State of California—Health and Human Services Agency
Department of Health Care Services

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

June 30, 2020

Long Term Services and Supports Feasibility Study Interim Report

The Budget Act of 2019, Assembly Bill 74 (Chapter 23, Statutes of 2019), Item 4260-101-0001, authorized funding for the Department of Health Care Services (DHCS) as follows:

> "16. Notwithstanding any other law, of the funds appropriated in this item, $1,000,000 shall be available to the State Department of Health Care Services for the purposes of contracting with a qualified entity for a feasibility study and actuarial analysis of long-term services and supports financing and services options. The study and analysis shall be developed in consultation with stakeholders and provide projected cost estimates of alternative financing and service options as well as possible impacts to existing state funded programs and services, including, but not limited to, Medi-Cal and the In-Home Supportive Services program. The results of the study shall be provided to the fiscal and policy committees of the Legislature and the Department of Finance no later than July 1, 2020."

DHCS selected Milliman, a national actuarial firm, to prepare this study. From November 2019 through January 2020, Milliman consulted with the state and a number of stakeholders in California, to gather information, priorities, and feedback for this study.

The attached Long Term Services and Supports Feasibility Study Interim Report was prepared by Milliman, and provides background, stakeholder findings, and a list of policy options. The upcoming Final Report will provide fiscal estimates of the policy options in the Interim Report. Please note that for both the Interim and Final Reports, the analysis, model design, and fiscal estimates are prepared independently by Milliman, and do not reflect proposals or commitments by the Administration.

For any questions on this Interim Report, please contact DHCS at PublicInput@dhcs.ca.gov.

MILLIMAN REPORT

Long-Term Services and Supports Feasibility Study Interim Report

Commissioned by the California Department of Health Care Services

June 18, 2020

Christopher Giese, FSA, MAAA
Principal and Consulting Actuary

Allen Schmitz, FSA, MAAA
Principal and Consulting Actuary

Rob Damler, FSA, MAAA
Principal and Consulting Actuary

Jeremy Cunningham, FSA, MAAA
Consulting Actuary

Annie Gunnlaugsson, ASA, MAAA
Associate Actuary

Sarah Wunder, FSA, MAAA
Consulting Actuary

15800 W. Bluemound Road
Suite 100
Brookfield, WI 53005
USA
Tel +1 262 784 2250
Fax +1 262 923 3680

milliman.com

Milliman


Milliman

Table of Contents

I. EXECUTIVE SUMMARY

OVERVIEW

Recognizing that California's over-65 population is projected to grow to 8.6 million by 2030, Governor Gavin Newsom issued an executive order calling for the creation of a Master Plan for Aging to be developed by October 1, 2020.[1] In conjunction with the Master Plan development efforts, Assembly Bill (AB) 74, Statutes of 2019, states that the California Department of Health Care Services (DHCS) will partner with a qualified contracting entity and various stakeholders to develop a long-term services and supports (LTSS) feasibility study (herein referred to as the feasibility study or LTSS feasibility study) that includes projected cost estimates of alternative financing and service options, as well as possible impacts to existing state-funded programs and services, including, but not limited to, Medi-Cal and the In-Home Supportive Services (IHSS) program.

Milliman, a national actuarial firm, was selected through a noncompetitive bid process to conduct the study. The feasibility study will include an analysis of a new public LTSS program, funded through a payroll deduction or other revenue, that would provide a limited LTSS insurance benefit in accordance with Assembly Bill 74, Statutes of 2019.[2] Future actuarial modeling after the feasibility study is completed may also include analyzing other options to help individuals finance LTSS needs, such as modifications to current public programs and private insurance.

Milliman will provide the final LTSS feasibility study in July 2020. Prior to the final report, Milliman agreed to provide an Interim Report. The purpose of this report is to provide background information on the LTSS feasibility study to both DHCS and to the Master Plan for Aging's LTSS Subcommittee, Stakeholder Advisory Committee, and the Cabinet Workgroup on Aging.

This report contains three main sections:

- Current and Proposed LTSS Financing Environment
- Stakeholder Report of Findings
- Feasibility Study Tasks and Next Steps

Current and Proposed LTSS Financing Environment

Before exploring alternative financing solutions, it is important to understand the current programs in place to finance LTSS. Section II of this report describes current LTSS financing at the state, federal, and global levels. In particular, this section summarizes:

- The current sources of LTSS financing in the United States, and specifically in California
- How LTSS is financed in several other countries
- Proposed alternative financing solutions for LTSS in the United States (both at the state and federal levels)

Stakeholder Report of Findings

A critical first step for the design of various LTSS finance reform approaches is to identify both the problems to be solved and the policy objectives that are most important to address. We gathered input from many stakeholders in California through a series of interviews and small group discussions. The stakeholder input was used to determine the final scope of program parameters to model. Section III: Stakeholder Report of Findings summarizes the stakeholder interview process and outcomes that, with guidance from the state, helped determine the potential new public LTSS program parameters and alternatives we will model as part of the study.

Feasibility Study Tasks and Next Steps

Milliman's final LTSS feasibility study report will include both qualitative and quantitative analyses. The analyses are currently in progress and, therefore, are not included in this report. We instead provide an update on the tasks completed to date, as well as a description of next steps for our actuarial analysis and final report. This should help individuals understand the type of information that will be presented in the final report.

[1] Executive Department State of California. Executive Order N-14-19. (2019) Retrieved February 20, 2020, from https://www.gov.ca.gov/wp-content/uploads/2019/06/6.10.19-Master-Plan-for-Aging-EO.pdf

[2] Assembly Bill 74, Statues of 2019. (2019) Retrieved February 20, 2020, from https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB74

II. CURRENT AND PROPOSED LTSS FINANCING ENVIRONMENT

BACKGROUND

The California Department of Health Care Services (DHCS) is conducting a feasibility study regarding options to help Californians prepare to meet their LTSS and long-term care (LTC) needs. The feasibility study was mandated by California AB 74 in the 2019-20 session. Milliman was engaged by DHCS as a contractor to perform this feasibility study, including the required modeling and actuarial analysis. As part of this study, Milliman was tasked with providing a summary of:

- The current state of LTSS financing in the United States, and specifically in California
- How LTSS is financed in other countries
- Potential alternative financing solutions for LTSS in the United States (proposed both at the state and federal levels)

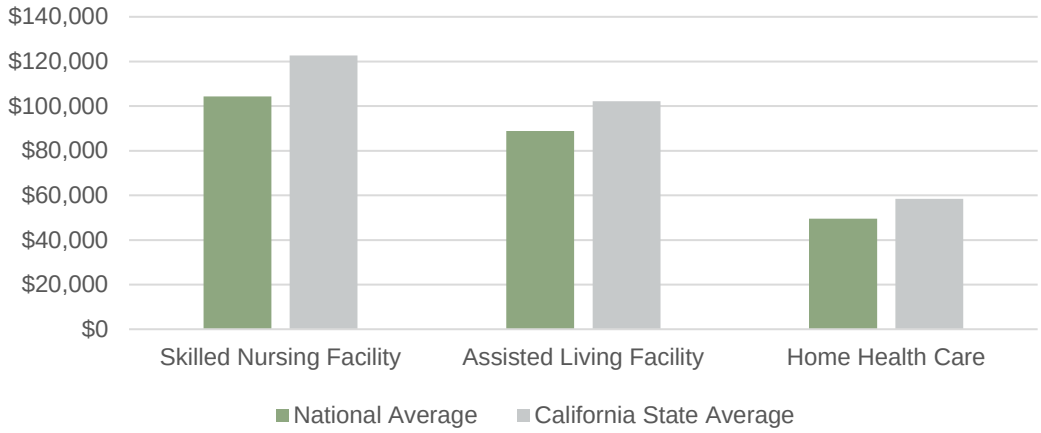
For the purposes of this report, we use the terms LTSS and LTC interchangeably. LTSS is a range of services and supports for individuals who need assistance with daily living tasks, such as bathing, dressing, ambulation, transfers, toileting, medication administration or assistance, personal hygiene, transportation, skilled and social supports, and other health-related tasks. Often, this type of assistance is needed by individuals who experience functional limitations that are due to age or physical or cognitive disability. LTSS includes services provided in:

- Institutional settings - Includes skilled, intermediate, and custodial care provided in an institutional facility setting, such as a nursing home or dedicated wing of a hospital.

- Home and community-based settings (HCBS) - Includes care provided in a person's own home or in a community-based setting, such as an assisted living facility or adult family home.

The average annual cost of LTSS varies by care setting and geographic setting. Figure 1 shows the median daily cost of formal LTSS in the three most common care settings nationally: skilled nursing facility (SNF), assisted living facility (ALF), and home health care (HHC). Please note that HHC reflects individuals receiving care through a home health agency and does not include California's IHSS program. While some areas in California have lower costs of care than the national average, most regions in California have average costs of care that exceed the national average.

FIGURE 1: 2019 ESTIMATED ANNUAL MEDIAN COST OF LONG-TERM CARE



Source: 2019 Genworth Cost of Care Survey, as well as other sources. ALF costs determined based on relative relationship to SNF as observed in private ILTCI market data.

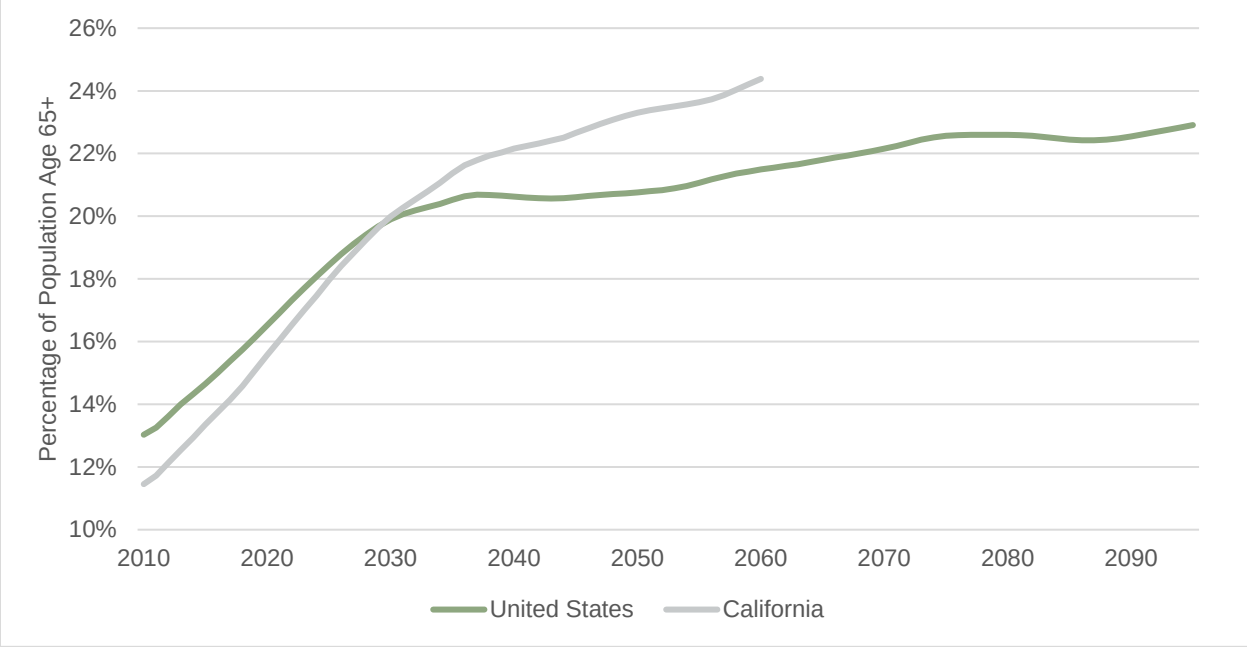
Further, most individuals require care for longer than one year, often driving total costs well beyond $100,000 in an individual's lifetime. Figure 2 provides a sample distribution of expected expenditures by year, paid over an individual's lifetime for someone currently age 65. The distribution is estimated from data on the claims experience of the private insurance market, where need is defined as an individual qualifying for benefits under the HIPAA benefit trigger (requiring substantial assistance with two of six activities of daily living, or severe cognitive impairment).[3] Figure 2 shows the average individual age 65 with some LTC needs will incur the majority of costs over a number of years (e.g., 73% of costs are paid beyond the first year of needing LTC).

FIGURE 2: SAMPLE LTC EXPENDITURES BY YEAR PAID FOR INDIVIDUAL CURRENTLY AGE 65 WITH SOME LTC NEEDS OVER REMAINING LIFETIME

	< 1 YEAR	1-2 YEARS	2-3 YEARS	3-4 YEARS	4-5 YEARS	5-6 YEARS	> 6 YEARS
Female	23%	18%	14%	11%	8%	6%	20%
Male	31%	21%	14%	10%	7%	5%	12%
Composite	27%	19%	14%	10%	8%	6%	16%

For a typical population, the need for LTSS increases sharply with age. As an example, in private LTC data we observe that individuals in their 80s might be 10 to 30 times more likely to require care compared to individuals in their 50s. The sharp increase in LTSS needs as individuals age creates significant financial challenges as the U.S. aged population continues to grow. Over the next several decades a larger percentage of the population will be at the ages when LTSS needs are greatest. The 2019 OASDI (Social Security) Trustees report projects that the percentage of the U.S. population over the age of 65 will exceed 20% by 2030.[4] Similarly, the California Department of Finance projects that the percentage of the Californians over age 65 will exceed 20% by 2031.[5] Both projections are illustrated in Figure 3.

FIGURE 3: PROJECTED PERCENTAGE OF POPULATION AGED 65+



[3] 26 U.S. Code § 7702B - Treatment of qualified long-term care insurance. (n.d.). Retrieved February 19, 2020, from https://www.law.cornell.edu/uscode/text/26/7702B.
[4] The Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds (2019). The 2019 Annual Report of the Board of Trustees of the Federal OASDI Trust Funds. Retrieved February 12, 2020, from https://www.ssa.gov/OACT/TR/2019/.
[5] State of California Department of Finance (2020). Demographics. Retrieved February 12, 2020, from http://www.dof.ca.gov/Forecasting/Demographics/.

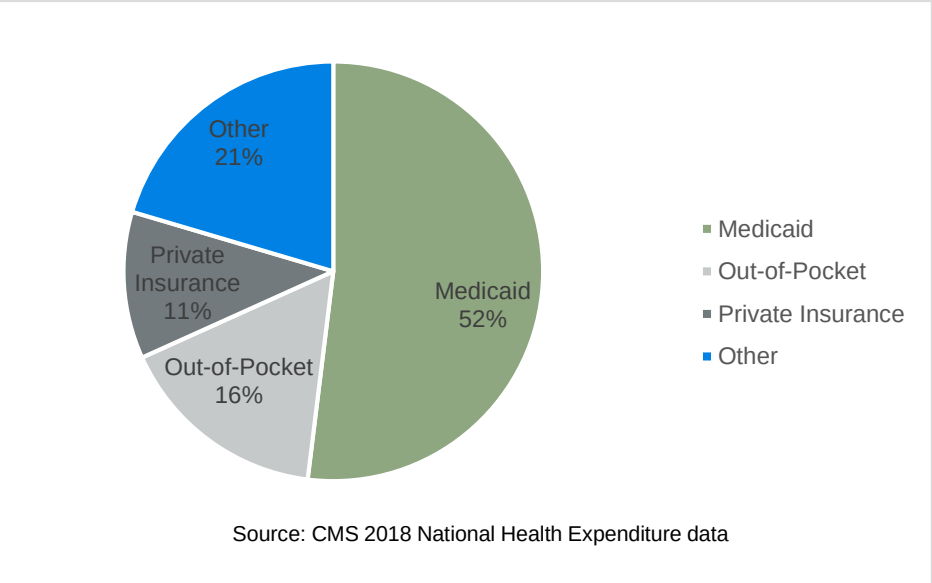
CURRENT LTSS FINANCING IN UNITED STATES

In the United States, a number of payers contribute to the cost of LTSS, including:

- Medicaid
- Individuals out-of-pocket
- Private insurance market
- Other sources, such as other private or federal revenues, the Indian Health Service, workers' compensation, general assistance, and other state and local programs

Figure 4 shows the percentage each payer contributes to total national spending on LTSS. The distribution of payers in Figure 4 comes from the 2018 National Health Expenditure Accounts (NHEA) data produced by the Centers for Medicare and Medicaid Services (CMS).[6] Notably, Medicaid is the largest payer, accounting for more than half of LTSS expenditures. For the purposes of this report, we exclude from the total LTSS expenditures Medicare spending on nursing care, home health care, or personal care provided as part of post-acute care.

FIGURE 4: 2018 NATIONAL SPENDING FOR LTSS BY PAYER



Source: CMS 2018 National Health Expenditure data

Medicaid

Medicaid LTSS Benefits and Programs

Medicaid is the primary payer of LTSS in the United States. Of the $379 billion spent on LTSS in 2017, 52% was paid for by Medicaid.[7] Medicaid is jointly funded by states and the federal government, but LTSS may require individual out-of-pocket costs as well. All state Medicaid programs are required to provide nursing facility services and home health state plan services to those who qualify for Medicaid and meet medical necessity criteria.[8] Many states have expanded the availability of LTSS to include more HCBS options in addition to home health because they are often lower-cost.[9] There are three optional state plan benefits—1915(i), personal care (i.e., 1915[j]), and Community First Choice (CFC, i.e., 1915[k])—and two types of waivers—1915(c) and 1115—that states can utilize to provide LTSS in home and community-based settings.[10] In recent years, states have either begun or continued efforts to increase HCBS

[6] CMS. National Health Expenditure Data. Retrieved February 12, 2020, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.

[7] Musumeci, M., Chidambaram, P., & O'Malley Watts, M. (February 2020). Medicaid Home and Community-Based Services Enrollment and Spending. Kaiser Family Foundation Issue Brief. Retrieved February 12, 2020, from http://files.kff.org/attachment/Issue-Brief-Medicaid-Home-and-Community-Based-Services-Enrollment-and-Spending.

[8] Thach, N., & Wiener, J. (May 2018). An Overview of Long-Term Services and Supports and Medicaid. U.S. Department of Health and Human Services.. Retrieved February 12, 2020, from https://aspe.hhs.gov/system/files/pdf/259521/LTSSMedicaid.pdf.

[9] Fox-Grage, W., & Walls, J. (March 2013). State Studies Find Home and Community-Based Services to Be Cost-Effective. AARP Public Policy Institute. Retrieved February 12, 2020, from https://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/state-studies-find-hcbs-cost-effective-spotlight-AARP-ppi-ltc.pdf.

[10] Musumeci, M. et al., op cit.

utilization in place of institutional care to contain LTSS spending and keep elderly and disabled individuals in their communities.[11]

California's Medicaid program, which encompasses "Medi-Cal," IHSS, and services provided under the Departments for Developmental Services and Aging among others, utilizes a number of waivers, state plan amendments, and other programs to serve Medicaid beneficiaries outside of institutional settings. As much of California's Medicaid program provides LTSS services within a managed care environment, we are unable to directly assess the total LTSS expenditures across the fee-for-service and managed care programs. However, we have estimated using national statistics that the California Medicaid program spent between $25 billion and $30 billion on LTSS expenditures in 2017, including both institutional care and HCBS. California spends approximately 76% of their fee-for-service LTSS expenditures in HCBS settings (compared to the U.S. average of 56%); however, the 76% value may be overstated for comparison purposes to the U.S. average to the extent the managed care LTSS expenditures (which are significant in California) reflect a higher proportion of institutional services.[12,13] Appendix 1 provides high-level background for each of California's Medicaid LTSS benefits and programs

Eligibility for Medicaid LTSS

The populations that require LTSS—typically older adults and individuals with physical or intellectual/developmental disabilities—generally qualify for Medicaid either because they receive Supplemental Security Income (SSI) or through an aged, blind, or disabled (ABD) pathway.[14] The ABD pathways in California include: Poverty-Related, Katie Beckett, Buy-In, and Medically Needy.[15,16] Figure 5 outlines the eligibility criteria for several of the ABD pathways, as well as how California covers the populations generally eligible for Medicaid using these pathways.

FIGURE 5: ABD ELIGIBILITY PATHWAYS, CRITERIA, AND CALIFORNIA COVERAGE

ABD PATHWAY	CRITERIA	CALIFORNIA
Poverty-Related	100% Federal Poverty Level (FPL)	Must be 65 or older, blind or disabled; have less than $2,000 in assets for an individual or $3,000 for a couple; have countable income less than 100% of FPL plus a standard income disregard of $230 for an individual or $310 for a couple
Katie Beckett	Children with disabilities under age 18 who live at home, meet the SSI definition of disability, require nursing facility care, and have income up to 300% FBR (222% FPL in 2019)	Covered under one of five comparable HCBS waivers
Buy-In	Working individuals with disabilities or working families who have children with a disability. Various income levels	Must be disabled; be working and earning income; have less than $2,000 in assets for an individual or $3,000 for a couple; have countable income less than 250% of FPL
Medically Needy	Individuals with high medical expenses, but too much income to otherwise qualify for Medicaid[17] Individuals eligible under this pathway do not have a maximum income limit, but are required to share in the cost as described below.	Must be 65 or older, blind, or disabled; have less than $2,000 in assets for an individual or $3,000 for a couple

In California, an individual can become eligible for Medicaid through the Medically Needy pathway by paying a share of the medical expenses, called a "share of cost." An individual's share of cost is calculated as that person's income less the "Maintenance Need Standard," which is $600 per month for an individual in the community, $934 for a couple,

[11] Medicaid.gov. Home & Community Based Services. Retrieved February 12, 2020, from https://www.medicaid.gov/medicaid/home-community-based-services/index.html; Fox-Grage, W., & Walls, J., op cit.

[12] Musumeci, M., Chidambaram, P., O'Malley Watts, M. (2019). Medicaid Home and Community-Based Services Enrollment and Spending. *Kaiser Family Foundation*, 2. Retrieved January 29, 2020, from http://files.kff.org/attachment/Issue-Brief-Medicaid-Home-and-Community-Based-Services-Enrollment-and-Spending

[13] MACPAC, 2019, analysis of CMS-64 FMR net expenditure data as of June 17, 2019. MACStats Exhibit 17. Total Medicaid Benefit Spending by State and Category. Retrieved February 5, 2020, from https://www.macpac.gov/publication/total-medicaid-benefit-spending-by-state-and-category/

[14] Colello, K. J., & Morton, W. R. (December 9, 2019). Medicaid Eligibility: Older Adults and Individuals with Disabilities. Congressional Research Service. Retrieved February 12, 2020, from https://crsreports.congress.gov/product/pdf/R/R46111. The ABD population is called "Seniors or Persons with Disabilities" (SPD) in California; California Health Care Foundation (June 29, 2017). Medi-Cal Enrollment of Seniors and People with Disabilities, County by County. Retrieved February 12, 2020, from https://www.chcf.org/publication/medi-cal-enrollment-of-seniors-and-people-with-disabilities-county-by-county/#related-links-and-downloads.

[15] Colello, K. J., & Morton, W. R., ibid.

[16] This paper does not discuss all Medicaid eligibility pathways. It focuses only on those pathways relevant to the populations receiving LTSS. Individuals may qualify for Medicaid in other ways, including by meeting Medicaid Expansion eligibility criteria.

[17] Colello, K. J., & Morton, W. R., op cit.

and $35 as a personal needs allowance for individuals in nursing homes (income deductions may also apply).[18] Once beneficiaries pay their share of cost, Medi-Cal covers the rest of their medical expenses for the month.[19] The share of cost payment has been described as functioning like a deductible.[20] This ensures that the majority of an individual's income would go towards their care while they are in the LTC facility, thus, offsetting some of the financial burden from the state.

Given the significant cost to receive LTSS, an individual's assets and/or income may decrease during that person's treatment. As a result, it is common for individuals (in particular for those in the middle class) to "spend down" their income and assets below the applicable federal poverty level and gain Medicaid eligibility through the Poverty-Related pathway. Research suggests nearly 40% of nursing home residents who receive Medicaid originally entered as private payers prior to spending down their assets and gaining Medicaid eligibility.[21] In California, this process can be complicated due to a California law that prohibits asset transfers for 30 months before an individual becomes eligible for Medicaid.[22] There are also trusts an individual can use to protect income and assets and still qualify for Medicaid.[23]

For purposes of this LTSS feasibility study, we will refer to the "share of cost" population as those who have too much income to qualify for Medicaid on an ongoing basis, so they share in the cost of services each month. The "spend-down" population will include those who spend down their income and assets and gain full Medicaid eligibility indefinitely.

How would a new public LTSS program interact with Medicaid?

Medicaid is generally the payer of last resort.[24] This means private insurance, including LTC insurance or Medicare must pay for medical costs incurred by a Medicaid-eligible individual before Medicaid.[25] This financing system generally incentivizes private sector initiatives and sees Medicaid as an option for individuals otherwise unable to provide for themselves.[26] If California created a new public LTSS program, it may provide LTSS coverage before Medicaid would pay or concurrently with Medicaid, similar to other non-Medicaid payers.

Given Medi-Cal is jointly funded by California and the federal government, if Medicaid expenditures were reduced because of the new public LTSS program, federal financial participation would also be reduced. Therefore, as part of this LTSS feasibility study, we are working with DHCS to understand how a new public LTSS program would interact with the Medicaid program and how DHCS could potentially limit the overlap between the two programs.

Understanding where the current Medicaid funding and a new public LTSS program would potentially overlap in the future (e.g., 40 years from now for a 35-year-old person needing LTSS at age 75) is challenging. Fully capturing the overlap in funding requires the following information:

- Has the person qualified for the new public LTSS program when needing LTSS (referred to as "benefit vesting")?
- Does the person qualify for Medicaid at the time of needing LTSS?
- Would the person "spend-down" and gain Medicaid eligibility *without* the new public LTSS program?
- Would the person "spend-down" and gain Medicaid eligibility *with* the new public LTSS program?

[18] California Advocates for Nursing Home Reform (February 3, 2020). Overview of Medi-Cal for Long Term Care. Retrieved February 12, 2020, from http://www.canhr.org/factsheets/medi-cal_fs/html/fs_medcal_overview.htm.
[19] California HealthCare Foundation (September 2010). Share of Cost Medi-Cal. Retrieved February 12, 2020, from https://www.chcf.org/wp-content/uploads/2017/12/PDF-ShareOfCostMediCal2010.pdf.
[20] California Health Advocates. Medi-Cal (for People with Medicare). Retrieved February 12, 2020, from https://cahealthadvocates.org/low-income-help/medi-cal-for-people-with-medicare/.

[21] U.S. Department of Health and Human Services (January 1, 1992). An Analysis of the Impact of Spend-Down on Medicaid Expenditures. ASPE. Retrieved February 12, 2020, from https://aspe.hhs.gov/basic-report/analysis-impact-spend-down-medicaid-expenditures#impact.
[22] American Council on Aging (January 2, 2020). California Medicaid (Medi-Cal) Income & Asset Limits for Nursing Homes & Long Term Care. Retrieved February 12, 2020, from https://www.medicaidplanningassistance.org/medicaid-eligibility-california/.
[23] Paying for Senior Care (January 2, 2020). Using the Medically Needy/Share of Cost Pathway as a Means to Gain Medicaid Eligibility. Retrieved February 12, 2020, from https://www.payingforseniorcare.com/medicaid/share_of_cost.
[24] U.S. Department of Health and Human Services (June 1, 2018). Medicaid Provisions in Recently Passed Federal Budget Legislation Bipartisan Budget Act of 2018 – Third Party Liability in Medicaid and CHIP. Retrieved February 12, 2020, from https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/cib060118.pdf
[25] Medicaid and CHIP Payment and Access Commission. Third party liability. Retrieved February 12, 2020, from https://www.macpac.gov/subtopic/third-party-liability/.
[26] Wiener, J. M. & O'Keeffe, J. (March 2011). Long-Term Care Reform Options in Hawaii. Hawaii Long-Term Care Commission. Retrieved February 12, 2020, from http://www.publicpolicycenter.hawaii.edu/projects-programs/_long-term-care/RTI_Options_Report-FINAL.pdf.

Setting up processes to capture the answers to these questions for each person receiving services through the new public LTSS program would likely be needed to best estimate the state and federal Medicaid savings resulting from the program. One avenue to capture the reduction in Medicaid federal financial participation (i.e., federal savings) that resulted from the creation of this potential new LTSS program is through a CMS Waiver. Currently, the state of Washington is pursuing a CMS Waiver as part of its new public LTSS program to retain the federal savings from the new program.[27]

LTSS and Managed Care

In California, LTSS are carved out of the managed care contract, except for individuals enrolled in managed care in Coordinated Care Initiative (CCI) counties, individuals enrolled in a County Organized Health System (COHS) plan in select programs and counties that cover LTSS, and the first 60 days of LTC for individuals enrolled in managed care in the Two Plan model counties. The CCI was passed in 2012 and requires nearly all Medi-Cal beneficiaries in selected counties age 21 and older to join a managed care plan to receive Medi-Cal LTSS benefits.[28,29]

The state of California recently released a proposal entitled "Medi-Cal Healthier California for All." The proposal calls for DHCS to transition the managed care programs under the CCI into a statewide Managed LTSS (MLTSS) program in conjunction with Dual-Eligible Special Needs Plans (D-SNPs). The state envisions the transition to statewide MLTSS would take six years.[30] The collection of complete and accurate encounter data from the statewide MLTSS program will be critical to measure LTSS expenditures over time, especially if DHCS pursues a CMS Waiver to capture federal savings from a potential new public LTSS program.

Private Insurance Market

Approximately 11% of national LTSS expenditures are financed through the private insurance market. Although long-term care is a risk with high frequency (approximately 50% of 65-year-olds will need formal long-term care in their lifetimes) and high severity (as seen in Figure 1 above, median annual costs often exceed $100,000), it is rarely insured in the private market. In fact, in California less than 5% of the adult population age 40 and older has purchased a private long-term care insurance policy as of 2018.[31]

One reason for the low prevalence of private long-term care insurance in the United States is the high cost of purchasing a policy, with the average premium per new life rising to $2,544 in 2018.[32] The cost of private insurance has continued to increase over the past decade. Many private market insurance companies have filed for rate increases on groups or "classes" of policyholders because actual experience has been worse than anticipated compared with original pricing assumptions. The high price serves as a barrier for many individuals outside of the upper class wishing to obtain coverage, as illustrated in a 2016 study of private LTC insurance purchasers.[33] While only 36% of the general population 50 and older have incomes above $75,000, approximately 61% of LTC insurance purchasers surveyed had incomes above $75,000.

In addition to financial barriers, underwriting is used in the private market to align premiums with the underlying health risks of policyholders; therefore, individuals who apply for LTC policies are not guaranteed to be accepted for coverage. For those able to purchase LTC insurance, the majority of policies offer comprehensive benefits that reimburse costs of formal long-term care received in institutional or home care settings up to a benefit maximum. The private insurance market offers individuals a wide variety of benefit options including:

- Benefit period options (three years is the most common and coverage is typically structured as a "pool of money" derived from the benefit period duration times the daily benefit amount)

[27] The full text of the Washington state law is available at https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/1087-S2.SL.pdf.
[28] DHCS (March 2013). Coordinated Care Initiative Executive Summary. Retrieved February 12, 2020, from http://calduals.org/wp-content/uploads/2013/03/1-CCI-Overview.pdf.
[29] DHCS (December 20, 2019). CCI Information for Beneficiaries. Retrieved February 12, 2020, from https://www.dhcs.ca.gov/Pages/CCI-Info-Bene.aspx.
[30] DHCS (December 9, 2019). Expanding Access to Integrated Care for Dual Eligible Californians. Retrieved February 12, 2020, from http://calduals.org/wp-content/uploads/2020/01/Expanding-Access-to-Integrated-Care-for-Dual-Eligible-Californians-FINAL.pdf.
[31] Summarized from CalPERS data (https://www.calpers.ca.gov/docs/board-agendas/201902/financeadmin/item9a-01_a.pdf) and company-submitted financial annual statement: Long-Term Care Experience Reporting Form 5 (source: Aggregated data from SNL Financial: http://www.snl.com).
[32] Thau, C., Schmitz, A., & Giese, C. (July 1, 2019). 2019 Milliman Long Term Care Insurance Survey. Broker World. Retrieved February 12, 2020, from https://brokerworldmag.com/2019-milliman-long-term-care-insurance-survey/.
[33] LifePlans (January 2017). Who Buys Long-Term Care Insurance? Twenty-Five Years of Study of Buyers and Non-Buyers in 2015-2016. Retrieved February 12, 2020, from https://www.ahip.org/wp-content/uploads/2017/01/LifePlans_LTC_2016_1.5.17.pdf.

- Elimination period options (the period of time during which the policyholder has a qualifying degree of disability, but policy benefits are not paid—90 days is the most common)
- Inflation options (3% compound inflation is common, inflating both the "pool of money" and any daily or monthly benefit limits)
- Various levels of underwriting
- Premium discounts including marital, preferred, and worksite
- Coordination with governmental programs including Medicaid and Medicare

Individuals are typically eligible for benefits when they have severe cognitive impairment or require assistance with two of the six designated activities of daily living (ADLs)—bathing, dressing, eating, transferring, toileting, and continence—where the condition is expected to last at least 90 days. More information on the private LTC insurance market and typical attributes of private LTC insurance policies can be found in the Broker World 2019 Milliman Long Term Care Survey.[34]

While most long-term care insurance sales continue to decrease, "combination" policies (or policies that provide LTC insurance benefits combined with life insurance or annuity coverage) are growing in popularity. The Pension Protection Act of 2006 (PPA) opened the door for combination products featuring long-term care riders. The PPA clarified that charges for tax-qualified or non-qualified LTC riders on life policies are deemed distributions (retroactive to the enactment of HIPAA in 1996), but for tax-qualified riders those distributions beginning in 2010 will not be taxable, but rather will reduce the basis in the contract. The law also addresses non-qualified annuity contracts by stating LTC benefits paid are generally paid as tax-free LTC benefits. LTC payments from tax-qualified LTC riders on life insurance or annuity contracts are tax-free to the extent that they reimburse actual LTC expenses or are less than an annually adjusted per diem limit if paid on an indemnity basis. The market outlook for combination products is described as positive in a recent Contingencies article.[35]

In California, the private market also includes the California Public Employees' Retirement System (CalPERS) LTC program, a voluntary LTC program available to California state employees since 1995. As of June 2018, the CalPERS program had 124,000 policies in-force.[36] The CalPERS program has faced many of the same challenges as the rest of the private market, including large rate increases that have been met with lawsuits.[37]

Individuals Out-of-Pocket

As shown in Figure 4 above, individuals paying out-of-pocket are the second-largest payer of LTSS, after Medicaid. The majority of this cost comes from individuals whose income is too high to qualify for Medicaid, but who still cannot afford or qualify for private LTC insurance. Many of these individuals are not prepared to pay for the ultimate cost of long-term care and end up spending down their assets until they do qualify for Medicaid.

The individuals who exist in the insurance "gap" between Medicaid and private LTC insurance are often the focus of efforts to explore alternative financing solutions for LTC. After conversations with stakeholders in California, it is clear this "middle-income" group is one of the main populations of focus as part of this feasibility study.

The cost allocated to individuals paying out-of-pocket does not include the cost to individuals who serve as informal caregivers to family and friends. Despite not being included in Figure 4, the intergenerational cost to those giving informal care is often part of the conversation with regard to exploring alternative financing solutions (for example, it is addressed as part of the Hawaii Kupuna Caregivers Act which is discussed later in this report).

[34] See https://brokerworldmag.com/2019-milliman-long-term-care-insurance-survey/.
[35] Friedrich, C. et al. Unlocking potential—new combination long-term care insurance solutions show promise. Contingencies. Retrieved February 12, 2020, from http://contingencies.org/unlocking-potential-new-combination-long-term-care-insurance-solutions-show-promise/.
[36] CalPERS Long-Term Care Program (June 30, 2018). CalPERS Long-Term Care Actuarial Valuation as of June 30, 2018. Retrieved February 12, 2020, from https://www.calpers.ca.gov/docs/board-agendas/201902/financeadmin/item9a-01_a.pdf.
[37] Venteicher, W. (2019, June 10). Did CalPERS mislead policyholders on long-term care insurance? Trial begins on a $1.2 billion lawsuit. Retrieved February 19, 2020, from https://www.sacbee.com/news/politics-government/the-state-worker/article231329758.html.

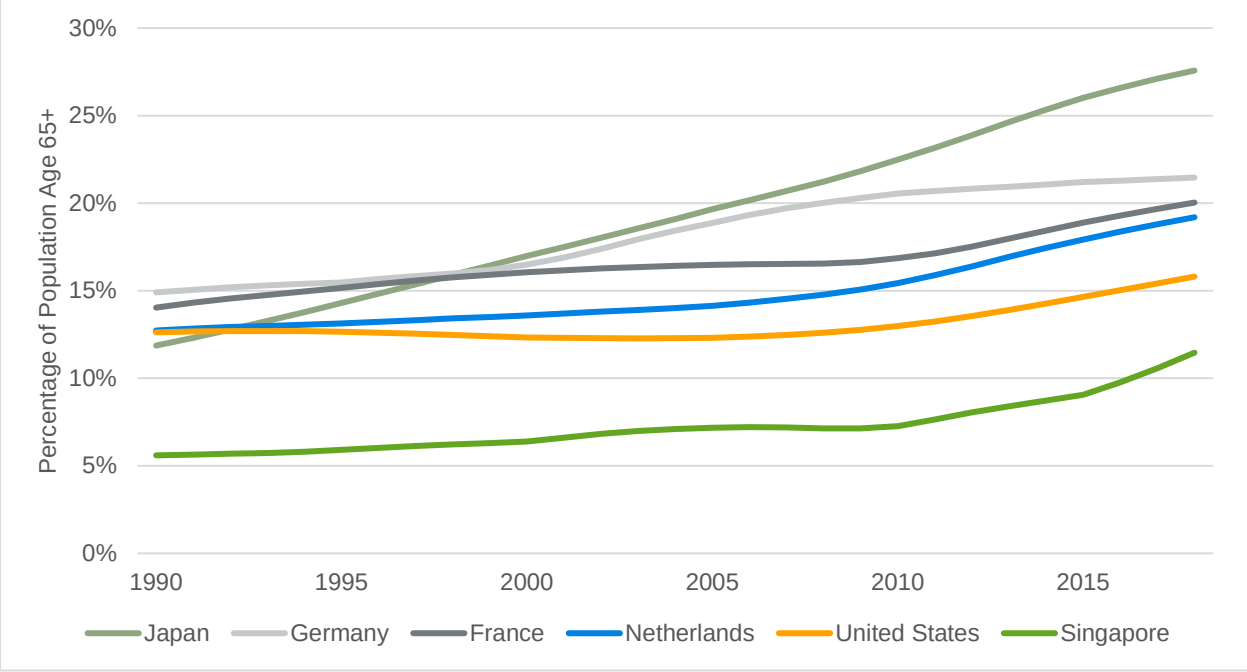
Other Sources

Other sources of funding for long-term services and supports include worksite healthcare, other private revenues, Indian Health Service, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, other federal programs, Substance Abuse and Mental Health Services Administration (SAMHSA), other state and local programs, and school health.[38]

CURRENT LTSS FINANCING IN OTHER COUNTRIES

The United States is not alone in its aging population. We examined rates of aging and the LTSS environment for five other nations. The five were selected in an effort to get a cross-section of funding approaches, aging growth, and based on the availability of information. As Figure 6 illustrates, the populations of the five other nations studied for this report are also experiencing significant rates of aging.[39] These nations (France, Germany, Japan, the Netherlands, and Singapore) support their aging populations in different ways, some of which are described below.

FIGURE 6: PERCENTAGE OF POPULATION AGED 65+ BY COUNTRY



Netherlands

In 1968, the Netherlands became the first country to establish a universal, social LTC insurance program: the General Exceptional Medical Expenses Act (AWBZ).[40] The program covered catastrophic medical costs and LTC expenses, including institutional care and home health care, as well as some cash benefits. All citizens were eligible for the program, which was administered by private insurance companies. Despite offering some cash benefits, over time the percentage of individuals receiving informal care decreased compared to other countries.

The increasing cost of the program ultimately led to the replacement of AWBZ with the Long-Term Care Act in 2015. The current program limits benefit recipients to “elderly people in the advanced stages of dementia, people with serious physical or intellectual disabilities, and people with long-term psychiatric disorders.” A standardized assessment

[38] CMS, National Health Expenditure Data, op cit.
[39] World Bank. Population Ages 65 and Above (% of total population). Retrieved February 12, 2020, from https://data.worldbank.org/indicator/SP.POP.65UP.TO.ZS.

[40] Gleckman, H. (February 2010). Long-Term Care Financing Reform: Lessons From the U.S. and Abroad. Washington, DC: Commonwealth Fund. Retrieved February 12, 2020, from https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2010_feb_1368_gleckman_longterm_care_financing_reform_lessons_us_abroad.pdf.

determines an individual's benefit eligibility and also the functions and services to which an individual is entitled. The program is funded by an income tax assessment (9.65% of income up to a maximum assessment of approximately USD 3,500 in 2015[41]), as well as an income-dependent contribution charged to beneficiaries.

Additional information on the Netherlands program can be found at: https://www.eiseverywhere.com/file_uploads/0f57b7c2d0d94ff45769269d50876905_P4-HealthcareintheNetherlands.pdf.

Japan

With 27.6% of its population over age 65 (the largest percentage in the world), Japan has long offered government-funded LTC for the country's aged population. Japan implemented its current universal long-term care insurance program in 2000. It covers 90% of an individual's cost of care (the individual is responsible for the other 10%, up to an income-adjusted out-of-pocket maximum). Benefits are provided to individuals age 65 and above (or disabled individuals 40 and above) who have met eligibility criteria determined at the local government level. Eligible benefits and services, which include institutional and home health care, vary by an individual's determination of need. An individual's level of need is reevaluated at least every two years. Cash benefits are not offered in Japan.

Japan's program is funded through means-tested mandatory premiums (for those over age 40) and various forms of tax revenue. Very few private LTC insurance policies are sold in Japan, and the ones that are sold are normally supplemental policies sold to wealthy individuals.

Over the years, Japan has struggled with "social hospitalization," long waiting lists, and a shortage of care facilities and health workers. Additional information on Japan's universal LTC program can be found at: http://japanhpn.org/en/longtermcare/.

Germany

Since the mid-1990s, Germany has mandated LTC coverage for its citizens with the option of receiving coverage either through a private insurance benefit or the more widely selected public offering. Only about 10% of individuals, who tend to be wealthier, elect to purchase private insurance plans. The remaining 90% of the population contribute to the public program through a payroll tax (which is split between the employer and employee) and retiree premiums.

The public program is administered by a combination of public and private insurers and is overseen by the government. Benefit eligibility is determined using ADL and mental cognition-driven criteria. These criteria are also used to determine the level of benefits and maximum expenditures for which an individual is eligible. Benefits include institutional and home health care, as well as a lower-valued cash benefit.

Despite the lower value of the cash benefit compared to the service benefits, the vast majority of beneficiaries opt to receive the cash benefit, which many use to pay for informal support while remaining in their own homes.[42] Germany continues to explore opportunities to promote the use of already popular home care benefits, including through two LTC-strengthening acts passed in 2015, which further expanded home care benefits and other benefits supporting self-reliance for beneficiaries, especially for beneficiaries living with dementia.[43]

Additional information can be found at: https://www.bundesgesundheitsministerium.de/english-version/topics/long-term-care/long-term-care-insurance.html.

France

France has explored a number of social LTC benefits over the past 30 years targeting different populations at federal, provincial, and local levels of government. The most notable form of LTC coverage in France is the Personalized Autonomy Allowance (APA) program.[44] APA is not intended to cover the full cost of long-term care, though it provides a partial benefit to individuals age 60 and older who need assistance performing essential activities of daily living. Benefit eligibility is determined by a set of standard criteria used across the country and administered by medical teams.

[41] Belastingdienst. Maximum Contribution Base for 2015. Retrieved February 12, 2020, from https://www.belastingdienst.nl/wps/wcm/connect/bldcontenten/belastingdienst/individuals/moving_internationally/social_security/how_is_the_contribution_calculated/maximum_contribution_base/maximum_contribution_base_for_2015.

[42] Gibson, M. J., & Redfoot, D. L. (October 2007). In Brief: Comparing Long-Term Care in Germany and the United States. Retrieved February 12, 2020, from https://www.aarp.org/home-garden/livable-communities/info-2007/inb150_usgerman_ltc.html.

[43] Federal Ministry of Health. The Long-Term Care Insurance in Germany. Retrieved February 13, 2020, from https://www.bundesgesundheitsministerium.de/english-version/topics/long-term-care/long-term-care-insurance.html.

[44] Le Bihan, B. & Sopadzhiyan, A. (November 2017). CEQUA Country Report: France. Retrieved February 13, 2020, from https://1d520973-35f0-4e46-8af0-304ac08d8794.filesusr.com/ugd/442c21_1248c8d9e1be47b791fd1254c2fb31d8.pdf.

Benefit eligibility also determines the benefit maximum for which an individual is eligible. The monthly benefit paid to an individual is the maximum benefit reduced by an individual's participation amount (or copayment). The copayment amount is based on income, where the wealthiest individuals' copayments are as high as 90%. The APA is funded through local and federal general revenues.

Additional information about the APA, as well as other government-funded LTC benefits in France, can be found at: https://ec.europa.eu/social/main.jsp?catId=1110&langId=en&intPageId=4536.

Singapore

Singapore originally introduced a long-term care social insurance program in 2002, called "ElderShield," providing a cash benefit of SGD 300 to SGD 400 per month (about USD 294) for up to five or six years (depending on the joining date) for its severely disabled citizens. The program's benefit eligibility is based on a person's inability to perform three or more activities of daily living. The ElderShield program was offered and administered by private insurers, requiring citizens to pay level premiums, varying by entry age, during their working years (i.e., up to age 65). The program was not compulsory. Though citizens were automatically enrolled around age 40, an enrollee could opt out of coverage.

Beginning in 2020, the government-run "CareShield Life" program will largely replace the ElderShield program. The CareShield Life program is compulsory and offers SGD 600 (about USD 430) cash payments per month for as long as a person is disabled. All Singaporeans currently age 30 to 40 are required to start paying CareShield Life premiums to replace the optional ElderShield coverage. Citizens over the age of 40 have the option of keeping the ElderShield benefits (and premium) or upgrading to CareShield Life benefits (and corresponding premium increase). Payments are made until age 67 and can increase in future years.

Additional information can be found at: https://www.moh.gov.sg/careshieldlife/about-eldershield.

PROPOSALS FOR ALTERNATIVE LTSS FINANCING

While California is at the forefront exploring alternative financing solutions for LTSS, initiatives have also been explored at the federal and state levels in the United States. At the federal level, this includes the repealed CLASS Act and proposed Medicare Long-Term Care Services and Supports Act. Two initiatives at the state level have been passed into law, with Washington passing the Trust Act in 2019 and Hawaii passing the Kupuna Caregivers Act in 2015. In this section we discuss these initiatives, as well as other proposals.

CLASS Act

Perhaps the most well-known example of proposed alternative financing for LTSS is the Community Living Assistance Services and Supports (CLASS) Act that was included (and ultimately repealed) as part of the Patient Protection and Affordable Care Act (ACA). The CLASS program was to be a voluntary, guaranteed-issue program funded through payroll deductions. Individuals who paid into the program for at least five years would be eligible for benefits if they met eligibility criteria. Benefits under the program were to be cash payments correlating to an individual's degree of impairment, but not subject to any lifetime maximum.

Ultimately, the CLASS Act was not deemed to be actuarially sound and was repealed in 2013. It was determined not to be actuarially sound primarily due to the potential adverse selection from offering a benefit on a voluntary and guaranteed issue basis. More information on the CLASS Act can be found at: https://www.soa.org/globalassets/assets/files/sections/prof-sec-ltc-class-act.pdf.

Hawaii Kupuna Caregivers Act[45]

The Kupuna Caregivers Act established a pilot program that currently provides up to a $210 weekly payment to informal caregivers in the state of Hawaii. To be eligible, the caregiver must work 30 hours per week beyond being an informal caregiver, and the individual receiving care must be at least 60 years old and require assistance with two ADLs or instrumental activities of daily living (IADLs) or have cognitive impairment. There are no income or asset requirements to qualify. The benefit is not an entitlement program, so if the program is at capacity, not all eligible individuals will be entitled to receive benefits.

Additional information on this program can be found at: https://www.payingforseniorcare.com/hawaii/kupuna-caregivers.

[45] Paying for Senior Care. Hawaii's Kupuna Caregivers Program: Helping Working Families to Care for Their Loved Ones. Retrieved February 13, 2020, from https://www.payingforseniorcare.com/hawaii/kupuna-caregivers.

Washington State Trust Act

The Washington Trust Act established the first U.S. social insurance program to pay for long-term care, with the first taxes to be collected in 2022 and first benefits to be paid in 2025. The Trust Act created a state-based social insurance program funded through a payroll tax (0.58% on all wages). The social program offers front-end benefits ($100 daily benefit amount, 365-day benefit period) to vested individuals. The daily benefit inflates each year by a rate less than or equal to the Washington consumer price index (CPI) and can be used to reimburse costs of receiving care in a home, residential community-based setting, or skilled nursing facility. Individuals vest into the program by paying the payroll tax for 10 years over their lifetimes or three of the last six years before benefit eligibility.

More information on the Trust Act can be found at: http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Amendments/Senate/1087-S2%20AMS%20ENGR%20S3352.E.pdf.

LTC in Medicare Advantage

Starting in 2019, Medicare Advantage (MA) plans are able to provide certain LTC benefits as primarily health-related (PHR) benefits for individuals who need assistance with ADLs or IADLs. While there are potential concerns about introducing LTC benefits as part of a MA plan (specifically related to anti-selection and potential increase to MA premiums[46]), a number of MA plans did start offering supplemental LTC benefits as part of the 2019 plan year. Figure 7 shows four of the nine supplemental benefits described in a CMS memorandum along with the number of plans covering them.

FIGURE 7: 2019 MA PLANS OFFERING CMS-SUGGESTED BENEFITS UNDER EXPANDED PHR DEFINITION[47]

2019 SUPPLEMENTAL BENEFIT	COUNT OF PLANS
Adult daycare services	2
Home-based palliative care	8
In-home support services	60
Support for caregivers (aka respite care)	421

Credit for Caring Act

In May 2019, the Credit for Caring Act was introduced to the U.S. House of Representatives and referred to the House Committee on Ways and Means. Similar to Hawaii's caregiver program, the Credit for Caring Act would create a tax credit for informal family caregivers. To receive the tax credit, the individual receiving care must be certified to need care for 180 days and the family caregiver must meet income requirements. The status of this bill can be followed on the U.S. Congress website: https://www.congress.gov/bill/116th-congress/house-bill/2730/all-info.

Medicare Long-Term Care Services and Supports Act of 2018

The Medicare Long-Term Care Services and Supports Act was a 2018 bill from Rep. Frank Pallone (D-N.J.) that was designed to establish an LTSS cash benefit within Medicare. The benefit would be offered as part of Medicare Part A (and also available to others without Part A who meet disability criteria) and would provide a cash benefit equal to at least five hours of home care services per day. Benefits would be available to individuals who require assistance with three or more ADLs after a two-year waiting period or cash deductible. The bill has not gained significant traction to date.

More information on the Medicare Long-Term Care Services and Supports Act of 2018 can be found at: https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/LTSS%20Act%20Section%20by%20Section%20May%202018.pdf.

[46] Giese, C. & Schmitz, A. (June 2018). Are Medicare Advantage Plans Ready for the High Costs of Long-Term Care? Milliman White Paper. Retrieved February 13, 2020, from https://us.milliman.com/insight/Are-Medicare-Advantage-plans-ready-for-the-high-costs-of-long-term-care.

[47] Alcocer, P., Eaton, R., & Laboy, P. (February 2019). LTSS Services in Medicare Advantage Plans. Milliman White Paper. Retrieved February 13, 2020, from https://www.milliman.com/insight/LTSS-services-in-Medicare-Advantage-Plans.

Other

Several government task forces and committees have been established to address aging-related issues, including:

- The U.S. House Committee on Ways and Means held a committee hearing on "Caring for Aging Americans" on November 14, 2019. Information on the testimony provided, including a transcript of the hearing, can be found at: https://waysandmeans.house.gov/legislation/hearings/caring-aging-americans.

- In 2017, the U.S. Department of the Treasury developed a Federal Interagency Task Force on Long-Term Care Insurance. The task force continues to explore reforms to LTC insurance regulation and as recently as July 2019 held a public meeting on this topic. Information on the task force and its work can be found at: https://home.treasury.gov/policy-issues/economic-policy/economic-policy-reports-and-notices/federal-interagency-task-force-on-long-term-care-insurance.

Other examples of organizations studying alternative LTSS financing solutions include: Bipartisan Policy Center (BPC), National Academy of Social Insurance (NASI), RWJ Foundation, SCAN Foundation, and the Society of Actuaries (SOA). As part of a 2014 think tank, the SOA published a study exploring a number of alternative financing options, which are included in Figure 8.

FIGURE 8: SOA STUDY OF ALTERNATIVE FINANCING OPTIONS

ALTERNATIVE FINANCING OPTION	DESCRIPTION
LTC savings program	Mandatory savings account to save for LTC or LTC insurance (LTCI).
High-deductible health plan (HDHP)	Back-end LTC insurance plan that would provide catastrophic coverage after a waiting period of one to three years.
Short-term care	Front-end LTC insurance plan that would provide limited coverage during the first one to two years of an LTC event.
Medicare LTC	Federal LTC program that would borrow Medicare's structure, where Part A would provide basic benefits and Parts B to F would provide supplemental coverage for extra premium.
Mutual LTC	Noncancelable LTC insurance plan where premiums are fixed and benefits are subject to available funds.
Tax-deferred savings	Tax reform to allow tax-deferred personal savings accounts to be used to purchase long-term care insurance or pay for long-term care expenses.
National reinsurance	Catastrophic reinsurance for private LTC insurers.
Medicaid tightening	Restriction on Medicaid eligibility to make it harder for individuals with significant assets to gain coverage.
Medicaid modernization	Enabling Medicaid to pay for care in a larger range of settings, including home and community-based settings.
Changing LTC legislation and regulations	Changes to National Association of Insurance Commissioners (NAIC) Model Act to provide more flexibility for LTC benefits.
Improving the way LTCI is marketed and sold	Increased education around the risks of LTC need.

More information on the ideas from the 2014 SOA think tank can be found at: https://www.soa.org/resources/research-reports/2014/research-2014-ltp-ltc/.

Additionally, the American Academy of Actuaries hosted a roundtable called "A National Conversation on Long-Term Care Financing" that established the following list of essential criteria for long-term care financing reform:

1. Coverage
2. Comprehensiveness of benefits
3. Quality of care
4. Understandability and choice
5. Affordability
6. Risk management and cost control
7. Financial soundness and sustainability

An overview of each of these criteria can be found at: https://www.actuary.org/content/essential-criteria-long-term-care-financing-reform-proposals.

III. STAKEHOLDER REPORT OF FINDINGS

INTRODUCTION

The first crucial step in this feasibility study is to understand the stakeholder perspectives on both the nature of the problem and the proposed alternative financing and service options. This section provides a summary of stakeholder perspectives and the methodology through which these insights were obtained.

METHODOLOGY

Stakeholder Identification

Stakeholders include a wide variety of entities within government, finance, advocacy, and the care delivery network. Please note that the definition of stakeholders for purposes of the LTSS feasibility study includes government entities, which is different than DHCS' usual definition of stakeholders. Note that the description of findings from the stakeholder interviews below primarily reflect the feedback from the Master Plan for Aging LTSS Subcommittee and the California Aging and Disability Alliance (CADA), rather than state agencies or departments. The perspectives summarized in this section do not represent an official opinion from the participating entities. DHCS organized and convened a three-day session for intensive interviews with stakeholders in November 2019. Individuals participating in the stakeholder interviews represented the following organizations and departments:

- CalPERS
- DHCS
- Master Plan for Aging LTSS Subcommittee
- California Department of Social Services (CDSS)
- California Department of Aging (CDA)
- California Department of Finance
- California Aging and Disability Alliance (CADA)
- Legislative Analyst's Office (LAO)
- California Department of Insurance (CDI)

Interview Protocol

We developed an interview protocol with variations appropriate to different stakeholder groups, as well as several common elements across all interviews. The interviews ranged from one-hour to three-hour timeframes in order to maximize the amount of feedback collected. While the protocol included some closed-category questions, it was largely exploratory and qualitative in nature, serving as a springboard for conversation and exploration on key topics. The team also encouraged stakeholders to raise issues that may not have been anticipated in the interview protocol.
A sample of the interview protocol is found in Appendix 2.

Pre-Interview Survey

In advance of the in-person interviews, we wanted to explore the extent of consensus and divergence with respect to stakeholder perspectives specifically related to the key principles of primary importance in LTSS finance reform. We also asked stakeholders to identify other important areas of concern to address in the analysis. A brief survey was created and distributed via email to stakeholders. Only a small sample of individuals completed the survey; therefore, no conclusions were derived from it.

A copy of the survey is included in Appendix 3.

KEY FINDINGS

This section summarizes the stakeholder feedback received during both the in-person meetings in November 2019 and other discussions with stakeholders via virtual meetings.

Primary Goals

An important starting place for a discussion of the design of various LTSS finance reform approaches is to identify both the problems to be solved and the policy objectives that are most important to address. There was consensus around the problem definition. Stakeholders believed many aging and disabled individuals that reside in California cannot afford and are not adequately supported when long-term services and supports are needed. There were many varying

opinions on what a new public LTSS program policy should address. Some individuals wanted to focus on the middle-class aging population, some wanted to focus on specific target populations (e.g., Alzheimer's), and others wanted the program to benefit all individuals in need of LTSS.

In the current environment, financial coverage for LTSS varies by economic status. Low economic status individuals are eligible for LTSS coverage through Medicaid. Medicaid eligibility varies by state and program. High economic status individuals are wealthy enough to purchase private LTC insurance policies or to self-fund LTSS needs. There is a gap for middle-income individuals. Typically, these individuals are required to spend down their assets to qualify for Medicaid and receive LTSS coverage. However, this creates financial strain on the individual, as well as their families, leading to a multigenerational problem.

Limitations of a Private Market Solution

Missteps of the private market were discussed briefly, pointing out that market penetration has remained small and citing concerns with affordability and rate stability. There was little to no interest in exploring private market alternatives. There was consensus the feasibility study should focus on public financing alternatives. There were several discussions surrounding the interaction of a potential public LTSS program and the current private market, including individuals with policies through CalPERS.

Medicaid Program Interaction

Stakeholders were proud of the current performance of California's Medicaid program, which provides extensive LTSS benefits, particularly through the IHSS program. However, many middle-class individuals have to spend down their assets to receive Medicaid benefits when an LTSS need occurs. Stakeholders expressed the desire to ensure that as few people as possible end up impoverishing themselves and their families because of LTSS costs. Delaying or preventing Medicaid spend-down was cited as an important policy objective for an LTSS finance reform.

Given CMS guidelines surrounding federal matching for state Medicaid spending, a stand-alone LTSS program may be required to pay before the Medicaid program, as Medicaid is typically the payer of last resort. Several discussions with stakeholders centered on the most efficient and effective way to pay for LTSS. A new stand-alone LTSS program would not receive federal matching dollars and, therefore, may not be the most cost-effective way to provide LTSS benefits to Medicaid-eligible individuals. As a result, stakeholders were interested in seeing scenarios that showed the impact of including and excluding the Medicaid-eligible population on overall state spending, including the impact to the Medicaid budget.

California Specifics

California is a geographically diverse state given its vast expanse. Regions in the state range from urban to very rural. Therefore, LTSS provider access, utilization of services, and cost of services vary widely across the state as well. Stakeholders were interested in ensuring the study focused on the state as a whole, not focusing only on the urban populations, to capture any differences among the state's regions.

LTSS Program Modeling Components

After the discussion of policy objectives and concerns, stakeholders were asked to share their thoughts and preferences with regard to each of the specific options to be included in the actuarial analysis. This was an opportunity for them to identify priorities for the parameters of those options or to raise questions and concerns about the various approaches.

Mandatory vs. Voluntary

There was consensus among stakeholders that the LTSS program should be mandatory. Many stakeholders were familiar with the CLASS Act and the challenges of addressing adverse selection. Stakeholders expressed their assumption that a voluntary program is not a viable option.

However, many stakeholders did want to consider opt-out privileges for individuals who already have LTC coverage, including individuals who have private LTC and CalPERS policies. There were some beginning discussions around the operational aspects of these opt-outs; however, more technical discussions will be needed if opt-outs are considered for the LTSS program.

Eligible Population

Throughout the interviews, a number of stakeholders believed the new LTSS program should benefit as many individuals as possible, including both the aged and disabled populations. There were several discussions surrounding the inclusion or exclusion of the working disabled population as their income may preclude them from receiving some of the benefits of California's current public programs. Many individuals felt as though this population is not receiving the funding that they deserve. However, there was not consensus on whether or not the LTSS program would be the correct venue to address this problem.

Most commonly, the private LTC insurance market requires the HIPAA benefit eligibility trigger of needing assistance with two or more ADLs. California's IHSS program has a more lenient benefit trigger of needing assistance with one or more ADLs, including IADLs. Stakeholders showed interest in the IHSS benefit trigger definitions in addition to private market definitions, indicating IADLs were important in the state of California for some stakeholders.

Partial vs. Robust

Some stakeholders believed the new LTSS program should ideally cover all LTSS costs for all individuals. However, stakeholders understand that providing a robust benefit comes at a significant cost. Therefore, stakeholders focused on discussing a program that would provide a smaller benefit to a greater number of individuals.

Eligible Benefits

Several of the stakeholder meetings had discussion surrounding the definition of LTC and LTSS, as well as what benefits would be eligible under a new public LTSS program. There was stakeholder consensus that the benefits should be transferrable across care settings (e.g., home and community-based services, assisted living facilities, nursing facilities, etc.), including having the ability to pay for one-time costs that would allow for individuals to remain in their homes. Further discussion will be required following the LTSS feasibility study to define what services will be eligible under a new public LTSS program.

Front-End vs Back-End Coverage

Many of the stakeholder discussions focused on a front-end benefit. A front-end benefit would provide a limited coverage benefit at or near the beginning of an individual's eligibility for LTSS. A back-end benefit would provide catastrophic coverage for individuals requiring LTSS that survived a longer period of time (e.g., two years) to receive benefits. They believed a back-end benefit would not support the targeted middle-income individual as these individuals would inevitably spend-down their assets quickly and become eligible for Medicaid LTSS coverage.

Portability

The challenge of addressing portability in a state program was raised. Many discussions regarding portability revolved around the operational issues surrounding allowing benefit portability. Stakeholders were interested in quantifying the financial impact of several portability variations.

Revenue Funding

A fundamental facet in creating a new LTSS program is the funding source for the LTSS benefits. There was consensus among the non-state entity stakeholders around creating an additional payroll tax to fund the benefits. Stakeholders did not show interest in funding through premium payments. Given the complexity of the tax system, a payroll tax can be applied in numerous ways. For the purposes of the feasibility study, a flat payroll tax will be calculated for ease of comparison. In practice, stakeholders believed a progressive tax might be more appropriate. More detailed discussions involving the revenue source should occur once more specifics are determined regarding the new LTSS program.

CONCLUSION

Over the three-day interview process and subsequent follow-up discussions, we collected a significant amount of valuable feedback. We were pleased with the engagement from all the stakeholders who provided new and thoughtful insights into this complex issue. It is crucial to understand what issues are most important to the stakeholders in California, as this will help inform the next steps in the feasibility study.

There are a variety of potential financing solutions for LTSS. This was evident throughout the interviews as there was not a consensus around the desired structure of the potential new public LTSS program.

The stakeholder feedback was used to create a list of modeling alternatives for actuarial analysis. Many stakeholders expressed that the actuarial analysis would be most useful if it contained a wide variety of options and alternatives. In particular, the analysis should show sensitivity testing around the major parameters. Stakeholders also stated it would be helpful to see options across the spectrum, with both lean and rich parameters. Appendix 4 contains the specifications we intend to model for the final LTSS feasibility study, which were compiled based on the stakeholder feedback. This is not intended to be an extensive list of options; instead, it should provide a wide variety of options that will help guide further discussions regarding the LTSS program options.

IV. FEASIBILITY STUDY TASKS AND NEXT STEPS

COMPLETED TASKS

The following tasks as defined in Milliman's Statement of Work with DHCS have already been performed:

- Task 1: LTSS planning activities: This includes meeting with the state to determine project scope and a data collection plan. Milliman worked with DHCS to request and receive data related to:

  - General information about the Medi-Cal program
  - Medi-Cal waiver information
  - Medi-Cal nursing home recipients
  - California's IHSS program
  - Population and wage information for California residents

  DHCS coordinated the collection of data from within their department and other California government entities, including:

  - California Department of Social Services (CDSS)
  - Employment Development Department (EDD)
  - Department of Finance (DOF)

  Ongoing work related to Task 1 includes providing monthly status reports regarding task updates, cost reports, and schedule updates.

- Task 2: Stakeholder involvement: Section III of this report above outlines the steps taken and information gathered from the stakeholder interview process, including:

  - Compiling a list of stakeholders
  - Facilitating stakeholder meetings and small group discussions
  - Submitting a Stakeholder Report of Findings (Section III of this report)
  - Utilizing stakeholder findings to plan the parameters for the LTSS analysis

NEXT STEPS

Final Report

Milliman is to provide the final feasibility study report in June 2020. As outlined in Task 3 of the Statement of Work, the report will include the following:

- **Summary of stakeholder input.**

  The summary of stakeholder input will be consistent with Section III of this report, Stakeholder Report of Findings.

- **Analysis of the current and future demand for LTSS.**

  We intend to project long-term care costs and utilization with a model developed by Milliman. The model will be adapted for this project to start with a projection of the population of the state of California by age, sex, region, and year for 75 years. Each year in the projection the model projects the California population by estimating the number of births, deaths, and net migrants.

  To calculate the long-term care costs and utilization for the projected population in each year, the model utilizes Milliman's proprietary Long-Term Care Guidelines calibrated to the California population characteristics. The Milliman LTC Guidelines provide frequencies, continuance curves, utilization assumptions, and claims costs developed from a large number of product designs over the past two decades. The Milliman LTC Guidelines incorporate both private and public sector data sources. The Guidelines are updated triennially to reflect the most comprehensive and current information available in the market. The breadth of underlying data and the comprehensiveness of analysis position the LTC Guidelines to be an unrivaled benchmark for LTC morbidity.

- **Actuarial modeling of the LTSS financing and services options.**

  Appendix 4 contains the modeling specifications we intend to model for the final LTSS feasibility study. They were compiled based on the stakeholder feedback. For each plan option, we will model the cost (payroll tax and possible premiums), the benefit payments, the progress of a possible separate trust fund, and the risks to the participants and to the government. Figure 8 shows the table we intend to include in the final report showing the payroll tax rate for each plan option.

  We intend to model the public program options with a model developed by Milliman. The model produces year-by-year cash flow projections such that the value and scope of the program can be estimated for any of the years in the 75-year projection period window. The cash flow consists of income to the program from taxes, premiums, subsidies, and interest on any fund. Outgo from the program consists of benefit payments for nursing home or home care and administrative expenses. We will project each of these items on a year-by-year basis for 75 years.

  As part of this actuarial analysis, we will also evaluate the current and future impact of LTSS on state-funded programs, including, but not limited to California's Medicaid programs (i.e., Medi-Cal, In-Home Supportive Services, Developmental Services, etc.).

Additional Actuarial Modeling

The feasibility study analysis is the initial step in exploring alternative financing solutions for LTSS expenditures. The feasibility study is intended to provide high-level projected cost estimates of alternative financing and service options, as well as possible impacts to existing state-funded programs and services. As the state continues to explore and refine the specifications of a proposed public LTSS program, additional modeling may be required.

FIGURE 9: SCENARIO PAYROLL TAX RATES COMPARED TO CORE PLAN 1

SCENARIO	PAYROLL TAX RATE	CHANGE FROM CORE PLAN 1
Core Plan 1		
Payroll Tax Alternative		
"Lean" Alternative		
"Rich" Alternative		
Catastrophic Alternative 1		
Catastrophic Alternative 2		
Catastrophic Alternative 3		
Catastrophic Alternative 4		*Results to*
Alternative 1 - Cash		*be provided*
Alternative 2 – Reimbursement With Partial Cash		*in final report*
Alternative 3 – Home Health Coverage Only		
Alternative 4 – Minimum Age for Benefits is 0		
Alternative 5 – Minimum Age for Benefits is 18		
Alternative 6 – Minimum Age for Benefits is 40		
Alternative 7 – Minimum Age for Benefits is 65		
Alternative 8 – Minimum Age for Benefits is 40, Disabled After 18		
Alternative 9 – Minimum Age for Benefits is 65, Disabled After 18		
Alternative 10 – IHSS Requirement for Benefit Eligibility		
Alternative 11 – 3 ADLs for Benefit Eligibility		
Alternative 12 – $70 Daily Benefit Amount (DBA)		
Alternative 13 – $100 DBA		
Alternative 14 – $200 DBA		

Alternative 15 – $300 DBA	
Alternative 16 – $400 DBA	
Alternative 17 – 4% DBA Inflation	
Alternative 18 – DBA Inflation Tied to Wage Growth	
Alternative 19 – DBA Inflation Tied to CPI	
Alternative 20 – 2-year Benefit Period (BP)	
Alternative 21 – 3-year BP	
Alternative 22 – 4-year BP	
Alternative 23 – 5-year BP	
Alternative 24 – Lifetime BP	
Alternative 25 – 30-day Elimination Period (EP)	
Alternative 26 – 60-day EP	
Alternative 27 – 180-day EP	
Alternative 28 – No Vesting	
Alternative 29 – 10 Years Total With Partial Vesting Credits	
Alternative 30 – 1 of Last 3 Years, or 10 Years Total Vesting	*Results to*
Alternative 31 – 5 Years Vesting	*be provided*
Alternative 32 – 10 Years Vesting	*in final report*
Alternative 33 – No Portability	
Alternative 34 – 2 Years Divesting Period	
Alternative 35 – 5 Years Divesting Period	
Alternative 36 – 10 Years Divesting Period	
Alternative 37 – Divesting Grading to 25% After 5 Years	
Alternative 38 – Divesting Grading to 50% After 5 Years	
Alternative 39 – Full Portability	
Alternative 40 – Payroll Above SS Threshold	
Alternative 41 – Additional $25 Monthly Premium for 65+	
Alternative 42 – Additional $50 Monthly Premium for 65+	
Alternative 43 – 4% Administrative Load	
Alternative 44 – 8% Administrative Load	
Alternative 45 – 10% Administrative Load	
Alternative 46 – Minimum Age for Benefits Is 50, Disabled After 18	
Alternative 47 – Payroll Tax for Individuals 40+ Only	
Alternative 48 – Medicaid Carve-out	
Alternative 49 – IDD Carve-out	
Alternative 50 – Opt-out for CalPERS / Private Insurance Members	
Alternative 51 – Opt-in for Self-employed Population	
Alternative 52 – 138% FPL, No Taxes or Benefits	
Alternative 53 – 138% FPL, Benefits but No Taxes	
Alternative 54 – 200% FPL, No Taxes or Benefits	
Alternative 55 – 200% FPL, Benefits but No Taxes	
Alternative 56 – 600% FPL, No Taxes or Benefits	

Alternative 57 – 600% FPL, Benefits but No Taxes
Alternative 58 – Tax / Benefit per Household
Alternative 59 – Buy in to Program at 65, No Underwriting
Alternative 60 – Buy in to Program at 65, Limited Underwriting
Alternative 61 – Buy in to Program at 65, Full Underwriting
Alternative 62 – Monthly Benefit

V. CAVEATS AND LIMITATIONS

This report has been prepared for the internal use of the California State Department of Health Care Services (DHCS), and it should not be distributed, in whole or in part, to any external parties without the prior permission of Milliman, subject to the following exception:

- This report shall be a public record that shall be subject to disclosure to the California State Legislature and its committees, persons participating in legislative reviews and deliberations, and parties making a request pursuant to the California Public Records Act.

We do not intend this information to benefit or create a legal liability to any third party. This communication must be read in its entirety.

The information in this report provides a current view of LTSS financing, a stakeholder perspectives report, and the final report outline for the actuarial modeling and analysis regarding the feasibility of policy options to finance long-term services and supports in the state of California. It may not be appropriate, and should not be used, for other purposes. In completing this analysis, we relied on information provided by DHCS and publicly available data, which we accepted without audit. However, we did review this information for general reasonableness.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Chris Giese, Al Schmitz, Rob Damler, Jeremy Cunningham, Annie Gunnlaugsson, and Sarah Wunder are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses in this report.

The terms of Personal Service Contract with California State DHCS effective November 12, 2019, apply to this engagement.

APPENDIX 1

CALIFORNIA MEDICAID LTSS STATE PLAN BENEFITS AND HCBS PROGRAMS

STATE PLAN BENEFITS PROVIDING LTSS

State Medicaid agencies must cover nursing facility care and home health care for individuals age 21 and older who require nursing facility care. States determine who is eligible for nursing facility admission by evaluating whether they meet nursing home level of care criteria.[48] Medi-Cal will only pay for skilled nursing facility services after a beneficiary has been in the institution for more than 91 days.[49]

Nursing homes must provide: nursing and related services, specialized rehabilitative services, medically related social services, pharmaceutical services, dietary services, activities designed to meet the interests and physical, mental, and psychosocial well-being of the resident, routine dental services, and treatment and services required by mentally ill residents.[50] Federal regulations require that home health services include nursing, home health aides, medical supplies, medical equipment, and appliances suitable for use in the home.[51]

1115 WAIVER BENEFITS

- **Community-Based Adult Services (CBAS):** CBAS is a managed care benefit provided through the state's California Medi-Cal 2020 1115 waiver. CBAS is available to individuals 18 and older who are eligible for Medicaid under the state plan and are either aged, blind, or disabled. Individuals must be managed care plan members or exempt from managed care enrollment and must reside within a geographic service area. CBAS provides beneficiaries with skilled nursing care, social services, therapies, personal care and more in outpatient, facility settings.[52]

1915(C) HOME AND COMMUNITY-BASED SERVICES WAIVERS

States can use 1915(c) waivers to serve Medicaid beneficiaries in need of LTSS in their homes or communities instead of in an institution. Unlike state plan options, 1915(c) waivers can only serve a limited number of individuals in need of institutional care and may have higher financial eligibility criteria or provide services that the state plan does not cover.[53]

- **Multipurpose Senior Services Program (MSSP), 1915(c):** The goal of the MSSP program is to prevent or delay institutionalization through ongoing care management, using available community services and resources, and purchasing needed services when they are not already available. The California Department of Aging administers the waiver.[54] The waiver serves Medi-Cal eligible individuals who are 65 years or older and disabled. Individuals must require nursing facility level of care, be enrolled in only one HCBS waiver at a time, and reside in a designated county.[55] The maximum number of unduplicated participants who are served in each year the waiver is in effect is 11,370.[56]

- **California Assisted Living Waiver (ALW), 1915(c):** The goals of ALW are to facilitate safe and timely transitions of seniors eligible for Medi-Cal and persons with disabilities from a nursing facility to a community home-like setting and to offer those individuals services that meet their healthcare needs.[57] The eligibility criteria for this waiver are 1) age 21 or older, 2) have full-scope Medi-Cal eligibility with zero share of cost, 3) have care needs equal to those of residents funded by Medi-Cal living and receiving care in nursing facilities, 4) willing to live in an assisted living setting as an alternative to a nursing facility, 5) able to reside

[48] CMS. Nursing Facilities. Retrieved February 13, 2020, from https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/nursing-facilities/index.html.

[49] DHCS (November 26, 2019). Essential Health Benefits. Retrieved February 13, 2020, from https://www.dhcs.ca.gov/services/medi-cal/Pages/Benefits_services.aspx.

[50] SSA §1919(4)(A), Requirements for Nursing Facilities. Retrieved February 13, 2020, from https://www.ssa.gov/OP_Home/ssact/title19/1919.htm.

[51] U.S. Department of Health and Human Services (2010). Understanding Medicaid Home and Community Services: A Primer. Retrieved from https://aspe.hhs.gov/report/understanding-medicaid-home-and-community-services-primer-2010-edition/mandatory-state-plan-services-home-health.

[52] Medicaid.gov (November 19, 2019). California Medi-Cal 2020 Demonstration (11-W-00193/9): Special terms and conditions. (2019). Retrieved March 3, 2020, from https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81046 (download Demonstration Approval, see p. 29-30 of PDF).

[53] Thach, N. & Wiener, J., An Overview of Long-Term Services and Supports and Medicaid, op cit.

[54] California Department of Aging. Multipurpose Senior Services Program (MSSP). Retrieved February 13, 2020, from https://aging.ca.gov/Providers_and_Partners/Multipurpose_Senior_Services_Program/Program_Narrative_and_Fact_Sheets/.

[55] DHCS (2019). Multipurpose Senior Services Program. Retrieved February 13, 2020, from https://www.dhcs.ca.gov/services/medi-cal/Pages/MSSPMedi-CalWaiver.aspx.

[56] Medicaid.gov (November 7, 2019). CA Multipurpose Senior Services Program (0141.R06.00): Application for a §1915(c) home and community-based services waiver. Retrieved February 13, 2020, from https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8174 (download Approved Application, see p. 26 of PDF).

[57] DHCS (December 19, 2019). Assisted Living Waiver. Retrieved February 13, 2020. From https://www.dhcs.ca.gov/services/ltc/Pages/AssistedLivingWaiver.aspx.

safely in an assisted living facility or public subsidized housing, and 6) willing to live in one of 15 counties.[58] The waiver is described by the state as offering "beneficiaries the choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility."[59] Assisted living facilities include residential/adult residential care facilities.[60] Available services vary based on the tier a member is assigned to.[61] The maximum number of unduplicated participants who are served in each year the waiver is in effect is 7,409.[62]

- **Home and Community-Based Alternatives Waiver, 1915(c)**: The goals of this waiver are to facilitate safe and timely transitions of members eligible for Medi-Cal from medical facilities to home or community settings utilizing waiver services, for members eligible for Medi-Cal who reside in the community but are at risk of being institutionalized within the next 30 days. This 1915(c) waiver offers community-based adult services to eligible older adults and / or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization.[63] This waiver is available to individuals of any age who are enrolled in or eligible for Medi-Cal and have been in the hospital for at least 60 consecutive days or require a nursing facility level of care.[64] Waiver services are varied and include care management, habilitation, home respite, community transition services, and more.[65] The maximum number of unduplicated participants who are served in each year the waiver is in effect ranges from about 6,000 to almost 10,000.[66]

- **HCBS Waiver for Californians With Developmental Disabilities, 1915(c):** This waiver serves persons with developmental disabilities and those at risk of becoming developmentally disabled in homes and communities as an alternative to intermediate care facilities. The waiver is administered by the California Department of Developmental Services.[67] Statutory services, those specifically authorized or otherwise included in Section 1915(c) of the Social Security Act,[68] include behavioral intervention, community living arrangement, day, homemaker, supported employment, and prevocational services, as well as respite care. There are also extended state plan services, supports for participant direction, and more.[69] The maximum numbers of unduplicated participants who are served in each year the waiver is in effect ranges from 130,000 to 150,000**.**[70]

- **Self-Determination Program for Individuals With Developmental Disabilities, 1915(c):** California's Self-Determination Program (SDP) Waiver for the developmentally disabled provides home and community-based services to individuals who would otherwise require care in an intermediate care facility, whether habilitative or nursing.[71] The SDP Waiver allows participants the opportunity to accept greater control and responsibility regarding the delivery of needed services. Services include community living and employment supports, homemaker and live-caregiver services, respite services, occupational therapy, and more.[72] The maximum number of unduplicated participants who are served in each year the waiver is in effect ranges from 1,000 to 2,500.[73]

[58] Ibid.
[59] Medicaid.gov (February 28, 2019). CA Assisted Living (0431.R03.00): Application for a §1915(c) home and community-based services waiver. Retrieved February 13, 2020, from https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8170 (download Approved Application, see p. 4 of PDF).
[60] DHCS (December 19, 2019), Assisted Living Waiver, op cit.
[61] Medicaid.gov (February 28, 2019). CA Assisted Living (0431.R03.00), op cit.
[62] Ibid., see p. 24 of PDF.
[63] DCHS (January 13, 2020). Community-Based Adult Services. Retrieved February 13, 2020, from https://www.dhcs.ca.gov/services/Pages/Community-BasedAdultServices(CBAS)AdultDayHealthCare(ADHC)Transition.aspx.
[64] Medicaid.gov (December 18, 2019). CA Home and Community Based Alternatives Waiver (0139.R05.00): Application for a §1915(c) home and community-based services waiver. Retrieved February 13, 2020, from https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8165 (download Approved Application, see pp. 1-5 of PDF).
[65] Ibid., see p. 52 of PDF).
[66] Ibid., see pp. 25-26 of PDF).
[67] California Department of Developmental Services (January 22, 2020). Home and Community-Based Services Programs. Retrieved February 13, 2020, from https://www.dds.ca.gov/initiatives/hcbs/.
[68] CMS (January 2015). Application for a §1915 Home and Community-Based Waiver: Instructions, Technical Guide, and Review Criteria, p. 103. Retrieved February 13, 2020, from https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/technical-guidance.pdf.
[69] Medicaid.gov (December 19, 2019). CA HCBS Waiver for Californians w/DD (0336.R04.00): Application. Retrieved February 13, 2020, from https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8162 (download Approved Application, see p. 66 of PDF).
[70] Ibid., pp. 45-46.
[71] Medicaid.gov (July 10, 2018). CA Self-Determination Program for Individuals with Developmental Disabilities (1166.R00.00): Application. Retrieved February 13, 2020, from https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=48570 (download Approved Application, see pp. 2-3 of PDF).
[72] Medicaid.gov. California Waiver Factsheet. Retrieved February 13, 2020, from https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/Waiver-Descript-Factsheet/CA-Waiver-Factsheet.html#CA1166.
[73] CA Self-Determination Program for Individuals with Developmental Disabilities, *supra* note 20, p. 22.

- **HIV/AIDS, 1915(c):** The goals of this waiver are to enroll individuals with HIV/AIDS into HCBS, assist participants with disease management, increase coordination among service providers, and eliminate duplication of services. Participants in this waiver must have a written diagnosis of HIV/AIDS, a health status to make home care appropriate, be eligible for Medi-Cal on the date of enrollment and each month thereafter, and have been certified to need a nursing facility level of care or higher.[74] Services range from enhanced case management to skilled nursing.[75] The maximum number of unduplicated participants who are served in each year the waiver is in effect ranges from 1,800 to almost 2,000.[76]

STATE PLAN AMENDMENTS

- **In-Home Supportive Services (IHSS):** IHSS is the name of a Medi-Cal program comprised of several optional HCBS state plan benefits.[77] All components of the program provide supportive personal care services to individuals who otherwise would not be able to remain in their homes.[78] Over 520,000 IHSS providers currently serve over 600,500 recipients. The four IHSS options are: CFC Option (CFCO), Personal Care Services Program, IHSS Plus Option, and IHSS-Residual Program.[79] The program an individual is assigned to depends on Medicaid eligibility and the level of care required.

  - **CFCO** provides home and community-based attendant services and supports to eligible individuals. Beneficiaries must be eligible for Medicaid under an existing eligibility pathway that offers state plan services and in an eligibility group under the state plan that covers nursing facility services. If not in such a group, beneficiaries must have incomes at or below 150% FPL and meet institutional level of care criteria.[80,81] States can receive an enhanced Federal Medical Assistance Percentage (FMAP) of 6% in addition to the standard federal match for CFC services.[82] CFCO recipients make up about 43% of the overall IHSS population.

  - The **Personal Care Services Program (**PCSP) enrolls individuals who are not eligible for CFC because they do not meet nursing facility level of care criteria.[83] PCSP recipients are eligible for full-scope Federal Financial Participation (FFP), and these Medi-Cal services are funded with 50% federal, 32.5 % state, and 17.5% county dollars. PCSP recipients make up about 53% of the overall IHSS population.

  - Individuals who are eligible for the **IHSS Plus Option (IPO)** are those who receive services from spouses or parents, an advance payment for monthly services to pay their providers directly, or a restaurant meal allowance.[84] IHSS Plus is a 1915(j) state plan option.[85] The IPO recipients make up a little over 2.5% of the overall IHSS population.

  - Beneficiaries in the **IHSS-Residual (IHSS-R) Program** either do not receive full-scope Medicaid or do not receive full-scope Medicaid with Federal Financial Participation (FFP).[86] IHSS-R recipients make up less than 1.5% of the overall IHSS population.

[74] California Department of Public Health (June 11, 2018). AIDS Medi-Cal Waiver Program. Retrieved February 13, 2020, from https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_care_mcwp.aspx.
[75] California Waiver Factsheet, op cit., CA HIV/AIDS Waiver (0183.R05.00).
[76] Medicaid.gov (January 10, 2018). CA HIV/AIDS Waiver (0183.R04.00): Application. Retrieved February 13, 2020, from https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8168 (download Approved Application, see p. 22 of PDF).
[77] California Medicaid Research Institute (August 2011). California's Medi-Cal Home and Community-Based Services Waivers, Benefits and Eligibility Policies, 2005-2008, p. 24. Retrieved February 13, 2020, from https://www.thescanfoundation.org/media/2019/07/camri_waiver_report_0_3.pdf.
[78] Ramsey, C. (June 2019). In-Home Supportive Services (IHSS): A Guide for Advocates, p. 5. Justice for Aging. Retrieved February 13, 2020, from https://www.justiceinaging.org/wp-content/uploads/2019/06/Final_IHSS-Adocate-Manual.pdf.
[79] Ibid., p. 9.
[80] Mitchell, A. et al. (March 9, 2015). President's FY2016 Budget: Centers for Medicare & Medicaid Services (CMS) Legislative Proposals, p. 51. Congressional Research Service. Retrieved February 13, 2020, from https://fas.org/sgp/crs/misc/R43934.pdf.
[81] Community First Choice is also referred to as 1915(k). See https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/community-first-choice-cfc-1915-k/index.html.
[82] CMS. 1915(k) Community First Choice Overview, p. 5. Retrieved February 13, 2020, from https://nasddds.org/uploads/documents/SOTA%2Bslides%2Bfor%2BCFC%2BHCBS%2BPresentation%2B9%2B10%2B%283%29.pdf.
[83] In-Home Supportive Services (IHSS): A Guide for Advocates, op cit., p. 10.
[84] California Department of Social Services. In-Home Supportive Services (IHSS) Program. Retrieved February 13, 2020, from https://www.cdss.ca.gov/inforesources/ihss.
[85] Chapter Seven: In-Home Supportive Services (IHSS), p. 2. Retrieved February 13, 2020, from https://www.bettzedek.org/wp-content/uploads/2019/08/Ch.7-IHSS2019-FINAL.pdf.
[86] Disability Rights California (June 2018). Understanding How IHSS Hours Are Calculated, p. 3. Retrieved February 13, 2020, from https://www.disabilityrightsca.org/system/files/file-attachments/561101.pdf. IHSS-Residual recipients are "usually persons with Satisfactory Immigration Status, which denies them federal reimbursement. There are very few people in this category." See http://www.canhr.org/factsheets/misc_fs/html/fs_ihss.htm.

- **1915(i) State Plan Amendment (SPA):** This option allows "states to target the HCBS benefit to specific populations, establish separate additional needs-based criteria for individual HBCS, establish a new Medicaid eligibility group for people who get state plan HCBS, define the HCBS included in the benefit, and allow any or all of the HCBS to be self-directed".[87] FFP is available for services provided. California has chosen to target its SPA to serve individuals with developmental disabilities.[88]

- **Program of All-Inclusive Care for the Elderly (PACE):** PACE is a Medicare program that can be provided to Medicaid beneficiaries as an optional benefit.[89] Recipients must be 55 or older, meet the requirement for skilled nursing home care, live in a service area, and are able to live in the community.[90] Once enrolled, a recipient will receive all Medicare and Medicaid services through the program.[91] There are approximately 10,000 individuals enrolled in California's PACE program.[92]

Other Optional Benefits

- **811 Project Rental Assistance:** The 811 program is a collaborative effort between the state of California and U.S. Department of Housing and Urban Development to provide rental assistance to low-income people with disabilities. The funds are intended to assist individuals in moving from nursing facilities back into the community. Recipients are required to receive or be eligible for LTSS through Medi-Cal.[93,94]

[87] Medicaid.gov. Home and Community-Based Services 1915 (i). Retrieved February 13, 2020, from https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915i/index.html.
[88] DHCS (January 11, 2018). Statewide Transition Plan for Compliance with Home and Community-Based Settings Rules, pp. 7-8. Retrieved February 13, 2020, from https://www.dhcs.ca.gov/services/ltc/Documents/CASTP-11Jan2018ADA.pdf.
[89] Medicaid.gov. Program of All-Inclusive Care for the Elderly. Retrieved February 13, 2020, from https://www.medicaid.gov/medicaid/long-term-services-supports/program-all-inclusive-care-elderly/index.html.
[90] DHCS (October 3, 2019). Program for All-Inclusive Care for the Elderly. Retrieved February 13, 2020, from https://www.dhcs.ca.gov/provgovpart/Pages/PACE.aspx.
[91] Medicaid.gov, Program of All-Inclusive Care for the Elderly, op cit.
[92] CalPACE (January 28, 2020). Program of All-inclusive Care for the Elderly. Retrieved February 13, 2020, from http://www.calpace.org/wp-content/uploads/2017/12/CalPACE-General-Fact-Sheet-01-28-20.pdf.
[93] DHCS (October 30, 2019). 811 Project Rental Assistance (PRA) Award Stakeholder Outreach and Engagement. Retrieved February 13, 2020, from https://www.dhcs.ca.gov/services/ltc/Pages/811_PRA_Stakeholder_-Page.aspx.
[94] California Housing Finance Agency. Section 811 Factsheet. Retrieved February 13, 2020, from https://www.calhfa.ca.gov/multifamily/section811/factsheet/index.htm.

APPENDIX 2

STAKEHOLDER INTERVIEW PROTOCOL

Long Term Services and Supports (LTSS) Feasibility Study
Sample Breakout Discussion Questions
Stakeholder Meetings – November 12 through14, 2019

- **Introductions**
- **Overview of Actuarial Report Scope and Timeline**
- **Discuss Stakeholder "Interview" Questions**
  - What critical questions / issues should be considered as part of the feasibility analysis?
  - For new LTSS programs, what should be the key measures for determining success?
  - What are your preferences / concerns with regard to a voluntary approach vs. a mandatory approach for a new LTSS program?
  - Should coverage under a new program be:
    - Partial, targeting a large number of people
    - Robust, targeting those with higher levels of need
  - Should coverage under a new program be:
    - "Front-end," where limited coverage is available at the start of when care is needed
    - "Back-end," where limited coverage is available at the end of when care is needed
    - "Lifetime," where coverage is available throughout when care is needed
  - What are your preferences / concerns with regard to collecting revenue to fund the new LTSS program through taxes vs. consumer premiums?
  - What amount of a new payroll tax on wages or consumer premiums is feasible?
    - From consumer viewpoint?
    - From political viewpoint?
  - How important is choice under a new program?
    - Choice when deciding on level of insurance coverage?
    - Choice when deciding how insurance benefits can used at time of need?
  - What role should the following play as part of a new solution?
    - Medicaid program
    - CalPERS program
    - Private insurance carriers
- **Wrap Up and Next Steps**

APPENDIX 3

STAKEHOLDER PRE-INTERVIEW SURVEY TOOL

California Department of Health Care Services
California Department of Aging

Survey - Perspectives on LTSS Financing Reform

Please take a few moments to share your thoughts with us with regard to long-term services and supports (LTSS) financing reform in California.

The results of this survey will be shared with the California Department of Health Care Services and the Contractor assisting them in the LTSS feasibility study described below.

Background

Recognizing that California's over-65 population is projected to grow to 8.6 million by 2030, Governor Gavin Newsom issued an executive order calling for the creation of a Master Plan for Aging to be developed by October 1, 2020. In conjunction with the Master Plan development efforts, Assembly Bill (AB) 74, Statutes of 2019, states that the California Department of Health Care Services (DHCS) will partner with a qualified contracting entity and various stakeholders to develop an LTSS feasibility study that includes projected cost estimates of alternative financing and service options as well as possible impacts to existing state funded programs and services, including, but not limited to, Medi-Cal and the In-Home Supportive Services program.

Long-Term Services and Supports

For purposes of this feasibility study, we will use the terms LTSS and long-term care (LTC) interchangeably. LTSS is a range of services and supports for individuals who need assistance with daily living tasks, such as bathing, dressing, ambulation, transfers, toileting, medication administration or assistance, personal hygiene, transportation, skilled and social supports, and other health-related tasks. Often, this type of assistance is needed by individuals who experience functional limitations that are due to age, physical, or cognitive disability. LTSS includes services provided in:

Institutional Settings: Includes skilled, intermediate, and custodial care provided in an institutional facility setting, such as a nursing home or dedicated wing of a hospital

Home and Community-Based Settings: Includes care provided in a person's own home or in a community-based setting, such as an assisted living facility or adult family home.

Survey

You have been identified as an important stakeholder. Your opinions are very important to the State's analysis of strategies and options. These questions ask for your thoughts on the relative importance of various goals and objectives which should be considered as the State explores different approaches to LTSS financing reform.

1. Respondent information (optional)

What is your name?

What organization are you affiliated with?

2. Which of the following best describes your affiliation?

- ○ Labor/union
- ○ Provider organization
- ○ LTSS Advocacy organization
- ○ Government
- ○ Insurance/finance
- ○ Community organization
- ○ Individual
- ○ Caregiver (family, friend, neighbor)
- ○ Other (please describe)

3. How important do you feel each of the following principles is with regard to the desired LTSS financing reform option(s) the State is considering? Please use a scale of 1 to 10 with 1 being “MOST IMPORTANT” and 10 being “LEAST IMPORTANT.”

	1	2	3	4	5	6	7	8	9	10
1. It is financially sound and sustainable.	○	○	○	○	○	○	○	○	○	○
2. It is affordable for the middle income market.	○	○	○	○	○	○	○	○	○	○
3. It is a relatively easy program to understand.	○	○	○	○	○	○	○	○	○	○
4. It recognizes and attempts to alleviate the budgetary constraints of Medicaid.	○	○	○	○	○	○	○	○	○	○
5. It provides a safety net for the poor.	○	○	○	○	○	○	○	○	○	○
6. It includes coverage choices and different premium or contribution amounts.	○	○	○	○	○	○	○	○	○	○
7. It addresses needs for the disabled population of all ages.	○	○	○	○	○	○	○	○	○	○
8. It encourages those who can afford it to prefund their LTC needs either through savings or insurance.	○	○	○	○	○	○	○	○	○	○
9. It provides modest coverage but reaches a broad population.	○	○	○	○	○	○	○	○	○	○
10. It provides comprehensive coverage for a specific targeted population.	○	○	○	○	○	○	○	○	○	○
11. It is both comprehensive and broad in terms of the population it addresses.	○	○	○	○	○	○	○	○	○	○
12. It addresses needs for today’s currently disabled population in addition to the future disabled population.	○	○	○	○	○	○	○	○	○	○

4. Which of the items listed in question 3 is the MOST important objective for LTC finance reform?

- 1. It is financially sound and sustainable.
- 2. It is affordable for the middle income market.
- 3. It is a relatively easy program to understand.
- 4. It recognizes and attempts to alleviate the budgetary constraints of Medicaid.
- 5. It provides a safety net for the poor.
- 6. It includes coverage choices and different premium or contribution amounts.
- 7. It addresses needs for the disabled population of all ages.
- 8. It encourages those who can afford it to prefund their LTC needs either through savings or insurance.
- 9. It provides modest coverage but reaches a broad population.
- 10. It provides comprehensive coverage for a specific targeted population.
- 11. It is both comprehensive and broad in terms of the population it addresses.
- 12. It addresses needs for today's currently disabled population in addition to the future disabled population.

5. Which of the items listed in question 3 is the LEAST important objective for LTC finance reform?

- 1. It is financially sound and sustainable.
- 2. It is affordable for the middle income market.
- 3. It is a relatively easy program to understand.
- 4. It recognizes and attempts to alleviate the budgetary constraints of Medicaid.
- 5. It provides a safety net for the poor.
- 6. It includes coverage choices and different premium or contribution amounts.
- 7. It addresses needs for the disabled population of all ages.
- 8. It encourages those who can afford it to prefund their LTC needs either through savings or insurance.
- 9. It provides modest coverage but reaches a broad population.
- 10. It provides comprehensive coverage for a specific targeted population.
- 11. It is both comprehensive and broad in terms of the population it addresses.
- 12. It addresses needs for today's currently disabled population in addition to the future disabled population.

6. What issues or areas of inquiry are of greatest importance to you as the State explores LTC financing approaches?

What critical question(s) do you feel must be answered to help inform next steps?

7. Please provide any additional comments below.

Please contact EngAGE@aging.ca.gov with any questions.

APPENDIX 4

POLICY OPTIONS MODELING SPECIFICATIONS GRID

DRAFT

California Department of Health Care Services
Long Term Services and Supports (LTSS) Feasibility Study
Proposed Modeling Specifications

Program Specification	Core Plan 1	Core Plan 2	Core Plan 3
Covered Services	Comprehensive, private market services	No restrictions due to cash benefit structure	Comprehensive, private market services
Minimum Age for Benefits	18; Disabled after 18	18; Disabled after 18	18; Disabled after 18
Benefit Eligibility	Private market requirements	Private market requirements	Private market requirements
Daily Benefit Amount	$150	$150	$100
Daily Benefit Index	3% (annual compound inflation)	3% (annual compound inflation)	3% (annual compound inflation)
Lifetime Maximum Benefit	1 year (if full daily benefit used every day)	1 year (if full daily benefit used every day)	1 year (if full daily benefit used every day)
Benefit Structure	Reimbursement	Cash	Reimbursement
Elimination Period (Calendar Days)	90 days	90 days	30 days
Vesting Requirements (1 credit / year if 500+ hours)	Full benefits if 3 of last 6 years, or 10 years total	Full benefits if 10 years total; Partial benefits if <10 years	Full benefits if 3 of last 6 years, or 10 years total
Portability / Divesting Period	Grade to 0% after 5 years	Grade to 0% after 5 years	Grade to 0% after 5 years
Program Revenue Source	Payroll tax on all wages	Payroll tax on all wages	Payroll tax on all wages
Administrative Load / Cost	7%	7%	7%

DRAFT

California Department of Health Care Services
Long Term Services and Supports (LTSS) Feasibility Study
Proposed Modeling Specifications

Program Specification	Catastrophic Alternative 1	Payroll Tax Alternative	"Lean" Alternative	"Rich" Alternative
Covered Services	No restrictions due to cash benefit structure	Comprehensive, private market services	Comprehensive, private market services	No restrictions due to cash benefit structure
Minimum Age for Benefits	18; Disabled after 18	50; Disabled after 18	65, Disabled after 18	0
Benefit Eligibility	Private market requirements	Private market requirements	Private market requirements	IHSS requirements
Daily Benefit Amount	$150	$150	$100	$350
Daily Benefit Index	3% (annual compound inflation)	3% (annual compound inflation)	3% (annual compound inflation)	4% (annual compound inflation)
Lifetime Maximum Benefit	Lifetime	1 year (if full daily benefit used every day)	1 year (if full daily benefit used every day)	Lifetime
Benefit Structure	Cash	Reimbursement	Reimbursement	Cash
Elimination Period (Calendar Days)	2 years	90 days	180 days	30 days
Vesting Requirements (1 credit / year if 500+ hours)	Full benefits if 3 of last 6 years, or 10 years total	Full benefits if 3 of last 6 years, or 10 years total	Full benefits if 10 years total	No vesting required
Portability / Divesting Period	Grade to 0% after 5 years	Grade to 0% after 5 years	No portability (in-state residency requirement)	Fully portable (no residency requirement)
Program Revenue Source	Payroll tax on all wages	Payroll tax on all wages for individuals age 40+	Payroll tax on all wages	Payroll tax on all wages
Administrative Load / Cost	7%	7%	7%	7%

DRAFT

California Department of Health Care Services
Long Term Services and Supports (LTSS) Feasibility Study
Proposed Modeling Specifications

Program Specification	Covered Services	Minimum Age for Benefits	Benefit Eligibility	Daily Benefit Amount	Daily Benefit Index	Lifetime Maximum Benefit	Benefit Structure	Elimination Period (Calendar Days)	Vesting Requirements	Portability / Divesting Period	Program Revenue Source	Administrative Load / Cost	Additional Features
Core Plan 1	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Core Plan 2	No restrictions due to cash benefit structure	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Cash	90 days	10 years total with partial vesting credits	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Core Plan 3	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$100	3% compound inflation	1 year	Reimbursement	30 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Payroll Tax Alternative	Comprehensive, private market services	50; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages for individuals age 40+	7%	NA
"Lean" Alternative	Comprehensive, private market services	65, Disabled after 18	Private market requirements	$100	3% compound inflation	1 year	Reimbursement	180 days	10 years total	No portability (in-state residency requirement)	Payroll tax on all wages	7%	NA
"Rich" Alternative	No restrictions due to cash benefit structure	0	IHSS requirements	$350	4% compound inflation	Lifetime	Cash	30 days	No vesting	Fully portable (no residency requirement)	Payroll tax on all wages	7%	NA
Catastrophic Alternative 1	No restrictions due to cash benefit structure	18; Disabled after 18	Private market requirements	$150	3% compound inflation	Lifetime	Cash	2 years	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Catastrophic Alternative 2	No restrictions due to cash benefit structure	18; Disabled after 18	Private market requirements	$150	3% compound inflation	Lifetime	Cash	3 years	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Catastrophic Alternative 3	No restrictions due to cash benefit structure	18; Disabled after 18	Private market requirements	$150	3% compound inflation	Lifetime	Cash	4 years	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Catastrophic Alternative 4	No restrictions due to cash benefit structure	18; Disabled after 18	Private market requirements	$150	3% compound inflation	Lifetime	Cash	5 years	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 1	No restrictions due to cash benefit structure	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Cash	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 2	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement with Partial Cash	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 3	Home Health Only, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 4	Comprehensive, private market services	0	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 5	Comprehensive, private market services	18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 6	Comprehensive, private market services	40	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 7	Comprehensive, private market services	65	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 8	Comprehensive, private market services	40, Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 9	Comprehensive, private market services	65, Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 10	Comprehensive, private market services	18; Disabled after 18	IHSS requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 11	Comprehensive, private market services	18; Disabled after 18	Private market requirements w/ 3 ADLs	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 12	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$70	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 13	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$100	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 14	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$200	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 15	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$300	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 16	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$400	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 17	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	4% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 18	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	Wages (−3.5%)	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 19	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	CPI (−2.5%)	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 20	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	2 years	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 21	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	3 years	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 22	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	4 years	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 23	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	5 years	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 24	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	Lifetime	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 25	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	30 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 26	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	60 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 27	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	180 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 28	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	No vesting	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 29	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	10 years total with partial vesting credits	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 30	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	1 of last 3 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 31	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	5 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 32	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 33	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	No portability (in-state residency requirement)	Payroll tax on all wages	7%	NA
Alternative 34	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	2 year divesting period	Payroll tax on all wages	7%	NA
Alternative 35	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	5 year divesting period	Payroll tax on all wages	7%	NA
Alternative 36	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	10 year divesting period	Payroll tax on all wages	7%	NA
Alternative 37	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 25% after 5 years	Payroll tax on all wages	7%	NA
Alternative 38	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 50% after 5 years	Payroll tax on all wages	7%	NA
Alternative 39	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Fully portable (no residency requirement)	Payroll tax on all wages	7%	NA
Alternative 40	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax above SS threshold	7%	NA
Alternative 41	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages with $25 monthly premium for 65+	7%	NA

DRAFT
California Department of Health Care Services
Long Term Services and Supports (LTSS) Feasibility Study
Proposed Modeling Specifications

Program Specification	Covered Services	Minimum Age for Benefits	Benefit Eligibility	Daily Benefit Amount	Daily Benefit Index	Lifetime Maximum Benefit	Benefit Structure	Elimination Period (Calendar Days)	Vesting Requirements	Portability / Divesting Period	Program Revenue Source	Administrative Load / Cost	Additional Features
Alternative 42	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages with $50 monthly premium for 65+	7%	NA
Alternative 43	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	4%	NA
Alternative 44	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	8%	NA
Alternative 45	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	10%	NA
Alternative 46	Comprehensive, private market services	50; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	NA
Alternative 47	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages for individuals age 40+	7%	NA
Alternative 48	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	Medicaid Carve-Out
Alternative 49	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	IDD Carve-Out
Alternative 50	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	Opt-Out for CalPERS / private insurance members
Alternative 51	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	Opt In for self-employed population
Alternative 52	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	138% FPL - No taxes nor benefits
Alternative 53	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	138% FPL - No taxes, benefits
Alternative 54	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	200% FPL - No taxes nor benefits
Alternative 55	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	200% FPL - No taxes, benefits
Alternative 56	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	600% FPL - No taxes nor benefits
Alternative 57	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	600% FPL - No taxes, benefits
Alternative 58	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	Tax / benefit per household
Alternative 59	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	Buy into program at 65, no underwriting
Alternative 60	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	Buy into program at 65, limited underwriting
Alternative 61	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	Buy into program at 65, full underwriting
Alternative 62	Comprehensive, private market services	18; Disabled after 18	Private market requirements	$150	3% compound inflation	1 year	Reimbursement	90 days	3 of last 6 years, or 10 years total	Grade to 0% after 5 years	Payroll tax on all wages	7%	Monthly benefit (instead of daily)

DRAFT

California Department of Health Care Services
Long Term Services and Supports (LTSS) Feasibility Study
Sensitivity by Program Feature

Program Feature	Sensitivities
Covered Services[1]	Comprehensive, Home Health Only, No restrictions (for cash benefit structure)
Covered Population	All vested are covered; Medicaid carve-out; IDD carve-out; Opt out option for individuals with CalPERS or private LTC insurance; Opt in for self-employed population
Minimum Age for Benefits	0, 18, 40, 65 (with variations to limit to disability onset after age 18)
Benefit Eligibility	Private market requirements: - 2 of 6 ADLs (substantial assistance) or severe cognitive impairment - Chronically ill (condition expected to last 90+ days) IHSS requirement Private market requirements with 3 of 6 ADLs
Daily Benefit Amount	None $70, $100, $150, $200, $300, $400
Daily Benefit Index	3%, 4%, Wages, CPI
Lifetime Maximum Benefit	1 year, 2 years, 3 years, 4 years, 5 years, Lifetime
Benefit Structure	Cash, Reimbursement, Reimbursement with partial cash
Elimination Period (Calendar Days)	30 days, 60 days, 90 days, 180 days 2 years, 3 years, 4 years, 5 years (for Catastrophic alternative)
Vesting Requirements	No vesting; 3 of last 6 years, or 10 years total; 1 of last 3 years, or 10 years total; 10 years with partial vesting; 5 years total; 10 years total
Portability / Divesting Period	No portability (in-state residency requirement), 2 years divesting period, 5 years divesting period, Grade to 0% after 5 years, Grade to 25% after 5 years, Grade to 50% after 5 years, Fully portable (no residency requirement)
Program Revenue Source	Payroll tax on all wages, Payroll tax above SS threshold Payroll tax with monthly premium for 65+: $50, $25
Administrative Load / Cost	4%, 7%, 8%, 10%

[1] *While modeling will be done by different population cohorts, we will assume covered services to be consistent across the covered population regardless of disability and geography.*

For more information about Milliman, please visit us at:

milliman.com

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

milliman.com

CONTACT

Christopher Giese
Chris.Giese@milliman.com

Allen Schmitz
Al.Schmitz@milliman.com

Rob Damler
Rob.Damler@milliman.com

Jeremy Cunningham
Jeremy.Cunningham@milliman.com

Annie Gunnlaugsson
Annie.Gunnlaugsson@milliman.com

Sarah Wunder
Sarah.Wunder@milliman.com

© 2020 Milliman, Inc. All Rights Reserved. The materials in this document represent the opinion of the authors and are not representative of the views of Milliman, Inc. Milliman does not certify the information, nor does it guarantee the accuracy and completeness of such information. Use of such information is voluntary and should not be relied upon unless an independent review of its accuracy and completeness has been performed. Materials may not be reproduced without the express consent of Milliman.