LTSS Trust Commission Recommendations Report

RCW 50B.04.030 (4)

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Long-Term Services and Supports Trust Commission

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Executive Summary

Enacted in 2019, the Long-Term Services and Supports (LTSS) Trust Program (RCW 50B.04), now called WA Cares Fund, is a contributory long-term service and supports insurance program that provides a maximum lifetime benefit of $36,500 (adjusted annually up to inflation) for all qualified, eligible Washingtonians.

It is financed by an employee premium of 0.58% of wages, the maximum rate which can be assessed according to the statute. Individuals who have met work and contribution requirements of 10 years with no more than a 5-year interruption (or 3 out of the last 6 years at the time of application) and who need assistance with three or more activities of daily living may claim full WA Cares Fund benefits from approved providers. Individuals born before 1968 also have the opportunity to earn partial WA Cares Fund benefits, namely 10 percent of the maximum lifetime benefit for each year they contribute.

WA Cares Fund is a multi-agency program administered collaboratively by the Department of Social and Health Services (DSHS), the Employment Security Department (ESD), and the Health Care Authority (HCA). The Office of the State Actuary performs actuarial valuations and makes recommendations to maintain trust solvency. The WA Cares Fund is overseen by the 21-member LTSS Trust Commission (see Appendix A for a list of Commission Members).

On July 1, 2023 premium assessments begin for covered workers and self-employed individuals can begin opting in. On July 1, 2026, DSHS will begin paying benefits on behalf of eligible beneficiaries.

Based on actuarial analysis updated in October 2022, under most scenarios evaluated, including the base plan scenario, the program's premium assessment of 0.58% ($0.58 per $100 of earnings, or about $24/month for the median covered earner making $50,100/year) is projected to keep the WA Cares Fund solvent over the entire 75-year projection period (through June 30, 2098). There were scenarios identified that, without corrective action, could lead the program to have insufficient revenue to provide for full program benefits over the entire projection period. (For more information on program solvency, see Appendix B; for the Commission's WA Cares Fund Risk Management Framework, see Appendix C). WA Cares Fund is projected to result in Medicaid cost avoidance for both the state general fund and the federal government as a result of delaying or diverting people from Medicaid long-term services and supports (see Appendix D). In addition, fewer Washingtonians will need to spend down their life savings to qualify for Medicaid long-term care due to WA Cares Fund.

Per Chapter 50B.04.030 RCW, the LTSS Trust Commission is charged with proposing recommendations to the Legislature or the appropriate Executive Agency on specific aspects of the program. The Commission's recommendations and decisions are guided by the joint goals of maintaining benefit adequacy and maintaining solvency and sustainability.

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During the 2022 legislative session, Operating Budget Bill ESSB 5693 required the Commission to submit the results of the following activities, including any legislative recommendations, to the governor and appropriate legislative committees no later than January 1, 2023:

- Options for extending benefits to out-of-state eligible beneficiaries (referred to in this report as "portability")

- Options for requiring ongoing verification of the maintenance of long-term care insurance coverage by persons who have received an exemption based on having private long-term care insurance (referred to in this report as "recertification")

- Options for providing workers who have received exemptions based on having private long-term care insurance an opportunity to rescind their exemption and permanently reenter WA Cares Fund (referred to in this report as "rescinding")

The Commission also considered the following issues required under RCW 50B.04.030:

- The establishment of criteria for determining that an individual has met the requirements to be an eligible beneficiary as established in RCW 50B.04.060 (referred to in this report as "benefit eligibility")

- Changes to rules or policies to improve operation of the program:

  - Consistency and accountability in employer premium reporting

  - Reporting of self-employment income

  - Pilot project for benefit implementation

  - Simplifying the ten-year contribution requirement

  - Crediting shared savings to WA Cares Fund

- Work with insurers to support the development of long-term care insurance products that supplement the program's benefit (referred to in this report as "Supplemental Private Long-Term Care Insurance Workgroup Report")

For each of the topics above, the LTSS Trust Commission researched policy options, impacts, and administrative feasibility and developed policy recommendations. Most recommendations would require legislative changes; these are indicated in the report. When a particular policy option had the potential to significantly impact the long-term solvency of the program, actuarial analysis was provided for each option. Please note that the estimated actuarial impact of enacting multiple policy options may not equal the sum of the individual policy impacts. Detailed actuarial assumptions can be found in Appendices D and F.

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January 1, 2023, Commission Recommendations

1) Portability: Options for extending benefits to out-of-state eligible beneficiaries

LEGISLATIVE REQUIREMENT

According to the 2022 operating budget bill ESSB 5693, Section 204 (58), the long-term services and supports trust commission established in RCW 50B.04.030 must submit the results of the following activities, including any *legislative* recommendations, to the governor and appropriate legislative committees no later than January 1, 2023.

(a) The commission shall develop options for allowing persons who become qualified individuals and subsequently move outside of Washington to access benefits in another state if they meet the minimum assistance requirements to become an eligible beneficiary. The commission must include consideration of options for conducting eligibility determinations for qualified individuals who subsequently move outside of Washington, alternative forms of benefits for out-of-state eligible beneficiaries, methods of cross-state coordination on long-term services and supports providers, and timing implications of extending benefits to out-of-state eligible beneficiaries with respect to short-term program implementation and long- term collaboration with other states establishing similar programs.

POLICY ISSUE

Per RCW 50B.04.010(6), "eligible beneficiary" means a qualified individual who is age eighteen or older, **resides in the state of Washington**, has been determined to meet the minimum level of assistance with *activities* of daily living necessary to receive benefits through the trust program (as established in this chapter) and has not exhausted the lifetime limit of benefit units. Some workers leave the state either during their working years or after retirement. Some may have paid in less than 10 years and left before they could permanently qualify, while others will have qualified and be unable to claim benefits when they need long-term care. Per the current statute, only people who reside in Washington can access WA Cares Fund benefits.

COMMISSION RECOMMENDATIONS TO THE LEGISLATURE ON PORTABILITY

Portability Challenge I: Managing the cost of expanding benefits to people who leave the state

Background: Under current statute, those who vest and leave the state cannot claim benefits outside of Washington. Making benefits portable without any policy adjustments to manage the cost of doing so would increase the premium required to fund the program significantly. This was not modeled in the 2022 actuarial study; in the 2020 study this change was estimated to have an actuarial impact equivalent to 0.36 (or a thirty-six cent increase in premium for every $100 earned). The workgroup

examined a number of ways to reduce the cost of making benefits portable and commissioned actuarial analysis of these options. For the remaining portability policy challenges (Challenges II-IV below), their feasibility and cost effectiveness will depend on which solution to Challenge I (cost management) is adopted. The solution to Challenge I will drive the expected number of out-of-state beneficiaries and the expected average amount of benefits they will receive. This, in turn, will significantly impact all other decisions points around portability (Challenges II-IV below).

Option 1 – Recommended by the Commission: Allow anyone with at least one year of qualifying contributions who leaves the state to elect portable benefits coverage by choosing to continue contributing premiums to WA Cares until the Normal Retirement Age under Social Security (currently age 67 for those born in 1960 or later). The premium would be equal to the last "in-state" premium assessed, adjusted for wage inflation. Workers who leave the state at age 67 or later would not be required to pay in further. This recommendation is contingent on finding ways to offset the cost of making benefits portable.

Actuarial analysis: The potential actuarial impact of this option is projected to be equivalent to between a .05 (or five cents for every $100 earned) and a .20 (or twenty cents for every $100 earned) increase to the premium rate depending on the percentage of individuals who choose to participate and the potential adverse selection associated with the participating population. In one plausible scenario, where 38% of the eligible population participates, the actuarial impact of this option is projected to be 0.11 (or an eleven cent increase for every $100 earned). **See Appendix "F" for more detail.**

- **Pros**: Gives all workers who leave the state the option of maintaining WA Cares coverage without requiring them to do so. For those who choose to buy in, requiring ongoing payment of premiums significantly reduces cost of portability. Ongoing premium collection also provides data to the program that eases both communication with insured persons and projection of expected numbers of beneficiaries (and hence projection of staffing needs around assessments and claims adjudication) in each of the other 49 states. As for in-state workers, this option requires continuous premium payment until a proxy retirement age to maintain coverage

- **Cons:** Not everyone will have permanent access to benefits – only those who choose to buy in. ESD is equipped to accept premiums from employer entities, as well as tribal entities and self-employed individuals who may elect coverage to participate. There will be significant administrative operational costs and technological development required to accept payments from individuals to assure that premiums are assessed and paid appropriately.

Option 2: Provide significantly reduced benefits to anyone who has paid in 10 years and then leaves the state.

Actuarial analysis: The potential actuarial impact of this option is projected to be equivalent to .18 (or an eighteen cent increase in premium for every $100 earned). **See Appendix "F" for more detail**.

- **Pros**: Everyone who pays in 10 years receives a modest amount of coverage
- **Cons**: May be hard to communicate to the public that the program has two different pro-ration formulas, one of which (the one for people born before 1968) is far more generous; would result in high administrative costs – large numbers of people with very low benefits, all of whom need assessments conducted and benefits managed and dispersed around the country; unclear how much utility a benefit of e.g. $1,000 or $3,000 has for people planning for their LTC needs

Portability Challenge II: Timing implications of extending benefits to out-of-state eligible beneficiaries with respect to short-term program implementation and long-term collaboration with other states establishing similar programs

Background: Endeavoring to make WA Cares benefits available nationwide by the same deadline they are statutorily required to be made available in-state could pose risk to Washington state staff's ability to implement the program successfully here. A small number of other states are exploring similar programs which, if implemented, could increase the feasibility of a multi-state benefit in the future. Due to uncertainty concerning whether (and if so, when) other states may implement similar programs, the option to bring on each state as they enact similar programs was rejected and the following options remain. The state will continue to closely monitor whether other states implement similar programs and if so, explore the feasibility of reciprocal agreements. **The Commission recommends Option 2, which would not undermine the ability of staff to implement WA Cares in timely fashion for in-state residents.**

Option 1: WA Cares Fund develops system to facilitate out-of-state eligible beneficiaries claiming WA Cares Fund benefits simultaneously with in-state eligible beneficiaries starting in July 2026

- **Pros:** Out-of-state eligible beneficiaries have immediate access to WA Cares Fund benefits
- **Cons:** Rushed development of new systems and processes to pay benefits nationwide would compromise the quality of those systems and processes and also risk undermining the ability of staff to implement benefits for Washingtonians in-state by July 2026

Option 2 – Recommended by the Commission: WA Cares Fund develops system to facilitate out-of-state eligible beneficiaries claiming WA Cares Fund benefits starting in 2030

- **Pros:** Does not risk undermining in-state implementation by July 2026; gives

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sufficient time to develop reliable systems and processes that work well for beneficiaries and minimize risk of fraud

- **Cons:** A small number of workers who have earned WA Cares benefits will need them out-of-state prior to 2030 and have to wait until 2030 to access their benefits

Portability Challenge III: Alternative forms of benefits for out-of-state eligible beneficiaries and methods of cross-state coordination on LTSS providers

Background: Current law requires payments be made only to approved providers who register with DSHS. There is no national standard for provider eligibility, which poses challenges for managing a provider network nationwide. Each state has its own laws and rules that define long-term care provider training, certification, and background check requirements. Alternative forms of benefits that do not require paying approved providers may assist in paying benefits without the administrative complexity of managing an out-of-state provider network.

Due to the administrative complexity and cost required, the option to coordinate with each state's Medicaid LTSS agency was rejected and the following options remain.
The Commission recommends Option 3, which allows DSHS and HCA flexibility to determine the most cost-effective and feasible approach once an overarching policy design (Challenge I above) has been developed.

Option 1: Reimburse the beneficiary or provider based on submission of receipts or invoices for care using a contracted vendor.

- **1A.** Restrict provider types to those licensed in the state where care is provided. A vendor would manage and process receipts and invoices, which would include license numbers from providers. Each state may have slightly different benefits depending on state licensing rules. For example, if in-home personal care does not require a license, it would not be reimbursed by WA Cares.
    - **Pros:** Ensures only long-term care services are being provided in other states; widens the pool of vendors that can do this work
    - **Cons:** Restricts access to unlicensed benefits like accessibility modifications in the home, home delivered meals that could have been received in WA State; frustration from beneficiaries whose claim is denied because they received services from an unlicensed provider; requires out-of-pocket payment for services; administrative complexity and cost to hire a vendor to manage out-of-state claims; time to develop this model
- **1B.** Allow unlicensed providers to be credentialed by a vendor based on standards set by DSHS in each state at the point of request for reimbursement or prior to services being rendered upon request from the beneficiary. Claims for services provided by a provider who did not meet credentialing requirements would not be reimbursed. For example, a claim from a home modification

provider that was not registered in that state as a contractor and in good standing would be denied.

- **Pros:** Ensures only long-term care services are being provided in other states; provides consistency in WA Cares benefits from state to state

- **Cons:** Frustration from beneficiaries who did not proactively seek credentialing, paid for services, then discovered the provider did not meet requirements to be credentialed; requires out-of-pocket payment for services; increased administrative complexity and costs to hire a vendor to manage claims and provider credentialing; time to develop this model

Option 2: Pay the beneficiary a lump sum of their entire benefit once determined eligible for care

- **Pros:** Simple to administer, especially if benefits will be pro-rated or reduced for people outside of Washington

- **Cons:** No way to determine whether long-term care was provided; could impact eligibility for Medicaid LTSS if the sum increased their resources beyond the required threshold and they were unable to spend it in time, could create a precedent – paying in cash is not allowable in state; more vulnerable to fraud

Option 3 – Recommended by the Commission: Allow DSHS and HCA flexibility to assess the most cost-effective option for paying benefits nationwide once a specific policy design has been enacted. Once a policy design has been decided, DSHS may issue an RFI to conduct a cost-benefit analysis of paying benefits in cash vs. utilizing a reimbursement model. If benefits are pro-rated or reduced for people outside of Washington, it may not be cost effective to pay for a vendor to manage long-term care provider payments. Understanding the volume of people who will receive benefits out of state and their expected average level of benefits is critical to understanding costs and feasibility of alternative forms of benefit administration.

Portability Challenge IV: Options for conducting eligibility determinations for qualified individuals who subsequently move outside of Washington

Background: There is no national functional eligibility standard for home and community based long-term services and supports. The WA Cares Fund eligibility standard will require specific assessor training to support eligibility determination out of state. Due to the administrative complexity and cost required, the option to coordinate with each state's Medicaid LTSS agency was rejected and the following options remain. **The Commission recommends Option 3, which allows DSHS flexibility to determine the most cost-effective and feasible approach once an overarching policy design (Challenge I above) has been developed.**

Option 1: Use WA Cares assessor capacity to conduct all out-of-state assessments virtually. Use a model that allows staff to gather medical records and do virtual or telephonic interviews to determine ADL need.

- **Pros:** WA Cares Fund can absorb the workload based on the small number of individuals nationwide; consistent standards would be applied; individual would access WA Cares Fund more quickly

- **Cons:** Not being able to visibly determine an individual's needs/environment; potential for providers in other states to claim WA Cares Fund and Medicaid in their state simultaneously (may need procedures to mitigate or prevent fraud risk with each state)

Option 2: Contract with a private vendor that would manage assessments nationwide. Today, private long-term care insurance carriers contract with vendors to provide telephonic, virtual and in-home assessments. Intensity of assessments depends on whether care is already in place, in which setting, and consistency in the story.

- **Pros:** Leveraging existing private infrastructure; base level of training already in place; may allow for in-person assessments

- **Cons:** Cost; need additional training with WA Cares Fund eligibility; contract management/monitoring; volume of assessments is likely to be very low in most states, making training investment inefficient and driving accuracy concerns; new processes to accept assessment data from out-of-state workers required; potential for providers in other states to claim WA Cares Fund and Medicaid in their state simultaneously (would need procedures to mitigate or prevent fraud risk with each state)

Option 3 – Recommended by the Commission: Allow DSHS to determine the method if and when portability has been enacted. DSHS could use WA Cares Fund staff to conduct virtual assessments or could contract with a private vendor to conduct assessments nationwide. The cost of these options will depend on a number of factors that could change between now and implementation of portable benefits. If portability is enacted, DSHS will then vet these options to determine most cost-effective approach at that time.

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2) Benefit Eligibility: Criteria for determining that an individual has met the requirements to be an eligible beneficiary as established in RCW 50B.04.060

LEGISLATIVE REQUIREMENT

The WA Cares Fund Statute (Chapter 50B.04 RCW) requires the LTSS Trust Commission to propose recommendations to the appropriate executive agency or the legislature regarding the establishment of criteria for determining that an individual has met the requirements to be an eligible beneficiary as established in RCW 50B.04.060.

According to RCW 50B.04.010(6), "Eligible beneficiary" means a qualified individual who is age eighteen or older, residing in the state of Washington, has been determined to meet the minimum level of assistance with activities of daily living necessary to receive benefits through WA Cares Fund program, as established in this chapter, and who has not exhausted the lifetime limit of benefit units.

DSHS will make determinations regarding an individual's status as an eligible beneficiary under RCW 50B.04.060:

(1) Beginning July 1, 2026, approved services must be available and benefits payable to a registered long-term services and supports provider on behalf of an eligible beneficiary under this section.

(2) A qualified individual may become an eligible beneficiary by filing an application with the department of social and health services and undergoing an eligibility determination which includes an evaluation that **the individual requires assistance with at least three activities of daily living**. The department of social and health services must engage sufficient qualified assessor capacity, including via contract, so that the determination may be made within forty-five days from receipt of a request by a beneficiary to use a benefit.

POLICY ISSUE

Long-term care is help with activities of daily living such as eating, dressing, and bathing. Services typically include hands-on assistance or supervision to complete these tasks and wrap around supports that help people live more independently in their homes, including support for family caregivers. Approximately 95% of people who qualify for Medicaid LTSS have a need for assistance with three or more activities of daily living as they are currently defined in Medicaid. Milliman's actuarial analysis modeled a benefit trigger based on Medicaid LTSS eligibility criteria.

DSHS has prepared draft definitions of the activities of daily living under consideration for WA Cares Fund eligibility. The LTSS Trust Commission workgroup reviewed scenarios and developed recommendations to guide DSHS' criteria for defining activities of daily living and engaging sufficient qualified assessor capacity in the following areas:

1. Ease of access to earned benefits

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2. Seamless transitions to Medicaid LTSS

3. Transitions to a private long-term care insurance policy

4. Ways to address cognitive impairment

5. Impacts to program solvency.

COMMISSION RECOMMENDATIONS ON BENEFIT ELIGIBILITY

(Note: On December 2, the Benefit Eligibility Workgroup reconvened and recommended tabling the Benefit Eligibility recommendations from the November Commission meeting and reconvening the workgroup in 2023. This would allow more time to consider the implications of the actuarial modeling on benefit eligibility, which did not become available until two days prior to the November Commission meeting. If the Commission adopts this workgroup recommendation, the benefit eligibility recommendations below will be tabled for reconsideration in 2023.)

1. Develop eligibility standards that promote ease of access to earned benefits, including support for unpaid family caregivers

    a. Develop a triage model for face-to-face assessments, virtual face-to-face assessments, and telephonic assessments to expedite eligibility; when feasible, assessments should be face-to-face or virtual face-to-face for people who are not yet accessing care to adequately evaluate living environment and daily living functioning

    b. Consider existing health records to expedite eligibility, such as diagnosis of dementia or paralysis, care provided by existing licensed LTC provider or care provided by a family member. Do not require diagnosis or existing health records to qualify for WA Cares benefits. Even when existing records may be used to determine eligibility, conduct an independent interview of the applicant to confirm activity of daily living assistance needs, which are not always accurately identified by health professionals, and mitigate risk of fraud.

    c. Create eligibility standards that are easy to understand and can be used to quickly ramp up outside assessors to increase capacity when needed

2. Promote seamless transitions to Medicaid

    a. Use an eligibility standard similar to Medicaid LTSS

    b. Provide access to information and continued planning through referrals when benefit balances are low

3. Prepare people for transitions to a private LTSS policy

    a. When an individual indicates they have private long-term care

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insurance upon application for WA Cares benefits, encourage them to check their policy's benefit trigger and covered care settings so that they are able to make choices that promote continuity of care

4. Develop ways to address cognitive impairment

    a. Consider a diagnosis of dementia or cognitive impairment that will progress as an indicator that ADL will be impacted; use screening tools to evaluate cognition for individuals who do not have a documented diagnosis such as AD8, mini-cog, SLUMS, MOCA or MMSE

    b. The assessment should include understanding a person's natural supports, or lack thereof, and evaluate what would happen if that person was not there, even for a short time. Supervision in order to complete tasks of daily living should be considered.

5. Consider impacts to program solvency and administrative costs

    a. Develop eligibility standards that mirror what was projected in the actuarial modeling, which aligns with Medicaid LTSS

    b. Allow individuals to remain eligible until their benefit balance is spent in full if they have a chronic long-term care need. Do not require re-assessment for individuals with chronic long-term care needs; instead provide access to continued care planning through referrals when benefit balances are low

Some Commissioners expressed concerns about how the benefit eligibility trigger could impact the long-term solvency of the program. Specifically, Commissioners expressed concerns around WA Cares paying for short-term care, particularly when some other benefits programs and/or natural supports might cover some of this need. A grid that shows whether people who are working could use other benefits to address their need for help with activities of daily living is included in Appendix E. The actuarial studies conducted in 2020 and 2022, based on the high-level benefit trigger language in statute, do not assume limits to the use of benefits based on length of time a person needs care or age of disability. This parallels Medicaid long-term services and supports, to which access is not restricted based on age or duration of functional disability. Some Commissioners expressed concerns that if many Washingtonians were to use some or all of their WA Cares benefits for short-term care needs, it could leave them unprotected later in life when they may need care for longer duration and have fewer resources and fewer natural supports.

The following options are under discussion to preserve WA Cares Fund benefits for longer term care needs. Each would require a statute change.

Recommended by the Commission: Adopt the HIPAA benefit eligibility trigger, same as the private long- term care insurance standard. This standard is defined as being

unable to perform (without substantial assistance from another person) at least two activities of daily living for a period expected to last at least 90 days or requiring substantial supervision to protect against threats to the individual's health and safety, due to severe cognitive impairment. This aligns better with what other states are considering as well as the potential supplemental private-long term care insurance market. It could significantly reduce program costs. People would not be able to access WA Cares until they have met the trigger.

Actuarial analysis: The potential actuarial impact of this option is projected to be equivalent to -.09 (or a nine cent reduction in premium for every $100 earned). **See Appendix "F" for more detail**.

Additional options for preserving WA Cares benefits for longer term care needs but rejected by the Commission:

- **Option 1**: Require a 90-day certification of need, similar to the private long-term care insurance standard for HIPAA qualified policies. This option would allow people access to care during a critical period of need but would only provide care to people whose conditions are not expected to resolve within three months.

  Actuarial analysis: The potential actuarial impact of this option is projected to be equivalent to -.02 (or a two cent reduction in premium for every $100 earned). **See Appendix "F" for more detail**.

- **Option 2**: Eliminate the ability to qualify based on contributing for three years within the last six years from the date of application for benefits. Under this option, the functional eligibility trigger would be unchanged but fewer people who need care during their working years would be qualified individuals (vested). Only people who have contributed for 10 years would be qualified individuals, except for people born before 1968 (who can qualify for 1/10th of the lifetime benefit for each year they have contributed).

  Actuarial analysis: The potential actuarial impact of this option is projected to be equivalent to -.04 (or a four cent reduction in premium for every $100 earned). **See Appendix "F" for more detail**.

- **Option 3**: Similar to Option 2, but rather than eliminating the three-year pathway to qualify, only allow people who are unable to work to be able to access care through that pathway. This option may be difficult to administer and could cause concern among people with disabilities who need long-term care services in order to work.

- **Option 4**: Cap the amount of a qualified individual's lifetime benefit that may be used for short-term care needs. A cap of $6,000 could pay for assistance with activities of daily living during a critical recovery period and preserve the

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remaining lifetime benefit for use in older age. Determining whether a care need is short-term could be difficult to administer and expose the program to administrative hearings. A doctor's certification that a person is expected to recover within a specific period of time would likely be needed.

- **Option 5**: Require a 90-day waiting period to use benefits after someone is determined eligible. This option was rejected by the workgroup because it would force everyone, even those with longer-term needs, to delay accessing their earned benefits when they may need them most.

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3) Recertification and Rescinding of Private Long-Term Care Insurance Exemptions

LEGISLATIVE REQUIREMENT

According to the 2022 operating budget bill ESSB 5693, Section 204 (58) The long-term services and supports trust commission established in RCW 50B.04.030 must submit the results of the following activities, including any legislative recommendations, to the governor and appropriate legislative committees no later than January 1, 2023:

- (58)(b) The commission shall develop options for requiring the ongoing verification of the maintenance of long-term care insurance coverage by persons who have received an exemption under RCW 50B.04.085, including consideration of procedures that minimize administrative burden, minimize negative impact on long-term services and supports trust account solvency, and incentivize maintenance of coverage

- (58)(c) The commission shall develop options for providing workers who have received exemptions based on having private long-term care insurance pursuant to RCW 50B.04.085 an opportunity to rescind their exemption and permanently reenter the long-term services and supports trust program.

POLICY ISSUE

Approximately 475,000 people have been approved for an exemption based on purchasing private long-term care insurance. The window to purchase private LTC insurance to be exempt from WA Cares Fund has closed.

Several themes regarding WA Cares exemptions, based on purchasing private long-term care insurance (PLTCI), have emerged from interactions with stakeholders over the last year. Concerns shared by stakeholders include:

1) Applicants are required only to self-attest to having LTC insurance purchased prior to November 2021, to receive approval for a lifetime exemption from WA Cares participation, without submitting proof of coverage.

2) Individuals who received an exemption may not have had qualifying coverage, and

3) Individuals may have canceled or not maintained their LTC insurance policy at some point after receiving approval for their exemption.

Furthermore, due to legislative changes in 2022, exemptions will be made available to groups who did not previously qualify, including workers who live outside of Washington, military spouses, workers holding non-immigrant visas, and certain veterans with disabilities. Exemption applications for newly eligible groups will become available

January 1, 2023.

COMMISSION RECOMMENDATION TO THE LEGISLATURE ON RECERTIFICATION

Option 1 - Recommended by the Commission: Require all individuals with approved exemptions to provide proof that they had purchased a qualifying LTC policy prior to November 2021 and that they have maintained their policy through the present day. To maintain an exemption, recertification is required to occur at an interval of no more frequently than annually and no less frequently than every three years, beginning in December 2024. Recertification is no longer required or possible after ten years. Legislative authority would be needed in 2023 to implement by December 2024.

Actuarial analysis: The potential actuarial impact of this option is projected to be equivalent to between -.04 (or a four cent reduction in premium for every $100 earned) and a .01 (or a one cent increase in premium for every $100 earned) depending on the volume and characteristics of the population that joins WA Cares as a result of recertification. If in the future WA Cares were allowed to invest a portion of its reserves in equities, the actuarial impact would increase to -.06 (or a six cent reduction in premium for every $100 earned). See Appendix D for more detail.

Pros:

- Is likely to reduce the premium required to fund program costs over the long-term by several basis points
- Provides reasonable assurance that individuals intend to maintain PLTCI plan, protecting Medicaid from people who are uninsured ultimately relying on Medicaid for all their LTSS needs
- Limits the burden to recertify to ten years for both consumers and ESD, which also limits administrative costs

Cons:

- There is administrative complexity. Additional administrative authority will be required as well as operational and technology investments. Current staff to address these exemptions were hired on as project with the expectation that applications end December 31, 2022. Project positions will end no later than January 31, 2023.

  Hiring and training of staff with skills to review the complexity of long-term care insurance policies will be required
- This solution would require program authority to cancel a permanent exemption

Additional recertification options considered by the workgroup but rejected

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Option 2: Require individuals with approved exemptions to provide proof that they have maintained their LTC policy when requested by the department, at an interval of no more frequently than annually and no less frequently than every three years. This process would go on indefinitely for all policy holders, which would increase administrative cost.

Option 3: Same as Option 1, and also allow people to buy back lost qualifying years if they had not maintained their policy. This option doesn't incentivize people to maintain their coverage, drives adverse selection, and would be administratively complex.

Option 4: Same as Option 1, but also assess a penalty. The administrative complexity and cost of seeking penalty payments for people who did not maintain their coverage may outweigh the benefits.

COMMISSION RECOMMENDATION TO THE LEGISLATURE ON RESCINDING WA CARES LIFETIME EXEMPTION

Option 1 – Recommended by the Commission: Provide everyone who has a lifetime exemption a one-time limited opportunity to permanently join WA Cares Fund until June 30, 2028, five years after the start of premium collection.

Pros:

- Allows workers to proactively identify themselves as people who want to enter the program instead of leaving it up to them failing a recertification process

- Gives near-retirees in particular, who under the original statute would have had trouble qualifying for WA Cares but due to 2022 legislative changes now easily qualify, an opportunity to rescind their exemption; if other coverage improvements, like making benefits portable, were to be enacted in the future, this would give affected individuals the ability to rescind their exemption as well

- Could reduce the amount of people who need participate in a recertification process and therefore reduce the administrative complexity and cost of recertification

Cons:

- As with Recertification recommendations, there is administrative complexity, as well as both operational and technology costs associated. Current staff to address these exemptions were hired on as project with the expectation that applications end December 31, 2022. Project positions will end no later than January 31, 2023.

- Allows people to enter the program without paying in for the first few years

- Potential adverse selection

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Additional rescinding options considered by the workgroup but rejected

Option 2: Same as the recommended option, but also require back-payment of premiums. Anyone who rescinds their exemption before 2024 is not required to pay retroactive premiums. This option is administratively complex, would be difficult to determine the amount of back-pay for workers who come in and out of the workforce, and would add administrative cost.

Option 3: Same as the recommended option, but available only for near-retirees (defined in RCW 50B.04 as born before 1968). This option limits the number of people who could re-enter WA Cares permanently to those who are now able to qualify who could not before. This option was rejected because there are other people who purchased a private policy to become exempt and after learning more about the benefits, want to be part of WA Cares Fund. If other policy changes like portability are enacted, more people may want to be in the program and limiting who can come back in would cause problems in the future.

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4) Employer Reporting Consistency and Premium Reporting Accountability

POLICY ISSUE 1

Employers will have one wage reporting experience to ESD for the WA Cares Fund and Paid Family and Medical Leave programs. Consistency in the reporting requirements minimizes administrative complexity for employers. In 2022, the legislature passed 2SSB 5649 which sunsets a provision in Paid Family and Medical Leave that excluded premium assessments from employees covered by a collective bargaining agreement if the collective bargaining agreement was in place before October 19, 2017 (RCW 50A.05.090.) The similar provision for WA Cares Fund was not addressed at that time.

COMMISSION RECOMMENDATION TO THE LEGISLATURE

To support consistency in combined employer reporting for Paid Family and Medical Leave and WA Cares Fund, the Commission recommends an amendment to RCW 50B.04.080 (3) to sunset the collective bargaining agreement exception effective December 31, 2023.

- (3) Nothing in this chapter requires any party to a collective bargaining agreement in existence on October 19, 2017, to reopen negotiations of the agreement or to apply any of the responsibilities under this chapter unless and until the existing agreement is reopened or renegotiated by the parties or expires.

POLICY ISSUE 2

Employers report employee wages for WA Cares Fund to ESD in the same way that they report wages for the Paid Family and Medical Leave program. ESD has the authority in statute to collect penalties from employers who do not report wages and may apply interest to unpaid premiums from employers only for Paid Family and Medical Leave. There is no recourse for the department if an employer does not report wages or pay premiums to the WA Cares Fund. Employers that do not report or pay premiums for the WA Cares Fund put their employees in jeopardy of not earning long-term care benefits and being left without a solution to pay for care in their retirement years.

COMMISSION RECOMMENDATION TO THE LEGISLATURE

Adopt for WA Cares Fund the premium accountability measures contained in the PFML statute, namely PFML authority in Chapter 50A.45 RCW. This would allow ESD to assess and collect penalties and interest from employers that do not report wages and remit premiums for WA Cares Fund. It is imperative that ESD have enforcement authority to ensure that employers with Washington workers are required to collect premiums, report hours and wages, and pay premiums to ESD in order to comply with the law. Employer compliance is critical to short and long-term solvency of the WA Cares Fund.

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5) Self-Employment Income Reporting

POLICY ISSUE

Self-employed individuals are not automatically included in WA Cares Fund. They can elect WA Cares Fund coverage and when they do, they are required to report their wages and pay assessed premiums to ESD. Generally, for self-employed individuals, the amount of hours worked is determined by taking the wages reported and dividing by state's the minimum wage. Depending on the number of self-employed individuals who elect coverage, accurate income reporting may be critical to meeting expected revenue forecasts.

By rule, ESD has the authority to request or require copies of tax returns, bank records or any other documentation to verify or determine self-employed hours and wages (WAC 192-915-015.) The number of self-employed individuals who will elect coverage is unknown.

COMMISSION RECOMMENDATION TO ESD

The Commission makes recommendations to ESD for the following rule amendments and policy changes:

As ESD does for PFML, ESD will require quarterly wage reports from individuals who are self-employed and elect coverage under the WA Cares Fund. The department will assess premiums each quarter based on reported wages. It is recommended that at the end of each taxable year, elected covered participants verify income that was reported to appropriately apply accurate premium assessment and "true up" any misreported income and to amend WAC 192-915-015 to require this. The workgroup recommends accomplishing this by aligning annual net profit, to which WA Cares premium is applied, with Line 2 of an individual's federal Schedule SE and requiring annual uploading of Schedule SE.

Communicate with those who elect coverage that they will be expected to report net income quarterly and true up annually on the basis of their Schedule SE.

Pros:

- Ensures accurate premium collection from the self-employed and equity in this regard vis-à-vis employees (W2 workers)

Cons:

- Using federal tax income data shows income earned in the United States and not just in the state of Washington
- ESD does not have data on the number of people who will opt in, so estimating administrative impacts is difficult
- Reconciling annual net profit with the federal tax return may not align and require further research and follow up with each participant, for example, self-employed workers who also work outside of Washington should not have all wages subject to premiums

6) Pilot Project in Early 2026 for Benefit Implementation

POLICY ISSUE

Actuarial projections anticipate that 25,000 to 35,000 people will use WA Cares Fund benefits in the first year of full implementation, which begins July 1, 2026. Implementing a new program with a high volume of beneficiaries poses a risk of long wait times and system errors at launch. A way to mitigate this risk is to implement a pilot with a small group of eligible beneficiaries. The state agencies do not have authority to pay benefits before July 1, 2026.

COMMISSION RECOMMENDATION TO THE LEGISLATURE

The Commission recommends the legislature provide the WA Cares' administering agencies with statutory authority to pay WA Cares benefits earlier than July 1, 2026 (but no earlier than January 1, 2026) for a small group of eligible individuals. Statutory authority for the agencies to engage in rulemaking to allow a pilot launch of WA Cares Fund services and payments prior to July 1, 2026 would offer flexibility for agencies to design a pilot launch. This would allow the agencies to use their production systems and processes with a smaller group of beneficiaries and fix any problems that are uncovered prior to going fully live in July 2026.

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7) Simplifying the Ten-Year Contribution Requirement

POLICY ISSUE

Over the past two years, the public and legislators have repeatedly expressed confusion over WA Cares' primary pathway to qualified individual status: "A total of ten years without interruption of five or more consecutive years; " (RCW 50B.04.050)(1)(a).
Milliman has determined that eliminating this requirement of no extended interruption would have a negligible effect on expected program finances. Removing this requirement will no longer potentially eliminate workers who may take extended time from the workforce to raise children or care for aging parents. The workers most disproportionately impacted by this are women and women of color.

COMMISSION RECOMMENDATION TO THE LEGISLATURE

Replace existing RCW 50B.04.050(1)(a) pathway language with the simpler formulation: "A total of ten years".

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8) Crediting Savings from Medicaid and Medicare Cost Avoidance to WA Cares Fund

POLICY ISSUE

WA Cares Fund is projected to provide substantial savings by way of future cost off-sets for the state budget due to delaying or diverting people from Medicaid long-term services and supports. WA Cares is also projected to reduce the growth in Medicare utilization and expenditure. In other demonstration projects implemented by Washington State where Medicare funds were saved (such as the Health Home demonstration), WA has reached an agreement with the federal Centers for Medicare and Medicaid Services (CMS) that has resulted in millions of dollars in payments back to Washington from the savings achieved to the Medicare program. With Medicaid demonstration waivers, such as the Medicaid Transformation Demonstration (1115 waiver), agreements with CMS have provided additional matching funds to relieve the state of all or a portion of its shared obligation when implementing innovative models that show promise to improve outcomes for participants. As directed by the Legislature, the state has begun negotiations with CMS seeking a new agreement to allow Washington State to share in the future savings generated in Medicare and in the federal match for Medicaid long-term services and supports due to the operation of WA Cares Fund.

COMMISSION RECOMMENDATION TO THE LEGISLATURE

The Commission recommends that any savings achieved through a potential shared savings waiver with the federal government should be credited to the WA Cares Fund since these savings result directly from WA Cares Fund expenditures. Since WA Cares Expenditures are funded by WA Cares premiums, savings resulting from WA Cares expenditures should be used to maintain or lower WA Cares premiums for Washington workers. By crediting any such potential savings to the WA Cares Fund in statute, it would allow for a more holistic picture of the net financial impact of the WA Cares Fund, providing an additional perspective on the program's finances. The legislature could implement this recommendation by adding the following language to RCW 50B.04:

- If Washington is successful in obtaining a waiver from the Centers for Medicare and Medicaid that results in shared savings because of WA Cares Fund spending, the amount of shared savings must be deposited into the WA Cares Fund Trust Fund.

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9) Supplemental Private Long-Term Care Insurance Workgroup Final Report

BACKGROUND

WA Cares' modest premium (0.58 percent of wages) and modest but critical benefit leave room for middle class consumers who seek additional coverage to purchase such coverage on the private market. The assumption of the first tranche of risk by WA Cares Fund may allow carriers to offer supplemental coverage at premiums more accessible to the broad middle class. Despite the promise of such a market, there are significant challenges to the emergence of a unique supplemental market in one state that is both attractive to insurers and protective of consumers. In June 2021, the legislature charged the LTSS Trust Commission to work with insurers to support the development of private long-term care insurance products that supplement the WA Cares Fund benefit.[1] In September 2021, the LTSS Trust Commission chartered a workgroup to focus on these challenges and issue recommendations to the Commission by summer 2022. The workgroup consisted of private long-term care insurance carrier representatives as well as consumer protection advocates, legislators, and other long-term care stakeholders. The workgroup issued a consensus report which was adopted by the full Commission.

RECOMMENDATIONS

The Workgroup's recommendations on the structuring of the SPLTCI market focused on six areas: consumer protection, the venue for filing policies, the benefit trigger and elimination period, transition issues for near-retiree cohorts, continuity of covered care settings and providers, and coordination of benefits between WA Cares and SPLTCI policies.

Consumer Protection

Recommendations:

- **Develop a consumer guide for people seeking SPLTCI coverage to help them make informed choices.** The SPLTCI market is a new type of long-term care insurance product and consumers will need guidance and support to help them understand what is and is not covered by SPLTCI policies, what consumers will be required to pay in terms of premiums and out-of-pocket payments, etc.

- **Direct and fund the Office of the Insurance Commissioner to expand the Statewide Health Insurance Benefits Advisors (SHIBA) program to educate SPTLCI consumers, with a focus on the middle-income market.** It is within the scope of the national State Health Insurance Assistance Program (SHIP), which funds the

[1] SHB 1323 (2021), available at https://app.leg.wa.gov/billsummary?BillNumber=1323&Initiative=false&Year=2021.

SHIBA program, to support information, counseling, and assistance activities related to long-term care insurance. The Commission recommends leveraging SHIBA to provide such consumer education.

- **For adequate consumer protection in policies marketed and sold as extending WA Cares, a new section of statute in Title 48 should be created to regulate policies that can be marketed and sold as supplemental to WA Cares.** The regulation should apply to SPLTCI products only and not disrupt the current long-term care insurance market. It should, however, be sufficiently detailed and thorough to give consumers adequate information to protect them as they make decisions about purchasing a product that entails a substantial long-term financial commitment. Everything known about SPLTCI policies should be disclosed up front so that consumers are not surprised later. This revised or new statute or section of statute should include the following provisions:

- **Disclosures:**

    - Disclosure of potential gaps in coverage or discontinuities of care between WA Cares Fund and SPLTCI

    - Disclosure that premiums may go up over time and under what conditions

    - Disclosure that individual circumstances can change over time (like job loss), and what if any options would be available to them if those events occur

    - Disclosure that if rates do go up and the consumer cannot afford the increase, the consumer has options such as a reduction in benefits, non-forfeiture of premiums, etc.

    - Disclosure that premiums continue after retirement

    - Disclosure of when premiums stop ("waiver of premiums") in a given SPLTCI policy

    - Disclosure that this policy (like all private long-term care insurance policies sold after 11/1/21) does not qualify the policyholder to opt out of WA Cares

    - The above disclosures should apply both to SPLTCI policy language and to SPLTCI policy marketing.

- **Requirements:**

- If rates do go up and the consumer cannot afford the increase, the consumer has options such as a reduction in benefits, non-forfeiture of premiums, etc.

- SPLTCI policies should be governed by the same suitability and affordability requirements currently in statute under [RCW 48.83.140]

- The suitability requirements should include a "best interest" standard, stipulating that an agent or broker shall act in the best interest of the consumer under the circumstances known at the time the recommendation is made, without placing their financial interest ahead of the consumer's interest.

- Statute should require that Inflation protection for SPLTCI benefit levels be offered at a minimum rate of three percent (and leverage SHIBA to help customers understand inflation protection and suitability) to protect the purchasing power of benefits from being eroded over time.

- SPLTCI policies may be designed with or without partnership protection. This should give flexibility to carriers and consumers by giving rise to a broader range of SPLTCI policy designs and price points.

Venue for Filing SPLTCI Policies

The interstate compact has not developed product standards for SPLTCI policies because this is a new type of product. The compact is unlikely to develop such product standards for SPLTCI policies until multiple states have adopted such uniform standards for public insurance programs that assume significant front-end risk, along the lines of WA Cares. Hence SPLTCI policies would need to be filed in Washington State.

It would reduce barriers to entering the SPLTCI market if carriers could leverage existing compact-approved policies sold nationally and modify them with a rider, for example, only to the extent needed to satisfy the specific SPLTCI statutory requirements. Under current administrative practice (although not prohibited by statute), Washington State does not allow this so-called "mix and match."

The Workgroup agreed that allowing "mix and match" would be critical to supporting the emergence of a SPLTCI market in Washington State by lowering the time and cost required to develop, price, and support new products. This would increase the likelihood that carriers will enter the SPLTCI market in the first place and could also increase the number of carriers that enter it. The more carriers that enter the SPLTCI market, the more competitive and affordable it will be, which will also benefit consumers.

At the same time, the Commission acknowledges that while "mix and match" is technically allowed under current statute, there are logistical challenges to the Office

of the Insurance Commissioner being able to support it. It would not only require additional staff capacity, but also new expertise in the interstate compact regulations. If the legislature were to allow "mix and match," the Commission recommends limiting this to the SPLTCI market.

Recommendation:

- The Commission recommends that the state endeavor to work through the logistical challenges for allowing "mix and match" to reach the agreed-upon goal of facilitating the development of a vibrant and competitive SPLTCI market.

Benefit Trigger and Elimination Period

The threshold of long-term care need for being eligible for benefits ("benefit trigger") is generally lower in WA Cares compared to private tax-qualified long-term care insurance (by far the most prevalent type of long-term care insurance). This means that a minority of SPLTCI policyholders are likely to be determined eligible for – and ultimately exhaust – their WA Cares benefits before they are eligible for private supplemental coverage. This potential gap in coverage is largely unavoidable. Private insurers and consumers both value tax-qualified insurance, and hence non-tax-qualified insurance – which could avoid this gap in coverage by using a trigger akin to that in WA Cares – is unlikely to become prevalent. Meanwhile, if the WA Cares trigger were to become as strict as that in private long-term care insurance, many workers who earn WA Cares benefits would end up being eligible for Medicaid long-term care *before* they would be eligible for WA Cares. That would be contrary to the intent of WA Cares, which is to give middle class Washingtonian access to long-term care such that they either don't need to – or can delay – spending down their life savings to qualify for Medicaid. The market will determine what types of private long-term care insurance coverage are marketed and purchased but tax-qualified coverage is likely to continue to be most prevalent. That said, workers particularly concerned with avoiding a gap in coverage may choose to purchase non-tax-qualified coverage, albeit with a risk of premiums not being tax-deductible and benefits potentially being to some extent taxable.

Another issue is the "elimination period" in SPLTCI policies, a period of time which has to transpire before benefits kick in. An elimination period can be measured either in days (e.g., calendar days, service days, etc.) or as a period of time until a consumer has purchased long-term care up to a specified dollar amount (also termed a deductible), or a combination of the two. A core rationale for the development of a WA Cares supplemental market is that the existence of WA Cares should make it possible for carriers to market and sell a new, more affordable type of long-term care insurance policy: one that takes WA Cares benefits as the deductible. For SPLTCI policies to truly "extend" WA Cares benefits, it is critical that the monetary component of the SPLTCI

elimination period (deductible) be identical to, or closely align with, the WA Cares lifetime benefit. If not, a gap in coverage (donut hole) emerges.

Recommendations:

- The SPLTCI deductible (the monetary component of the SPLTCI elimination period) should be equal to the WA Cares full maximum lifetime benefit (starting at $36,500) and automatically adjusted for inflation. And the WA Cares annual benefit inflation adjustment should be automatic, rather than an annual discretionary determination by the LTSS Trust Council. Together, these measures will prevent emergence of an elimination-period related donut hole between exhaustion of WA Cares benefits and beginning of SPLTCI benefits. If the WA Cares lifetime benefit is not automatically indexed for inflation, it will be impossible for carriers to ensure that over time their SPLTCI deductible is equal to the WA Cares full lifetime benefit amount which, in turn, is key to SPLTCI policies truly "extending" WA Cares benefits. In other words, without automatic indexation of WA Cares benefits, carriers will have to guess what WA Cares benefit indexation rates will be (as these must be assumed in order to price a policy and must be specified in the insurance contract at time of sale); if WA Cares inflation adjustments turn out to be lower in practice, this will create a gap in coverage (donut hole) for consumers that could become sizable over time. However, from the perspective of the Risk Management Framework, replacing the discretionary determination by the LTSS Trust Council on the annual inflation adjustment with a non-discretionary, automatic adjustment would remove one of the potential response strategies for managing future program solvency.

- Carriers may not require that a client undergo a functional assessment or satisfy a benefit trigger in order to determine that a SPLTCI elimination period has begun or ended. (A carrier may, of course, conduct a functional assessment and apply a benefit trigger for purposes of approving the SPLTCI claim and authorizing SPLTCI benefits.) SPLTCI policies must accept exhaustion of maximum WA Cares benefits (currently $36,500) by a SPLTCI policyholder – or for WA Cares beneficiaries with partial benefits, exhaustion of WA Cares benefits and utilization of paid care which together total the proposed statutory SPLTCI deductible (currently $36,500) – as sufficient to satisfy the monetary component (deductible) of the SPLTCI elimination period. (Note: This recommendation assumes the above two recommendations are also adopted, which ensure that the maximum WA Cares lifetime benefit is equal to the monetary component [deductible] of SPLTCI policies. If not, then SPLTCI policies must accept exhaustion of WA Cares benefits by a SPLTCI policyholder as sufficient to satisfy the portion of the SPLTCI elimination period equal to the dollar amount of the person's lifetime benefit.)

- For proof of exhaustion of WA Cares benefits, it will suffice that WA Cares Fund informs the carrier when a client's WA Cares benefits are exhausted.

- SPLTCI policies' elimination period may include, in addition to the monetary component (deductible), a time component such as 3, 6, 9, or 12 months, but

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not to exceed 12 months. For policies that include both the monetary and time component, a policyholder would satisfy the SPLTCI elimination period after the later of two events: exhausting WA Cares benefits and being on their WA Cares claim for the time period specified in the policy. Allowing a time component in SPLTCI elimination periods serves two goals. First, it provides more actuarial predictability to carriers as they design and price their SPLTCI policies, increasing their willingness to enter a market that requires them to accept a policyholder exhausting WA Cares benefits as satisfying the monetary component of an SPLTCI elimination period (key to SPLTCI policies truly extending WA Cares benefits). Second, allowing a time component in SPLTCI elimination periods makes it possible for carriers to offer more affordable SPLTCI policy variants because they will be able to rule out that a beneficiary will need to go on claim earlier than the policy's specified time period, reducing the carrier's risk exposure. If carriers can price their SPLTCI policies lower, this will make SPLTCI policies more affordable for middle-income consumers. In sum, allowing a time component in SPLTCI elimination periods will make the emerging SPLTCI market more viable.

In exchange for a significantly lower premium, consumers who choose to purchase a SPLTCI with a time component in the elimination period run the risk of exhausting their WA Cares benefits prior to this time period (after going on WA Cares claim) being reached. If that risk transpires, the SPLTCI policyholder will have to pay out of pocket (donut hole) until their SPLTCI policy begins paying. Consumers will be responsible for making choices in the context of this tradeoff between elimination period duration, premium rate, and donut hole risk.

- The new SPLTCI consumer guide, SHIBA counseling, and disclosures should support consumers in assessing the tradeoffs between various elimination period options and price points and educate consumers about the importance of budgeting their WA Cares benefits carefully to reduce the likelihood and size of a potential donut hole.

Transition Issues for Near Retiree Cohorts

If a worker nearing retirement contributes to WA Cares, for example, for only two years and thereby earns a lifetime benefit of $7,300 (subject to inflation adjustment over time), and that worker has purchased a SPLTCI policy, the SPLTCI policy will have an elimination period (deductible) of $36,500. Near-retirees, such as the worker in this example, who choose to purchase an SPLTCI policy will need to pay out of pocket for their long-term care up to an amount equal to the difference between their earned WA Cares benefit and their SPLTCI policy's $36,500 elimination period (in this example, the worker will need to pay $29,200 out of pocket).

Recommendations:

- The SPLTCI consumer guide and SHIBA counseling will work to educate near-retirees on the cost and benefits of purchasing SPLTCI policies. A particular focus of materials and counseling aimed at near-retirees will be the potential for a

large deductible before the SPLTCI policy begins paying claims, its implications, and strategies for managing this.

- For SPLTCI policies marketed and sold to workers born prior to 1968 (“near-retirees”), the dollar component of the elimination period (deductible) may be $36,500 or less. This will reduce the size of a potential donut hole between exhaustion of partial “near-retiree” WA Cares benefits and commencement of SPLTCI benefits.

Continuity of Covered Care Settings and Providers

A core goal of the SPLTCI market is to ensure that a person who is transitioning from WA Cares to SPLTCI benefits and is receiving care in a given care setting can continue to receive care in that setting. For example, if a person is in an adult family home, that person should not be forced to move into a different, more expensive care setting due to limitation of care settings in SPLTCI coverage. The biggest continuity of care challenge is for care by family providers. It could be destabilizing for a person receiving paid care from their adult child, for example, to have to “fire” them and hire a professional caregiver simply because they were transitioning from WA Cares to SPLTCI benefits. Not only could such disruptions in continuity of care potentially worsen the health and long-term care trajectory of the person receiving care, they could also oblige the beneficiary to exhaust their insurance benefits more quickly than would otherwise be the case, resulting in them having to spend down their savings and potentially rely on Medicaid sooner than might have otherwise been necessary (or it might not have become necessary at all). Furthermore, some WA Cares beneficiaries might be reluctant to make use of certain care settings or providers approved in WA Cares if there is lack of clarity around whether their SPLTCI policy will allow them to continue to receive care in that care setting or from that provider.

Recommendations:

- Unless there is good-faith reason to believe that a care setting or provider is not suited to meeting the care and safety needs of a beneficiary, SPLTCI policies must allow continuity from WA Cares to SPLTCI coverage of care setting and provider, including family providers, so that SPLTCI “extends” WA Cares benefits without disrupting care. In other words, unless there is good-faith reason to believe that a care setting or provider is not suited to meeting the care and safety needs of a beneficiary, a SPLTCI policy cannot require a policyholder to change the care setting or provider (including family providers) of the care they were receiving under WA Cares. Carriers may audit for fraud, however, i.e., to determine whether care being billed is actually being provided.

- If a carrier determines that a care setting or provider is not suited to meeting the care and safety needs of a beneficiary the carrier may, effective 90 days after the transition from WA Cares to SPLTCI benefits, require a change in care setting or provider. The beneficiary will have a right to appeal this decision through a

third-party independent review tracked by the Office of the Insurance Commissioner.

- In their covered care settings and providers, SPLTCI policies must generally include coverage of family providers.

Collaboration in Benefit Administration between WA Cares and SPLTCI Policies

Agreements:

- To support a seamless transition from WA Cares to SPLTCI, a process of reciprocal administrative notification should be developed:
  - When a WA Cares Fund qualified individual applies for WA Cares benefits, WA Cares Fund asks whether the individual has SPLTCI coverage and if yes, requests written consent from the applicant to share this information with the SPLTCI carrier for the purpose of triggering the SPLTCI policy's elimination period as well as any potential care coordination.
  - When a Washingtonian purchases a SPLTCI policy, the carrier requests written consent from policyholder to share this information directly with WA Cares Fund and if this consent is granted, shares that information with WA Cares Fund.
- Only basic demographic information that would allow a person to be identified in each system would be shared, no health information or data on claims would be shared.

As the Commission considers recommendations on other policy questions related to WA Cares Fund, it will consider any potential impact of those policy changes on the SPLTCI market.

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Appendix A: Long-Term Services and Supports Trust Commission Members

Senator Karen Keiser (D)
Representative Paul Harris (R)
Senator Judy Warnick (R)
Representative Frank Chopp (D)
Representative Nicole Macri (D)
Senator Steve Conway (D)
Senator Curtis King (R)
Representative Drew MacEwen (R)
Secretary Jilma Meneses Department of Social and Health Services
Commissioner Cami Feek Employment Security Department
Taylor Linke Health Care Authority
Madeleine Foutch Representative of a union representing long-term care workers
Ruth Egger Individual receiving LTSS (or designee or representative of consumers receiving LTSS)
Andrew Nicholas Worker who is paying the premium (or will likely be paying the premium)
Rachel Smith Representative of an organization of employers whose members collect the premium (or will likely be collecting)
John Ficker Adult Family Home providers representative
Laura Cepoi Area Agencies on Aging representative
Peter Nazzal Home Care Association representative
Michael Tucker Representative of an organization representing retired persons
Lauri St. Ours Representative of an association representing skilled nursing facilities and assisted living providers
Brenda Edwards-Charles Recipient of LTSS (or designee or representative of consumers under the program)

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Appendix B: Office of the State Actuary Report on WA Cares Fund Solvency

See The Office of the State Actuary report on WA Cares Fund solvency

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Appendix C: WA Cares Fund Risk Management Framework

See WA Cares Fund Risk Management Framework

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Appendix D: Milliman Actuarial Analysis

1. "**2022 WA Cares Fund Actuarial Study":** Milliman's update to the 2020 study to refresh underlying modeling assumptions and reflect more up-to-date program parameters

   https://leg.wa.gov/osa/additionalservices/Documents/Report01-2022WACaresFundActuarialStudy.pdf

2. **"WA Cares Fund Savings for the Medicaid Program, November 2021**": Analysis of Medicaid savings achieved by WA Cares Fund. Note: This analysis was conducted prior to the legislative changes from the 2022 legislative session and prior to the 2022 updated actuarial baseline analysis.

   https://leg.wa.gov/osa/additionalservices/Documents/Report02-WA.Cares.Fund.Medicaid.Savings_20211105.pdf

3. "**Recertification Analysis":** Milliman's analysis of the actuarial impact of requiring recertification of a WA Cares exemption on the basis of having private long-term care insurance

   https://leg.wa.gov/osa/additionalservices/Documents/RecertificationAnalysis.pdf

4. "Portability Analysis": Milliman's analysis of the actuarial impact of making WA Cares benefits available to people who leave the state and reside elsewhere when they need long-term care

   https://leg.wa.gov/osa/additionalservices/Documents/Masselink12-PortabilityWorkgroupAnalysis.pdf

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Appendix E: WA Cares Fund and Other Benefits Grid

WA Cares Fund Coverage for Workers and Other Benefits

Long-term care coverage is based upon a need for assistance with activities of daily living (ADL) such as getting in/out of bed, using the toilet, getting dressed, bathing and brushing of teeth. When individuals meet the ADL criteria, they can also receive services with things such as house cleaning, making meals and transportation.

WA Cares Fund is designed to help pay for care when people can't do these things on their own due to a functional disability. Car accidents, strokes, and other reasons for functional disability may be temporary, but still require the same level of support in the home as someone with a degenerative condition. Below is a grid that shows the extent to which other benefits could support people who are working to address their need for help with activities of daily living.

BENEFITS AND COVERAGE	**WORKER SCENARIOS**		
Benefits and Coverage Criteria	Working person needs assistance to get ready for work due to functional disability	Working person takes time off for major surgery like hip replacement, needs shorter-term help with activities of daily living	Working person fractures spine doing recreational activities, needs help with activities of daily living
WA Cares Fund: Services and supports when people need assistance with at least three activities of daily living regardless of the reason for disability, covers help with bathing, dressing, hygiene, transportation, meals, etc.	Yes	Yes	Yes
WA Paid Medical Leave: Partial wage replacement when not working based on a qualifying event; a maximum of $1,327 per week (in 2022) or up to 90% of your average wage	No	Partial wage replacement only, assistance with ADLs would be out of pocket	Partial wage replacement only, assistance with ADLs would be out of pocket.
WA Paid Family Leave: Partial wage replacement when not working based on a qualifying event; a maximum of $1,327 per week (in 2022) or up	No	Partial wage replacement for family caregiver, if they can afford to take the	Partial wage replacement for family caregiver, if they can afford to take the

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to 90% of your average wage for a family member		reduction in income	reduction in income
Private Health Insurance Out of pocket costs vary based on plan. If a person needs skilled care (RN, OT, PT, speech), may also cover limited home health care including bathing, toileting, dressing. Doesn't cover help with tasks like eating, hygiene, cooking, cleaning, shopping, transportation	No	Maybe for a limited time when skilled care is required, does not cover help with certain daily living activities	Maybe for a limited time when skilled care is required, does not cover help with certain daily living activities
Medicaid Apple Health with Long-Term Care Covers medical care and services and supports when people meet assistance with activities of daily living criteria regardless of the reason for disability. Health care for Workers with Disabilities allows workers who meet federal disability requirements to pay a premium up to 7.5% of income for coverage without income or asset tests.	Yes, when eligibility criteria are met	No (unless low income and low asset)	No (unless low income and low asset)
Private Short-Term or Long-Term Disability (not a universal benefit) Pays partial wage replacement while unable to work; amount depends on the policy (60% or 50% is common)	No	If purchased a policy, partial wage replacement only, assistance with ADLs would be out of pocket	If purchased a policy, partial wage replacement only, assistance with ADLs would be out of pocket
Social Security Disability Insurance Wage replacement only for people who are unable to work for 1 year or more. No benefits are payable for partial disability or for short-term disability	No	No	No
Workers Compensation Pays some medical expenses and partial wage replacement only for people who are	No	No	No

recovering from an on-the-job injury			
Older Americans Act Services May provide limited services to people 60+, including meals, transportation, and respite. There are some costs to some services. Not designed for daily supports. Not available for people under 60.	No (unless age 60 or older)	No (unless age 60 or older)	No (unless age 60 or older)

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Appendix F: Milliman Plan Design Change Analyses

See Milliman Plan Design Changes

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