OliverWyman

DRAFT - FOR DISCUSSION

Memo

Date: **21 July 2022**

Subject: **AB 567 Program Design "Straw Man" Task Force Member Commentary**

Assembly Bill 567 (AB 567) Task Force Members were asked to provide commentary on a "straw man" containing several potential program designs for inclusion in the AB 567 Feasibility Report. The following pages contain the commentary received (verbatim) from Task Force Members and members of the public (with minor edits for spelling, grammar, and punctuation).

Task Force Member	Designs 1 - 2	Designs 3 - 6	General commentary
Aron Alexander *Representative of residential care facilities for the elderly*		• If I were to make a vote today with the [straw man] as is, I would vote on Design 4 and may be swayed to vote for Design 5.	• The [program] design should be conservative enough to get passed through. • The [program] design should include [those ages] 65+. • The [program] design must include an approved selection of all types of care settings, including assisted living. • It is imperative that our older adults have the right to choose the care setting that best [suits] their physical, social, emotional, and financial needs. The reality is that the cost of moving into an assisted living [facility] is the most [cost-effective] option. The care costs are much less expensive in an assisted living setting than in a home care scenario. In addition, the cost to live at home and manage a household is also much more expensive for an individual vs a person living in an assisted living setting. [The] 2021 Genworth [Cost of Care] study shows assisted living as the least expensive option outside of Adult Day [Care] (which is not a comprehensive care option).

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Jamala Arland *Representative of the long-term care insurance industry*	• How was the $1,500 monthly benefit determined [for Design 1]? Genworth's Cost of Care [survey] notes adult day care at [a] median cost of a little over $1,800 [per month] in California. • [Furthermore], how was the [2-year benefit period] determined to be appropriate for this type of care? Many of these elements may be lump sum amounts vs. monthly ongoing costs. How does the design address [this]? • Also, a [5-year] vesting period seems very long for this type of benefit, and pro-rating too punitive. • [For Design 2, is] it right to think of this as income replacement / supplement? How was the $2,000 [monthly benefit] determined? [Median] formal home care costs are $6,000 monthly in California per Genworth's Cost of Care survey. • [Designs] 1 and 2 seem more like add-ons than programs meeting the spirit of [AB 567]. They do create a clear opportunity for a private supplemental market, with education about the extent of what is [covered].	• Designs 3-5 seem to be [for] a targeted population. • Design 3 mimics WA Cares and Design 6 is everything on the [Task Force] wish list—how do you extrapolate between those two bookends to define something intentional and [California]-specific? • I don't understand the approach for [Designs] 4 and 5, to the extent they are meant to be the result of the culmination of the last [year] of discussion.	• I don't think a [tax like Social Security] can be defined as progressive. Having an income cap is a regressive construct. • How does the intergenerational equity feature work with the vesting requirement? • What is the back-up plan if the investment initiative doesn't pass?

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	• What I do like about Design 1 and 2 is that they have a clear and important purpose, i.e., what they are intending to address, which [I] think is important politically. It is harder to see how to define that in the other program design options.		
Dean Chalios *Representative of hospice and palliative care providers*			• I thought [the straw man document] did a great job on laying out the alternatives and don't have any edits or suggestions.
Anastasia Dodson *California Department of Health Care Services Director Michelle Baass designee*			• I think the [Medi-Cal] "mutually exclusive" language may be confusing on its own, without the explanation about the potential federal waiver, or how it relates to the context of the other row about coordination, which specifies Medi-Cal is the payer of last resort. • Also, it may be confusing to have two separate rows. Perhaps combine the two rows, and add reference to the interest of the state in regaining the federal funds that would otherwise be lost? • Also, I haven't heard "mutually exclusive" used much before in policy discussions in this area, so perhaps don't use that phrase, since "mutually exclusive" may sound consistent with "coordinated" in the prior row.
Joe Garbanzos *Representative of a senior/consumer organization*			• Program design should include investments in novel delivery of care and services to achieve good outcomes. [Examples include] the PACE Program and [targeted cash] payments for outcome-based support/services to help beneficiaries stay at home and in their community. • [Benefits should be portable] ([i.e.,] qualified beneficiaries should be given the option to take prescribed benefits in a new home location).

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			• Program financing should be broad-based, progressive, sustainable, and capable of growing with enrollment. It should include a small payroll tax deduction [adjusted] based on income, [with an option for] an employer payroll tax. • Additional [modelling] runs that are based only on an employee payroll tax should be initiated to inform financing proposals. • Financing for a new LTSS program should be earmarked to an LTSS trust fund, [as] this would build adequate reserves to cover later generations. • Consumers have the right to determine and direct the LTSS they receive. That should include how and where LTSS is delivered and who provides it. • Services should be comprehensive, in accord with individuals' values and preferences, and should be provided in the least restrictive setting possible. • Limiting the benefit to specific care settings, such as restricting the option to receive ongoing 24-hour care provided [in] institutional settings or limiting the benefit only to the family caregiver will result in overly prescriptive plans that will not meet individuals' unique needs and wants, which would be unfair to Californians who have otherwise qualified for the care benefit. • Additionally, it is discriminatory to limit the benefit exclusively to individuals receiving care in a home setting performed by informal caregivers. Such a restriction negates an individual's contribution to the program and makes it inaccessible if they do not have friends or family willing or able to provide care in home. • Most California families do not have the ability to pay for significant services out-of-pocket for any [period]. Medicare only pays for short-term home health services after a hospitalization, but not for long-term care.

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			• [Benefits should be front-end]. Genworth's 2020 Cost of Care Survey found that, on average, home health and homemaker services cost around $4,500 per month at a national level, yet only 4.2% of Californians over the age of 40 have purchased a long-term care insurance policy. Additionally, adult day services cost an average of $1,603 per month nationally, while services provided in a nursing home are much more expensive—$7,756 per month for a semi-private room or $8,821 per month for a private room. • Eligibility should not exclude individuals disabled before the age of 18. Individuals who have vested into the program and meet [Activities of Daily Living (ADL)] requirements should qualify for the program, regardless of the age of disability onset. • Many people with disabilities work, and they may not qualify for Medi-Cal if they earn too much money. If they cannot receive coverage through the [program] benefit, they would be forced to spend down their own savings, quit work, or rely on family members to shoulder the high cost of LTSS. • California needs a new LTSS program that provides benefits that are flexible and responsive to each individual's unique needs. Such a program would preserve dignity and choice for individuals and their families by providing for their [services and supports] needs while these services are being funded by a new, sustainable source. • This new social program would also help relieve the increasing demographic and financial pressure on the Medi-Cal system, while also bringing California families much-needed relief.

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Laurel Lucia *Nongovernment health policy expert*		• For Design 6, I wanted to reiterate my question about the non-voluntary premium contributions and whether that is truly a feasible option. • My question partly stems from my experience with the ACA individual mandate and thinking about the legal challenges, the many exemptions to that mandate that should probably be considered here, etc. I don't think we need to figure out all of the details as a Task Force, but I think this idea warrants more discussion to at least address the basics of how this might work and whether this is an idea that is feasible enough to put forth in a report to policymakers.	• I would suggest re-labeling the 18+ and 65+ population options to something like "Adult population covered (18+)" and "Older adult population covered (65+)." I think there is a significant difference between those two population coverage options and using the same "broad population" wording for both diminishes that difference.
Doug Moore *Representative of independent providers of in-home personal care services*		• We [the United Domestic Workers of America] support [program design option] 3 (WA State model) as the modest proposal. • We would like to see [program design option] 6 because it covers everyone over 18, which doesn't cost that much more to do and then it's a program of LTSS for All not just LTSS for Seniors.	

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Parag Shah *Certified actuary with expertise in long-term care insurance*	• The distinction between designs 1 and 2 is not currently clear. • It may make sense to consider one lower-cost design that is a combination of designs 1 and 2 and then add a new design that is a more targeted (i.e., home care only) version of design 3. • For these designs, can we revisit the financing mechanism to consider alternative (non-payroll) taxes, such as general revenues or an employer/ corporate tax, which may only be feasible for lower cost designs (e.g., $100-200M range)? • [For Design 2, we should clarify whether the caregiver or care recipient receives the cash benefit]. If the former, some of the other design elements may not make sense (e.g., benefit eligibility trigger of 2 of 6 [ADLs]) and the vesting criteria would mean that a caregiver not on payroll (and thus not able to vest) cannot [receive the] benefit (e.g., a [stay-at-home] spouse who provides care to a family member)—is this the intent?	• [Design 3] currently looks like WA Cares Fund, which is the intent, but is that really desirable vs. having richer benefits with a more [targeted] application? Revising to only cover home care could allow for a [2-year] benefit period and $4,500 / month benefit for [roughly] same cost [based on my Task Force Meeting #12 presentation]. • Either update Design 3 to be more targeted on services with richer benefits or keep Design 3 as is (so we have a baseline WA Cares Fund version for cost comparison) and then create an alternative that is [leaner]. • At a minimum, revise Design 3 to assume no equity investments, which is consistent with WA Cares Fund. • "Select institutions" needs to be better defined ([maybe] include an example) as it is currently unclear.	• Should we have an upper age limit [for contributions] (such as age 65, if this is when benefit eligibility starts)? [This] may be more equitable given [the] typical retirement age and variation by income level. • Consider imposing an upper [program contribution] limit that is defined based on lifetime contributions paid vs. [an] upper wage limit ([e.g.,] the maximum contributions could be [twice] the maximum program benefits). • If an upper wage limit is applied, [$147,000] (the Social Security cap) is too low given California's income range—[a] limit [between $250,000 and $400,000] is more appropriate. • All designs currently assume investment in equities is allowed, which is optimistic given this requires a constitutional amendment. • Why were provisions for inter-generational equity applied only on the more rich/expensive program designs? Is this because there is greater inequity on these options? • Risk for discussion: those with businesses may be able to bypass [a payroll] tax; how can we design the financing so there is an expense to business owners? • The choice of age 65+ [for benefit eligibility] seems arbitrary. Why not age 60 or an alternative age? • Only having to contribute 5 years for full vesting seems too short (increases cost/risk)— [for simplicity], don't offer partial vesting until 5 years [of contributions] (vs. after 1 year). • The distinction between the various elements of private insurance coordination is not clear and should be refined to explicitly state the following options:

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			– Individuals with private insurance before program enactment may choose to opt out. In this case, they will be exempt from making program contributions and will not be eligible to receive any program benefits in the future. – If an individual purchases substitutive/non-wrap around private insurance after program enactment, they will be eligible for reduced program contributions (but full program benefits). Substitutive/non-wrap around private insurance pays before the state program. – In the future, private insurers may develop supplementary/ wrap-around private insurance that pays second relative to the state program. Such insurance is not eligible for reduced contributions. • It may be prudent to offer some form of incentivization for individuals to purchase supplementary/ wrap-around private insurance [in the future, as such] coverage would still reduce the burden on Medi-Cal, if not the [statewide] program. • The legislation and ultimate program design should mitigate the potential for fire sales—if there's a discount offered for substitutive/non-wrap around prive insurance, this may create a fire sale as consumers will want to maximize the discount offered. One solution could be to provide a refund for contributions paid over the reduced amount prior to purchase of eligible private insurance.
Dr. Karl Steinberg *Representative of long-term care health professionals*		• My [first] impressions would favor [program design] options 3 or 4, depending on the appetite for higher costs.	

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Brandi Wolf *Representative of an employee organization that represents long-term care workers*		• Overall, my support leans towards Designs 4 [and] 5, with some caveats.	• As part of my work [with the California Association of Directors of Activities (CADA)], it is our position that coverage should include all individuals who have vested in the program, including those [with] acquired disabilities at birth. The Milliman actuarial study showed that this wouldn't result in significant payroll tax increases. • The [Task Force] should carefully consider opt-outs and the potential for unintended consequences/ fiscal implications.

Public commentary - General
Response #1 • I would encourage us to prioritize the benefit and program designs which promotes flexibility: allowing funds (regardless of the daily or monthly dollar amount allocation) for choice in care settings. • Limiting the benefit to specific care settings (designs 1,2 & 3), restricting the option to receive PACE, ongoing 24-hour care provided outside of the home, or limiting the benefit to compensate only family (informal) caregivers providing care in a "home" (design 2) is overly prescriptive. • I sincerely hope that I am misreading the chart for design 2. If it does require care provided at home by informal caregivers I would think that approach is discriminatory against otherwise qualifying individuals if they do not have friends or family willing or able to provide care in a home. • Eligibility for the program should depend on vesting, the ADL need, and the beneficiary's personal preferences subject to the benefit period's financial limits or benefit maximum. **Response #2** • A corporate tax (i.e., a non-zero employer paid portion of the payroll tax) is likely a non-starter in California. The state is already unfriendly toward businesses in terms of the level of taxation. More business may move outside of California if additional taxes are imposed. • I like the proposed approach for private LTC coordination and suggest defining "eligible" LTC insurance for the purpose of the reduced contributions more broadly to promote private industry. For example, you could require eligible insurance to have the same benefit eligibility triggers (e.g., 2 of 6 ADLs or cognitive impairment) as the state program. This would allow chronic illness riders and short-term care insurance to quality for reduced contributions (these coverages provide LTC-type benefits and will reduce the program cost if they pay before the state program).