers custodial care in nursing facilities for up to 100 days following an in-patient stay. Further, home health care benefits provided by Medicare often begin immediately following an in-patient stay and are typically initiated via a referral from a doctor within the hospital. If the Program pays before Medicare, individuals will have to submit a claim and may be required to undergo benefit eligibility assessment(s) prior to being able to identify a provider through the Program. This may delay individuals needing home health services immediately following an unplanned in-patient stay from being reimbursed for care that would have been more easily coordinated under Medicare.

Having Medicare pay first would also negate the potential need to pursue a CMS federal demonstration waiver to retain federal Medicare savings attributable to the Program.

Further analysis and stakeholder interviews are needed to assess the feasibility of having the Program pay second to Medicare.

4.3.2.4. Coordination with other LTSS programs and services

Several LTSS programs and services are administered by the CDA, including:

1. **No Wrong Door**: This system aims to minimize confusion by streamlining access to LTSS through ADRCs, which provide person-centered information, care planning, and care coordination to all ages, incomes, and disabilities. This program is on a path to statewide expansion.
2. **HICAP**: This program provides free one-on-one counseling, education, and assistance to individuals and their families on Medicare, LTC insurance, other health insurance-related issues, and planning for LTC needs.

A summary of additional programs administered by the CDA is summarized in Appendix C.

Lastly, individuals who have served in the active military may be eligible for health benefits through the VA. The health benefits provided by the VA include a comprehensive range of HCBS (such as ADC, respite care, personal care and homemaker services, and home health aide). Assisted living and nursing home care is available through State Veterans Homes but is subject to limited availability and significant cost sharing. Nursing home care is also provided by VA-run and VA-contracted nursing homes for veterans who are enrolled in the VA health care program and have a clinical need, but admission is subject to availability. Nursing home admission is guaranteed only for veterans with a service-connected disability rating of 70% or higher or a disability rating of 60% or higher if the veteran is determined to be unemployable or permanently and totally disabled.

Due to the complex nature of the existing LTSS programs and services described above, the Task Force recommended establishing a separate group to assess how the Program could best coordinate with all available LTSS resources in the state (beyond Medi-Cal and Medicare).

4.4. Eligibility and enrollment

The Program's eligibility and enrollment provisions establish guidelines for participation in the Program and criteria that must be satisfied by Program participants to receive benefits. Task Force discussions focused on the following eligibility and enrollment provisions:

1. Benefit eligibility criteria
2. Benefit eligibility age
3. Vesting criteria
4. Portability and divesting criteria
5. Enrollment type
6. Opt-in and buy-in provisions

4.4.1. Eligibility and enrollment recommendations

The Program eligibility and enrollment provisions recommended by the Task Force are outlined in Exhibit 4.5, along with key considerations and rationale for these recommendations. While not unanimous, the recommendations in this exhibit represent the most prevalent views among the Task Force and have informed the five recommended Program designs.

Exhibit 4.5: Program eligibility and enrollment – design recommendations

Design element	Recommendation[9]	Considerations and rationale
Benefit eligibility criteria	• Health Insurance Portability and Accountability Act of 1996 ("**HIPAA"**) benefit eligibility trigger (i.e., 2 of 6 ADLs for at least 90 days or severe cognitive impairment)	• Establishing a benefit eligibility trigger consistent with private LTC insurance products facilitates coordination with existing and future supplemental private LTC insurance • The primary drawback of this recommendation is that vested individuals may satisfy Medi-Cal eligibility criteria prior to meeting the Program criteria and would thus have to rely on Medi-Cal at the onset of their LTSS need. • The Task Force assessed a triaged benefit eligibility criteria[10] design with varying tiers of benefits but deemed it too complex. The Task Force was also concerned that individuals might face challenges moving between benefit tiers due to delays in benefit eligibility assessments.

[9] Recommendation represents the most prevalent views expressed by the Task Force based on Task Force member questionnaire results and Task Force meeting discussions.

[10] The triaged benefit eligibility criteria would have included three tiers, with more comprehensive benefits available if an individual's condition worsens. In particular, "Tier 1" would have provided preventative benefits after satisfying the Program vesting requirement, "Tier 2" would have provided ancillary LTSS benefits after satisfying instrumental activities of daily living based benefit eligibility triggers (e.g., cooking, cleaning, transportation, etc.), and "Tier 3" would have provided full LTSS benefits after satisfying the HIPAA (ADL-based) benefit eligibility trigger.

Design element	Recommendation[9]	Considerations and rationale
Benefit eligibility age	• Offer benefits to individuals aged 18 and older (subject to the satisfaction of vesting requirements)[11] • Individuals who become disabled prior to the benefit eligibility age would be eligible to receive benefits (subject to the satisfaction of vesting requirements)	• A benefit eligibility age of 18 aligns with the minimum Program contribution age of 18 (refer to Section 4.6 for further detail on the Program's contribution requirements) • Having a lower minimum benefit eligibility age than 18 (e.g., no minimum age) would not increase access to benefits for individuals below age 18, given the Program vesting requirement and minimum Program contribution age (age 18)
Vesting criteria	• Individuals become fully vested after contributing for a specific number of years (5 or 10 years, depending on the Program design) • Offer pro-rated (partial) benefits to those unable to satisfy the full vesting requirement • 5-year vesting period design: – No benefits for individuals who contribute for less than 3 years – 50% of benefits for individuals who contribute between 3 and 5 years – 100% of benefits for individuals who contribute for 5 or more years	• The Task Force acknowledged that including a vesting requirement in the Program design is critical to ensuring that the Program remains financially viable

[11] Design 2 has a minimum benefit eligibility age of 65, which is inconsistent with the Task Force's benefit eligibility age recommendation. However, the Task Force separately recommended that Design 2 be included as a lower-cost targeted design for consideration.

Design element	Recommendation[9]	Considerations and rationale
	• 10-year vesting period design: – No benefits for individuals who contribute for less than 5 years – 50% of benefits for individuals who contribute for 5 years, grading up by 10% each year to 100% of benefits in year 10	
Portability and divesting criteria	• Allow benefits to be used outside the state of California • Allow international portability • Consider design options with both full and partial portability • For partial portability designs, grade linearly to 50% of benefits over 5 years	• The Task Force acknowledged that a portability provision is a vital step toward a culturally competent Program (e.g., individuals of certain cultures may prefer to receive care in their home country or from a family member residing outside of California) • Task Force members felt that requiring individuals who contributed to the Program to remain in California to receive benefits is inequitable
Enrollment type	• Mandatory program with select exemptions and opt-out provisions (refer to Section 4.3 for further details on private LTC insurance opt-outs)	• The Task Force acknowledged that broader Program participation would increase Program sustainability. Further, a voluntary (or partially voluntary) program is not financially sustainable
Opt-in and buy-in provisions	• No opt-in or buy-in provision with few exceptions: – As states do not have the authority to require sovereign tribal communities to participate in social insurance programs, sovereign tribal communities should be	• Minimizing voluntary elements will increase Program sustainability

Design element	Recommendation[9]	Considerations and rationale
	offered the choice of opting into the Program voluntarily[12] – Individuals with private LTC insurance who have opted out of the Program should be permitted to opt back into the Program under select circumstances, which have yet to be defined	

Additional recommendations and next steps outlined by the Task Force with regard to the Program's eligibility and enrollment provisions include:

1. A separate working group should be established to assess LTSS needs for individuals with developmental and acquired disabilities in early adulthood. The type of care and duration of need is expected to differ significantly for these individuals relative to individuals who require LTSS as a result of aging.
2. Further exploration is required regarding potential Program variances for sovereign tribal communities that opt into the Program (e.g., allowing Program contributions for tribal communities to be covered by alternative revenue sources that are only available to tribes).
3. The Task Force expressed particular interest in exploring several alternative scenarios (i.e., financial sensitivities) for the following aspects of Program eligibility and enrollment to inform potential changes to the recommended Program designs:
    a. **Benefit eligibility age**. Assess the financial impact of a range of Program benefit eligibility ages (e.g., no minimum age, 18+, 30+, 40+, 50+, 65+)
    b. **Vesting criteria**. Assess the financial impact of increasing the Design 5 vesting criteria from 5 years to 10 years.
    c. **Portability and divesting criteria**. Assess the financial impact of including full or partial international portability for all Program designs

4.4.2. Eligibility and enrollment considerations

Design considerations for the Program's eligibility and enrollment provisions were primarily discussed with the Task Force at Task Force Meeting #5 in December 2021.

[12] States do not have the authority to require participation from members of a federally recognized tribe who reside in the tribal territory if Program contributions are derived from activities that take place in the tribal territory.

Relevant educational materials on this topic included:

- Eligibility and enrollment
- International portability considerations
- Benefit eligibility age considerations

Key concepts and takeaways from this discussion are summarized below.

There are six primary program eligibility and enrollment provisions, as follows:

1. **Benefit eligibility criteria:** Defines the minimum disablement or financial criteria an individual must meet to qualify for benefits under the Program. The disablement criteria are generally based on an individual's need for assistance in performing ADLs or requiring support for cognitive impairment. Financial criteria are generally based on an individual's income (such as the case for Medi-Cal) or asset levels.
2. **Benefit eligibility age:** Defines the minimum age at which individuals could become eligible to receive benefits from the Program (subject to the satisfaction of the vesting criteria).
3. **Vesting criteria:** Defines the minimum requirements that an individual must satisfy before becoming eligible to receive benefits from the Program (subject to the satisfaction of the benefit eligibility age). The vesting criteria could be defined based on a specified number of years of Program contributions or a cumulative amount of Program contributions.
4. **Portability and divesting criteria:** Defines whether or not an individual could access Program benefits outside the state of California and the amount of benefits available.
5. **Enrollment type:** Defines whether or not the Program is mandatory for the entire population, a subset of the population, or not mandatory at all (i.e., a voluntary program).
6. **Opt-in and buy-in provisions:** Defines whether certain groups of individuals who are excluded from the Program or unable to meet the Program's vesting requirements could enter the Program by either opting in or buying in (i.e., paying a specified amount to bypass the vesting requirements).

To facilitate the assessment of each of these eligibility and enrollment provisions, we defined an illustrative 'baseline assumption'. Baseline assumptions included in this report should not be viewed as recommendations by the Task Force or Oliver Wyman and may not align with the recommended Program designs.

The pros and cons of the baseline assumption for each eligibility and enrollment provision were assessed, as summarized in Exhibit 4.6.

Exhibit 4.6: Program eligibility and enrollment – design considerations

Design element	Baseline Assumption[13]	Pros	Cons
Benefit eligibility criteria	HIPAA benefit eligibility trigger (2 of 6 ADLs for at least 90 days or severe cognitive impairment)	• Consistent with private LTC insurance benefit triggers (HIPAA), which may: – Facilitate coordination and interaction with existing private LTC insurance – Promote the development of supplemental (or wrap-around) private LTC insurance coverages that coordinate with public benefits	• More restrictive than Medi-Cal benefit triggers – Individuals may qualify for Medi-Cal benefits without being eligible for the Program
Benefit eligibility age	Benefits are available for those aged 18 and older (irrespective of when an individual became disabled)	• Benefits available to a broad facet of the California population	• Does not cover intellectually and developmentally disabled ("**IDD**") individuals until age 18 – IDD individuals are those born with a disability or who develop a disability before age 18 – These individuals typically receive benefits from other state-funded programs (e.g., Medi-Cal)

[13] Baseline assumptions are illustrative and intended to facilitate pros and cons considerations and cost benchmarking; baseline assumptions do not represent a recommendation by the Task Force or Oliver Wyman

Design element	Baseline Assumption[13]	Pros	Cons
			• Encompassing a wider range of ages increases the number of individuals that will require benefits, which will increase anticipated costs
Vesting criteria	Uniform vesting requirement defined as a specified number of contribution years	• Allows for pre-funding of the Program prior to benefits being paid • Lower cost relative to limited or no vesting requirements	• Certain individuals that pay into the Program may not be able to fully vest and thus may not receive benefits – Potential examples include individuals that become permanently disabled, retire, or move out of California before fully vesting – Alternative vesting criteria may need to be defined if these individuals are required to contribute to the Program
Portability and divesting criteria	Full portability (individuals that leave California retain vesting indefinitely)	• Increases flexibility and may limit need for exemptions • Limits potential inequity for individuals that pay into the Program but move out of California before needing to use Program benefits • Costs may be lower for care received outside of California or outside of the U.S.	• Will increase anticipated costs as it increases the number of individuals that could receive benefits • May limit cost control mechanisms as California may have less influence on provider rates in other states • Reduces incentive for individuals to stay in California and invest

Design element	Baseline Assumption[13]	Pros	Cons
		• May avoid potential litigation (the lack of portability may be viewed as a violation of certain clauses of the U.S. Constitution)	Program dollars into California's economy • More complicated administration – Need to track individuals that move out of California and establish provider networks outside of California
Enrollment type	Mandatory with no opt-out provisions	• May mitigate risk of anti-selection and improve sustainability of the Program (e.g., because healthier individuals or those who may potentially have higher contribution requirements do not have the option to opt-out) • Mitigates rate setting challenges that may be associated with opt-out provisions (such as difficulty estimating the number of individuals that elect to opt out of the Program)	• Individuals with existing private LTC insurance may be required to pay for a public benefit that they do not need • Depending on other Program provisions, individuals may be required to contribute to the Program but will not have an opportunity to receive (full) benefits • Reduces consumer flexibility and choice • Inconsistent with SDI (employers can opt out of SDI if they provide a private plan for short-term disability insurance and family leave, known as a Voluntary Plan)
Opt-in and buy-in provisions	No opt-in or buy-in provisions (require participation by self-employed, retirees, etc.)	• May mitigate risk of anti-selection • Avoids a voluntary aspect to participation that would increase uncertainty related to participation rates	• May increase risk of litigation (e.g., if participation is required by individuals not able to receive benefits) • May allow older generations to

Design element	Baseline Assumption[13]	Pros	Cons
		• May simplify administrative functions related to tracking opt-in elections • Program would cover a larger portion of Californians (and alleviate potential future out-of-pocket LTSS costs)	contribute less than future generations • May increase administrative complexity of collecting contributions as different contribution collection mechanisms would likely be required for those not on payroll • Reduces consumer flexibility and choice • Retirees may have financial limitations due to fixed income that could be impacted by required Program participation

4.5. Benefits and services

Central to developing the Program is determining the benefits and services to be covered. Task Force discussions focused on the following LTSS benefit and service components:

1. Benefit type
2. Benefit maximum amounts
3. Benefit inflation
4. Elimination period
5. Family and spousal benefits
6. Approved care settings
7. Covered services
8. Preventative benefits and measures

4.5.1. Benefits and services recommendations

The Program benefits and services recommended by the Task Force are outlined in Exhibit 4.7, along with key considerations and rationale for these recommendations. While not unanimous, the recommendations in this exhibit represent the most prevalent views among the Task Force and have informed the five recommended Program designs.

Exhibit 4.7: Program benefits and services – design recommendations

Design element	Recommendation[14]	Considerations and rationale
Benefit type	• Reimbursement benefit type • Consider designs with and without reduced cash benefit options	• Task Force members noted that a reimbursement design facilitates tracking of benefits to ensure individuals use benefits for covered services • Cash benefits are considered to be more subject to fraud
Benefit maximum amounts	• Monthly maximum benefit amount between $3,000 and $6,000 • Two-year benefit period • The combination of the above benefits results in a maximum lifetime benefit amount between $72,000 and $144,000	• A monthly maximum offers beneficiaries more flexibility than a daily maximum • Task Force members generally preferred a higher monthly maximum given the high cost of LTSS in California but acknowledged that it might not be feasible for the Program to cover the full monthly cost for certain services • Task Force members generally preferred a 2-year benefit period and noted that this benefit period length aligns with the average duration of an individual's LTSS need • Task Force members acknowledged that it might be cost-prohibitive for the Program to provide a higher

[14] Recommendation represents the most prevalent views expressed by the Task Force based on Task Force member questionnaire results and Task Force meeting discussions.

Design element	Recommendation[14]	Considerations and rationale
		benefit amount based on a 2-year benefit period
Benefit inflation	• Benefit inflation indexed to CPI (exact index or indices to be determined) or cost of care trends • Review inflation annually, if not automatically applied	• Inflation indexed to CPI will likely be less expensive than indexing inflation to cost of care trends • Task Force members generally viewed the CPI as a reasonable proxy for LTSS costs • Task Force members felt it was essential to include inflation to ensure benefits keep up with costs over time
Elimination period	• No EP	• Task Force members noted that an EP might serve as a barrier to individuals being able to access LTSS benefits
Family and spousal benefits	• Consider a design that allows an eligible individual to extend program benefits to their spouse or domestic partner via a shared benefit pool if their spouse or domestic partner is not otherwise eligible for program benefits	• A shared pool design could allow the Program to benefit individuals who stay home (e.g., to care for children or other family members) and are not able to contribute via the Program's financing mechanism • A shared benefit may be more costly due to an increased likelihood of use; that is, if two individuals have access to a shared benefit pool, it is more likely that at least one of the individuals will use the benefits

Design element	Recommendation[14]	Considerations and rationale
Approved care settings	• Comprehensive coverage (i.e., including both home and community-based care as well as institutional care)	• A broad range of approved care settings increases individual choice and offers flexibility • Task Force members emphasized the importance of helping individuals remain safely in their homes and promoting lower levels of care where possible, but noted that home care might not be the best option for all individuals and institutional care should also be available to those who need it
Covered services	• Cover a broad range of services, including care provided by a family caregiver, respite care, and services provided by PACE	• A broad range of covered services increases individual choice and offers flexibility • The Task Force felt that PACE's holistic approach to care delivery aligned well with the objectives of AB 567 • Including benefits to cover services provided by family caregivers was viewed as a crucial element in addressing broader LTSS workforce shortages
Preventative benefits and measures	• Preventative benefits should be available after an individual has satisfied program vesting requirements but before an individual satisfies program benefit eligibility criteria	• Offering certain preventative benefits could improve beneficiaries' quality of life and may delay their need for additional services • At least one Task Force member noted that culture and language should be reflected in the Program's preventative benefits

Additional recommendations and next steps outlined by the Task Force with regard to the Program's benefits and services include:

1. The specific preventative services to be covered under the Program still need to be determined; there was not an attempt to compile a comprehensive list of potential measures and services that could be covered for this Feasibility Report.
2. The Task Force recommended that the Program require informal or family caregivers to satisfy minimum caregiver training requirements to be eligible for service reimbursement under the Program. These training requirements should be defined in a manner that is culturally competent and does not discourage benefit utilization. Caregiver training recommendations are covered in more detail in Section 4.8 below.
3. The Task Force expressed particular interest in exploring several alternative scenarios (i.e., financial sensitivities) for the following aspect of Program benefits and services to inform potential changes to the recommended Program designs:
    a. **Benefit maximum**. Assess the financial impact of reducing the Design 1 benefit maximum from $1,500 to $1,000 per month.

4.5.2. Benefits and services considerations

Design considerations for the Program's benefits and services were discussed with the Task Force at Task Force Meeting #6 in January 2022.

Relevant educational materials on this topic included:

- Benefits and services
- Social determinants of health primer

Key concepts and takeaways from this discussion are summarized below.

4.5.2.1. Benefits

There are five primary components to program benefits, as follows:

1. **Benefit type**: Defines how benefits are provided to eligible individuals. Common benefit types include reimbursement, indemnity, cash, or a combination of benefit types[15].
2. **Benefit maximum amounts**: Defines the maximum daily, monthly, and lifetime benefit amount available to eligible individuals.

[15] As an illustrative example, assume there is a specified maximum daily benefit and that the individual in question meets the benefit eligibility criteria. Under a reimbursement design, benefits equal to actual charges incurred up to the daily maximum amount are paid each day that qualified services are received. Under an indemnity design, benefits equal to the daily maximum amount are paid each day that qualified services are received (regardless of actual charges incurred). Under a cash design, benefits equal to the daily maximum amount are paid each day that the individual is benefit eligible (regardless of whether qualified services are received).

3. **Benefit inflation**: Defines the amount and frequency of increases to program benefits. Benefit inflation may be level or tied to a specified index and may be applied annually or at a less frequent interval.
4. **Elimination period**: Defines how long an individual must wait (after satisfying benefit eligibility criteria) before program benefits are payable. An EP may be defined in terms of a length of time (e.g., 90 days) or a dollar amount (e.g., $5,000).
5. **Family and spousal benefits**: Defines whether program benefits could be used by an eligible individual's spouse, domestic partner, or other family members (as opposed to benefits only being available to the eligible individual).

To facilitate the assessment of each of these program benefit components, we defined an illustrative 'baseline assumption'. Baseline assumptions included in this report should not be viewed as recommendations by the Task Force or Oliver Wyman and may not align with the recommended Program designs.

The pros and cons of the baseline assumption for each program benefit component were assessed, as summarized in Exhibit 4.8.

Exhibit 4.8: Program benefits – design considerations

Design element	Baseline Assumption[16]	Pros	Cons
Benefit type	Reimbursement with reduced cash benefit	• Multiple benefit options increase flexibility and choice • Cash option could be used to pay for informal or family care, which may reduce supply strain on formal caregiver workforce • Cash option promotes equity for low-income individuals and individuals in areas of California where formal services may not be as readily accessible	• Reimbursement benefits may only be used on specific covered services • Cash option may increase risk of fraud, abuse, and exploitation; promote stereotypical gender roles; lead to substandard care; and/or create substandard working conditions • Cash option may induce higher benefit utilization (relative to a reimbursement-only option)

[16] Baseline assumptions are illustrative and intended to facilitate pros and cons considerations and cost benchmarking; baseline assumptions do not represent a recommendation by the Task Force or Oliver Wyman

Design element	Baseline Assumption[16]	Pros	Cons
		• Offering a cash benefit option may enable management of out-of-state care options • Reimbursement benefits may be less costly if individuals do not utilize full benefit amount each day/month	• Additional administrative complexities: – Additional processes/resources required for fraud detection (relative to a reimbursement-only option) – If benefits are portable, additional processes may be required to handle out-of-state reimbursement claims (relative to a cash-only option) – Verification of providers, services, and expense receipts (relative to a cash-only option)
Benefit maximum amounts	Monthly benefit amount of $4,600 (about $150/day) Lifetime maximum amount of $110,400 (based on a 2-year benefit period)	• Monthly benefit amount aligns with average monthly cost of home care in California[17] • Monthly benefit amount consistent with average benefit sold on private stand-alone LTC insurance policies (2020), which may be perceived as high value by the public (vs. offering a lower benefit than typical private LTC insurance)	• More costly relative to a lower monthly and/or lifetime maximum (such as the WA Cares Fund) • Individuals may face material out-of-pocket costs if institutional care benefits are provided under the Program, as the average semi-private nursing home cost is about $9,000 per month in California • Individuals with lower income/assets or higher

[17] Genworth 2020 Cost of Care Survey

Design element	Baseline Assumption[16]	Pros	Cons
		• Offering a monthly benefit provides individuals more flexibility relative to a daily benefit • Initial maximum lifetime benefit amount will cover formal LTSS costs for over 70% of the population[18] • 2-year benefit period aligns with preliminary Task Force recommendation for a front-end benefit design • Complementary to active federal LTSS proposals (e.g., WISH Act, Medicare LTSS Act)	care needs may be less able to afford necessary services (relative to a program with non-uniform maximums)
Benefit inflation	Annual inflation indexed to care cost trends, capped at 4%	• Inflation level aligns with cost of care trends, which ensures benefits remain adequate for future generations of beneficiaries	• Likely more costly than if inflation were linked to CPI (specific index or indices to be determined) because LTSS cost trends have outpaced the CPI over the last 16 years[19] • May increase administrative complexity as annual cost of care analysis would be required
Elimination period	Zero-day EP	• Simpler (and potentially less costly as a result) to	• More costly than a non-zero-day EP

[18] Formal Costs of Long-Term Care Services, PwC, 2021 (https://acl.gov/ltc/basic-needs/how-much-care-will-you-need); captures the estimate cited in the 2018 version of the PwC study that at least 50% of persons reaching age 65 will receive formal long-term care

[19] Genworth 2020 Cost of Care Survey and US Bureau of Labor Statistics for relevant CPI indices

Design element	Baseline Assumption[16]	Pros	Cons
		administer than a non-zero or varied EP • Culturally competent by being mindful of potential burden of initial self-funding on lower-income Californians – Helps mitigate risk that individuals will not be able to fund early LTSS costs • Aligns with preliminary Task Force recommendation for a front-end benefit design • Having no (or a short) EP is consistent with typical benefit design for private short-term care insurance	• May result in a larger number of claims and potentially higher administration costs as a result • May create complexities for coordination with private LTC insurance as a first payer (private LTC insurance typically has a non-zero EP) • Could be subject to abuse, especially if a cash benefit option is provided and/or there are no age restrictions in program eligibility
Family and spousal benefits	No family and spousal benefits (i.e., individual coverage only)	• Most cost effective • May simplify administration	• Dependent family members may not be able to meet vesting requirements, if applicable, on their own and thus would not be eligible for coverage by the Program

4.5.2.2. Services

There are three primary components to program services, as follows:

1. **Approved care settings**: Defines the care settings where the Program's covered LTSS services could be received. Care settings are typically categorized as home and community-based care or institutional care. Home and community-based care encompass LTSS received in an eligible individual's home or community (e.g., at an ADC). In contrast, institutional care encompasses LTSS received in an institution such as a skilled nursing facility ("**SNF**") or residential care facility.

2. **Covered services**: Defines the services that qualify for payment under the Program, including but not limited to care provided by family caregivers and enrollment in PACE.
3. **Preventative benefits and measures**: Defines any benefits or measures covered under the Program that intend to minimize the likelihood of an individual needing support from the Program's covered services. For example, preventative benefits and measures could include fall prevention, home inspections and modifications, and pre-claim wellness programs.

To facilitate the assessment of each of these program service components, we defined an illustrative 'baseline assumption'. Baseline assumptions included in this report should not be viewed as recommendations by the Task Force or Oliver Wyman and may not align with the recommended Program designs.

The pros and cons of the baseline assumption for each program service component were assessed, as summarized in Exhibit 4.9.

Exhibit 4.9: Program services – design considerations

Design element	Baseline Assumption[20]	Pros	Cons
Approved care settings	HCBS only	• Aligns with individuals' preference to stay at home and promotes independence • Less costly as HCBS is typically less expensive than institutional care – Multiple state initiatives to reduce Medicaid costs have demonstrated that shifting care from institutional settings to HCBS is a significant driver of savings • Facilitates use of informal caregiving and may reduce supply strain on formal caregivers	• Certain program-eligible individuals may not have a home – Consideration will need to be given to the definition of "home" and how care will be provided to these individuals

[20] Baseline assumptions are illustrative and intended to facilitate pros and cons considerations and cost benchmarking; baseline assumptions do not represent a recommendation by the Task Force or Oliver Wyman

Design element	Baseline Assumption[20]	Pros	Cons
		• May promote private LTC insurance industry to offer supplemental products focused on institutional care (i.e., clear delineation of coverage between the Program and supplemental private insurance) • May alleviate demand for Medi-Cal IHSS program • Aligns with Task Force preliminary recommendation for a front-end benefit design (as HCBS is typically used before facility care) • Aligns with AB 567 goal of "[h]elping individuals with functional or cognitive limitations remain in their communities" • HCBS may be more accessible to individuals across California, which promotes equity	• Individuals that need institutional care would need to rely on self-funding, private insurance, or other programs • May be duplicative with upcoming expansion of HCBS coverage under Medi-Cal (for Medi-Cal eligible individuals) • Does not mitigate risk that individuals will impoverish themselves due to higher costs associated with institutional care • May promote stereotypical gender roles • Reduced flexibility and individual choice due to a narrower range of care settings being covered
Covered services	No restrictions on covered services so long as they could be provided in a home or community-based setting Provide benefits for informal care received in the home, respite care,	• Increases flexibility and choice • Culturally competent and more equitable – Recognizes that different facets of the California population may have different care preferences	• May increase complexity of Program administration – Need to establish broader provider networks – Approval of informal caregivers

Design element	Baseline Assumption[20]	Pros	Cons
	caregiver training, home modifications, etc.	– Offering a more comprehensive range of approved services increases the likelihood that there will be something for everyone • Offers significant perceived value for a minimal additional cost under the Program	– Adjudication of claims for informal care • May exacerbate potential LTSS workforce supply issues
Preventative benefits and measures	Provide a maximum lifetime benefit of $1,000 (separate from other benefit maximums) for preventative measures and services that could be used any time following satisfaction of program vesting requirements, if applicable	• Providing ancillary preventative benefits earlier may reduce anticipated costs under the Program – May lessen claim severity and delay deterioration in an individual's ability to perform ADLs – May facilitate an individual living at home independently for a longer time before needing formal LTSS	• May result in a limited increase in costs (and potential for fraud) – Potentially offset by delay or reduction in claims • May create (or exacerbate) workforce supply issues for LTSS related services (e.g., the workforce qualified to perform home assessments)

4.6. Administration

To understand the potential scope of the Program's administration, we assessed existing infrastructure for similar established programs in California and elsewhere (e.g., WA Cares Fund) to identify key administrative functions that will be needed. These key administrative functions were grouped into five broad categories, as follows:

1. Oversight, management, and actuarial analysis
2. Processing and tracking
3. Benefits and claims

4. Support and customer service
5. Coordination and accessibility

4.6.1. Administration recommendations

The Task Force recommended the Program be kept as simple as possible to reduce administrative complexity and cost. Key considerations for this recommendation include:

1. A simpler Program is expected to have lower administrative costs, which means a larger proportion of the Program revenue could be paid as benefits
2. A simpler Program may also be easier for the public to understand, leading to increased public awareness and support
3. Implementation may be expedited for a Program with less administrative complexity relative to a more complex Program, which may require a longer timeline for implementation

The Task Force acknowledged that a key trade-off associated with simplicity is a higher potential for perceived Program gaps or inequities. For example, a program that only includes individuals who are on payroll or self-employed may be easier to administer but creates a "gap" for those who do not meet this definition. Further, having uniform benefits is easier to administer but may be less equitable than benefits that vary by attributes such as income level or amount of Program contributions made.

The Task Force's recommendations regarding Program administration were intentionally non-prescriptive, given that administrative needs are highly dependent on the ultimate Program design. Additional recommendations and next steps outlined by the Task Force with regard to the Program's administration include:

1. Prior to Program enactment, confirm the administrative functions needed, identify staff and resource needs, determine whether existing infrastructure in California could be expanded to support the Program, and decide if a new board, department, or agency is required to administer the Program. Expanding current infrastructure or creating a new board, department, or agency would require legislation and funding.
2. Determine whether or not there are opportunities to leverage the administrative framework in the private LTC insurance industry to execute certain administrative functions required for the Program.

4.6.2. Administration considerations

Design considerations for the Program's administration were discussed with the Task Force at Task Force Meeting #5 in December 2021.

Relevant educational materials on this topic included:

- Program administration

- California's State Disability Insurance Program

Key concepts and takeaways from this discussion are summarized below.

4.6.2.1. Key administrative functions

The five primary categories of program administration identified are as follows:

1. **Oversight, management, and actuarial analysis**. Administrative functions in this category are primarily related to the high-level implementation and operation of the Program. They involve Program oversight, managing care providers, managing investments and allocation of Program funds, and actuarial analyses of the Program to ensure long-term solvency and sustainability.
2. **Processing and tracking**. Administrative functions in this category are primarily related to Program enrollment and premium collection. They involve processing Program revenue, approving exemption and opt-in requests, determining vesting status, and tracking individuals who move in or out of the state.
3. **Benefits and claims**. Administrative functions in this category are primarily related to Program benefit payment. They involve determining benefit eligibility; processing, adjudicating, and paying claims; tracking benefit usage relative to Program maximums; and ensuring approved services are provided.
4. **Support and customer service**. Administrative functions in this category are primarily related to supporting Program participants. They involve providing customer service; addressing questions and complaints from the public; detecting fraud, waste, and abuse; managing appeals; and providing general administrative support to the Program.
5. **Coordination and accessibility**. Administrative functions in this category are primarily related to coordination with other existing LTC programs (including private LTC insurance), accessibility of Program benefits and services, and Program outreach and communication.

Exhibit 4.10 expands on each of these key administrative functions. Based on discussions with the CDI and the California Health and Human Services Agency, several agencies or third parties in California that could potentially perform each administrative function were identified. These agencies (or third parties) perform parallel functions for other programs in California. At a minimum, the Program may be able to leverage learnings or infrastructure from these agencies to establish an effective and efficient administration system.

In addition to the agencies listed in Exhibit 4.10, other potential reference points for certain Program administrative functions (e.g., managing care providers, overseeing accessibility, awareness and communication strategy) may include ADRCs, Community-Based Adult Services ("**CBAS**"), HICAP, and the Multipurpose Senior Services Program ("**MSSP**").

Exhibit 4.10: Program administration – potential agencies to perform key administrative functions

Category	Administrative function	Description	Agencies (or third parties) that could potentially perform this function for the Program or provide technical direction
Oversight, management, and actuarial analysis	Program oversight	• Oversee program implementation, administration, and operation • Provide recommendations and decisions to maintain benefit adequacy, fund solvency, and sustainability	• DHCS • California Health Benefit Exchange (Covered California) • New board or agency to oversee the Program administered by several state agencies
	Manage care providers	• Manage providers, including approving and credentialing prospective providers (formal and informal) • Enforce different requirements, if any, for formal and informal providers	• DHCS • Covered California • ADRCs
	Manage investment and allocation of program funds	• Establish an investment policy for funds collected under the Program, if applicable • Provide guidance and advice on investment strategies and allowed assets • Active management (invest, reinvest, manage, contract, sell, or exchange investment money) by in-house or external money managers • Authorize disbursements	• State Controller's Office • State Treasurer's Office • New board or agency

Category	Administrative function	Description	Agencies (or third parties) that could potentially perform this function for the Program or provide technical direction
	Perform actuarial analysis	• Provide ongoing actuarial analysis and valuations to assess funded status of the Program • Make recommendations to maintain solvency (e.g., adjust contributions, redesign benefits)	• CDI • Department of Managed Health Care • Establish a state actuary
Processing and tracking	Process revenue	• Process revenue (e.g., payroll tax, income tax, etc.) • Collect premiums, if applicable	• Employment Development Department • Franchise Tax Board • State Controller's Office • California Department of Public Health
	Process exemptions and opt-in requests	• Process and approve program exemptions (e.g., opt-out requests), if applicable • Process and approve program opt-in requests, if applicable	• DHCS • Covered California
	Determine vesting status	• Determine vesting status, if applicable	• DHCS • Covered California
	Track individuals who move in or out of the state	• Keep track of address changes for individuals who move into or out of the state • Keep track of divesting status, if applicable	

Category	Administrative function	Description	Agencies (or third parties) that could potentially perform this function for the Program or provide technical direction
Benefits and claims	Determine benefit eligibility	• Process and approve benefit applications • Perform care need assessments • Determine benefit eligibility (e.g., confirm individual meets criteria to receive benefits)	• DHCS • Covered California
	Process, adjudicate, and pay claims	• Approve services eligible for payments • Process payments to providers • Reimburse expenses paid by (or on behalf of) benefit-eligible individuals	• DHCS • Covered California • California Department of Social Services ("**CDSS**")
	Track benefit usage	• Track individual's benefit usage relative to maximum benefits allowable, if applicable	• DHCS • Covered California
	Oversee benefit payments	• Establish and enforce criteria for benefit payments to approved providers • Ensure approved services are provided through audits or service verification processes, recoup any inappropriate payments	• DHCS • Covered California
Support and customer service	Customer service	• Provide customer service • Address questions and complaints from public (e.g., related to premiums, benefits, eligibility, services, etc.) • Refer individuals to other appropriate agencies	• DHCS • Covered California • LTC Ombudsman (CDA)

Category	Administrative function	Description	Agencies (or third parties) that could potentially perform this function for the Program or provide technical direction
	General administration	• Provide administrative and operational support to the Program • Track data useful in monitoring and informing the Program	• DHCS • Covered California
	Fraud, waste, and abuse detection	• Identify potential cases of fraud, waste, and abuse • Impose sanctions, as appropriate • Establish procedures for administrative appeal and criminal prosecution	• California State Auditor • State Controller's Office • CDI
	Appeals	• Manage beneficiary grievance and appeals process, related to eligibility and benefit decisions, as well as provider appeals process	• DHCS • CDSS
Coordination and accessibility	Coordinate with other programs	• Establish rules and procedures for benefit coordination when the eligible beneficiary is also eligible for Medi-Cal and other LTSS	• DHCS • Covered California
	Oversee program accessibility	• Oversee care navigation and ensure program benefits are accessible to all eligible individuals	• DHCS • Covered California • LTC Ombudsman (CDA)
	Program roll-out awareness and communication strategy	• Develop and execute a communication strategy for the Program that could reach all stakeholders, including the broader California population that may be eligible for the Program	• CDA • CDI • Covered California • AARP

Category	Administrative function	Description	Agencies (or third parties) that could potentially perform this function for the Program or provide technical direction
	Coordination with private LTC insurance	• Establish connection with private LTC insurance products (regulation and perhaps facilitation of new product development)	• CDI • DHCS – Partnership Program

4.7. Financing

Program financing encompasses a range of considerations related to how the Program could be funded to ensure adequate revenue is available to pay out benefits in the future. Task Force discussions focused on the following financing components:

1. Revenue source(s)
2. Contribution age
3. Contribution limits
4. Contribution rate structure
5. Funding approach
6. Investment strategy
7. Intergenerational equity

4.7.1. Financing recommendations

The Program financing provisions recommended by the Task Force are outlined in Exhibit 4.11, along with key considerations and rationale for these recommendations. While not unanimous, the recommendations in this exhibit represent the most prevalent views among the Task Force and have informed the five recommended Program designs.

Exhibit 4.11: Program financing – design recommendations

Design element	Recommendation[21]	Considerations and rationale
Revenue source(s)	• Finance via a progressive payroll tax split between employees and employers • Require non-voluntary premium contributions via an income tax for self-employed individuals • Consider designs that utilize multiple revenue sources	• Although the Task Force recommended a payroll tax with an employer-paid portion, there was recognition that it might be challenging to garner support for an employer-paid tax from the business community. Thus, the Task Force recommended assessing the financial impact of various employer-paid portions of the Program contribution rate (e.g., 0% employer paid or fully employee paid, 25% employer paid, 50% employer paid)
Contribution age	• Require contributions from non-juvenile individuals (i.e., contributions from individuals aged 18+)	• The Task Force acknowledged that the Program should include contributions beginning at younger adult ages (e.g., 18+) rather than deferring contributions to older adult ages to allow for the pre-funding of benefits
Contribution limits	• Vary contributions by level of wages or income, with higher contributions required from higher-income individuals and lower or zero contributions required from lower-income individuals (i.e., a progressive tax structure) • Waive contributions for individuals below a specified poverty level (e.g., 138% of the Federal Poverty Level) but allow	• While the Task Force initially recommended a progressive tax structure, there was ultimately a recognition that there should be some form of contribution cap to ensure that higher earners perceive value in the Program to incentivize their participation and garner support. The specific level of the contribution cap has yet to be defined, but the Task Force recommended that it exceed the Social Security cap. The Social

[21] Recommendation represents the most prevalent views expressed by the Task Force based on Task Force member questionnaire results and Task Force meeting discussions.

Design element	Recommendation[21]	Considerations and rationale
	these individuals to receive benefits • Establish a contribution cap (i.e., limit the amount of payroll subject to the Program's tax). Contribution caps above the Social Security cap should be considered (e.g., two times the Social Security contribution limit)	Security cap is currently $147,000 (2022) – While the contribution cap introduces a regressive element to the tax structure, it is relevant to note that the waiver of contributions for lower earners introduces a corresponding progressive element (though these may not be offsetting)
Contribution rate structure	• Level contribution rate (i.e., the contribution rate should not vary by age or any other characteristic)	• The Task Force recommended that explicit guidelines be established up front stipulating how the Program contribution rate could change in the future if needed
Funding approach	• The Task Force recommended a hybrid funding approach, including both pay-as-you-go ("**PAYGO**") and pre-funding elements	• The need for a PAYGO element during the Program's earlier years is mitigated because of the intergenerational equity recommendations noted later in this table (i.e., the grading up of benefits as the Program matures) • The Program could transition from pre-funding to PAYGO in the future if an inflection point is reached where Program revenue and investment income stabilize at a level that is equal to (or above) Program disbursements and expenses
Investment strategy	• Invest Program revenue in U.S. treasuries, bonds, stocks, and other equities	• An amendment to the California Constitution is required to invest in bonds, stocks, and other equities (specifically Article XVI, Section 17 of the California Constitution)

Design element	Recommendation[21]	Considerations and rationale
Inter-generational equity[22]	• Include provision(s) to reduce intergenerational inequity (e.g., grade up Program benefits during the Program's early years)	• As noted above, grading up benefits in the years following the establishment of the Program facilitates pre-funding and may lessen the need for a PAYGO element in the early years of the Program

Additional recommendations and next steps outlined by the Task Force with regard to the Program's financing include:

1. The Task Force expressed particular interest in exploring several alternative scenarios (i.e., financial sensitivities) for the following aspects of Program financing to inform potential changes to the recommended Program designs:
    a. **Revenue source(s)**. Assess the financial impact of a range of employer-paid portions of the Program contribution rate (e.g., 0% employer paid or fully employee paid, 25% employer paid, 50% employer paid).
    b. **Contribution limits**. Assess the financial impact of a range of contribution limits (e.g., various multiples of the Social Security contribution limit).
    c. **Investment strategy**. Assess the financial impact of an investment strategy that includes bonds, stocks, and other equities versus one that only includes U.S. Treasuries (i.e., if an amendment to Article XVI, Section 17 of the California Constitution is not obtained).
2. The income level below which contributions will be waived for lower-income individuals has yet to be determined.

4.7.2. Financing considerations

Design considerations for the Program's financing were primarily discussed with the Task Force at Task Force Meeting #8 in February 2022.

Relevant educational materials on this topic included:

- Affordability considerations
- Long-term care insurance financing options and considerations
- Other financing and sustainability considerations

[22] Upon Program inception, older individuals are likely to contribute less to the Program over their lifetime relative to younger individuals; this "intergenerational inequity" wanes as the Program matures.

- Program contribution limits and intergenerational (in)equity illustrative examples

Key concepts and takeaways from this discussion are summarized below.

There are seven primary Program financing elements, as follows:

1. **Revenue source(s):** Defines the source(s) from which revenue should be collected to fund the Program.
2. **Contribution age:** Defines the ages at which contributions should be collected to fund the Program.
3. **Contribution limits:** Defines limitations imposed on the Program's contribution structure, including the waiver of contributions for lower-income individuals and the capping of contributions for higher-income individuals.
4. **Contribution rate structure:** Defines whether the Program's contribution rates should be established with the expectation that they would remain level over time or be step-rated (i.e., with *planned* increments to the contribution rate over time).
5. **Funding approach:** Defines whether the Program should be pre-funded, financed on a PAYGO basis, or a hybrid of the two.
6. **Investment strategy:** Defines the financial instruments in which Program revenue should be invested when not needed to fund immediate Program disbursements.
7. **Intergenerational equity:** 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. Intergenerational equity considerations define whether explicit provisions should be introduced to mitigate this inequity in the years following the establishment of the Program.

4.7.2.1. Revenue sources

The pros and cons of eight potential revenue sources, along with several hybrid financing options, were assessed, as summarized in Exhibits 4.12 and 4.13.

Exhibit 4.12: Revenue sources – design considerations

Design option	Pros	Cons
Payroll tax • Generally set as a percentage of a worker's wage • Could be paid by an employee, employer, or both • Could be applied to wages above or below a certain threshold • Total wages and salaries in California have ranged from about $1 trillion to $1.5 trillion since 2015	• Social insurance benefits are generally financed with payroll taxes • This structure helps with buy-in and long-term support as the Program would generally be funded by the same population who would have access to benefits • Mechanism(s) established for SDI may be leverageable for employee payroll tax collection	• A payroll tax could be regressive as it would only apply to wage income – The regressive nature of a payroll tax could be mitigated by applying the tax to only wages above a certain level • Business groups would likely oppose a payroll tax on employers
Personal income tax • Current rates range from 1% to 13.3% • Could be across-the-board or a surtax on high incomes • 2019 taxable income of California tax filers was $1.4 trillion	• Could be highly progressive • Comparatively low volatility • Applies to types of income not covered by payroll taxes, including investment and business income	• May be challenging to implement as California's personal income tax rates are among the highest in the country. An increase may result in people leaving the state, particularly higher earners
Corporate income tax • Current rate for general corporations is 8.84% • Could be across-the-board or a surtax on corporate income above certain levels • 2019 taxable income of corporations was about $284 billion	• Generally progressive as wealthy shareholders pay a significant portion of corporate income tax	• May be challenging to implement as business communities would likely mobilize against tax rate increases • Relatively limited revenue potential
Sales or excise tax • Sales tax is a tax on the sale or use of tangible goods	• Comparatively large tax base for sales tax, especially if expanded to include some services	• Both taxes are regressive, falling disproportionately on households with lower incomes

Design option	Pros	Cons
• Excise tax is a tax on the sale of a specific good • Total California taxable sales in 2019 were about $733 billion		• Generally levied on products that have adverse societal consequences. Revenues are often used for mitigating those consequences or related purposes
Estate or inheritance tax • An estate tax applies to the value of a decedent's estate and generally only applies to high-value estates • An inheritance tax applies to a portion of the estate inherited by each heir • California currently has neither type of tax • Revenue potential from various proposals ranges from $300 million to $3 billion	• Progressive, especially if targeted to high-value estates • Could help narrow wealth inequality in the state	• Need voter approval since voters previously approved a prohibition on these types of taxes • Comparatively limited revenue potential
General revenue and premium taxes • General revenue refers to revenues accruing to the state from taxes, fees, interest earnings, and other sources for the general operation of the state government • Insurance premium tax revenue is allocated to the general fund	• Provides policymakers flexibility to respond to changing circumstances	• Competition with other funding priorities • Potential instability due to legislative changes or insufficiencies in the general revenue • If the Program offers a guaranteed benefit, it could crowd out funding for other essential services
Provider tax • In California, provider taxes are imposed on SNFs, inpatient hospitals, dentists,	• A process is already in place in California (and across most other states) to collect provider taxes	• Comparatively limited revenue potential

Design option	Pros	Cons
HCBS, and managed care organizations	– The provider tax rates would need to be increased (subject to federal limits), or new taxes may need to be imposed on providers not currently subject to a provider tax	
Premium contributions	• Could apply to a broad portion of the population • Could be combined with other revenue sources (e.g., a payroll tax for wage earners coupled with premium contributions for the self-employed)	• A premium could be regressive (unless it is structured to vary based on an individual's income) • A new process would need to be established to administer premium collection

Exhibit 4.13: Hybrid financing options – design considerations

Design option	Pros	Cons
Tax applied to all income, potentially up to a limit, with offsets for payroll tax collections	• Could allow eligibility for individuals unable to vest via payroll tax contributions (e.g., spouses of employees) • Tax revenue automatically increases with inflation in income • Tax base captures non-wage income such as pensions, investment returns, business income, capital gains, residuals, and royalties	• Contributions for high-income individuals may exceed program benefits (partially mitigated if a contribution cap is imposed) • Increases administration complexity, especially if a contribution cap is imposed • Individuals may leave California to go to a state with lower state income taxes, particularly if they could collect income while living outside California
Insurance premiums for persons aged 65+ with offsets for individuals still working and paying payroll taxes	• Could allow eligibility for individuals unable to vest via payroll tax contributions (e.g., near-retirees)	• Difficult to collect unless structured as withholding from pension (like an income tax)

Design option	Pros	Cons
Voluntary premiums for individuals not subject to payroll or income taxes	• Could allow eligibility for individuals who could not otherwise vest	• Participation may be limited due to overlap with Medi-Cal • High risk of anti-selection as those who choose to pay premiums are more likely to need LTC
No payroll tax (or a reduced payroll tax) before a certain age (e.g., age 40)	• May improve affordability as other expenses (e.g., childcare) may decrease over time while wages may increase with age and workforce experience • More aligned with timing of LTC need, which is not typically top-of-mind for younger individuals	• Contribution rate would need to be higher for those paying the full amount • Increases administrative complexity • Individuals who need LTC at a younger age than average may not be able to vest
Payroll tax that increases at a certain age (e.g., age 55)	• May improve affordability as other expenses (e.g., childcare) may decrease over time while wages may increase with age and workforce experience	• Increases administrative complexity
Stacking multiple taxes	• Multiple stacked taxes already exist (e.g., multiple sales taxes)	• May increase administrative complexity (e.g., if stacked taxes feed into a trust) • Stacking a new tax on top of an existing tax could harm beneficiaries of the existing structure as higher tax rates on an activity tend to reduce demand for that activity

4.7.2.2. Contribution age

The Program's contribution age requirement defines the ages at which contributions should be collected to fund the Program. The Task Force assessed which age groups should be required to contribute to the Program (e.g., juveniles, younger adults, pre-retirement age older adults, and retirement age adults). The primary considerations discussed with the Task Force included:

1. The broader the age base contributing to the Program, the lower the overall contribution rate.
2. For the Program to remain viable, there likely needs to be a level of pre-funding from individuals long before the need for benefits arises.
3. Requiring contributions in an individual's later years may include a degree of inequity based on the conjecture that lower-income individuals are more likely to retire from the workforce at older ages compared to higher-income individuals.
4. Limiting contributions to older ages (e.g., age 40+) could mitigate intergeneration inequity issues (intergeneration inequity considerations are discussed further below in this section).

4.7.2.3. Contribution limits

Contribution limits define limitations imposed on the Program's contribution structure, including the waiver of contributions for lower-income individuals and the capping of contributions for higher-income individuals.

The concept of waiving contributions for lower-income individuals was borne through a discussion with the Task Force around designing a Program that is affordable and accessible to as many Californians as possible.

4.7.2.3.1. Program affordability

The pros and cons of three affordability levers, including the waiver of contributions for lower-income individuals, were assessed, as summarized in Exhibit 4.14.

Exhibit 4.14: Affordability levers – design considerations

Affordability lever	Pros	Cons
Reduced/subsidized tax contributions based on income Examples: • Vary contributions by income (e.g., waive contributions for lower-income individuals) • Exempt first $x,000 of income from tax • Provide a tax rebate for lower-income individuals through the income tax system	• Reduced hardship for Californians that are struggling to pay for basic household expenses	• Increased administrative complexity compared to a uniform tax rate, with complexities varying based on the type of tax and which agency administers the tax • May garner reduced public support for the Program due to subsidization from those who do not benefit from the reduced contributions

Affordability lever	Pros	Cons
Limit out-of-pocket costs incurred when accessing services Examples: • Minimize EP • Increase monthly benefit amount	• Increased affordability when accessing benefits	• Increased Program cost relative to a design with a longer EP or lower benefit amount
Lower deductibles or copays based on income Examples: • Vary monthly benefit amounts or length of EP based on income or assets	• Improved affordability for those with low income • Improved equity in access to LTSS	• Increased Program cost • Increased administrative complexity relative to a flat benefit amount

4.7.2.3.2. Contribution caps

The concept of establishing a contribution cap for higher-income individuals was borne through a discussion around balancing the Program's value proposition to minimize instances where benefits offered by the Program pale in comparison to the Program's required contributions. Introducing a contribution cap for higher-income individuals increases the value they might perceive in the Program, which could incentivize their participation and enhance their support for the Program.

Introducing design elements that increase the Program's affordability (e.g., through contribution waivers for lower-income individuals) and design elements that promote the Program's value proposition (particularly for higher-income individuals) could help achieve a more equitable Program design that caters to the needs of many Californians.

4.7.2.4. Contribution rate structure

The contribution rate structure defines whether the Program's contribution rates should be established with the expectation that they would remain level over time or be step-rated (i.e., with *planned* increments over time).

It is important to note that the Program's contribution rates may need to be adjusted if the Program's expenditures emerge unfavorably relative to expectations, regardless of whether the Program utilizes a level or step-rated contribution structure. The distinguishing factor between these options is that a level contribution rate is designed without planned increments over time. In contrast, a step-rated contribution rate is designed with planned increments over time.

The pros and cons of the level and step-rated contribution rate strictures were assessed, as summarized in Exhibit 4.15.

Exhibit 4.15: Contribution rate structure – design considerations

Design option	Pros	Cons
Level (i.e., contribution rates are not intended to increase as the Program ages)	• Simpler design • Promotes pre-funding as a level contribution rate would be higher than an actuarially equivalent step-rated rate in the early years of the Program	• Program members may be more sensitized to contribution rate increases in the event of an unplanned contribution rate increase (e.g., if claims experience emerges unfavorably relative to expectations)
Step-rated (i.e., contribution rates are intended to increase or decrease at planned increments as the Program ages)	• Could facilitate easing into Program contributions upon launch • Program members would be more de-sensitized to contribution rate increases in the event of an unplanned contribution rate increase (e.g., if claims experience emerges unfavorably relative to expectations)	• More complex design • Planned contribution rate increases may be perceived negatively by individuals who are unaware of the intended design

4.7.2.5. Funding approach

The funding approach defines whether the Program should be pre-funded, financed on a PAYGO basis, or a hybrid of the two.

The pros and cons of three funding approaches were assessed, as summarized in Exhibit 4.16.

Exhibit 4.16: Funding approach – design considerations

Design option	Pros	Cons
Pre-funding (e.g., private LTC insurance)	• Potentially significant investment income • Allows for lower contribution rate • Allows for more time to adjust for changes in demographics and claims experience	• Requires vesting to establish funds necessary to pay out benefits • May receive less public support if certain cohorts (e.g., current seniors) are not eligible for benefits due to vesting requirements

PAYGO (e.g., Medi-Cal)	• Does not require vesting • Covering everyone immediately may make the Program more feasible as it is likely to receive more public support	• Limited investment income • Higher contribution rate required • Increased volatility as PAYGO is dependent on the number of contributors and beneficiaries at any given point in time • Sustainability is more challenging with an aging population • Increased intergenerational inequity without a vesting requirement
Hybrid pre-funding and pay-as-you-go (e.g., Germany's LTSS program, WA Cares Fund)	• PAYGO component could provide immediate coverage for those who currently need LTSS • Pre-funding component could provide more generous benefits for those requiring LTSS in the future	• May be more complex to administer

4.7.2.6. Investment strategy

The investment strategy defines the financial instruments for which Program revenue should be invested when not needed to fund immediate Program disbursements.

A Program that includes an extended period of pre-funding could achieve significant investment income, reducing the Program's required contribution rate. However, to maximize potential investment income, Program revenues would need to be invested in a broad range of financial instruments such as U.S. treasuries, bonds, stocks, and other equities. California's current Constitution (Article XVI, Section 17) states that "the State shall not in any manner loan its credit, nor shall it subscribe to, or be interested in the stock of any company, association, or corporation…". Thus, an amendment to the California Constitution would be required before the Program could access higher-yielding financial instruments such as bonds and stocks. A constitutional amendment would have to be approved by a majority of California voters. For the amendment to come before voters would require either an initiative measure involving signatures equal to 8% of the votes cast in the last election for Governor (currently 997, 139), or a legislative referral that requires a two-thirds vote in both chambers of the state Legislature.

4.7.2.7. Intergenerational equity

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. Intergenerational equity should be assessed to determine if explicit provisions should be introduced to mitigate this inequity in the years following the establishment of the Program.

The Task Force discussed three primary approaches for addressing the initial intergenerational inequity.

1. Grade-up Program benefits (i.e., launch the Program with a base level of coverage and increase benefits over time to a target level of coverage).
2. Increased Program contributions (i.e., require 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 recommended Program designs reflect the grade-up Program benefits methodology. This approach would not require additional contributions in earlier years, which may alleviate certain feasibility challenges, particularly if the long-term contribution rates are on the higher end of what is considered feasible. Further, the grade-up construct would likely be more straightforward for the public to understand and less administratively complex relative to temporarily adjusting individual benefit provisions such as reducing portability or increasing the EP.

4.8. LTSS workforce

Establishing a Program that could expand LTSS access to millions of Californians could significantly impact the demand for LTSS providers and caregivers. For the Program to be operationally viable, it is paramount that the supply of adequately trained providers and caregivers increase in lockstep with the establishment of the Program. Task Force discussions focused on understanding existing challenges facing the LTSS workforce and making recommendations that could help address some of these challenges. Perspectives were shared from formal providers (who are paid for their services) and family caregivers (who are often not paid for their services).

4.8.1. LTSS workforce recommendations and considerations

Considerations related to the Program's impact on the LTSS workforce were discussed at Task Force Meeting #10 in April 2022.

An in-depth analysis of LTSS workforce issues and specific actions that could be taken to remedy these issues are outside the scope of this report. That said, representatives from the CDA provided the Task Force with an overview of investments currently being made in California to address the LTSS workforce crisis.

Other relevant educational materials on this topic included:

- LTSS workforce considerations: supply, demand, and costs

- LTSS workforce considerations: the programs and solutions
- Home care and ADC considerations (verbal presentation)

Given the extent and complexity of issues faced by the LTSS workforce, we asked the Task Force to focus their recommendations within the confines of AB 567, which specifies that the Task Force should evaluate the demands on the LTSS workforce as the need for LTC in California grows, and how the LTC workforce can be prepared to meet those demands.

Exhibit 4.17 outlines the Task Force's recommendations related to the LTSS workforce along with associated considerations, which reflect high-level perspectives provided by members of the Task Force.

These recommendations are not associated with the specific Program designs recommended by the Task Force; rather, they reflect overarching recommendations necessary for the Program to operate effectively, irrespective of the selected design.

Exhibit 4.17: LTSS workforce recommendations and considerations

Recommendation	Recommendation detail	Considerations and rationale
Improve caregiver wages and benefits	• Establish minimum wages for caregivers • Increase wage equity among caregivers • Expand benefits offered to caregivers (e.g., health insurance)	• Wages for direct care workers have experienced limited growth in recent history, particularly before the COVID-19 pandemic • Direct care worker wages have not remained competitive relative to many other careers (e.g., the average direct care worker wage is less than that of a short-order cook, a housekeeper, and a gardener) • Increasing the wage floor (and offering benefits) could have a profound positive impact on addressing LTSS labor shortages (through increased retention) and improving care quality (through reduced turnover) • Increasing wages is far from simple as there are many interdependent factors (e.g., existing provider reimbursement rates)

Recommendation	Recommendation detail	Considerations and rationale
Improve caregiver training and career progression	• Provide career ladders and lattices • Increase investment in caregiver training programs	• Improving career ladders and latices could promote direct care workers in developing competencies and skills and allowing them to access advanced or alternative caregiving opportunities
Promote and incentivize expansion of caregiver workforce	• Promote career opportunities to younger individuals (e.g., community college programs) • Draw from the 'grey market' workforce	• The CDA estimates that the shortage of direct care workers in California will be between 600,000 and 3.2 million by 2030 • Broadening the pipeline of potential future caregivers could help address the shortage
Improve governance, oversight, and representation of the caregiver workforce	• Establish a Department of Caregivers • Establish an LTSS labor standards board • Establish a system to monitor caregiver workforce supply, demand, pay, and benefits • Provide access to unions	• A labor standards board could set minimum standards for wages, benefits, and working conditions for caregivers

Recommendation	Recommendation detail	Considerations and rationale
Support for informal caregivers	• Provide financial support (e.g., lost wages, expense reimbursement) • Provide access to training programs • Offer respite programs • Consider solutions similar to Germany and Hawaii (Kapuna Caregivers Program)	• The Task Force recommended that the Program establish minimum training requirements for informal or family caregivers to become certified caregivers • While the specifics of the training requirements have yet to be defined, the Task Force recommended that the minimum standards be established in a culturally competent manner that does not discourage benefit utilization • California's IHSS program offers financial support for informal caregivers and lessons learned in regard to the IHSS program's informal caregiver support benefits should be evaluated to inform how the Program can most effectively support informal caregivers • The Task Force discussed that cultural differences should be examined in designing a Program that provides financial support for informal caregivers
Other recommendations	• Embrace automation technology • Identify ways in which the undocumented workforce could be leveraged	• The shortage of LTSS workers could be partially alleviated through the use of automation and technology – Leveraging automation and technology to perform tasks customarily provided by caregivers could allow caregivers to focus on performing tasks that requires human interaction – Certain technology may improve health outcomes for individuals, thus reducing their need for LTSS

4.9. Access and regulation

In terms of Program access, Task Force discussions focused on effective Program outreach and education to ensure that the Program is widely accessible and understood by Californians. In terms of regulatory considerations for the Program, Task Force discussions largely focused on coordination and interaction as well as financing.

4.9.1. Access and regulation recommendations and considerations

Considerations related to Program access and regulation were primarily discussed with the Task Force at Task Force Meeting #12 in June 2022.

Relevant educational materials on these topics included:

- AARP California outreach and education
- LTSS access and care preferences in California
- Recommendations on access to LTC programs

Key concepts and takeaways from this discussion are summarized below.

4.9.1.1. Access

Key considerations to ensure that outreach and education are culturally competent include:

- Use multiple communication platforms to reach individuals where they are (e.g., in-person, online, TV, radio) and in the languages that they speak
- Communication should be peer to peer, grassroots to grassroots
- Work with trusted community partners with experience and connection to the community
- Voices, imagery, and materials should resonate with each community
- Expert advisors from the community should inform the Program's outreach plan (including outreach with sovereign tribal communities)

The Task Force recommended that a separate working group be established to develop a plan for Program outreach and education. The establishment of this working group received the highest degree of consensus among the various working groups proposed by the Task Force.

4.9.1.2. Regulation

Regulatory considerations related to Program coordination include (but are not limited to) the coordination of benefits, data collection, and benefit eligibility determination. Given the complexity of California's existing LTSS programs and services, an in-depth assessment of the regulation associated with these existing programs is needed to ensure effective and efficient coordination. This regulatory assessment should consider Medi-Cal, IHSS, Medicare, Medicare Advantage, PACE, LTSS

programs and services administered by the CDA, the VA, and private LTC insurance. Additional (non-regulatory) considerations related to the Program's interaction with these programs and services is included in Section 4.3.

To allow Program contributions to be invested in a broad range of financial instruments such as bonds, stocks, and other equities, as recommended by the Task Force, an amendment to the California Constitution would be required, as outlined in Section 4.7.

Other regulatory obstacles that may be faced by the Program at the state and federal levels were beyond the scope of this report.

5. Interaction with California's Master Plan for Aging

In recognition of California's aging population, Governor Gavin Newsom issued an Executive Order in 2019 calling for the creation of a Master Plan for Aging ("Master Plan"). The Master Plan aims to prioritize the health and well-being of older Californians, as well as policies that promote healthy aging. The Master Plan identifies five goals and 23 strategies to build a California for all ages by 2030. The Master Plan's five major goals are outlined below:

1. **Housing for All Ages and Stages**: promote communities for older Californians that are age-, disability-, and dementia-friendly, and climate- and disaster-ready
2. **Health Reimagined:** provide the services necessary for individuals to live at home in their communities and to optimize their health and quality of life
3. **Inclusion and Equity, not Isolation:** provide lifelong opportunities for work, volunteering, engagement, and leadership, and protect all aging and disabled Californians from isolation, discrimination, abuse, neglect, and exploitation
4. **Caregiving that Works:** provide high-quality direct caregiving jobs to support aging and disabled Californians
5. **Affording Aging**: provide affordable access to LTSS and promote economic security for aging Californians

Establishing a statewide LTSS program, as outlined in this Feasibility Report, would closely align with the second goal of the Master Plan (i.e., Health Reimagined), which includes sub-initiatives aimed at advocating for a universal LTSS benefit and assessing opportunities for federal and state partnerships. In addition, the Program's focus on cultural competency aligns with the Master Plan's overarching goal to provide equitable opportunities for all Californians to age how they choose. Further, Task Force recommendations for the Program illustrate a similar commitment to caregiver support and affordable access to LTSS as the Master Plan.

The Program could also help advance progress on the fifth goal of the Master Plan (i.e., Affording Aging), which aims to improve economic security for Californians. Specifically, implementing one of the five program designs recommended by the Task Force could help alleviate some of the financial burdens for aging individuals who cannot afford private LTC insurance. Finally, the Program is complementary to the other three Master Plan goals (i.e., housing, inclusions and equity, and caregiving) as they each aim to improve the quality of life for all Californians as they age, which is ultimately the goal of the Program as well.

6. Distribution and use

Oliver Wyman was commissioned by the 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.

Oliver Wyman shall not have any liability to any third party in respect of this report or any actions taken or decisions made as a consequence of the results, advice or recommendations set forth herein.

7. Reliances and limitations

The opinions expressed herein are valid only for the purpose stated herein and as of the date hereof. Information furnished by others, upon which all or portions of this report are based, is believed to be reliable but has not been verified. No warranty is given as to the accuracy of such information. Public information and industry and statistical data are from sources Oliver Wyman deems to be reliable; however, Oliver Wyman makes no representation as to the accuracy or completeness of such information and has accepted the information without further verification. No responsibility is taken for changes in market conditions or laws or regulations and no obligation is assumed to revise this report to reflect changes, events or conditions, which occur subsequent to the date hereof.

As between Oliver Wyman and the CDI, all decisions in connection with the implementation or use of advice or recommendations contained in this report are the sole responsibility of the CDI. This report does not represent investment advice, nor does it provide an opinion regarding the fairness of any transaction to any and all parties.

The findings contained in this report contain predictions based on current data and historical trends. Any such predictions are subject to inherent risks and uncertainties. Oliver Wyman accepts no responsibility for actual results or future events.

The opinions expressed in this report are valid only for the purpose stated herein and as of the date of this report. No obligation is assumed to revise this report to reflect changes, events or conditions, which occur subsequent to the date hereof.

This report is not considered a Statement of Actuarial Opinion under the guidelines promulgated by the American Academy of Actuaries, as it does not contain actuarial advice or actuarial opinions by the report's authors. The recommendations contained in this report are those of the AB 567 Task Force.

Appendix A. Glossary of terms

The following list contains the definition of all abbreviations contained in this report:

AB: Assembly bill

ADC: Adult day care

ADLs: Activities of daily living

ADRCs: Aging and Disability Resource Centers

CBAS: Community-Based Adult Services

CDA: California Department of Aging

CDI: California Department of Insurance

CDSS: California Department of Social Services

CMS: Centers for Medicare and Medicaid Services

CPI: Consumer Price Index

DHCS: California Department of Health Care Services

EP: Elimination period

HCBS: Home and community-based services

HICAP: Health Insurance Couseling and Advocacy Program

HIPAA: Health Insurance Portability and Accountability Act of 1996

IDD: Intellectually and developmentally disabled

IHSS: California's In-Home Supportive Services Program

LTC: Long-term care

LTSS: Long-term services and supports

MSSP: Multipurpose Senior Services Program

PACE: California's Program for All-Inclusive Care for the Elderly

PAYGO: Pay-as-you-go

PFL: California's Paid Family Leave Program

Program: Culturally competent statewide long-term care insurance program in California that is being explored per AB 567

SDI: California's State Disability Insurance Program

SNF: Skilled nursing facility

Task Force: 15 member Long Term Care Insurance Task Force established by AB 567 to explore the feasibility of developing and implementing a culturally competent statewide insurance program for long-term care services and supports in California.

VA: United States Department of Veterans Affairs

WISH: Well-Being Insurance for Seniors to be at Home

Appendix B. Program design “straw man”

AB 567 - Program Design "Straw Man"

This "straw man" summarizes the five program designs included in the draft Feasibility Report dated October 5, 2022.

The program designs included in this file are subject to

Legend
- **[✓]** indicates a plan design element that is consistent with preliminary Task Force recommendations
- **Yellow** shading represents a less generous plan design element relative to Design 3
- **Green** shading represents a more generous plan design element relative to Design 3
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Lower Cost ⟷ **Higher Cost**

Plan design element	*Supportive LTC benefits & adult population covered (18+)* **Design 1**	*Home care benefits & senior population covered (65+)* **Design 2**	*Comprehensive benefits (low-range) & adult population covered (18+)* **Design 3**	*Comprehensive benefits (mid-range) & adult population covered (18+)* **Design 4**	*Comprehensive benefits (high-range) & adult population covered (18+)* **Design 5**	*Relative cost benchmarks[1]* *(high-level estimates for reference only; actual Program cost relativities will differ)*
Indicative program cost ($ - $$$$$)	$	$$	$$ (Estimated payroll tax range: 0.40% to 0.60%[1])	$$$	$$$$$	
Design philosophy						
Program benefit richness	Targeted benefits	Targeted benefits	Comprehensive benefits (low-range)	Comprehensive benefits (mid-range)	Comprehensive benefits (high-range) [✓]	
California population coverage	Adult population covered (18+) [✓]	Senior population covered (65+)	Adult population covered (18+) [✓]	Adult population covered (18+) [✓]	Adult population covered (18+) [✓]	
Taxation progressivity	Proportional tax with a contribution cap and a contribution waiver for lower-income individuals	Proportional tax with a contribution cap	Proportional tax with a contribution cap and a contribution waiver for lower-income individuals	Proportional tax with a contribution waiver for lower-income individuals[✓]	Proportional tax with a contribution cap and a contribution waiver for lower-income individuals[✓]	
Structure and design						
Program structure	Front-end coverage [✓] Vested social insurance [✓]	Front-end coverage [✓] Vested social insurance [✓]	Front-end coverage [✓] Vested social insurance [✓]	Front-end coverage [✓] Vested social insurance [✓]	Front-end coverage [✓] Vested social insurance [✓]	
Program benefits						
Benefit type	Reimbursement for all covered benefits (actual benefit amount reimbursed, subject to limitations)	Reimbursement for all covered benefits (actual benefit amount reimbursed, subject to limitations) with reduced (50%) cash benefit alternative [✓]	Reimbursement for all covered benefits (actual benefit amount reimbursed, subject to limitations)	Reimbursement for all covered benefits (actual benefit amount reimbursed, subject to limitations)	Reimbursement for all covered benefits (actual benefit amount reimbursed, subject to limitations) with reduced (50%) cash benefit alternative [✓]	N/A
Benefit period	2 years [✓]	2 years [✓]	1 year	18 months	2 years [✓]	- Decrease benefit period from 2 years to 18 months: **22% savings** - Decrease benefit period from 2 years to 1 year: **45% savings**
Benefit maximum	$1,500 per month [alternative scenario: $1,000 per month]	$4,600 per month [✓]	$3,000 per month [✓]	$4,500 per month [✓]	$6,000 per month [✓]	- Decrease monthly benefit maximum from $6,000 to $4,500: **27% savings** - Decrease monthly benefit maximum from $6,000 to $3,000: **50% savings** - Decrease monthly benefit maximum from $6,000 to $1,500: **75% savings**
Benefit inflation	Inflation as a function of CPI; assessed annually (not automatically applied)	Inflation as a function of CPI; assessed annually (not automatically applied)	Inflation as a function of CPI; assessed annually (not automatically applied)	Inflation as a function of CPI; assessed annually (not automatically applied)	Inflation as a function of CPI; applied annually [✓]	N/A
Elimination period	No elimination period [✓]	90-day elimination period	30-day elimination period	No elimination period [✓]	No elimination period [✓]	- Increase elimination period from 0 days to 30 days: **4% savings** - Increase elimination period form 0 days to 90 days: **8% savings**
Approved care settings	Supportive LTSS (e.g., caregiver support, adult day care, meal delivery, transportation, preventative equipment, home assessment, and minor home modifications) Caregiver support includes: training, respite care, and financial support via certified provider reimbursement	Home and community-based care only	Home and community-based care with select institutional care (e.g., adult day care, respite care, residential care facility)	Comprehensive (i.e., institutional care and home and community-based care) [✓]	Comprehensive (i.e., institutional care and home and community-based care) [✓]	- Change approved care settings from comprehensive to home care only: **39% savings**
PACE coverage	N/A	N/A	Covered service; certified provider reimbursement [✓]	Covered service; certified provider reimbursement [✓]	Covered service; certified provider reimbursement [✓]	N/A
Informal / family caregivers	Covered service; reimbursement to caregivers (subject to completion of certified caregiver training; minimum requirements that do not discourage benefit utilization to be defined in a culturally competent manner) [✓]	Covered service; reimbursement to caregivers (subject to completion of certified caregiver training; minimum requirements that do not discourage benefit utilization to be defined in a culturally competent manner) [✓]	Covered service; reimbursement to caregivers (subject to completion of certified caregiver training; minimum requirements that do not discourage benefit utilization to be defined in a culturally competent manner) [✓]	Covered service; reimbursement to caregivers (subject to completion of certified caregiver training; minimum requirements that do not discourage benefit utilization to be defined in a culturally competent manner) [✓]	Covered service; reimbursement to caregivers (subject to completion of certified caregiver training; minimum requirements that do not discourage benefit utilization to be defined in a culturally competent manner) [✓]	N/A
Preventative benefits	N/A	Limited/contingent preventative benefits (e.g., partake in wellness program)	Limited/contingent preventative benefits (e.g., partake in wellness program)	Preventative benefits before satisfying the benefit eligibility criteria but only after becoming fully vested in the program [✓]	Preventative benefits before satisfying the benefit eligibility criteria but only after becoming fully vested in the program [✓]	N/A
Portability	Domestic portability; full benefits	Domestic portability; partial benefits outside of California (grade to 50% over 5 years)	Domestic portability; partial benefits outside of California (grade to 50% over 5 years)	Domestic portability; full benefits	International portability; full benefits [✓]	- Change from full domestic portability to partial domestic portability (grade to 50% over 5 years): **17% savings**
Family / spousal coverage	Individual coverage only	Individual coverage only	Individual coverage only	Coverage can be extended to a spouse or domestic partner through a shared benefit pool	Coverage can be extended to a spouse or domestic partner through a shared benefit pool	N/A
Program eligibility and enrollment						
Benefit eligibility age	Age 18+ (subject to vesting requirements) [✓]	Age 65+ (subject to vesting requirements)	Age 18+ (subject to vesting requirements) [✓]	Age 18+ (subject to vesting requirements) [✓]	Age 18+ (subject to vesting requirements) [✓]	- Increase benefit eligibility age from 18+ to 65+: **12% savings**
Benefit eligibility criteria	HIPAA benefit eligibility (2 of 6 ADLs for 90 days or severe cognitive impairment) [✓]	HIPAA benefit eligibility (2 of 6 ADLs for 90 days or severe cognitive impairment) [✓]	HIPAA benefit eligibility (2 of 6 ADLs for 90 days or severe cognitive impairment) [✓]	HIPAA benefit eligibility (2 of 6 ADLs for 90 days or severe cognitive impairment) [✓]	HIPAA benefit eligibility (2 of 6 ADLs for 90 days or severe cognitive impairment) [✓]	N/A
Vesting criteria	5 years of contributions [✓]	5 years of contributions [✓]	10 years of contribution	10 years of contribution	5 years of contributions [✓] [alternative scenario: 10 years of contribution]	- Increase vesting criteria from 5 years to 10 years: **13% savings**
Flexibility for those unable to vest	Pro-rated benefits (no benefits for individuals who contribute for less than 3 years, 50% of the benefits for individuals who contribute between 3 and 5 years, 100% of the benefits for individuals who contribute for 5 or more years)	Pro-rated benefits (no benefits for individuals who contribute for less than 3 years, 50% of the benefits for individuals who contribute between 3 and 5 years, 100% of the benefits for individuals who contribute for 5 or more years)	Pro-rated benefits (no benefits for individuals who contribute for less than 5 years, 50% of the benefits for individuals who contribute for 5 years, grading up by 10% each year up to 100% of benefits in year 10)	Pro-rated benefits (no benefits for individuals who contribute for less than 5 years, 50% of the benefits for individuals who contribute for 5 years, grading up by 10% each year up to 100% of benefits in year 10)	Pro-rated benefits (no benefits for individuals who contribute for less than 3 years, 50% of the benefits for individuals who contribute between 3 and 5 years, 100% of the benefits for individuals who contribute for 5 or more years) and voluntary alternative program contribution option to “top up” benefits [✓]	- Remove partial vesting (10 year vesting criteria): **14% savings**
Private LTC considerations: before program enactment	N/A	Individuals with eligible private LTC insurance[2] may opt out of the program. They would be exempt from making program contributions and will not be eligible to receive program benefits [✓]	Individuals with eligible private LTC insurance[2] may opt out of the program. They would be exempt from making program contributions and will not be eligible to receive program benefits [✓]	Individuals with eligible private LTC insurance[2] may opt out of the program. They would be exempt from making program contributions and will not be eligible to receive program benefits [✓]	Individuals with eligible private LTC insurance[2] may opt out of the program. They would be exempt from making program contributions and will not be eligible to receive program benefits [✓]	N/A
Private LTC considerations: after program enactment[3]	N/A	Individuals with eligible substitutive (i.e., non-supplemental) private LTC insurance[2] would be subject to reduced program contributions (and will remain eligible to receive program benefits as a secondary payor to their private LTC insurance) [✓]	Individuals with eligible substitutive (i.e., non-supplemental) private LTC insurance[2] would be subject to reduced program contributions (and will remain eligible to receive program benefits as a secondary payor to their private LTC insurance) [✓]	Individuals with eligible substitutive (i.e., non-supplemental) private LTC insurance[2] would be subject to reduced program contributions (and will remain eligible to receive program benefits as a secondary payor to their private LTC insurance) [✓]	Individuals with eligible substitutive (i.e., non-supplemental) private LTC insurance[2] would be subject to reduced program contributions (and will remain eligible to receive program benefits as a secondary payor to their private LTC insurance) [✓]	N/A

[1] Estimates are based on the 2020 Milliman CA LTSS Feasibility Study

[2] The criteria for private LTC insurance to be considered eligible under the opt-out provision are TBD (and will be determined at a later date)

[3] Supplemental LTC products designed after program enactment would not qualify for reduced program contributions (e.g., private LTC insurance with a 2-year elimination period)

AB 567 - Program Design "Straw Man"

This "straw man" summarizes the five program designs included in the draft Feasibility Report dated October 5, 2022.

The program designs included in this file are subject to

Legend

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Lower Cost → **Higher Cost**

Plan design element	*Supportive LTC benefits & adult population covered (18+)* Design 1	*Home care benefits & senior population covered (65+)* Design 2	*Comprehensive benefits (low-range) & adult population covered (18+)* Design 3	*Comprehensive benefits (mid-range) & adult population covered (18+)* Design 4	*Comprehensive benefits (high-range) & adult population covered (18+)* Design 5	*Relative cost benchmarks[1] (high-level estimates for reference only; actual Program cost relativities will differ)*
Program financing						
Revenue source	Payroll tax (split between employees and employers); non-voluntary premium contributions via an income tax for the self-employed; alternative funding sources beyond payroll/income tax may also be considered [√] [Alternative scenario: reduce/eliminate employer portion of the program contributions]	Payroll tax (split between employees and employers); non-voluntary premium contributions via an income tax for the self-employed; alternative funding sources beyond payroll/income tax may also be considered [√] [Alternative scenario: reduce/eliminate employer portion of the program contributions]	Payroll tax (split between employees and employers); non-voluntary premium contributions via an income tax for the self-employed [√] [Alternative scenario: reduce/eliminate employer portion of the program contributions]	Payroll tax (split between employees and employers); non-voluntary premium contributions via an income tax for the self-employed [√] [Alternative scenario: reduce/eliminate employer portion of the program contributions]	Payroll tax (split between employees and employers); non-voluntary premium contributions via an income tax for the self-employed [√] [Alternative scenario: reduce/eliminate employer portion of the program contributions]	N/A
Program contribution age: minimum	Age 18 [√]	Age 18 [√]	Age 18 [√]	Age 18 [√]	Age 18 [√]	N/A
Program contribution age: maximum	No maximum (contributions dependent on being on payroll or self-employed) [√]	No maximum (contributions dependent on being on payroll or self-employed) [√]	No maximum (contributions dependent on being on payroll or self-employed) [√]	No maximum (contributions dependent on being on payroll or self-employed) [√]	No maximum (contributions dependent on being on payroll or self-employed) [√]	N/A
Program contribution limits: taxable earnings waiver	Waive contributions for individuals below a specified poverty level (e.g., 138% of FPL) [√]	Individuals below a specified poverty level will not contribute or receive vesting credits (the individual may still vest in the program if they meet the vesting requirement over their working lifetime). Such individuals could receive LTSS benefits from Medi-Cal (subject to Medi-Cal eligibility	Waive contributions for individuals below a specified poverty level (e.g., 138% of FPL) [√]	Waive contributions for individuals below a specified poverty level (e.g., 138% of FPL) [√]	Waive contributions for individuals below a specified poverty level (e.g., 138% of FPL) [√]	- Do not waive program contributions for individuals below 138% of FPL (but still receive benefits): **3% savings** - Do not waive program contributions for individuals below 138% of FPL (but do not receive benefits): **22% savings**
Program contribution limits: taxable earnings maximum	Apply a contribution cap. Consider contribution caps in excess of Social Security (e.g., 2x Social Security cap) [√]	Apply a contribution cap. Consider contribution caps in excess of Social Security (e.g., 2x Social Security cap) [√]	Apply a contribution cap. Consider contribution caps in excess of Social Security (e.g., 2x Social Security cap) [√]	No maximum contribution limitations	Apply a contribution cap. Consider contribution caps in excess of Social Security (e.g., 2x Social Security cap) [√]	N/A
Contribution rate structure	Level tax rate (with guidelines stipulating the process to amend the tax rate); no variability by age (or any other characteristics) [√]	Level tax rate (with guidelines stipulating the process to amend the tax rate); no variability by age (or any other characteristics) [√]	Level tax rate (with guidelines stipulating the process to amend the tax rate); no variability by age (or any other characteristics) [√]	Level tax rate (with guidelines stipulating the process to amend the tax rate); no variability by age (or any other characteristics) [√]	Level tax rate (with guidelines stipulating the process to amend the tax rate); no variability by age (or any other characteristics) [√]	N/A
Investment strategy	Invest program contributions in stocks, bonds, and U.S. Treasuries (constitutional amendment required) [Alternative scenario: consider the financial implications of not obtaining a constitutional amendment][√]	Invest program contributions in stocks, bonds, and U.S. Treasuries (constitutional amendment required) [Alternative scenario: consider the financial implications of not obtaining a constitutional amendment][√]	Invest program contributions in stocks, bonds, and U.S. Treasuries (constitutional amendment required) [Alternative scenario: consider the financial implications of not obtaining a constitutional amendment][√]	Invest program contributions in stocks, bonds, and U.S. Treasuries (constitutional amendment required) [Alternative scenario: consider the financial implications of not obtaining a constitutional amendment][√]	Invest program contributions in stocks, bonds, and U.S. Treasuries (constitutional amendment required) [Alternative scenario: consider the financial implications of not obtaining a constitutional amendment][√]	- Restrict investment strategy to U.S. treasuries: **20% cost increase**[4]
Intergenerational consideration (i.e., 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)	None	Grade-up benefits over first 20 years [√]	Grade-up benefits over first 20 years [√]	Grade-up benefits over first 20 years [√]	Grade-up benefits over first 20 years [√]	N/A
Coordination and interaction (with other LTSS financing sources)						
Coordination: private LTC	Private LTC pays before Program; concurrent, non-duplicative payments permitted [√]	Private LTC pays before Program; concurrent, non-duplicative payments permitted [√]	Private LTC pays before Program; concurrent, non-duplicative payments permitted [√]	Private LTC pays before Program; concurrent, non-duplicative payments permitted [√]	Private LTC pays before Program; concurrent, non-duplicative payments permitted [√]	N/A
Coordination: Medi-Cal	Program pays before Medi-Cal; concurrent, non-duplicative payments permitted. Program benefits should not influence Medi-Cal eligibility. The program should not exclude contributions or benefits for individuals eligible for Medi-Cal in the past, present, or future. Pursue a CMS federal demonstration waiver to retain federal Medicaid savings from the program	Program pays before Medi-Cal; concurrent, non-duplicative payments permitted. Program benefits should not influence Medi-Cal eligibility. The program should not exclude contributions or benefits for individuals eligible for Medi-Cal in the past, present, or future. Pursue a CMS federal demonstration waiver to retain federal Medicaid savings from the program	Program pays before Medi-Cal; concurrent, non-duplicative payments permitted. Program benefits should not influence Medi-Cal eligibility. The program should not exclude contributions or benefits for individuals eligible for Medi-Cal in the past, present, or future. Pursue a CMS federal demonstration waiver to retain federal Medicaid savings from the program	Program pays before Medi-Cal; concurrent, non-duplicative payments permitted. Program benefits should not influence Medi-Cal eligibility. The program should not exclude contributions or benefits for individuals eligible for Medi-Cal in the past, present, or future. Pursue a CMS federal demonstration waiver to retain federal Medicaid savings from the program	Program pays before Medi-Cal; concurrent, non-duplicative payments permitted. Program benefits should not influence Medi-Cal eligibility. The program should not exclude contributions or benefits for individuals eligible for Medi-Cal in the past, present, or future. Pursue a CMS federal demonstration waiver to retain federal Medicaid savings from the program	N/A
Coordination: Medicare	Assess the feasibility of having Program pay after Medicare.	Assess the feasibility of having Program pay after Medicare.	Assess the feasibility of having Program pay after Medicare.	Assess the feasibility of having Program pay after Medicare.	Assess the feasibility of having Program pay after Medicare.	N/A

[4] Estimate is based on the 2020 Milliman WA Cares LTSS Actuarial Study, so it does not reflect California demographics

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.

Oliver Wyman shall not have any liability to any third party in respect of this report or any actions taken or decisions made as a consequence of the results, advice or recommendations set forth herein.

The opinions expressed herein are valid only for the purpose stated herein and as of the date hereof. Information furnished by others, upon which all or portions of this report are based, is believed to be reliable but has not been verified. No warranty is given as to the accuracy of such information. Public information and industry and statistical data are from sources Oliver Wyman deems to be reliable; however, Oliver Wyman makes no representation as to the accuracy or completeness of such information and has accepted the information without further verification. No

Appendix C. LTSS programs and services administered by California's Department of Aging

The CDA administers several programs that serve older adults, adults with disabilities, and family caregivers. The CDA contracts with a network of 33 Area Agencies on Aging, which directly manage a wide array of federal and state-funded services. The services help older adults find employment, support older adults and adults with disabilities in the community, promote healthy aging and community involvement, and provide caregiver support.

Select LTSS and related programs and services administered by the CDA are summarized in Exhibit C.1 below.

Exhibit C.1: Overview of CDA LTSS programs and services

Program/service	Description
Community-Based Adult Services	• Available to eligible Medi-Cal beneficiaries enrolled in Medi-Cal Managed Care • Offers services to eligible older adults and adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent institutionalization • Services offered include: – Professional nursing services – Mental health services – Personal (i.e., custodial) care – Nutritional counseling – Transportation assistance
Multipurpose Senior Services Program	• HCBS to Medi-Cal eligible individuals who are 65 years and older and disabled • Alternative to nursing facility placement
Aging and Disability Resource Connections	• Assists individuals with disabilities or chronic conditions in accessing health care, medical care, social supports, and other LTSS • Highly integrated network of various community-based organizations and extended partners, including health plans • Information, care planning, and care coordination to all Californians regardless of age, income, or disability status • ADRCs currently operate in eight California counties

Program/service	Description
Long-Term Care Ombudsman Program	• Investigates and endeavors to resolve complaints made by, or on behalf of, residents in LTC facilities including nursing homes and assisted living facilities
Nutrition Services	• Provides nutrition services in group and home-based settings (i.e., meal delivery) • Preference given to those in greatest economic or social need
Senior Community Service Employment Program	• Provides part-time work-based training opportunities for older workers • To be eligible, individuals must be at least 55 years of age, with an income not exceeding 125 percent of the federal poverty level
Health Insurance Counseling and Advocacy Program	• California's State Health Insurance Assistance Program • Provides consumer counseling on Medicare, Medicare supplement policies, Health Maintenance Organizations and LTC insurance
Family Caregiver Support Program	• Provided across 33 local Area Agencies on Aging • Services include caregiving information, access to services and supports, and temporary respite care

Additionally, the CDA offers a variety of programs and services under the Older Californians Act. While no longer receiving funding, these programs and services are still in the ordinance and provide value to aging Californians requiring LTSS. The local Area Agencies on Aging determine funding for these programs and services. These programs and services are summarized in Exhibit C.2 below.

Exhibit C.2: Overview of programs and services under the Older Californians Act

Program/service	Description
Alzheimer's Day Care Resource Centers	• Provides care for persons with Alzheimer's disease and other dementia
Brown Bag Program	• Provides food products to lower-income individuals 60 years of age and older
Foster Grandparent Program	• Intergenerational volunteer program that provides aid to children and youth with special and exceptional needs

Linkages	• Provides comprehensive care management for elderly adults and adults with disabilities, age 18 years and older, who are not eligible for other care management programs
Senior Companion	• Volunteers provide services to elderly adults • Services include: – Respite for caregivers – Companionship – Assistance with simple chores, grocery shopping, and meal preparation – Transportation assistance

Oliver Wyman
3560 Lenox Road
Suite 2400
Atlanta, GA 30326
United States

Qualifications, assumptions, and limiting conditions

Oliver Wyman was commissioned by the 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.

Oliver Wyman shall not have any liability to any third party in respect of this report or any actions taken or decisions made as a consequence of the results, advice or recommendations set forth herein.

Information furnished by others, upon which all or portions of this report are based, is believed to be reliable but has not been independently verified, unless otherwise expressly indicated. Public information and industry and statistical data are from sources Oliver Wyman deem to be reliable; however, Oliver Wyman make no representation as to the accuracy or completeness of such information. The findings contained in this report may contain predictions based on current data and historical trends. Any such predictions are subject to inherent risks and uncertainties. Oliver Wyman accepts no responsibility for actual results or future events.

The opinions expressed in this report are valid only for the purpose stated herein and as of the date of this report. No responsibility is taken for changes in market conditions or laws or regulations and no obligation is assumed to revise this report to reflect changes, events, or conditions, which occur subsequent to the date hereof.

As between Oliver Wyman and the CDI, all decisions in connection with the implementation or use of advice or recommendations contained in this report are the sole responsibility of CDI. This report does not represent investment advice nor does it provide an opinion regarding the fairness of any transaction to any and all parties. In addition, this report does not represent legal, medical, accounting, safety, or other specialized advice. For any such advice, Oliver Wyman recommends seeking and obtaining advice from a qualified professional.