LTSS Trust Commission Recommendations Report

RCW 50B.04.030 (4)

Authored by:
Long-Term Services and Supports Trust Commission

Date:
January 1, 2024

Contents

Executive Summary

Enacted in 2019, the Long-Term Services and Supports (LTSS) Trust Program (Chapter 50B.04 RCW), 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 began for covered workers and self-employed individuals began electing coverage. 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 wages, or about $24/month for the median covered earner making $50,100/year) was 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). This also means that fewer Washingtonians will need to spend down their life savings to qualify for Medicaid long-term care due to WA Cares Fund. WA Cares Fund is also projected to result in a reduction in Medicare utilization and expenditure.

Per RCW 50B.04.030, 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.

The Commission considered two main policy issues this year:

1. Portability cost offsets
2. Eligible beneficiary criteria

For each of the topics above, the LTSS Trust Commission researched policy options, impacts, and administrative feasibility and developed policy recommendations. When a particular policy option had the potential to impact the long-term solvency of the program, actuarial analysis was conducted. Please note that the estimated actuarial impact of enacting multiple policy options may not equal the sum of the individual policy impacts. Detailed actuarial analysis can be found in Appendix D.

In addition, two technical issues were brought to the attention of the Commission related to implementation of the existing statute. These concern:

- Exemptions for holders of temporary non-immigrant work visas; and
- Exemptions for civilian employment of active-duty services members.

The Commission recommended fixes for these two issues.

In addition to the recommendations outlined in this year's report, the Commission made a set of recommendations in a report issued to the legislature last year. Those recommendations concerned nine policy issues:

- Options for extending benefits to out-of-state eligible beneficiaries ("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 ("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 ("rescinding")
- Consistency and accountability in employer premium reporting
- Reporting of self-employment income
- Authorizing a pilot project for benefit implementation
- Simplifying the ten-year contribution requirement
- Crediting shared savings to WA Cares Fund
- Working with insurers to support the development of long-term care insurance products that supplement the WA Cares benefit ("Supplemental Private Long-Term Care Insurance").

The recommendations from last year's Commission Recommendations report have not yet been considered but still stand. The sole exception is its portability recommendation, which was superseded by the portability recommendations in this year's report.

January 1, 2024, Commission Recommendations

1) Portability Cost Offsets

LEGISLATIVE REQUIREMENT

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.

During the 2022 legislative session, Operating Budget Bill ESSB 5693 required the Commission to recommend options for extending benefits to out-of-state eligible beneficiaries. In its 2023 report to the legislature (submitted January 1, 2023, based on work conducted throughout 2022), the Commission made the following recommendation on managing the cost of expanding benefits to people who leave the state (one of four portability challenges addressed in its 2023 report):

> *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.*

During its work over the course of 2023, the Commission refined this recommendation by considering, supported by actuarial analysis, a number of ways to offset the cost of making benefits portable.

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. Many 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. In order to fund portability, the Commission weighed a range of potential cost offsets, including modifications to both program structure and to the portability recommendation made in 2022.

COMMISSION RECOMMENDATION

The 2024 Commission recommendation on managing the cost of portability supersedes the 2023 report recommendation referenced above. The 2024 portability cost offset recommendation (Option 1 below) modifies the 2023 recommendation and makes modest changes to program structure.

Option 1 - Recommended by the Commission: The following set of measures are recommended to offset the expected cost of portability. By adopting these, the state would make it possible for most Washington workers who leave the state and have a care need to still receive their earned WA Cares benefits, without having to increase the premium on the basis of expected costs. The recommendation includes the following set of measures:

- Allow anyone who leaves the state after making at least three years of in-state qualifying contributions to elect portable benefits coverage by agreeing to continue contributing premiums as long as they continue working.
- Require workers who elect portable coverage upon leaving the state to contribute to WA Cares as long as they continue to work based on their actual wages (or in the case of self-employment, net profit). Require workers to report their wages, pay premiums regularly, and provide documentation of their wages at the time of payment of premium. If an individual who elects portable coverage reports no wages, the lack of wages earned through employment or self-employment must be verified. ESD will research what documentation could be provided to verify wages at time of payment of premium and any exceptions that should apply. ESD will consider user experience and develop ways to support individuals accurately reporting their wages at time of payment. Failure to remit assessed premiums after electing portable coverage will have consequences, including cancellation of coverage, or payment of back premiums and interest, or a combination of those. The Commission recommends ESD and DSHS research viable options to include in statute.[1]
- Once a worker turns 67, they are no longer required to provide documentation of their wages or lack thereof, although they are still required to contribute on any wages earned through employment or self-employment.
- Increase the number of hours worked required to earn a qualifying year from 500 to 1000. This recommendation applies to all workers, both in and out of state.
- Use Washington's Medicaid-style long-term care threshold and incorporate a 90-day forward certification of need into the eligibility criteria. The intent of this certification is to determine that a person's need for assistance with activities of daily living is expected to last for at least 90 days. If a person's need for assistance with activities of daily living is not expected to last for at least 90 days, they would not be deemed an eligible beneficiary. This is neither an elimination period nor a waiting period. This threshold would apply to all individuals who live in Washington when they need care.
- Adopt a HIPAA-style benefit eligibility threshold for out-of-state residents. This is the standard benefit eligibility threshold required for tax-qualified private long-term care insurance policies nationwide. This standard would apply to all beneficiaries who live out-of-state when they need care, reducing administrative costs by leveraging the benefit eligibility threshold which the vast majority of assessors outside of Washington are already experienced administering.
- Give the State Investment Board (SIB) authority to invest Trust assets in a diversified portfolio, including equities**.** This would require a ballot initiative to amend the state constitution.
- Continue to leverage the Risk Management Framework to regularly monitor emerging experience and its impacts on actuarial status of the program.

Actuarial analysis: According to analysis prepared by the independent actuarial firm Milliman, this package of recommendations would require an estimated total program premium assessment of 0.54% if the recommended ballot initiative allowing investment in equities passes (an estimated reduction of the current total program premium assessment of 0.04%), or 0.58% if it does not (no change to the estimated current total program premium assessment). See Appendix D for supporting information.

[1] Workgroup recommendation is pending a full vote of the LTSS Trust Commission and may be revised.

Pros:

- Would offset portability expected costs without any significant negative effects on program participants.
- Would preserve benefits for longer-term care needs, whether during working years or old age. This aligns with the benefit eligibility workgroup recommendation.

Cons:

- Would eliminate the ability for beneficiaries to use their benefit for short-term care needs (lasting fewer than 90 days).
- Some part-time workers in the transition cohort (born before 1968) might not currently work 1000 hours per year and therefore not earn qualifying years. These workers would have to increase their hours to nearly half-time in a given year to earn a qualifying year. (Over the long-term, most workers will meet the qualifying years requirement by working at least 1000 hours per year in 10 different years over the course of their career.)

Additional portability cost offsets options considered by the workgroup but rejected (all options include 90-day forward certification, HIPAA out of state, and investing in equities):

Option 2: Similar to option 2, but this removes the pathway for beneficiaries to be eligible after 3 years of contributions in the past six years. This option limits the number of beneficiaries who would be eligible to receive benefits before 2033. This option was rejected because working age people with disabilities would have pay in for 10 years to earn benefits and not just 3. This option limits being able to show metrics or gain experience during the first decade of the program.

Option 3: Similar to the option 2 but reduces benefits to 50% for 3 of the last 6 years pathway. This option limits working-aged people with disabilities to only be able to receive half of their lifetime benefit after 3 years of contribution. This option was rejected due to the similar implications as option 2 but with less impact.

Option 4: Similar to option 2, but this option pauses on making a decision on the 3 out of the 6 years pathway and re-evaluating in 2026 once we a better understanding of program finances. This option could potentially limit the option for beneficiaries to be eligible after 3 years of contributions. This option was rejected because it would not take action on this pathway for three years and doesn't give beneficiaries clarity on whether this pathway would be available to them. This option could have impacts on working aged people with disabilities who may be counting on being able to utilize the benefit after 3 years.

Option 5: This option requires periodic recertification of Private Long-Term Care Insurance coverage. This option would ensure those that purchased Private Long-Term Care Insurance have coverage and are maintaining it. This option was rejected because it would require skilled staff to review complex long-term care policies and would require authority to cancel previously permanent exemptions.

Option 6: Similar to option 5, but this allows individuals who dropped their Private Long-Term Care Insurance coverage to repurchase it in order to pass recertifications. This option was rejected due to similar implication as option 5.

2) Benefit Eligibility

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

POLICY ISSUE

The Commission began considering eligibility criteria in 2022 and reconvened in 2023. Per RCW 50.04.010(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 the trust program, as established in this chapter, and has not exhausted the lifetime limit of benefit units.
Per RCW 50B.04.060(2), Beginning July 1, 2026, 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.

In 2023, the Benefit Eligibility workgroup reviewed the components of two benefit eligibility threshold options: A Washington Medicaid-style threshold or a national private insurance HIPAA-style threshold, and the impacts and challenges of each.

The Medicaid style threshold evaluates self-performance, meaning what a person was able to do for themselves and/or how much assistance was required by a caregiver. Under this threshold, a person could qualify depending on how an activity of daily living (ADL) occurred three or more times in the last seven days and if the person needs assistance with at least three out of seven ADLs. It also considers cognitive impairment when some ADL assistance is also required.

The HIPAA style threshold evaluates if a person is chronically ill and requires substantial assistance with at least two out of six ADLs. A person is considered chronically ill when it is certified that the person is unable to perform at least two ADLs without substantial assistance from another person for a period of at least 90 days. There is no ADL requirement if a person has a severe cognitive impairment or requires substantial supervision.

COMMISSION RECOMMENDATION

Option 1 - Recommended by the Commission:

Adopt the Medicaid-style benefit threshold which aligns with Washington state Medicaid standard that is currently used.

Incorporate a 90-day forward certification of need into eligibility. This is not an elimination period nor a waiting period, which are typically used in private long-term care insurance where individuals pay out of pocket.

Adopt the HIPAA benefit eligibility threshold for out-of-state residents, same as the private long- term care insurance standard. This would allow DSHS to simplify administration of conducting assessments nationwide.

Actuarial analysis: According to analysis prepared by the independent actuarial firm Milliman, these recommendations, taken together with the portability recommendations

discussed above, would require an estimated total program premium assessment of 0.54% if the recommended ballot initiative allowing investment in equities passes (an estimated reduction of the current total program premium assessment of 0.04%), or 0.58% if it does not (no change to the estimated current total program premium assessment). See Appendix D for supporting information.

Pros:

- Would preserve benefits for longer-term care needs, whether during an individual's working years or old age. This would eliminate the risk of benefits being used for short-term care needs, many of which are partially addressed through other policies like paid family and medical leave.
- Under this threshold, individuals in state who are in earlier stages of cognitive impairment could be considered eligible. This could help get support to individuals earlier in their care trajectory and potentially slow or mitigate degeneration of functional or cognitive capacity.

Cons:

- Would eliminate the ability for beneficiaries to use their benefit for very short-term care needs, such as a ski accident.

Additional eligibility threshold options considered by the workgroup but rejected:

Option 2: HIPAA-style benefit threshold for all
This option could help preserve benefits for long-term care needs that can be used later in life. The HIPAA benefit threshold is used across the private long-term care insurance industry. Therefore, assessments, ADLs, and definitions would be consistent nationwide. It could help support a more seamless transition to private long-term care insurance policies. This option creates less opportunities for beneficiaries to quality as less ADLs are assessed. Individuals would need to have a severe cognitive impairment to be eligible. This creates less opportunities for individuals with mild to moderate cognitive impairment to qualify. This option could reduce program costs.

Option 3: Medicaid-style benefit threshold for all
Similar to Option 1, but this would not include the 90-day forward certification of need and it does not include the HIPAA-style threshold for those that move out of state. This option would allow individuals who have short term care needs to become eligible sooner. This could be an incentive for beneficiaries to use their benefit earlier in life, which could cause them to not have enough funds to use later. Although this creates more opportunities to be eligible, this could drive up the cost of the program long-term.

Option 4: Medicaid-style benefit threshold and 90-day forward certification of need
Similar to Option 3, but this does not include the HIPAA-style threshold for those that move out of state. 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.

3) Exemptions for Holders of Temporary Non-Immigrant Work Visas

POLICY ISSUE

Currently, for employees who hold nonimmigrant temporary work visas to obtain a voluntary exemption under RCW 50B.04.055, they must apply for the exemption, provide documentation that they meet exemption requirements, and once approved, provide proof of their exemption to all current and future employers.

The voluntary exemption for employees who hold nonimmigrant temporary work visas has proven challenging for all parties involved, including the ESD, impacted workers, and their employers. Some of the challenges include:

- Ineffective processing of applications for this category of voluntary exemptions due to the volume of workers, to include over 30,000 H-2A agricultural workers that travel to Washington to work each year.
- Thousands of paper exemption applications were transmitted to Employment Security and will continue to be an ongoing body of regular work without a change in law. Employers largely assist these employees with their applications at onboarding, then mail the paper applications in bulk to the department.
- It is challenging to provide these workers with a portable exemption for future use of continued employment in Washington if they change employers.
- Employment Security anticipates receiving duplicate applications for workers, and then again, each following year for many employees with temporary work visas who return to Washington for employment, even if the employee is already considered exempt for WA Cares Fund.
- Documentation that qualifies a person to work in the U.S. changes frequently. It takes considerable time and resources for Employment Security to stay current on the requirements to ensure clear and accurate services to individuals employed under non-immigrant visa authorization and their employers.

Automatically exempting these employees will not change the number of employees eligible for exemption, although it will increase the number of employees who receive an exemption. Because this is a comparatively small pool of workers, the actuarial effects of this policy change on long-term program solvency are estimated to be negligible. Individuals exempt from WA Cares due to this policy would fully participate if their employment status were to change at a future date. Making the exemption an automatic process relieves all parties of a challenging and time-consuming administrative process.

COMMISSION RECOMMENDATION

Modify the exemption process for temporary non-immigrant visa holders working in Washington state. Exempt wages earned by non-immigrant visa holders from premium collection, with the ability to voluntarily participate if they so choose.

4) Exemptions for Civilian Employment of Active-Duty Service Members

POLICY ISSUE

Active-duty service members may engage in off-duty civilian employment in the state. They are full-time members of the military and typically stationed at a base for anywhere from two to six years. Under current law, there is no exemption available for "off-duty employment" of an active-duty service member. Federal employees will not have premiums collected from their federal employment. However, if they have a civilian job in Washington State, those wages are subject to the premium assessment unless they meet the criteria of a different exemption (out of state residence, spouse is active duty service member, 70% disability rating, non-immigrant visa holder).

COMMISSION RECOMMENDATION

Allow for a conditional voluntary exemption to be requested by active-duty service people who are engaged in off-duty civilian employment.

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 Bryan Sandlin (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
Mark Stensager Recipient of LTSS (or designee or representative of consumers under the program)

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

Appendix C: WA Cares Fund Risk Management Framework

See WA Cares Fund Risk Management Framework

Appendix D: Milliman Actuarial Analysis & Plan Design Change Analyses

Milliman's Plan Design Change Analysis can be found at: https://leg.wa.gov/osa/additionalservices/Pages/WACaresFund.aspx

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. "**Potential Program Changes with Portability of Benefits**": Milliman's modeling of alternative program packages to assess feasibility of adjusting the program to feature portability of benefits.

   https://leg.wa.gov/osa/additionalservices/Documents/Masselink16-2023PortabilityPackagedModelingRequests.pdf