November LTSS Trust Commission Meeting Minutes

Meeting Date		11/10/2022		Time		8:30 am – 11:30 am	
Attendees							
✓	Representative Paul Harris	x	Representative Drew MacEwan	✓	Representative Frank Chopp	✓	Representative Nicole Macri
✓	Senator Curtis King	✓	Senator Judy Warnick	✓	Senator Karen Keiser	✓	Senator Steve Conway
✓	Secretary Jilma Meneses, Department of Social and Health Services (Chair)	✓	Cami Feek, Employment Security Department	✓	Taylor Linke, Health Care Authority	✓	Peter Nazzal, Home Care Association representative
✓	Madeleine Foutch, Representative of a union representing LTC workers	✓	Michael Tucker, Representative of an organization representing retired persons	✓	Lauri St. Ours, Representative of an association representing SNF/ALF providers	✓	John Ficker, Adult Family Homes Providers Representative
✓	Ruth Egger, Individual receiving LTSS #2 (or designee or representative of consumers receiving LTSS)	✓	Andrew Nicholas, Worker who is paying the premium (or will likely be paying)	x	Brenda Charles-Edwards, Individual receiving LTSS #1 (or designee or representative of consumers receiving LTSS)	✓	Rachel Smith, Representative of an organization of employers who's members collect the premium (or will likely be collecting)
Guest Speakers							
✓	Ben Veghte, Department of Social and Health Services	✓	Andrea Meewes Sanchez, Department of Social and Health Services	✓	Matt Buelow, Employment Security Department	✓	Matt Smith, Office of State Actuary
✓	Chris Giese, Milliman	✓	Annie Gunnlaugsson, Milliman				

Topic	Minutes
Welcome and Call to Order	• Commission members in attendance indicated above. • Secretary Meneses reviewed the meeting goals.
Consent Agenda	• No objections made; item was adopted.
Agency Administrative Expenses Report	• Michael Tucker made a motion to approve the Agency Administrative Expenses Report. Senator King seconded the motion. A voice vote was taken, and the motion was passed unanimously. • Ruth Eggar volunteered to deliver the Agency Administrative Expenses Report to the legislature.

Milliman report on final baseline	• Annie Gunnlaugsson presented on Milliman's report on the final baseline. Chris Giese available to answer questions.
	• Premium Rate Results – 2022 Actuarial Study
	  o Base Plan = 0.57%
	  o Baseline: Range of equally likely scenarios given uncertainty of voluntary participation and defined program features
	  o Base Plan: Specific illustrative scenario from Baseline, not intended to be a most likely scenario
	  o Baseline Range: 0.52% - 0.63%
	  o Sensitivity Range: 0.37% - 1.23%
	• Changes due to clarifications of the program, -0.07% impacts
	  o Walkthrough from 2020 Actuarial Study to 2022 Actuarial Study
	  ▪ Updated wage base definition based on ESD clarification decreases premium 0.08%
	  ▪ Changes assumed adjudication period from 45 to 30 days increases premium 0.01%
	• Changes due to WA Cares Fund plan design, +0.03% impact
	  o Walkthrough from 2020 Actuarial Study to 2022 Actuarial Study
	  ▪ Self-employed "ground rules" decreases premium 0.02%

- New exempted populations increases premium 0.04%
- 18-month program delay decreases premium 0.02%
- Remove exclusion for those disabled before age 18 increases premium 0.02%
- Add partial benefits for near retirees increases premiums 0.01%

- Changes to key assumptions, -0.01% impact
  - Walkthrough from 2020 Actuarial Study to 2022 Actuarial Study
    - Utilize actual private market opt-out data increases premium 0.03%
    - Update Washington-specific wage adjustment and grade-off decreases premium 0.01%
    - Update assumptions for 2022 OASDI Trustees Report decreases premium 0.04%
    - Other assumption updates increases premium 0.01%
- Changes to key assumptions, -0.05% impact
  - Walkthrough from 2020 Actuarial Study to 2022 Actuarial Study
    - Update investment strategy: Target Bloomberg US Aggregate Bond Index decreases premium 0.05%

Open for questions

- Senator King: Requested a copy of the slides presented. There were ESD clarifications when talking about health care premiums as part of wages. Did ESD just make that assumption? Unaware of legislation passed to do that and wondering about the authority to make these clarifications. Where and why did you get that information that changed the adjudication period from 45 to 30 days? Why do we think that's a better way of looking at it? Asked for clarification on how the 18-month delay causes a reduction.
  - Chris Giese: On the wages, this isn't a change from a statutory perspective. When reviewing the language of what "covered wages" were going to be as part of the 2020 study, they assumed the wage-based definition that was consistent with prior feasibility study work. When doing first analysis back in 2015-2016, the underlying wage base was consistent with the wages that are subject to the Medicare tax. After the 2020 study, had the opportunity to talk with ESD around what wages will be considered gross wages as they're defined in statute. They were able to identify that additional wages that are deducted for the Medicare tax would be subject to the premium assessment under WA Cares. To help make this determination, they were able to look at some of the wages coming through the Paid Family and Medical Leave program which, from their understanding, is ultimately the intention for the wage base to be consistent between the two programs, other than no Social Security cap on the wage base for WA Cares.
  - Chris Giese: In regard to claim adjudication period, previously called elimination period. Had discussions with DSHS about how in statute they have up to 45 days from when an individual files a claim to make a benefit determination. In prior study, they assumed that full 45-days would be taken. During that window, if they incurred costs, they would be responsible to pay for those expenses out of pocket. After discussing with DSHS further, after the 2020 study, they felt 30 days was a better approximation for the average adjudication period. Lowering it from 45 to 30 days did move up the premium a little bit.
  - Chris Giese: The 18-month delay lowers the cost because they assumed the starting pool of money ($36,500) when benefits are first available is unchanged. Initially the program was going to start collecting revenue on January 1, 2022 and then the first payments would be made on January 1, 2025. Assumed the pool of money starting on January 1, 2025 was $36,500. With the 18-month delay, now the first benefit payments are not going to happen until July 1, 2026, but that same starting pool of money ($36,500) is still being used as the starting point. By delaying the program, the benefit is a little bit lower in the middle of 2026 than it would be if the program would have started a year and a half earlier.
- Senator Keiser: When referring to the gross wages issue, the reference to health premium was regarding the Medicare premium tax. Is that correct? You're not talking about if an employer provides health care benefits through an insurance plan, not adding that to gross wages?

- Chris Giese: Yes and no. It might be helpful to be grounded in the Medicare tax. We have gross wages and then the wages that are subject to the federal Medicare tax. There are certain things that are deducted before that Medicare FICA tax is applied to that amount. Something like an employee's contribution to their healthcare, medical health insurance premiums is deducted from that wage base before the Medicare tax is applied.
- Senator Keiser: You're not looking at employer-provided health plan with an employer paid premium for that plan as part of gross wages, correct?
- Chris Giese: Employer-paid premiums would not be included. Employees do not get a deduction for their medical health insurance premium. The WA Cares premium assessment is applied without any reduction for healthcare premiums.

- Senator Keiser: Another question, in the chart with the grey lines, it was called out by Annie as an extreme assumption, but she didn't explain what that extreme assumption was. Wanting to know what the assumption was to be sure not to do anything too extreme.
  - Chris Giese: Hate to call extreme or a doomsday scenario, but basically every assumption that could go wrong, they assumed it goes in the wrong direction. This is included in the report, but they increased CPI measure (so benefits would inflate faster than projected), decreased investment earnings supporting the fund, increased frequency of how many go on claims, assumed that when people use benefits they would use more, assumed people would live longer and assumed people would earn vesting. This is meant to be a very extreme test with all these assumptions at the same time going in the wrong direction. Hopes that all those things don't happen immediately at the same time, but as mentioned in the presentation, it helps for context to understand what assumptions have a meaningful impact on the fund balance and that premium.
  - Senator Keiser: This is also assuming the Commission or oversight program doesn't adjust anything in the meantime, just maintaining the doomsday scenario and not doing anything for 20 years.
- Senator Conway: Has a question on long-term wage assumption. Knows at one point in the original study, the average wage in Washington equaling the average national income. Noticed the wage inflation figure of 3.6%. How are you looking at the growth of wages in Washington state? Thinks this is a critical variable to the plan since the tax is based on income. What assumption are you using for the long-term income assumption?
  - Chris Giese: There are a few things that go into projecting wages. They start with wages at a national level. Came up with Medicare covered wages from the Social Security Trustee's Report, then made adjustment for gross wages, and then the starting wage base they make an adjustment to be Washington-specific. There are various public sources they are able to look at and then compare that to information that to some of the information that ESD shared with them. That's the starting point for average wages. There are two things they use to project that wage into the future. One is wage growth as predicted from the trustee's report. They have high, medium, and low scenarios. Took the medium scenario to apply a future inflation adjustment to wages and that is around 3.6% annually. The second assumption looked at historically how Washington wages compare to nationwide wages. Washington wages and nationwide wages were fairly close to each other over time, but then over the last 10 years or so, they have deviated quite a bit. In the last handful of years, Washington wages on average are probably about 16% above nationwide average level. It's an assumption they sensitivity tested as a baseline, given that growth has happened over the last couple of years, so unsure if it would stay like that forever. What they did assume is that relationship of Washington versus the nationwide wages would downgrade back over time. Has a similar assumption for 2020 study, the downgrade hasn't happened yet, but assumed it would happen over a long period as part of the 2022 work. In combination with that change for this study, they also revised the approach for the CPI measure as well. Commonly individuals think of CPI as a component of wage growth. They did an assumption where they made it Washington specific for the early part of the projection and graded the CPI measure down to nationwide levels. They did sensitivity test that and that is Figure 27 in the report. This shows what happens when they turn off the grading assumptions over time and how that impacts the premium rate.

	• Senator Conway: Has question that came up during the Investment Strategy Subcommittee meeting on how inflation will impact these assumptions. Inflation has impacts on the wages and wage assumptions. This came up as a question from someone in California that handles the Paid Family Leave program there. Inflation impacts the income coming into the plan because if the increases are higher than 3.6%, it will impact the assumptions. Unsure if the sensitivity tests looked at inflation. o Chris Giese: Didn't do any shock tests to those assumptions. They didn't assume it would spike for a while and then come back down. The sensitivity tests were more about persistent changes to those assumptions. For example, they subtracted 50 bases points annually for the CPI assumptions if inflation comes in lower or added 50 bases points annually if inflation over the long run comes in higher. Two of the assumptions that are very critical and very sensitive to the performance of the program is wage growth and how that CPI changes over time. Their understanding is that CPI measure is one of the levers as an oversight of the program. They assume that every year the choice would be made to increase benefits at the full CPI changes every year. Their understanding is the way that statute is written, the increase is up to the CPI number. In theory, depending on the performance of the program and how things emerge, a decision could be made to have less of an inflation increase than the full CPI change. • Ben Veghte: Thinks it is accurate to say that worker health insurance premiums are not subject to WA Cares contributions, but rather at the federal level, worker health insurance premiums are for FICA pre-tax and at the state level they are after tax. It's not premiums being taxed, but how you define the wage base of what's pretax and after tax. Is that correct? o Chris Giese: Correct. For Medicare, the health insurance premiums are deducted. It all comes down to if it's under Section 125 Cafeteria Plan definition, that kind of determines what's subject to the FICA tax. After talking with ESD, their understanding is that same deduction would not happen for the WA Cares assessment. • Senator King: We have a clarification that if you work 3 out of the last 6 years, you are eligible for this program. They interpret that if they work the last 3 years, they are immediately eligible. Is that correct? o Chris Giese: Correct, that is how they modeled it. They modeled the full 10 years of work history, then the three of the last six years, so at the time when an individual files for benefits, it's kind of this lookback period of the last six years. Seeing if they worked in three of those years and if they worked 500 or more hours. The other modeled path is for near retirees where they're able to get partial benefits. • Secretary Meneses: Appreciated all of the information and presentation from Chris Giese and Annie Gunnlaugsson.
Update on OSA Solvency Report	• Matt Smith gave an update on the OSA Solvency Report and Recommendations. • Evaluation of Projected Fund Solvency: o A solvent fund will have sufficient expected revenue, based on the current law premium rate, to pay all expected future program benefits and expenses over the projection period ▪ Current program projections extend through June 30, 2098 o Based on the data, assumptions and methods used in Milliman's 2022 Actuarial Study, and current law as of that study, the program is projected to be solvent for most scenarios evaluated including the base plan scenario o 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 • Improved Fund Status from Last Study: o OSA estimates a base plan funded status of 104% versus 91% from the 2020 study, assuming assessment of 0.58% premium rate o Funded status represents the ratio of projected revenue to projected program benefits and expenses, in today's dollars o OSA plans to finalize this measurement later this year • OSA's Preliminary Recommendations to Support Fund Solvency: o Clarify key program parameters to ensure program administration aligns with actuarial modeling

	▪ Benefit eligibility trigger o Re-assess program's financial outlook after 2023 Legislative Session and initial program experience ▪ May not require a full actuarial study like Milliman's 2022 Study o If program's funded status falls below 100% based on updated analysis, develop response strategies during Phase 1 to return program to at least 100% funded
Report on policy recommendations from Workgroup on Portability	• Ben Veghte presented the legislative requirements on Portability. • Commissioner Madeleine Foutch presented the workgroup recommendation regarding Challenge I. • Ben Veghte spoke to the actuarial modeling. • Portability Challenge I: Managing the cost of expanding benefits to people who leave the state o **Workgroup recommendation:** Allow anyone with at least one year of qualifying coverage 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. The workgroup acknowledges that more research may be necessary to identify appropriate offsets. Senator Keiser made a motion to adopt the Workgroup's recommendation regarding Challenge I. Michael Tucker seconded the motion. A voice vote was taken, and the motion was passed unanimously. • Commissioner Madeleine Foutch presented the workgroup recommendation regarding Challenge II. • 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 o **Workgroup recommendation:** WCF develops system to facilitate out-of-state eligible beneficiaries claiming WCF benefits starting in 2030 Open for questions • Representative Harris: Wants to clarify that they are moving this from now to 2030. Wants to know where they sit now versus where they're going. o Ben Veghte: The recommendation would be for the benefit payment of portable payments to begin in 2030. The rest of the program would implement in 2026 as planned. Let's say I were to pay-in for a year or two and then move to Kentucky. If my health deteriorated and I needed long-term care in 2028, I couldn't claim benefits yet as benefit administration wouldn't start until 2030 for people who left the state. Michael Tucker made a motion to adopt the Workgroup recommendation regarding Challenge II. Andrew Nicholas seconded the motion. A vote was taken, and 15 voted aye, 3 voted nay. The motion was passed. • Commissioner Madeleine Foutch presented the Workgroup's recommendation regarding Challenge III. • Portability Challenge III: Alternative forms of benefits for out-of-state eligible beneficiaries and methods of cross-state coordination on LTSS providers o **Workgroup recommendation:** 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. Open for questions • Senator King: Are we going to review these options in the coming meetings? All they're saying is DSHS and HCA can look at how this might be structured and then we will have to approve the structure? Is that the idea? o Ben Veghte: This will stay on the Commission's agenda. Research could start next year and could involve the Commission in that work if they desired. Senator Conway made a motion to adopt the Workgroup's recommendation regarding Challenge III. Michael Tucker seconded the motion. A voice vote was taken, and the motion was passed unanimously. • Commissioner Madeleine Foutch presented the Workgroup's recommendation regarding Challenge IV. • Portability Challenge IV: Options for conducting eligibility determinations for qualified individuals who subsequently move outside of Washington (continued) o **Workgroup recommendation:** 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. Senator King made a motion to adopt the Workgroup's recommendation regarding Challenge IV. Ruth Egger seconded the motion. A voice vote was taken, and the motion was passed unanimously.
Report on policy recommendations from Workgroup on Recertification and Rescinding or Private LTC Insurance Exemption	• Ben Veghte presented the legislative requirements on Recertification of Private LTC Insurance Exemption and Rescinding of WA Cares Lifetime Exemption. • Commissioner Andrew Nicholas presented the Workgroup's recommendation regarding Recertification of Private LTC Insurance Exemption. • Ben Veghte spoke to the actuarial modeling. • 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 in order to be exempt from WA Cares Fund has closed. o **Workgroup Recommendation:** Require all individuals with approved exemptions to provide proof that they had purchased a qualifying LTC policy prior to 11/2021 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. Open for questions • Senator King: We're saying that those people that met the criteria of the law and filed for an exemption saying they had a LTC plan, and they have a letter that says they are opted out. Now, we are coming back a year and half or two years letter and we want to say time out, now you have to show us that you have that plan. Doesn't see how they can legally do this. These people have a letter and been opted out, and there is no requirement to keep that plan and now we're coming back and saying oops. Doesn't make sense to them. If wanting to make a new law and start all over again, that is one thing, but to start making major changes doesn't make sense to them. • Senator Keiser: Wants to say that the insurance industry that they worked closely with on the Supplemental Private LTC Insurance project with are very concerned about the gaming of those that opted out. They sold them in good faith assuming they would be maintained. The insurance industry is worried about its instability for those who don't maintain their policy and something to take into consideration with this approach.

	Michael Tucker made a motion to adopt the Workgroup's recommendation regarding Recertification of Private LTC Insurance Exemption. Senator Keiser seconded the motion. A voice vote was taken, and the motion was passed unanimously. • Commissioner Andrew Nicholas presented the Workgroup's recommendation regarding Rescinding of WA Cares Lifetime Exemption. • Allow workers to rescind their lifetime exemption o **Workgroup Recommendation**: Provide everyone who has a lifetime exemption a one-time limited opportunity to permanently join WCF until June 30, 2028, five years after the start of premium collection. Open for questions • Senator King: If we are going to allow people to come in, then we should offer the option of people having the availability to go find a long-term care plan and opt-out. Thinks the reverse should be viable. When this first started, everyone was adamant about not letting people buy a long-term care plan and then that changed. We've given the insurance companies the only option of having a supplemental long-term care plan to go with WA Cares but knows there's some disagreement in regards to whether those insurance policies are available. Still thinks we need to offer people that option if going to offer for them to come back in. Ruth Egger made a motion to adopt the Workgroup's recommendation regarding Rescinding of WA Cares Lifetime Exemption. Madeleine Foutch seconded the motion. A voice vote was taken, and the motion was passed unanimously.

Report on policy recommendations from Workgroup on Benefit Eligibility	• Andrea Meewes-Sanchez presented the legislative requirements on Benefit Eligibility.
	• Commissioner Ruth Egger presented the five Workgroup's recommendations.
	• **Draft Commission Recommendations to DSHS**:
	  o 1. Develop eligibility standards that promote ease of access to earned benefits, including support for unpaid family caregivers
	  ▪ 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
	  ▪ 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 or their authorized representative to confirm activity of daily living assistance needs, which are not always accurately identified by health professionals, and mitigate risk of fraud.
	  ▪ Create eligibility standards that are easy to understand and can be used to quickly ramp up outside assessors to increase capacity when needed
	  o 2. Promote seamless transitions to Medicaid
	  ▪ Use an eligibility standard similar to Medicaid LTSS
	  ▪ Provide access to information and continued planning through referrals when benefit balances are low
	  o 3. Prepare people for transitions to a private LTSS policy
	  ▪ When an individual indicates they have private long-term care 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
	  o 4. Develop ways to address cognitive impairment
	  ▪ 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
	  ▪ 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
        - Develop eligibility standards that mirror what was projected in the actuarial modeling, which aligns with Medicaid LTSS
        - 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

Open for questions
- Senator Conway: Is eligibility still a 10-year vesting requirement?
    - Andrea Meewes Sanchez: They would have to meet either of the three paths for qualifying. The near retiree, the 3 out of the last 6 years, and the 10 years before they could become eligible to use the benefit.
- Senator Conway: When a caregiver is working with a person who has a disability, that person's wage records are part of the analysis, right?
    - Andrea Meewes Sanchez: That is determined first and only people who have contributed long enough will be assessed.

Madeleine Foutch made a motion to adopt the Workgroup's recommendation regarding Benefit Eligibility. Michael Tucker seconded the motion. A voice vote was taken, and the motion was passed unanimously.

- Ben Veghte presents the preservation of WA Cares Benefits for longer-term care needs
- Preserving WA Cares benefits for longer term care needs
    - **Workgroup recommendation**: Adopt the HIPAA benefit eligibility trigger, the same trigger used in private long-term care insurance
- Senator Keiser provided additional comments.
    - The big take away is the insurance industry is very interested in this. They really want to work with us so they can provide supplemental insurance for beneficiaries, but they want to make it as seamless and smooth as possible between states and programs. Thinks that's a very reasonable thing to do. The HIPAA benefit is very well vetted and used all over the country and throughout the insurance industry. Thinks this makes sense and very workable.

Open for questions
- Senator King: This does more than just reduce the eligibility to meet the 3 criteria, which is what is in the current WA Cares plan and drops it to two. Are there other benefits beyond that?
    - Ben Veghte: That's correct. It changes the eligibility from three of ten to two of six. It also requires the care need lasts at least 90 days or longer. For example, if I had foot surgery, I might only need a month of help. That wouldn't qualify for the HIPAA trigger, but if I had a degenerative condition in older age, I would qualify because the assessor would determine that lasts for 90 days or longer. If I had a motorcycle accident with a traumatic brain injury, I would definitely qualify. The substantive part of this is they would need assistance with two out of the six activities of daily living. Things like eating, bathing, dressing, mobility, toileting, those types of things, or could also qualify through severe cognitive impairment, such as dementia
    - Senator King: So, temporary disabilities are still applicable here?
    - Ben Veghte: If an assessor determines that the need for assistance is less than 90 days, then they would not qualify for WA Cares. They would have access to Paid Family and Medical Leave. Depends on what you mean by temporary, but if temporary were less than 90 days then they would not get WA Cares.
    - Senator King: Thinking of temporary as a year for an example. After a year, they've recovered and they're able to go back to jobs before that. That would still be possible under this plan?
    - Ben Veghte: Yes, that would.

	• Senator King: Have talked about how great the insurance companies are for wanting to work with us and has no problem with that. Would like to point out that this is the only option that we have left them with, so if they want to sell any kind of long-term care insurance, then this is their only option in the state of WA. • Madeleine Foutch: Hoping someone can talk about the cost savings and how the assumptions are made that allow for the 9 bases point saving. o Chris Giese: To clarify, we're talking about the HIPAA trigger replacing the three ADL requirements that's currently in statute for all individuals (both portable and individuals that live in state). o Ben Veghte: Just stick with the base program and not complicate it with portability. o Chris Giese: We see that HIPAA would end up with a stricter view on being eligible for benefits. There are a few points would like to point to where they think HIPAA would drive costs lower. One would be the 90 day forward certification. The other is the level of functional assistance needed by ADL, that is a little more restrictive than some of the Medicaid pathways. The last one is the number of ADLs considered. Under the HIPAA trigger, there were only six ADLs considered, where depending on the pathway under the Medicaid program, it might consider up to 10 ADLs. Depending on your view of those ADLs, some of those might be easier to satisfy versus perhaps a little bit higher level of assistance needed for the ADLs under the HIPAA trigger. It was trying to align the number of ADLs considered, the functional level of help needed, and the forward looking certification. They looked at all of those when making their cost estimate. Senator Keiser made a motion to adopt the Workgroup's recommendation regarding the preservation of WA Cares Benefits for longer-term care needs. Senator Conway seconded the motion. A voice vote was taken, and the motion was passed unanimously.
Review Annual Commission Report	• Ben Veghte reviewed the Commission Recommendations Report. • April Amundson reviewed the Employer reporting consistency and premium reporting accountability. • Reviewing the Commission Recommendations Report o Employer reporting consistency and premium reporting accountability ▪ Policy issue 1: To support consistency in combined employer reporting for Paid Family and Medicaid Leave and WA Cares Fund, the Commission recommends a statute change to add WA Cares Fund in the collective bargaining agreement exception that expires December 31, 2023. The clause to sunset for WA Cares is found in RCW 50B.04.080 (3). • 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: Adopt for WA Cares Fund the premium accountability measures contained in the PFML statute, namely PFML authority 50A.45. This would allow ESD to collect penalties from employers that do not report wages for WA Cares Fund and to apply interest to unpaid premium from employers. o Self-employment income reporting ▪ As the Employment Security Department (ESD) does for PFML, ESD will require quarterly wage reports from individuals who are self-employed and elect coverage for WA Cares. The department will assess premiums each quarter based on reported wage. 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 is 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. o Pilot project for benefit implementation

	▪ Recommend to legislature providing 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. This would allow the agencies to test their systems and processes in production with a smaller group of beneficiaries and fix any problems that are uncovered prior to going fully live in July 2026. o Supplemental Private Long-Term Care Insurance ▪ See final report for list of recommendations
Public Comment	• Public comment captured in the table below • There were 4 pieces of written correspondence received. This was attached with the meeting materials.
Review Agenda	• Approve Final Commission Report • Final OSA Solvency Report • Commission recommendation topics for 2023 • Agency WA Cares Budget Requests for 2023-2025 Biennium • Communications Update
Wrap up • Action Items review • Adjourn	• No action items captured • Meeting adjourned at 10:52 am

Public Comment	
David Wolf	I had to exit the meeting to do another meeting, but I left right at the point of interest for me, which was the discussion about recertification. And it seems to me from the documentation I've seen so far that recertification right now is only considering whether an individual who obtained an opt out certificate maintains the same policy with the original effective date before 11 1 of 2021. And my concern is this, that many people last year purchased policies that weren't optimal for them, simply because that was the only thing that was available. Right? And is there going to be provision for replacement of products to improve the individual's circumstances, and if they maintain coverage throughout, or they can demonstrate that they had maintained coverage throughout and there wasn't a lapse in coverage, would a replacement product qualify for the original opt out and the recertification? The concern is that we have yet to accommodate for or allow for people to maintain their opt out and better their circumstances via right to replacement.
Brent Price	I'd like to thank the members of the commission for your efforts to shore up holes and to make the program better. Thank you very much. I'm going to echo what David started with because my concern is exactly the same. That as we've been shoring this up, the hole we haven't addressed is the what if. What if somebody does have the opportunity, the ability to now put a better product in place, there needs to be a provision I believe to allow for seamless coverage being the same as having the coverage in effect before August 31st of last year. And so, I think that seamless coverage with replacement needs to be addressed. That's the big hole that I see that remains, and for the good of the folks who have coverage, who would like to make it better, I think that needs to be addressed. Thank you very much.
William Judge	I appreciate the opportunity to address you. Three times is a charm here. I'm going to be following up with the two previous advisors that there has to be some kind of rule with regards to replacing existing policy. You probably need a little bit of back story here. There was a limited amount of carriers that were write can individual policies, and even group policies, that had the proper long term care riders. But as a certain point, there wasn't enough what we call parameds, people that go out and draw the blood and so on and so forth. So there was a lot of individuals who say in the beginning of August, mid-August could not find a policy, and they opted for maybe their employer was offering a group product, whether it was trust mark or Allstate, and they opted for the minimum policy. It really doesn't do the job for true long-term care planning. So as David and Brent said, it would really help the citizens of Washington to know that they can go out, explore, find the right policy for them without any consequences of being, violating any rules that the WA Cares Fund is going to lay down. That's my public comment, I think it would be wise to do that. Obviously, people in my opinion have already gone and replaced their policies, or made a change to their existing policy, bringing it down to the very minimum coverage or premium that insurance carriers are allowed to keep your policy, and then they bought something else. That's in my opinion, that's a disservice to the citizens of Washington, and

	something that you should make concrete and say, hey, if you follow these rules, you can go from one policy to the next. Thank you very much for the opportunity. Have a great rest of the day.