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AB 567 Oliver Wyman Feasibility Report and Actuarial Report

Frequently Asked Questions

Revised 12-20-23

1. **Question: What is the purpose of the Feasibility and Actuarial Reports?**
   Answer: Per Assembly Bill 567 (Calderon, Chapter 746, Statutes of 2019), which was further amended by Senate Bill 1255 (Committee on Insurance, Chapter 184, Statutes of 2020), the Feasibility Report explores how a statewide long-term care insurance program could be designed and implemented in California. The Actuarial Report assesses the potential cost and viability of the program recommendations contained in the Feasibility Report. Both reports include recommendations from the Task Force, however, the reports themselves do not establish any program. Task Force members were appointed by the Insurance Commissioner, the Governor, the Senate Committee on Rules, and the Assembly Speaker in addition to having the directors of the Departments of Health Care Services and Aging.

   Subsequent legislation would need to be introduced that would establish a statewide program and, in doing so, the Legislature may choose to follow many, some, or none of the recommendations of the Task Force. The Legislature would receive input from stakeholders and the public as part of its public deliberation process, and any subsequent legislation would also need to be signed by the Governor to be enacted.

2. **Question: What is the Task Force recommending in these reports?**
   Answer: In keeping with the statute, the Task Force is recommending five different options for establishing a statewide long-term care insurance program in California which span a wide range of benefits/coverage levels. These options have undergone financial analysis by Oliver Wyman to determine cost and solvency, and their findings are included in the Actuarial Report.

3. **Question: How were the reports developed?**
   Answer: The California Department of Insurance contracted with Oliver Wyman Actuarial Consulting, Inc. to facilitate Task Force discussions and help write both the Feasibility Report and the Actuarial Report. The Task Force held 24 public meetings, and three public Actuarial Subcommittee meetings, to develop and refine their recommendations, with robust participation and input from members of the public.

4. **Question: How soon could the Program be implemented?**
   Answer: The Task Force made its final recommendations to the Legislature in the Actuarial Report, which was due, and submitted by, January 1, 2024. At this point, subsequent legislation would be required to establish and implement a statewide program. January 1, 2024 is not the program effective date. It was the deadline for the Task Force to submit the Actuarial Report to the Legislature as set forth in the law. Neither the

Feasibility Report nor the Actuarial Report have the authority to establish any program.

5. **Question: How is the Program opt-out designed?**
   Answer: For four of the five program design options, the Task Force is recommending that individuals who own eligible private insurance on or before the program effective date (TBD) be permitted to opt out of the program. Any new policies sold after this deadline would be ineligible for program opt out, but could qualify for reduced program contributions. To be eligible to opt out, or receive reduced program contributions, the policy would have to meet certain standards (yet to be determined) and would be subject to periodic recertification. For one of the proposed design options, the Task Force did not recommend an opt-out provision.

6. **Question: What is the deadline to opt out of the Program?**
   Answer: At this time, there is no deadline. The Task Force is recommending that the deadline be on or before the effective date of any program the Legislature may choose to propose. It is up to the Legislature to determine the details of any program they may recommend, including the effective date of the Program and the deadline (if any) to opt out. The Legislature may choose to follow many, some, or none of the recommendations of the Task Force. The Legislature has not yet made any decisions about a public program and there is currently no "opt-out" date. Any communications that suggest otherwise are factually untrue.

7. **Question: How would the program be funded?**
   Answer: A progressive payroll tax, perhaps split between employees and employers, with an income-based tax for self-employed individuals is the prevalent design recommendation. Refer to Question 13 regarding the consideration of alternative financing mechanisms for individuals outside the payroll system.

8. **Question: Who will run this program?**
   Answer: Subsequent legislation would have to specify if existing infrastructure in California could be expanded upon to administer the program or if a new board, department, or agency would need to be created.

9. **Question: What services are covered under the program? Is the benefit enough to cover the cost of a nursing home?**
   Answer: Most of the recommended program design options in the report would provide comprehensive LTSS benefits, including coverage for a wide range of services such as home and community-based care, residential care facilities, and assisted living. Two of the program designs would also cover skilled nursing facilities. Under most designs, the maximum monthly benefit would cover most of the cost of an assisted living facility. Under the two program designs that cover skilled nursing facilities, the maximum monthly benefit would cover around half the cost of a semi-private room in a skilled nursing facility.

10. **Question: Will the program pay for care from family members?**
    Answer: There are recommended program designs in the reports that would provide reimbursement to informal or family caregivers subject to completion of certified caregiver training. Minimum training requirements that do not discourage benefit utilization would need to be defined in a culturally competent manner. Three out of five designs also include a cash benefit alternative (50% of reimbursement levels), which could also be used to pay family members who are providing care (without requiring certified caregiver

training). Each of the five designs also include supportive services such as caregiver relief, adult day care, transportation, durable medical equipment, home assessment, and minor home modifications.

11. **Question: Who is eligible for the program? Are undocumented residents eligible?**
    Answer: For most of the program designs, anyone that is fully vested in the program and over age 18 is eligible to receive benefits. Undocumented residents are eligible for benefits under every program design option.

12. **Question: If someone pays the tax for several years and then retires in another state, would they forfeit their benefits? What about people who work in California, but live in another state?**
    Answer: Each of the program design options recommended by the Task Force includes international portability, meaning some, if not all, of the individual's benefits would be accessible if the retiree moved to another state or country and was fully vested in the program. Similarly, if a person works in California, but lives in another state, they would be eligible for the program (if they are fully vested). [Note: The Task Force's preliminary recommendation on this issue in the Feasibility Report was updated in the Actuarial Report such that Designs 1 through 4 were expanded to include international portability based on the preliminary actuarial results.]

13. **Question: What about current retirees and people outside of the payroll tax system – will they be able to participate in the program?**
    Answer: The recommended program designs do not include current retirees. But several revenue sources were discussed to cover the current retiree population that is unable to vest into the program, including California General Fund revenue. See section 4.7.3.7.2. of the Feasibility Report and section 3.3 of the Actuarial Report for a full list of options and an analysis of the potential program expenditures for current retirees if they were included in the program.

14. **Question: Will there be a contribution cap?**
    Answer: Contribution limits were considered to ensure that benefit amounts are reasonable in relation to an individual's program contributions. The Actuarial Report assesses the financial impact of a range of caps (e.g., various multiples of the Social Security contribution limit), including the impact of not having a contribution cap. For all designs except Design 4, the Task Force recommended including a contribution cap of $400,000, indexed annually based on inflation.

15. **Question: Would lower-income workers make contributions and participate in the program?**
    Answer: For all designs, an individual's wages/income below a specified threshold (recommended as $30,000 by the Task Force, indexed annually based on inflation) are not subject to the program's contribution rates. This means individuals would be taxed only for the amount of their income that exceeds the threshold amount. In addition, for all designs except for Design 2, individuals with wages/income below the specified threshold would make no program contribution, but would receive a vesting credit as long as they work a minimum number of hours. For Design 2, individuals with wages/income below the specified threshold do not contribute and do not receive vesting credits to minimize duplication with California's Medicaid program (Medi-Cal).

16. **Question: Are the contribution/tax rates listed in the Actuarial Report what a person should expect to pay for the program?**

    Answer: The actuarial estimates in the report are intended to assist the Legislature in evaluating the feasibility of establishing a new public long-term care ("LTC") program. If the Legislature proceeds with such subsequent legislation, it may choose to adopt some, all, or none of the Task Force's recommendations. Given the numerous unknowns at this time, the contribution rate estimates in the Actuarial Report are not intended to, and should not, be used for setting a tax rate for a public LTC program without further refinement.

17. **Question: How do the Task Force's recommendations compare with Washington's public LTC program (WA Cares Fund)?**

    Answer: Both are considered state-sponsored LTC insurance programs, but there are numerous differences between WA Cares Fund and the Task Force's recommended program designs. While Design 3 was loosely inspired by WA Cares Fund, it has several notable differences, including (but not limited to), different benefit eligibility trigger, contribution waiver, contribution cap, employee/employer cost sharing, and benefits portability. Refer to section 2 of the Actuarial Report for an overview of each program design.

18. **Question: How would the program's benefits interact with California's Medicaid program (Medi-Cal)?**

    Answer: The Task Force recommended that the program coordinate with Medi-Cal as follows (refer to section 4 of the Actuarial Report for further details):

    - The program should pay LTSS benefits before Medi-Cal, because Medi-Cal is the payer of last resort by federal law.
    - 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 needs exceed the program's maximum benefit, the remaining services for a Medi-Cal eligible individual could be covered by Medi-Cal, subject to Medi-Cal eligibility rules, provider enrollment requirements, and reimbursement rates. 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 would receive these services through Medi-Cal.
    - 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).
    - 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 recommendation, because it intentionally targets individuals who are less likely to qualify for Medi-Cal as a means of limiting duplication with Medi-Cal and reducing program costs).
    - A federal demonstration waiver from CMS should be pursued to allow the state to retain any federal Medicaid savings (and Medicare savings, if applicable) attributable to the program. The Task Force proposed that any funds retained as a result of this waiver, if approved, be held in a trust fund to benefit the Program's enrollees.