OliverWyman

Presentation #6.C

Prepared for the California Department of Insurance

BENEFITS AND SERVICES

Considerations for potential benefits and services under a statewide long-term care (LTC) insurance program in California

January 2022

QUALIFICATIONS, ASSUMPTIONS AND LIMITING CONDITIONS

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

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PLEASE KEEP IN MIND…

1: SCOPE

The following benefits and services are discussed:

- Benefit type
- Benefit maximum amounts
- Benefit inflation
- Elimination period
- Approved care settings
- Covered services
- Prevention measures and benefits

2: BASELINE ASSUMPTIONS

- To facilitate pros/cons considerations and cost benchmarking, we established an **illustrative** baseline assumption for each provision
- **These baseline assumptions are <u>not</u> recommendations**

3: INTERDEPENDENCIES

- Interdependencies between program benefits and services and other program design elements (e.g., program structure, financing, and workforce) will be covered at future Task Force Meetings

4: NEXT STEPS

- Shortly after this meeting, Task Force Members will be asked to provide preliminary recommendations regarding program benefits and services via our Administration and Services Questionnaire
- Questionnaire results will be discussed at Task Force Meeting #7 (February 16, 2022)

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RELEVANT DATA POINTS

BENEFIT TYPE

Common dimensions[1]: Reimbursement, indemnity, cash, or a combination of benefit types

Medi-Cal	• Combination of reimbursement and cash • For nursing home stays, eligible individuals keep $35 of their monthly income as a personal needs allowance
Private Insurance	• Reimbursement, indemnity, or cash • The most common benefit type is reimbursement
Washington State	• Reimbursement
France	• Reimbursement or cash
Germany	• Reimbursement, cash, or a combination of reimbursement and cash • Vast majority of beneficiaries opt to receive cash benefit (even though lower in value) as cash can be used to pay for informal support while remaining at home

[1] 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).

BENEFIT MAXIMUM AMOUNTS

Common dimensions: Daily or monthly benefit amount, maximum lifetime benefit amount, unlimited benefits

Medi-Cal	• No daily maximums if care is considered medically necessary (or is covered under a waiver program) – Monthly out-of-pocket maximums determined based on individual's monthly income with Medi-Cal covering remainder – Individuals that do not meet income limits can still qualify if they pay a portion of their monthly income to cover medical costs (share of cost)
Private Insurance	• Maximum benefit amounts may be defined on a daily or monthly basis – Average monthly benefit amount for stand-alone LTC insurance policies sold in 2020 was $4,888 (or approx. $161 per day) • Maximum lifetime benefit amounts are typically defined in terms of a pool of money, which is determined based on policyholder elections for benefit period and daily/monthly benefit amount – Average benefit period for stand-alone LTC insurance policies sold in 2020 was 3.75 years (excluding policies with unlimited benefits) • Average monthly benefit amount and benefit period above equate to a pool of money around $220,000
Washington State	• Daily benefit amount of $100 per day for a maximum of 365 days • Initial lifetime maximum benefit amount is $36,500
France	• The Allowance for Personal Autonomy (APA) benefit amount is based on the facility's dependency rate (institutional care) or the help plan used (home care), reduced by beneficiary participation, up to a maximum of 90% – Participation is set based on an individual's income • There is a maximum monthly amount for the home care APA that increases based on intensity of care need – Increases to this maximum amount are allowed if an individual's caregiver needs relief (respite) or hospitalization • There is no lifetime maximum benefit amount
Germany	• Monthly benefits are capped at a specific dollar amount of reimbursed services, cash benefits, or a combination of the two – Capped benefits are designed to cover only a portion of the cost (remainder falls to families, backstopped by social assistance) • Benefit amounts increase with intensity of care need • There is no lifetime maximum benefit amount

BENEFIT INFLATION

Common dimensions: Benefit increases that are level or tied to a specified index, may be applied annually or at a less frequent interval

Medi-Cal	• For recipients covered under fee-for-service, Medi-Cal establishes payment rates by facility based on each facility's allowed costs as determined by audit • For services delivered in the home, Medi-Cal determines when and by how much to change fee schedule amounts • For care delivered through managed care organizations (MCOs), payment amounts are determined based on contracts between the MCO and providers – These contracts often use fee schedules that are the same as the Medi-Cal fee schedule (as of a particular date) or a percentage of it • If providers consider payment levels to be insufficient, they may reduce the availability of services
Private Insurance	• Benefit inflation is elected by the policyholder with options varying by company and product – Options may include simple inflation, compound inflation, future purchase options, or indexed inflation – Inflation may apply for life or for a limited duration; future purchase options only apply when elected by the policyholder – The rate of inflation also varies and typically ranges from 0% (i.e., no inflation) to 5% • In 2020, the most common inflation option elected for new stand-alone LTC insurance sales was 3% (compound interest)
Washington State	• Benefit adjustment is foreseen annually but is not automatic • Benefit adjustments will be indexed at a rate no greater than the Washington state consumer price index (CPI)
France	• Benefit amounts increase over time, though the specific inflation rate (or indexation) and timing of adjustments is not readily available
Germany	• Since 2014 (with indexation effective in 2015) benefits are reviewed every three years and adjusted to keep pace with the cost of living, within the constraints of Germany's overall economic situation

ELIMINATION PERIOD

Common dimensions: Length of time an individual must wait (after satisfying benefit eligibility criteria) before benefits are payable (e.g., 0, 30, 90 days)

Medi-Cal	• No elimination period – The eligibility approval process may take several weeks, but eligibility is retroactive to the date of application – Once individuals are approved as eligible, Medi-Cal covers the cost of their services
Private Insurance	• Typically, policyholders elect an elimination period from specified options (though some products do not offer a choice) • The most common elimination period for stand-alone LTC insurance is 90 days but options range from 0 days to over 200 days – Over 90% of stand-alone LTC insurance policies sold in 2020 had an elimination period between 84 and 100 days
Washington State	• No explicit elimination period – Legislation specifies that benefit applications must be processed within 45 days; this acts as an implicit (maximum) elimination period because costs incurred by an individual during this period are not reimbursed under the program
France	• No elimination period – The APA allocation (“award”) decision must be made within 2 months of receiving a complete benefit application – The first payment is made in the month following the award decision and captures payment due from the starting date of an individual’s program rights
Germany	• No explicit elimination period – Benefit applications must be processed within 25 working days (or less in certain situations) – If this deadline is not met the program must pay the applicant 70 euros for each week that the deadline is exceeded

APPROVED CARE SETTINGS

Common dimensions: Nursing home facilities, residential care facilities/assisted living facilities, home and community-based care

Medi-Cal	• Skilled nursing facilities • Assisted living facilities – Covered via Assisted Living Waiver (ALW) program • Home and community-based services (HCBS) – Provided via several programs including In-Home Supportive Services (IHSS), Community Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP), Home and Community Based Alternatives (HCBA)
Private Insurance	• HCBS and institutional care (including skilled nursing facilities and assisted living/residential care facilities) – Stand-alone LTC insurance products may offer comprehensive coverage (i.e., including both HCBS and institutional care), home-care only, or facility only benefits – 99% of policies sold in 2020 provided comprehensive benefits
Washington State	• Comprehensive coverage (HCBS and institutional care)
France	• Comprehensive coverage (HCBS and institutional care)
Germany	• Comprehensive coverage (HCBS and institutional care)

COVERED SERVICES (1 OF 2)

Common dimensions: Institutional care, home care services, community-based services, adult day care, respite care, memory care, etc.

Medi-Cal	• Medi-Cal pays for medically necessary services related to physical, mental, and substance-use disorder health care • Services can vary by eligibility criteria and include, but are not limited to: – Prescriptions (although the Medicare Part D program now covers most prescriptions for dual-eligible beneficiaries), – Inpatient hospital and outpatient services – Emergency department and ambulance services – Physician visits, X-ray and laboratory costs, and some dental care – Orthopedic devices, eyeglasses, hearing aids, and some medical equipment – Certain long-term services and supports (LTSS) (e.g., custodial care in nursing facilities, IHSS, adult day health service, etc.)
Private Insurance	• Private LTC insurance policies cover a wide range of services, which can vary by product, including but not limited to: – Nursing home and/or assisted living facility care – Home health care services - Homemaker services (e.g., light work, household tasks, preparing meals, laundry) - Personal care attendant services (e.g., personal hygiene, assistance with activities of daily living, managing medications) - Nursing services - Physical, occupational, respiratory and speech therapy - Home delivered meals – Adult day care, respite care, bed reservation, and/or hospice care – Supportive equipment/home modification – International care • Typical exclusions include treatment for substance abuse, for an illness or medical condition arising from war, or for intentionally self-inflicted injury • Non-duplication of coverage provisions generally stipulates that a policy will not pay for services reimbursable under Medicare or any other federal, state, or other governmental health care plan or law (except Medicaid)

COVERED SERVICES (2 OF 2)

Common dimensions: Institutional care, home care services, community-based services, adult day care, respite care, memory care, etc.

 **Washington State**	• The WA Cares Fund covers a wide range of services including, but not limited to: – Adult day services and adult family home services – Assisted living and nursing home services – In-home personal care and professional services – Care transition coordination – Memory care and dementia supports – Adaptive equipment and technology, environmental modification, personal emergency response system, and home safety evaluation – Respite for family caregivers – Home delivered meals, transportation, and education and consultation – Eligible relative care and services that assist paid and unpaid family members caring for eligible individuals, including training
 **France**	• For institutional care, medical costs are covered, but families are responsible for housing costs • Home care coverage is based on medical need • Temporary care for dependent patients and respite services for their caregivers is available
 **Germany**	• For institutional care, the program covers only a portion of the personal care cost component and does not cover room and board • For home care, a range of ancillary benefits are available, such as day and night care, respite care, and care counselling (for beneficiaries and their relatives) • Additional covered home care services include: – Body-related care measures (e.g., personal hygiene, nutrition, promotion of mobility) – Nursing support measures (e.g., help with orientation, with structuring everyday life or with maintaining social contacts) – Home health care (e.g., medication, dressing change, or injections) – Support in arranging auxiliary services (e.g., food delivery) or organizing driving and ambulance services – Help with housekeeping (e.g., cooking or cleaning) – Home modifications

OTHER COVERED SERVICES

Common dimensions: Compensation for informal caregivers, cost-sharing (e.g., room and board/medical costs, copays)

Medi-Cal	• Additional long-term supports and services are available through federal waiver programs, including community transition services, family training, and home health aides – These benefits are not available statewide and have varying eligibility requirements
Private Insurance	• Some products may offer informal care coverage • Some products may cover alternative plans of care, caregiver training, care planning, and/or personal care advisors
Washington State	• Qualified family members may be paid for approved personal care services
France	• Means-tested cash allowances are provided to frail elderly to pay for in-kind non-medical services – Allowances are adjusted based on individual's dependence level, living conditions, and needs • Informal caregivers benefit from tax deductions but do not receive a cash allowance
Germany	• Nursing training courses are provided free of charge for voluntary caregivers • Informal caregivers can be compensated using the cash benefit available under the program – Cash benefits are intended not to be sufficient to pay the full cost of needed levels of professional home care

PREVENTION MEASURES AND BENEFITS

Common dimensions: Fall prevention, home inspections, electronic monitoring, pre-claim wellness programs, post-claim managed care

Medi-Cal	• The rate structure within the Coordinated Care Initiative (CCI) incentivizes MCOs to appropriately keep dual-eligible members out of nursing facilities • The CalAIM (California Advancing & Innovating Medi-Cal) proposal includes two key provisions related to prevention: – Enhanced care management (ECM) targets a variety of populations, including individuals at risk for institutionalization who are eligible for LTC services and nursing facility residents who want to transition to the community – Community Supports services are flexible wrap-around services (such as home modifications) provided as a substitute to, or to avoid, other covered services, such as a hospital or skilled nursing facility admission
Private Insurance	• Certain products may cover preventative services such as home modifications and supportive equipment – Benefits are available after a policyholder meets benefit eligibility criteria – Benefits may be subject to separate limits (e.g., $1,000 per calendar year up to a lifetime limit of $5,000) • Private LTC insurers are exploring aging-in-place/wellness programs for in-force insureds on both a pre-claim (i.e., before benefit eligibility criteria satisfaction) and post-claim basis – Programs may cover preventative services that facilitate individuals remaining in their home as long as it is safe for them to do so – Preventative services may include policyholder education, pro-active care while insureds are healthy, and/or interventions while insureds are disabled – Programs may utilize predictive analytics to identify risks and/or intervention points
Washington State	• After a vested individual meets benefit eligibility criteria, benefits can be used for preventative services that fall within the list of approved services – Examples include adaptive equipment and technology, environmental modification, personal emergency response system, home safety evaluation, and education and consultation
France	• The Health Pathway of Seniors for Preserved Autonomy aims to improve quality of care, prevent loss of autonomy, and reduce hospital use among the frail elderly through various internal activities that increase collaboration between local health and social service providers
Germany	• Up to $4,000 is available to individuals in care levels 1-5 (upon application) to subsidize home modifications that facilitate an individual receiving care at home or continuing to live as independently as possible • The program covers the cost of devices and materials that are necessary for home care, facilitate home care, or help enable a person in need of care to lead a more independent life

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CONSIDERATIONS AND BENCHMARKS

BENEFIT TYPE: CONSIDERATIONS

Baseline assumption
Reimbursement with a reduced cash benefit option (e.g., 50% reduction)

⚠ Baseline assumptions are **only** used to facilitate pros/cons considerations and cost benchmarking

Pros

- Multiple benefit options increase flexibility and choice
- Cash option can be used to pay for informal care, which may reduce supply strain on formal caregiver workforce
- Promotes equity for low-income individuals and individuals in areas of California where formal services may not be as readily accessible
- Offering a cash benefit option may enable management of out-of-state care options

Cons

- 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)
- 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)

Potential alternatives (non-exhaustive)

- Reimbursement only or cash only
- Combination of reimbursement and cash with no reduction on cash benefit amount
- Indemnity (i.e., full daily/monthly benefit amount is paid as long as eligible services are received)
- Varied by type of care needed (e.g., reimbursement for facility care vs. cash for home care), location (e.g., in California versus outside California), etc.

BENEFIT TYPE: BENCHMARKS

Cost Benchmarks

Benefit type scenario	Estimated (multiplicative) impact on cost
Reimbursement with partial cash	**N/A (baseline assumption)**
Reimbursement only	- 4.3%
Cash only	+ 29.0%

⚠ Baseline assumptions are **only** used to facilitate pros/cons considerations and cost benchmarking

Source: 2020 Milliman CA LTSS Feasibility Study

Informal caregiving in California (2020)

1 in 6 **Californians provide informal care[1]**

1 in 4 **California informal caregivers[1] provide 20 or more hours of care to a family member or friend in a typical week**

91% **Of California informal caregivers[1] did not receive payment for providing care**

$63 Billion **Estimated value of unpaid caregiver contributions in California (in 2017)**

Cash benefits can be used to support informal caregivers

Sources: UCLA Center for Health Policy Research

[1] Caregivers are defined as adults who reported providing help in the last 12 months to a family member or friend with a serious or chronic illness or disability

BENEFIT MAXIMUM AMOUNTS: CONSIDERATIONS

Baseline assumption

Monthly benefit amount[1]: $4,600 per month (about $150 per day)

Lifetime maximum: About $110,000 per lifetime (based on a 2-year benefit period)

⚠ Baseline assumptions are **only** used to facilitate pros/cons considerations and cost benchmarking

Pros

- Monthly benefit amount aligns with average monthly cost of home care in California
- Monthly benefit amount consistent with average benefit sold on private stand-alone LTC insurance policies (2020)
  - Perceived as high-value (vs. offering a lower benefit than typical private insurance)
- 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[2]
- 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)

Cons

- More costly relative to a lower monthly and/or lifetime maximum (such as in Washington)
- 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 care needs may be less able to afford necessary services (relative to a program with non-uniform maximums)

Potential alternatives (non-exhaustive)

- Higher/lower benefit amount (e.g., $50 per day up to $500+ per day)
- Higher/lower benefit period (e.g., 1-year up to unlimited)
- Varied by type of care needed (e.g., facility care vs. home care), location (e.g., in California versus outside California), income level, number of years of program contribution, etc.

[1] Monthly maximum stated is for the reimbursement option; benefit would be lower for the cash option under the baseline assumption (e.g., 50% or $2,300)

[2] Based on private insurance data on a nationwide basis; excludes costs paid by Medicaid or Medicare and costs for care provided to individuals with disability levels below insurance benefit triggers

MONTHLY BENEFIT MAXIMUM AMOUNTS: BENCHMARKS (1 OF 2)

Cost Benchmarks

Daily/monthly benefit maximum scenario	Estimated (multiplicative) impact on cost
$150 / day (about $4,600 / month)	**N/A (baseline assumption)**
$100 / day (about $3,000 / month)	- 33.3%
$200 / day (about $6,100 / month)	+ 33.3%
$300 / day (about $9,100 / month)	+ 84.8%
$400 / day (about $12,200 / month)	+ 140.9%

⚠ Baseline assumptions are **only** used to facilitate pros/cons considerations and cost benchmarking

Source: 2020 Milliman CA LTSS Feasibility Study

Monthly cost by level of care (2020)

Level of care	Nationwide monthly median cost	California monthly cost		
		Low	Median	High
Homemaker	$4,481	$4,195	$5,529	$6,292
Home health aide	$4,576	$4,195	$5,529	$6,673
Adult day care	$1,603	$1,652	$1,733	$2,546
Assisted living facility (ALF)	$4,300	$3,613	$5,000	$6,250
NHF[1] - Semi-private room	$7,756	$7,396	$9,247	$12,547
NHF - Private room	$8,821	$7,396	$11,437	$15,208

Median home care cost by number of service hours

$4,398 35 hours of services per week

$5,529 44 hours of services per week

$7,037 56 hours of services per week

Source: Genworth 2020 Cost of Care survey

[1] NHF = Nursing Home Facility

LIFETIME BENEFIT MAXIMUM AMOUNTS: BENCHMARKS (2 OF 2)

Cost Benchmarks

Benefit period (BP) / lifetime maximum scenario	Estimated (multiplicative) impact on cost
2-year BP (about $110,000 lifetime)	**N/A (baseline assumption)**
1-year BP (about $55,000 lifetime)	- 44.5%
3-year BP (about $165,000 lifetime)	+ 37.0%
4-year BP (about $220,000 lifetime)	+ 67.2%
5-year BP (about $275,000 lifetime)	+ 91.6%
Unlimited/lifetime BP	+ 195.8%

⚠ Baseline assumptions are **only** used to facilitate pros/cons considerations and cost benchmarking

Source: 2020 Milliman CA LTSS Feasibility Study

Lifetime duration and cost of long-term care (2020)

3.7 average number of years of LTSS care needed for females

2.2 average number of years of LTSS care needed for males

$180,000 average lifetime cost of formal long-term care[1]

50% of individuals receive no formal care

70% of individuals incur formal costs below $50,000[2]

81% of individuals incur formal costs below $150,000[2]

12% of individuals incur formal costs above $250,000[2]

Sources: https://acl.gov/ltc/basic-needs/how-much-care-will-you-need; Formal Costs of Long-Term Care Services, PwC, 2021

[1] Based on private insurance data on a nationwide basis; excludes costs paid by Medicaid or Medicare and costs for care provided to individuals with disability levels below insurance benefit triggers
[2] After applying estimate cited in 2018 version of the PwC study that at least 50% of persons reaching age 65 will receive formal care

BENEFIT INFLATION: CONSIDERATIONS

Baseline assumption
Annual inflation, indexed to home care cost trends, capped at 4%
Inflation also applies to preventative benefit

⚠ Baseline assumptions are **only** used to facilitate pros/cons considerations and cost benchmarking

Pros

- Inflation level aligns with cost of care trends, which ensures benefits remain adequate for future generations of beneficiaries

Cons

- More costly than if inflation were linked to the CPI because home care cost trends have outpaced the CPI over the last 16 years[1]
- May increase administrative complexity as annual cost of care analysis would be required

Potential alternatives (non-exhaustive)

- Adjustments applied less frequently (e.g., bi-annually)
- Level inflation (e.g., 1% up to 5%)
- No inflation
- Inflation indexed to the CPI (or a sub-series of the CPI)
- Inflation indexed to California wage growth
- Varied by type of care needed (e.g., facility care vs. home care), location (e.g., in California versus outside California), etc.

[1] Genworth 2020 Cost of Care Survey

BENEFIT INFLATION: BENCHMARKS

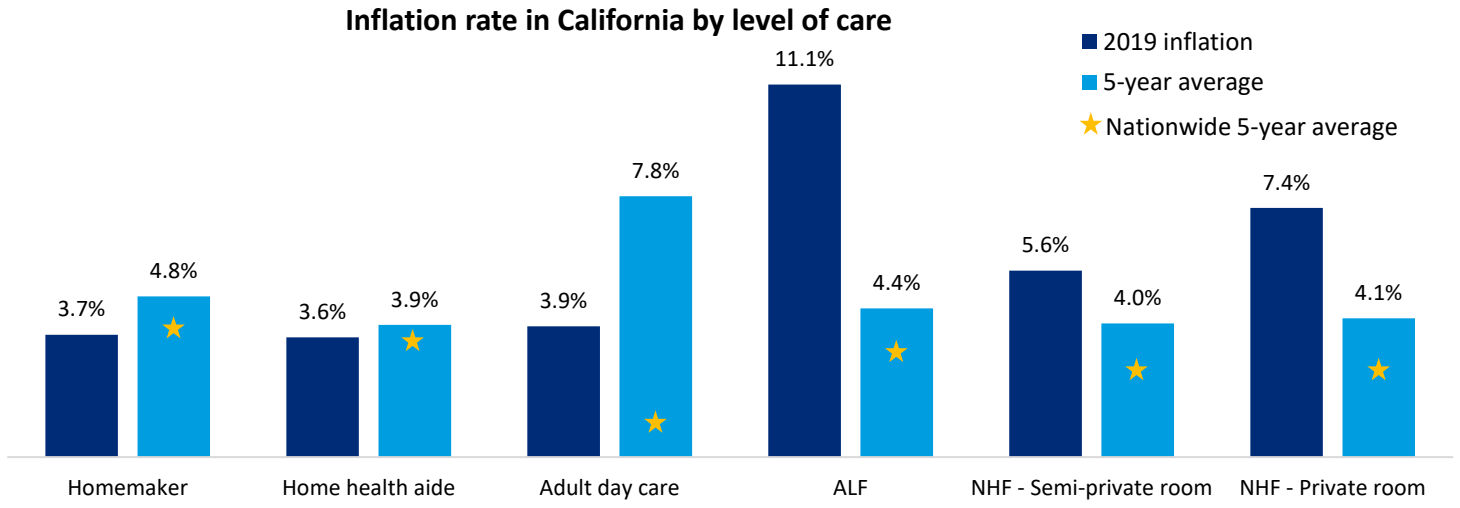
Cost Benchmarks

Benefit inflation scenario	Estimated (multiplicative) impact on cost
4.0% annual (proxy for inflation tied to care cost trends)	**N/A (baseline assumption)**
2.5% annual (proxy for inflation tied to CPI)	- 46.5%
3.0% annual	- 34.7%
3.5% annual (proxy for inflation tied to wage growth)	- 19.8%

⚠ Baseline assumptions are **only** used to facilitate pros/cons considerations and cost benchmarking

Source: 2020 Milliman CA LTSS Feasibility Study

Historical cost of care inflation by level of care (2020)



5-year average inflation

2.0%	**CPI-U**
3.2%	**CPI-U: Nursing homes[1]**
2.3%	**CPI-U: Care of elderly at home[1]**

Sources: Genworth 2020 Cost of Care survey; US Bureau of Labor Statistics

[1] Full CPI-U series titles are "Nursing homes and adult day services in U.S. city average, all urban consumers" and "Care of invalids and elderly at home in U.S. city average, all urban consumers"

ELIMINATION PERIOD: CONSIDERATIONS

Baseline assumption

Zero-day elimination period

⚠ Baseline assumptions are **only** used to facilitate pros/cons considerations and cost benchmarking

Pros

- Simpler (and potentially less costly as a result) to administer than a non-zero or varied elimination period
- 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-on LTSS costs
- Aligns with preliminary Task Force recommendation for a front-end benefit design
- Having no (or a short) elimination period is consistent with typical benefit design for private short-term care insurance

Cons

- More costly than a non-zero-day elimination period
- May result in a larger number of claims and potentially higher administration costs as a result
- May not facilitate coordination with private LTC insurance as a first payer
  - Private insurance policies typically have a non-zero elimination period
- Could be subject to abuse, especially if there is a cash benefit option and/or no age restrictions in program eligibility

Potential alternatives (non-exhaustive)

- Longer elimination period (e.g., 30-day up to 180-day)
- Varied by type of care needed (e.g., facility care vs. home care), location (e.g., in California versus outside California), income level, etc.

ELIMINATION PERIOD: BENCHMARKS

Cost Benchmarks

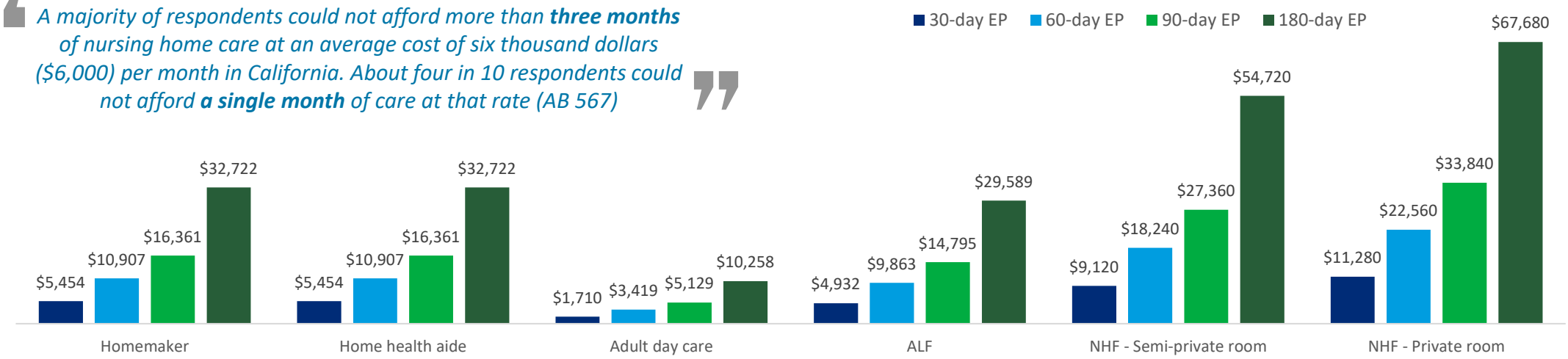
Elimination period (EP) scenario	Estimated (multiplicative) impact on cost
No (0-day) EP	**N/A (baseline assumption)**
30-day EP	- 4.2%
60-day EP	- 5.6%
90-day EP	- 8.3%
180-day EP	- 12.5%

⚠ Baseline assumptions are **only** used to facilitate pros/cons considerations and cost benchmarking

Source: 2020 Milliman CA LTSS Feasibility Study

Potential out-of-pocket costs incurred during an EP by level of care (California median monthly costs; 2020)

*"A majority of respondents could not afford more than **three months** of nursing home care at an average cost of six thousand dollars ($6,000) per month in California. About four in 10 respondents could not afford **a single month** of care at that rate (AB 567)"*



Source: Genworth 2020 Cost of Care survey

APPROVED CARE SETTINGS: CONSIDERATIONS

Baseline assumption

Home- and community-based services (HCBS) only

⚠ Baseline assumptions are **only** used to facilitate pros/cons considerations and cost benchmarking

Pros

- 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
- May promote private industry to offer supplementary products focused on institutional care (i.e., clear delineation of coverage between the program and supplementary private insurance)
- May be politically more feasible to enact and may alleviate demand on Medi-Cal IHSS program
- Aligns with Task Force preliminary recommendation for a front-end benefit design
- 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

Cons

- 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
- 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

Potential alternatives (non-exhaustive)

- Institutional care only coverage or comprehensive coverage

APPROVED CARE SETTING: BENCHMARKS

Cost Benchmarks

Approved care setting scenario	Estimated (multiplicative) impact on cost
Home care only	N/A (baseline assumption)
Comprehensive (home care and institutional care)	+ 65.0%

⚠ Baseline assumptions are **only** used to facilitate pros/cons considerations and cost benchmarking

Source: 2020 Milliman CA LTSS Feasibility Study

Usage by level of care (2020)

Level of care	Average number of years this type of care is used	Percent of individuals who use this type of care[1]
Home care		
Unpaid care only	1 year	59%
Paid care	Less than 1 year	42%
Any home care	2 years	65%
Facility care		
Nursing facilities	1 year	35%
Assisted living	Less than 1 year	13%
Any facility care	1 year	37%

Source: https://acl.gov/ltc/basic-needs/how-much-care-will-you-need

[1] Percentages do not add up to 100% as an individual may transition through multiple levels of care in their lifetime

COVERED SERVICES: CONSIDERATIONS

Baseline assumption

No restrictions on covered services so long as they can be provided in a home or community-based setting

Provide benefits for informal care received in the home, respite care, caregiver training, home modifications, etc.

⚠ Baseline assumptions are **only** used to facilitate pros/cons considerations and cost benchmarking

Pros

- Increases flexibility and choice
- Culturally competent and more equitable
  - Recognizes that different facets of California population may have different care preferences
  - Offering a wider range of approved services increases likelihood that there will be something for everyone
- Offers significant perceived value for minimal additional cost under the program

Cons

- May increase complexity of program administration
  - Need to establish broader provider networks
  - Approval of informal caregivers
  - Adjudication of claims for informal care
- May exacerbate potential LTSS workforce supply issues

Potential alternatives (non-exhaustive)

- Targeted services that are narrower in focus
- Varied by type of care needed (e.g., facility care vs. home care), location (e.g., in California versus outside California), etc.
- No explicit list of covered services (only applicable under a cash benefit only option)

PREVENTION MEASURES AND BENEFITS: CONSIDERATIONS

Baseline assumption

Provide maximum lifetime benefit of $1,000 (separate from other benefit maximums) for preventative measures/services that can be used at any time following satisfaction of program vesting requirements, if applicable.

⚠ Baseline assumptions are **only** used to facilitate pros/cons considerations and cost benchmarking

Pros

- Providing ancillary preventive benefits earlier may reduce anticipated costs under the program
  - May lessen claim severity and/or delay deterioration in an individual's ability to perform activities of daily living
  - May facilitate an individual living at home independently for a longer time before needing formal LTSS

Cons

- May result in a limited increase in costs (and potential for fraud)
  - Potentially offset by delay or reduction in claims
- May exacerbate potential LTSS workforce supply issues

Potential alternatives (non-exhaustive)

- Higher/lower preventative benefit amount (e.g., $500, $1,000 per year up to a $5,000 lifetime limit)
- Preventative benefits not available until after benefit eligibility criteria is satisfied
- No preventative benefit

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