H-2376.5

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HOUSE BILL 2272**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**State of Washington 68th Legislature 2024 Regular Session**

**By** Representatives Macri, Chopp, Kloba, Davis, Thai, Riccelli, and Pollet

AN ACT Relating to addressing recommendations of the long-term services and supports trust commission by increasing access to benefits, establishing a voluntary private market supplemental long-term care insurance option, creating a pilot project to assess the long-term services and supports trust program, and making operational changes to streamline and enhance fairness in the administration of the long-term services and supports trust program; amending RCW 50B.04.010, 50B.04.020, 50B.04.030, 50B.04.055, 50B.04.060, 50B.04.070, 50B.04.085, and 50B.04.100; reenacting and amending RCW 50B.04.050; adding new sections to chapter 50B.04 RCW; adding a new section to chapter 48.83 RCW; adding a new chapter to Title 48 RCW; creating new sections; repealing RCW 50B.04.040; providing a contingent effective date; and providing an expiration date.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec.**  (1) The legislature finds that:

(a) Seventy percent of Washingtonians will eventually need long-term services and supports, including help with activities of daily living such as bathing, eating, and taking medications;

(b) Long-term care can be expensive, most long-term care services are not covered by medicare or private health insurance, and medicaid only covers services after a person has spent their life savings down to $2,000; and

(c) The WA Cares fund is the result of years of research on how to make long-term services and supports accessible for all workers in Washington. As a public long-term care insurance program, WA Cares guarantees coverage for all workers regardless of preexisting conditions. Washington is the first state in the nation to create an affordable way for the broad middle class to access long-term services and supports without having to spend down their life savings.

(2)(a) The legislature intends to improve the functionality of the WA Cares fund for Washington workers by increasing access to the benefits of the program by allowing anyone with at least three years of qualifying contributions who leaves the state to elect portable benefits coverage by choosing to continue contributing premiums to the WA Cares fund, allowing individuals who have purchased private long-term care insurance to rescind the exemption and elect to join the program, and establishing private market long-term care insurance options to enhance the benefits of the program; and

(b) The legislature further intends to streamline the administration of the program by including technical changes related to the implementation of the existing statutes.

NEW SECTION. **Sec.**  A new section is added to chapter 50B.04 RCW to read as follows:

(1) Beginning July 1, 2026, an employee or self-employed person, who has elected coverage under RCW 50B.04.090, who relocates outside of Washington may elect to continue participation in the program if:

(a) The employee or self-employed person has been assessed premiums by the employment security department for at least three years in which the employee or self-employed person has worked at least 1,000 hours in each of those years in Washington; and

(b) The employee or self-employed person notifies the employment security department within one year of establishing a primary residence outside of Washington that the employee or self-employed person is no longer a resident of Washington and elects to continue participation in the program.

(2) Out-of-state participants under subsection (1) of this section must report their wages or self-employment earnings to the employment security department according to standards for manner and timing of reporting and documentation submission, as adopted by rule by the employment security department. An out-of-state participant must submit documentation to the employment security department whether or not the out-of-state participant earned wages or self-employment earnings, as applicable, during the applicable reporting period. When an out-of-state participant reaches the age of 67, the participant is no longer required to provide the documentation of their wages or self-employment earnings, but if the participant earns wages or self-employment earnings, the participant must submit reports of those wages or self-employment earnings and remit the required premiums.

(3) Out-of-state participants under subsection (1) of this section must provide documentation of wages and self-employment earnings earned at the time that they report their wages or self-employment earnings to the employment security department.

(4) An out-of-state participant who has elected to continue participation in the program under subsection (1) of this section may not withdraw from coverage under the program. The employment security department may cancel elective coverage if the out-of-state participant fails to make required payments or submit reports. The employment security department may collect due and unpaid premiums and may levy an additional premium for the remainder of the period of coverage. The cancellation must be effective no later than 30 days from the date of the notice in writing advising the out-of-state participant of the cancellation.

(5) The employment security department shall:

(a) Adopt standards by rule for the manner and timing of reporting and documentation submission for out-of-state participants. The employment security department must consider user experience with the wage and self-employment earnings reporting process and the document submission process and regularly update the standards to minimize the procedural burden on out-of-state participants and support the accurate reporting of wages and self-employment earnings at the time of the payment of premiums;

(b) Collect premiums from out-of-state participants as provided in RCW 50B.04.080, as relevant to out-of-state participants; and

(c) Verify the wages or self-employment earnings as reported by an out-of-state participant.

(6) For the purposes of this section, "wages" includes remuneration for services performed within or without or both within and without this state.

**Sec.**  RCW 50B.04.010 and 2021 c 113 s 1 are each amended to read as follows:

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Account" means the long-term services and supports trust account created in RCW 50B.04.100.

(2) "Approved service" means long-term services and supports including, but not limited to:

(a) Adult day services;

(b) Care transition coordination;

(c) Memory care;

(d) Adaptive equipment and technology;

(e) Environmental modification;

(f) Personal emergency response system;

(g) Home safety evaluation;

(h) Respite for family caregivers;

(i) Home delivered meals;

(j) Transportation;

(k) Dementia supports;

(l) Education and consultation;

(m) Eligible relative care;

(n) Professional services;

(o) Services that assist paid and unpaid family members caring for eligible individuals, including training for individuals providing care who are not otherwise employed as long-term care workers under RCW 74.39A.074;

(p) In-home personal care;

(q) Assisted living services;

(r) Adult family home services; and

(s) Nursing home services.

(3) "Benefit unit" means up to ((~~one hundred dollars~~)) $100 paid by the department of social and health services to a long-term services and supports provider as reimbursement for approved services provided to an eligible beneficiary on a specific date. The benefit unit must be adjusted annually ((~~at a rate no greater than the Washington state consumer price index, as determined solely by the council. Any changes adopted by the council shall be subject to revision by the legislature~~)) for inflation by the consumer price index. The adjusted benefit unit must be calculated to the nearest cent/dollar using the consumer price index for the Seattle, Washington area for urban wage earners and clerical workers, all items, CPI-W, or a successor index, for the 12 months before each September 1st compiled by the United States department of labor's bureau of labor statistics. Each adjusted benefit unit calculated under this subsection takes effect on the following January 1st.

(4) "Commission" means the long-term services and supports trust commission established in RCW 50B.04.030.

(5) ((~~"Council" means the long-term services and supports trust council established in RCW 50B.04.040.~~

~~(6)~~)) "Eligible beneficiary" means a qualified individual who is age ((~~eighteen~~)) 18 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~~)) provided in RCW 50B.04.060, and has not exhausted the lifetime limit of benefit units.

((~~(7)~~)) (6) "Employee" has the meaning provided in RCW 50A.05.010.

((~~(8)~~)) (7) "Employer" has the meaning provided in RCW 50A.05.010.

((~~(9)~~)) (8) "Employment" has the meaning provided in RCW 50A.05.010.

((~~(10)~~)) (9) "Exempt employee" means a person who has been granted a premium assessment exemption by the employment security department.

((~~(11)~~)) (10) "Long-term services and supports provider" means:

(a) For entities providing services to an eligible beneficiary in Washington, an entity that meets the qualifications applicable in law to the approved service they provide, including a qualified or certified home care aide, licensed assisted living facility, licensed adult family home, licensed nursing home, licensed in-home services agency, adult day services program, vendor, instructor, qualified family member, or other entities as registered by the department of social and health services; and

(b) For entities providing services to an eligible beneficiary outside Washington, an entity that meets minimum standards for care provision and program administration, as established by the department of social and health services, and that is appropriately credentialed in the jurisdiction in which the services are being provided as established by the department of social and health services.

((~~(12)~~)) (11) "Premium" or "premiums" means the payments required by RCW 50B.04.080 and paid to the employment security department for deposit in the account created in RCW 50B.04.100.

((~~(13)~~)) (12) "Program" means the long-term services and supports trust program established in this chapter.

((~~(14)~~)) (13) "Qualified family member" means a relative of an eligible beneficiary qualified to meet requirements established ((~~in state law~~)) by the department of social and health services for the approved service they provide ((~~that would be required of any other long-term services and supports provider to receive payments from the state~~)).

((~~(15)~~)) (14) "Qualified individual" means an individual who meets the duration of payment requirements, as established in this chapter.

((~~(16)~~)) (15) "State actuary" means the office of the state actuary created in RCW 44.44.010.

((~~(17)~~)) (16) "Wage or wages" means all remuneration paid by an employer to an employee. Remuneration has the meaning provided in RCW 50A.05.010. All wages are subject to a premium assessment and not limited by the commissioner of the employment security department, as provided under RCW 50A.10.030(4).

**Sec.**  RCW 50B.04.020 and 2022 c 1 s 1 are each amended to read as follows:

(1) The health care authority, the department of social and health services, the office of the state actuary, and the employment security department each have distinct responsibilities in the implementation and administration of the program. In the performance of their activities, they shall actively collaborate to realize program efficiencies and provide persons served by the program with a well-coordinated experience.

(2) The health care authority shall:

(a) Track the use of lifetime benefit units to verify the individual's status as an eligible beneficiary as determined by the department of social and health services;

(b) Ensure approved services are provided through audits or service verification processes within the service provider payment system for registered long-term services and supports providers and recoup any inappropriate payments;

(c) Establish criteria for the payment of benefits to ((~~registered~~)) long-term services and supports providers under RCW 50B.04.070;

(d) Establish rules and procedures for benefit coordination when the eligible beneficiary is also funded for medicaid and other long-term services and supports, including medicare, coverage through the department of labor and industries, and private long-term care coverage; ((~~and~~))

(e) Assist the department of social and health services with the leveraging of existing payment systems for the provision of approved services to beneficiaries under RCW 50B.04.070; and

(f) Adopt rules and procedures necessary to implement and administer the activities specified in this section related to the program.

(3) The department of social and health services shall:

(a) Make determinations regarding an individual's status as an eligible beneficiary under RCW 50B.04.060;

(b) Approve long-term services and supports eligible for payment as approved services under the program, as informed by the commission;

(c) Register long-term services and supports providers that meet minimum qualifications;

(d) Discontinue the registration of long-term services and supports providers that: (i) Fail to meet the minimum qualifications applicable in law to the approved service that they provide; or (ii) violate the operational standards of the program;

(e) Disburse payments of benefits to ((~~registered~~)) long-term services and supports providers, utilizing and leveraging existing payment systems for the provision of approved services to eligible beneficiaries under RCW 50B.04.070;

(f) Prepare and distribute written or electronic materials to qualified individuals, eligible beneficiaries, and the public as deemed necessary by the commission to inform them of program design and updates;

(g) Provide customer service and address questions and complaints, including referring individuals to other appropriate agencies;

(h) Provide administrative and operational support to the commission;

(i) Track data useful in monitoring and informing the program, as identified by the commission; and

(j) Adopt rules and procedures necessary to implement and administer the activities specified in this section related to the program.

(4) The employment security department shall:

(a) Collect and assess employee premiums as provided in RCW 50B.04.080 and 50B.04.090 and section 2 of this act;

(b) Assist the commission((~~, council,~~)) and state actuary in monitoring the solvency and financial status of the program;

(c) Perform investigations to determine the compliance of premium payments in RCW 50B.04.080 and 50B.04.090 and section 2 of this act in coordination with the same activities conducted under the family and medical leave act, Title 50A RCW, to the extent possible;

(d) Make determinations regarding an individual's status as a qualified individual under RCW 50B.04.050, including criteria to determine the status of persons receiving partial benefit units under RCW 50B.04.050(2) and out-of-state participants under section 2 of this act; and

(e) Adopt rules and procedures necessary to implement and administer the activities specified in this section related to the program.

(5) The office of the state actuary shall:

(a) Beginning July 1, 2025, and biennially thereafter, perform an actuarial audit and valuation of the long-term services and supports trust fund. Additional or more frequent actuarial audits and valuations may be performed at the request of the ((~~council~~)) commission;

(b) Make recommendations to the ((~~council~~)) commission and the legislature on actions necessary to maintain trust solvency. The recommendations must include options to redesign or reduce benefit units, approved services, or both, to prevent or eliminate any unfunded actuarially accrued liability in the trust or to maintain solvency; and

(c) Select and contract for such actuarial, research, technical, and other consultants as the actuary deems necessary to perform its duties under chapter 363, Laws of 2019.

(6) By October 1, 2021, the employment security department and the department of social and health services shall jointly conduct outreach to provide employers with educational materials to ensure employees are aware of the program and that the premium assessments will begin on July 1, 2023. In conducting the outreach, the employment security department and the department of social and health services shall provide on a public website information that explains the program and premium assessment in an easy to understand format. Outreach information must be available in English and other primary languages as defined in RCW 74.04.025.

**Sec.**  RCW 50B.04.030 and 2022 c 1 s 2 are each amended to read as follows:

(1) The long-term services and supports trust commission is established. The commission's recommendations and decisions must be guided by the joint goals of maintaining benefit adequacy and maintaining fund solvency and sustainability.

(2) The commission includes:

(a) Two members from each of the two largest caucuses of the house of representatives, appointed by the speaker of the house of representatives;

(b) Two members from each of the two largest caucuses of the senate, appointed by the president of the senate;

(c) The commissioner of the employment security department, or the commissioner's designee;

(d) The secretary of the department of social and health services, or the secretary's designee;

(e) The director of the health care authority, or the director's designee, who shall serve as a nonvoting member;

(f) One representative of the organization representing the area agencies on aging;

(g) One representative of a home care association that represents caregivers who provide services to private pay and medicaid clients;

(h) One representative of a union representing long-term care workers;

(i) One representative of an organization representing retired persons;

(j) One representative of an association representing skilled nursing facilities and assisted living providers;

(k) One representative of an association representing adult family home providers;

(l) Two individuals receiving long-term services and supports, or their designees, or representatives of consumers receiving long-term services and supports under the program;

(m) One member who is a worker who is, or will likely be, paying the premium established in RCW 50B.04.080 and who is not employed by a long-term services and supports provider; and

(n) One representative of an organization of employers whose members collect, or will likely be collecting, the premium established in RCW 50B.04.080.

(3)(a) Other than the legislators and agency heads identified in subsection (2) of this section, members of the commission are appointed by the governor for terms of two years, except that the governor shall appoint the initial members identified in subsection (2)(f) through (n) of this section to staggered terms not to exceed four years.

(b) The secretary of the department of social and health services, or the secretary's designee, shall serve as chair of the commission. Meetings of the commission are at the call of the chair. A majority of the voting members of the commission shall constitute a quorum for any votes of the commission. Approval of ((~~sixty~~)) 60 percent of those voting members of the commission who are in attendance is required for the passage of any vote.

(c) Members of the commission and the subcommittee established in subsection (6) of this section must be compensated in accordance with RCW 43.03.250 and must be reimbursed for their travel expenses while on official business in accordance with RCW 43.03.050 and 43.03.060.

(4) Beginning January 1, 2021, the commission shall propose recommendations to the appropriate executive agency or the legislature regarding:

(a) The establishment of criteria for determining that an individual has met the requirements to be a qualified individual as established in RCW 50B.04.050 or an eligible beneficiary as established in RCW 50B.04.060;

(b) The establishment of criteria for minimum qualifications for the registration of long-term services and supports providers who provide approved services to eligible beneficiaries;

(c) The establishment of payment maximums for approved services consistent with actuarial soundness which shall not be lower than medicaid payments for comparable services. A service or supply may be limited by dollar amount, duration, or number of visits. The commission shall engage affected stakeholders to develop this recommendation;

(d) Changes to rules or policies to improve the operation of the program;

(e) ((~~Providing a recommendation to the council for the annual adjustment of the benefit unit in accordance with RCW 50B.04.010 and 50B.04.040;~~

~~(f)~~)) A refund of premiums for a deceased qualified individual with a dependent who is an individual with a developmental disability who is dependent for support from a qualified individual. The qualified individual must not have been determined to be an eligible beneficiary by the department of social and health services. The refund shall be deposited into an individual trust account within the developmental disabilities endowment trust fund for the benefit of the dependent with a developmental disability. The commission shall consider:

(i) The value of the refund to be ((~~one hundred~~)) 100 percent of the current value of the qualified individual's lifetime premium payments at the time that certification of death of the qualified individual is submitted, less any administrative process fees; and

(ii) The criteria for determining whether the individual is developmentally disabled. The determination shall not be based on whether or not the individual with a developmental disability is receiving services under Title 71A RCW, or another state or local program; and

((~~(g)~~)) (f) Assisting the state actuary with the preparation of regular actuarial reports on the solvency and financial status of the program and advising the legislature on actions necessary to maintain trust solvency. The commission shall provide the office of the state actuary with all actuarial reports for review. The office of the state actuary shall provide any recommendations to the commission and the legislature on actions necessary to maintain trust solvency((~~;~~

~~(h) For the January 1, 2021, report only, recommendations on whether and how to extend coverage to individuals who became disabled before the age of eighteen, including the impact on the financial status and solvency of the trust. The commission shall engage affected stakeholders to develop this recommendation; and~~

~~(i) For the January 1, 2021, report only, the commission shall consult with the office of the state actuary on the development of an actuarial report of the projected solvency and financial status of the program. The office of the state actuary shall provide any recommendations to the commission and the legislature on actions necessary to achieve trust solvency~~)).

(5) The commission shall monitor agency administrative expenses over time. Beginning November 15, 2020, the commission must annually report to the governor and the fiscal committees of the legislature on agency spending for administrative expenses and anticipated administrative expenses as the program shifts into different phases of implementation and operation. The November 15, 2027, report must include recommendations for a method of calculating future agency administrative expenses to limit administrative expenses while providing sufficient funds to adequately operate the program. The agency heads identified in subsection (2) of this section may advise the commission on the reports prepared under this subsection, but must recuse themselves from the commission's process for review, approval, and submission to the legislature.

(6) The commission shall establish an investment strategy subcommittee consisting of the members identified in subsection (2)(a) through (d) of this section as voting members of the subcommittee. In addition, four members appointed by the governor who are considered experienced and qualified in the field of investment shall serve as nonvoting members. The subcommittee shall provide guidance and advice to the state investment board on investment strategies for the account, including seeking counsel and advice on the types of investments that are constitutionally permitted.

(7) The commission shall work with insurers to develop long-term care insurance products that supplement the program's benefit.

**Sec.**  RCW 50B.04.050 and 2022 c 2 s 3 and 2022 c 1 s 3 are each reenacted and amended to read as follows:

(1) Except as provided in subsection (2) of this section, the employment security department shall deem a person to be a qualified individual as provided in this chapter if the person has paid the long-term services and supports premiums required by RCW 50B.04.080 for the equivalent of either:

(a) A total of ten years ((~~without interruption of five or more consecutive years~~)); or

(b) Three years within the last six years from the date of application for benefits.

(2) A person born before January 1, 1968, who has not met the duration requirements under subsection (1)(a) of this section may become a qualified individual with fewer than the number of years identified in subsection (1)(a) of this section if the person has paid the long-term services and supports premiums required by RCW 50B.04.080 for at least one year. A person becoming a qualified individual pursuant to this subsection (2) may receive one-tenth of the maximum number of benefit units available under RCW 50B.04.060(3)(b) for each year of premium payments. In accordance with RCW 50B.04.060, benefits for eligible beneficiaries in Washington will not be available until July 1, 2026, and benefits for out-of-state participants who become eligible beneficiaries will not be available until July 1, 2030, and nothing in this section requires the department of social and health services to accept applications for determining an individual's status as an eligible beneficiary prior to July 1, 2026. Nothing in this subsection (2) prohibits a person born before January 1, 1968, who meets the conditions of subsection (1)(b) of this section from receiving the maximum number of benefit units available under RCW 50B.04.060(3)(b).

(3) When deeming a person to be a qualified individual, the employment security department shall require that the person have worked at least ((~~five hundred~~)) 500 hours during each of the ten years in subsection (1)(a) of this section, each of the three years in subsection (1)(b) of this section, or each of the years identified in subsection (2) of this section.

(4) An exempt employee may never be deemed to be a qualified individual, unless the employee's exemption was discontinued under RCW 50B.04.055 or rescinded under RCW 50B.04.085.

NEW SECTION. **Sec.**  A new section is added to chapter 50B.04 RCW to read as follows:

(1) An employee who holds a nonimmigrant visa for temporary workers, as recognized by federal law, is not subject to the rights and responsibilities of this title, unless the employee notifies the employee's employer that the employee would like to participate.

(2) If an employee who holds a nonimmigrant visa for temporary workers becomes a permanent resident or citizen employed in Washington, the employee must be subject to the rights and responsibilities of this title.

(3) The employment security department may adopt rules necessary to implement this section.

**Sec.**  RCW 50B.04.055 and 2022 c 2 s 2 are each amended to read as follows:

(1) ((~~Beginning January 1, 2023, the~~)) The employment security department shall accept and approve applications for voluntary exemptions from the premium assessment under RCW 50B.04.080 for any employee who meets criteria established by the employment security department for an exemption based on the employee's status as:

(a) A veteran of the United States military who has been rated by the United States department of veterans affairs as having a service-connected disability of 70 percent or greater;

(b) A spouse or registered domestic partner of an active duty service member in the United States armed forces whether or not deployed or stationed within or outside of Washington;

(c) ((~~An employee who holds a nonimmigrant visa for temporary workers, as recognized by federal law, and is employed by an employer in Washington; or~~

~~(d)~~)) An employee who is employed by an employer in Washington, but maintains a permanent address outside of Washington as the employee's primary location of residence; or

(d) Beginning January 1, 2025, an active duty service member in the United States armed forces, whether or not deployed or stationed within or outside of Washington, who is concurrently engaged in off-duty civilian employment as an employee of an employer.

(2) The employment security department shall adopt criteria, procedures, and rules for verifying the information submitted by the applicant for an exemption under subsection (1) of this section.

(3) An employee who receives an exemption under subsection (1) of this section may not become a qualified individual or eligible beneficiary and is permanently ineligible for coverage under this title, unless the exemption has been discontinued as provided in subsection (4)((~~, (5), or (6)~~)) of this section.

(4)(a) An exemption granted in accordance with the conditions under subsection (1)(b) of this section must be discontinued within 90 days of:

(i) The discharge or separation from military service of the employee's spouse or registered domestic partner; or

(ii) The dissolution of the employee's marriage or registered domestic partnership with the active duty service member.

(b) An exemption granted in accordance with the conditions under subsection (1)(c) of this section must be discontinued within 90 days of establishing a permanent address within Washington as the employee's primary location of residence.

(c) An exemption granted in accordance with the conditions under subsection (1)(d) of this section must be discontinued within 90 days of the discharge or separation from military service.

(5)(a) Within 90 days of the occurrence of ((~~either of~~)) the events described in ((~~(a) of this~~)) subsection (4) of this section, an employee who has received an exemption under subsection (1) of this section shall:

(i) Notify the employment security department that the exemption must be discontinued because of the occurrence of ((~~either of~~)) the events described in ((~~(a) of this~~)) subsection (4) of this section; and

(ii) Notify the employee's employer that the employee is no longer exempt and that the employer must begin collecting premiums from the employee in accordance with RCW 50B.04.080.

((~~(c)~~)) (b) Upon notification to the employment security department and the employer, premium assessments established under RCW 50B.04.080 must begin and the employee may become a qualified individual or eligible beneficiary upon meeting the requirements established in this chapter.

((~~(d)~~)) (c) Failure to begin paying the premium established under RCW 50B.04.080 within 90 days of the occurrence of ((~~either of~~)) the events described in ((~~(a) of this~~)) subsection (4) of this section shall result in the payment of any unpaid premiums from the employee, with interest at the rate of one percent per month or fraction thereof, by the employee to the employment security department from the date on which the payment should have begun.

((~~(5)(a) An exemption granted in accordance with the conditions under subsection (1)(c) of this section must be discontinued within 90 days of an employee changing the employee's nonimmigrant visa for temporary workers status to become a permanent resident or citizen employed in Washington.~~

~~(b) Within 90 days of the employee changing the employee's nonimmigrant visa for temporary workers status to become a permanent resident or citizen employed in Washington, the employee who has received an exemption under subsection (1)(c) of this section shall:~~

~~(i) Notify the employment security department that the employee no longer holds a nonimmigrant visa for temporary workers and is a permanent resident or citizen employed in Washington and the exemption must be discontinued; and~~

~~(ii) Notify the employee's employer that the employee no longer holds a nonimmigrant visa for temporary workers and is a permanent resident or citizen employed in Washington, and that the employer must begin collecting premiums from the employee in accordance with RCW 50B.04.080.~~

~~(c) Upon notification to the employment security department and the employer, premium assessments established under RCW 50B.04.080 must begin and the employee may become a qualified individual or eligible beneficiary upon meeting the requirements established in this chapter.~~

~~(d) Failure to begin paying the premium established under RCW 50B.04.080 within 90 days of an employee no longer holding a nonimmigrant visa for temporary workers and becoming a permanent resident or citizen employed in Washington shall result in the payment of any unpaid premiums from the employee, with interest at the rate of one percent per month or fraction thereof, by the employee to the employment security department from the date on which the payment should have begun.~~

~~(6)(a) An exemption granted in accordance with the conditions under subsection (1)(d) of this section must be discontinued within 90 days of an employee establishing a permanent address within Washington as the employee's primary location of residence.~~

~~(b) Within 90 days of the employee establishing a permanent address within Washington as the employee's primary location of residence, the employee who has received an exemption under subsection (1)(d) of this section shall:~~

~~(i) Notify the employment security department that the employee is residing in Washington and the exemption must be discontinued; and~~

~~(ii) Notify the employee's employer that the employee is no longer exempt and that the employer must begin collecting premiums from the employee in accordance with RCW 50B.04.080.~~

~~(c) Upon notification to the employment security department and the employer, premium assessments established under RCW 50B.04.080 must begin and the employee may become a qualified individual or eligible beneficiary upon meeting the requirements established in this chapter.~~

~~(d) Failure to begin paying the premium established under RCW 50B.04.080 within 90 days of an employee establishing a permanent address within Washington as the employee's primary location of residence shall result in the payment of any unpaid premiums from the employee, with interest at the rate of one percent per month or fraction thereof, by the employee to the employment security department from the date on which the payment should have begun.~~

~~(7)~~)) (6) Exempt employees are not entitled to a refund of any premium deductions made before the effective date of an approved exemption, except for premiums collected prior to the effective date of the premium assessment under RCW 50B.04.080.

((~~(8)~~)) (7) An employee who has received an exemption pursuant to this section shall provide written notification to all current and future employers of an approved exemption.

((~~(9)~~)) (8) If an exempt employee fails to notify an employer of an exemption, the exempt employee is not entitled to a refund of any premium deductions made before notification is provided, except for premiums collected prior to the effective date of the premium assessment under RCW 50B.04.080.

((~~(10)~~)) (9) Employers may not deduct premiums after being notified by an employee of an approved exemption issued under this section.

(a) Employers shall retain written notifications of exemptions received from employees.

(b) An employer who deducts premiums after being notified by the employee of an exemption is solely responsible for refunding to the employee any premiums deducted after the notification.

(c) The employer is not entitled to a refund from the employment security department for any premiums remitted to the employment security department that were deducted from exempt employees.

((~~(11)~~)) (10) The provisions of RCW 50B.04.085 do not apply to the exemptions issued pursuant to this section.

((~~(12)~~)) (11) The employment security department shall adopt rules necessary to implement and administer the activities specified in this section related to the program, including rules on the submission and processing of applications under this section.

**Sec.**  RCW 50B.04.060 and 2022 c 1 s 4 are each amended to read as follows:

(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) ((~~Beginning~~)) (a)(i) Except for qualified individuals residing outside of Washington as provided in (a)(ii) of this subsection, 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((~~.~~)), as defined by the department of social and health services for long-term services and supports programs, which is expected to last for at least 90 days.

(ii) For a qualified individual residing outside of Washington, beginning January 1, 2030, the out-of-state qualified individual may become an eligible beneficiary by filing an application with the department of social and health services and undergoing an eligibility determination. The eligibility determination must include an evaluation that the individual either (A) is unable to perform, without substantial assistance from another individual, at least two of the following activities of daily living for a period of at least 90 days due to a loss of functional capacity: Eating, toileting, transferring, bathing, dressing, or continence, or (B) requires substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairments.

(b) The department of social and health services must engage sufficient qualified assessor capacity, including via contract, so that the determination may be made within 45 days from receipt of a request by a beneficiary to use a benefit.

(3)(a) An eligible beneficiary may receive approved services and benefits through the program in the form of a benefit unit payable to a ((~~registered~~)) long-term services and supports provider.

(b) Except as limited in RCW 50B.04.050(2), an eligible beneficiary may not receive more than the dollar equivalent of 365 benefit units over the course of the eligible beneficiary's lifetime.

(i) If the department of social and health services reimburses a long-term services and supports provider for approved services provided to an eligible beneficiary and the payment is less than the benefit unit, only the portion of the benefit unit that is used shall be taken into consideration when calculating the person's remaining lifetime limit on receipt of benefits.

(ii) Eligible beneficiaries may combine benefit units to receive more approved services per day as long as the total number of lifetime benefit units has not been exceeded.

**Sec.**  RCW 50B.04.070 and 2019 c 363 s 8 are each amended to read as follows:

(1)(a) Benefits provided under this chapter shall be paid periodically and promptly to ((~~registered~~)) long-term services and supports providers((~~.~~

~~(2)~~)) who provide approved services to:

(i) Eligible beneficiaries in Washington if the long-term services and supports provider is registered with the department of social and health services; and

(ii) Eligible beneficiaries outside Washington if the long-term services and supports providers meet minimum standards established by the department.

(b) The department of social and health services may contract with a third party to administer payments to long-term services and supports providers providing services to eligible beneficiaries whether inside or outside of Washington.

(c) Qualified family members may be paid for approved personal care services in the same way as individual providers, through a licensed home care agency, or through a third option if recommended by the commission and adopted by the department of social and health services.

(2) The department of social and health services shall establish payment methods and procedures that are most appropriate and efficient for the different categories of service providers identified in subsection (1) of this section, including collaboration with other agencies and contracting with third parties, as necessary.

**Sec.**  RCW 50B.04.085 and 2021 c 113 s 5 are each amended to read as follows:

(1) An employee who attests that the employee has long-term care insurance purchased before November 1, 2021, may apply for an exemption from the premium assessment under RCW 50B.04.080. ((~~An exempt employee may not become a qualified individual or eligible beneficiary and is permanently ineligible for coverage under this title.~~))

(2)(a) The employment security department must accept applications for exemptions only from October 1, 2021, through December 31, 2022.

(b) Only employees who are eighteen years of age or older may apply for an exemption.

(3) The employment security department is not required to verify the attestation of an employee that the employee has long-term care insurance.

(4) Approved exemptions will take effect on the first day of the quarter immediately following the approval of the exemption.

(5) Exempt employees are not entitled to a refund of any premium deductions made before the effective date of an approved exemption.

(6) An exempt employee must provide written notification to all current and future employers of an approved exemption.

(7) If an exempt employee fails to notify an employer of an exemption, the exempt employee is not entitled to a refund of any premium deductions made before notification is provided.

(8) Employers must not deduct premiums after being notified by an employee of an approved exemption.

(a) Employers must retain written notifications of exemptions received from employees.

(b) An employer who deducts premiums after being notified by the employee of an exemption is solely responsible for refunding to the employee any premiums deducted after the notification.

(c) The employer is not entitled to a refund from the employment security department for any premiums remitted to the employment security department that were deducted from exempt employees.

(9) (a) Except as provided in (b) of this subsection, an exempt employee may not become a qualified individual or eligible beneficiary and is permanently ineligible for coverage under this title.

(b) Prior to July 1, 2028, an employee who has received an approved exemption pursuant to this section may rescind the exemption and participate in the program. The employee must notify the employment security department of the rescission according to procedures established by the employment security department. The employee will be subject to premium assessments under RCW 50B.04.080 or 50B.04.090 upon notification to the employment security department of the rescission. The employee is not responsible for any premiums that would have been assessed prior to the rescission. When deeming a person to be a qualified individual under RCW 50B.04.050, the employment security department may not consider any years in which the rescinding employee had been in exempt status unless the employee had been assessed the premium for a part of the year and the number of hours worked while being assessed met the minimum hour requirement.

(10) The employment security department must adopt rules necessary to implement and administer the activities specified in this section related to the program, including rules on the submission and processing of applications and the rescission of an exemption under this section.

**Sec.**  RCW 50B.04.100 and 2019 c 363 s 11 are each amended to read as follows:

(1) The long-term services and supports trust account is created in the custody of the state treasurer. All receipts from employers under RCW 50B.04.080 and from out-of-state participants under section 2 of this act, and any funds attributable to savings derived through a waiver with the federal centers for medicare and medicaid services pursuant to RCW 50B.04.130 must be deposited in the account. Expenditures from the account may be used for the administrative activities of the department of social and health services, the health care authority, and the employment security department. Benefits associated with the program must be disbursed from the account by the department of social and health services. Only the secretary of the department of social and health services or the secretary's designee may authorize disbursements from the account. The account is subject to the allotment procedures under chapter 43.88 RCW. An appropriation is required for administrative expenses, but not for benefit payments. The account must provide reimbursement of any amounts from other sources that may have been used for the initial establishment of the program.

(2) The revenue generated pursuant to this chapter shall be utilized to expand long-term care in the state. These funds may not be used either in whole or in part to supplant existing state or county funds for programs that meet the definition of approved services.

(3) The moneys deposited in the account must remain in the account until expended in accordance with the requirements of this chapter. If moneys are appropriated for any purpose other than supporting the long-term services and supports program, the legislature shall notify each qualified individual by mail that the person's premiums have been appropriated for an alternate use, describe the alternate use, and state its plan for restoring the funds so that premiums are not increased and benefits are not reduced.

NEW SECTION. **Sec.**  A new section is added to chapter 50B.04 RCW to read as follows:

(1) When a qualified individual applies for benefits as provided in RCW 50B.040.060, the department of social and health services must: (a) Ask whether the qualified individual has supplemental long-term care insurance as provided in chapter 48.--- RCW (the new chapter created in section 38 of this act); and (b) request written consent and the policy issuer's contact information from the qualified individual to share information with the policy issuer for any potential care coordination.

(2) If the individual provides written consent and the policy issuer's contact information, the department of social and health services must notify the policy issuer that the qualified individual has applied for benefits under this chapter and may share information for any potential care coordination.

(3) Only basic demographic information that would allow a person to be identified in the program may be shared if the qualified individual consents to sharing information. No health information or data on claims may be shared.

NEW SECTION. **Sec.**  (1) The department of social and health services, the employment security department, and the health care authority may design and conduct a pilot project to assess the administrative processes and system capabilities for managing eligibility determinations for qualified individuals and distributing payments to long-term services and supports providers. The pilot project may identify persons who are eligible to be qualified individuals, except that they do not meet the duration requirements under RCW 50B.04.050, and offer them access to benefit units under the program in return for their participation in the pilot project. The pilot project may only be conducted between January 1, 2026, and June 30, 2026. The pilot project may not have more than 500 participants.

(2) When designing and implementing the pilot project, the agencies identified in subsection (1) of this section must provide regular updates to and consider recommendations from the long-term services and supports trust commission. Upon completion of the pilot project, the agencies must provide a summary of the pilot project, including key operational challenges, to the commission. The commission may include any outstanding concerns identified by the pilot project that require a legislative response in the commission's 2027 report.

(3) The employment security department may adopt rules necessary to implement this section.

(4) This section expires July 1, 2027.

NEW SECTION. **Sec.**  The intent of this chapter is to promote the public interest, support the availability of supplemental long-term care coverage, establish standards for supplemental long-term care coverage, facilitate public understanding and comparison of supplemental long-term care contract benefits, protect persons insured under supplemental long-term care insurance policies and certificates, protect applicants for supplemental long-term care policies from unfair or deceptive sales or enrollment practices, and provide for flexibility and innovation in the development of supplemental long-term care insurance coverage.

NEW SECTION. **Sec.**  (1) This chapter applies to all supplemental long-term care insurance policies, contracts, or riders delivered or issued for delivery in this state on or after January 1, 2026. This chapter does not supersede the obligations of entities subject to this chapter to comply with other applicable laws to the extent that they do not conflict with this chapter, except that laws and regulations designed and intended to apply to medicare supplement insurance policies shall not be applied to supplemental long-term care insurance.

(2) Coverage advertised, marketed, or offered as supplemental long-term care insurance must comply with this chapter. Any coverage, policy, or rider advertised, marketed, or offered as supplemental long-term care or nursing home insurance shall comply with this chapter.

(3) This chapter is not intended to prohibit approval of supplemental long-term care funded through life insurance policies, contracts, or riders, provided the policy meets the definition of supplemental long-term care insurance and provides all required benefits of this chapter.

NEW SECTION. **Sec.**  The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Applicant" means: (a) In the case of an individual supplemental long-term care insurance policy, the person who seeks to contract for benefits; and (b) in the case of a group supplemental long-term care insurance policy, the proposed certificate holder.

(2) "Certificate" includes any certificate issued under a group supplemental long-term care insurance policy that has been delivered or issued for delivery in this state.

(3) "Commissioner" means the insurance commissioner of Washington state.

(4) "Issuer" includes insurance companies, fraternal benefit societies, health care service contractors, health maintenance organizations, or other entity delivering or issuing for delivery any supplemental long-term care insurance policy, contract, or rider.

(5) "Group supplemental long-term care insurance" means a supplemental long-term care insurance policy or contract that is delivered or issued for delivery in this state and is issued to:

(a) One or more employers; one or more labor organizations; or a trust or the trustees of a fund established by one or more employers or labor organizations for current or former employees, current or former members of the labor organizations, or a combination of current and former employees or members, or a combination of such employers, labor organizations, trusts, or trustees; or

(b) A professional, trade, or occupational association for its members or former or retired members, if the association:

(i) Is composed of persons who are or were all actively engaged in the same profession, trade, or occupation; and

(ii) Has been maintained in good faith for purposes other than obtaining insurance; or

(c)(i) An association, trust, or the trustees of a fund established, created, or maintained for the benefit of members of one or more associations. Before advertising, marketing, or offering supplemental long-term care coverage in this state, the association or associations, or the insurer of the association or associations, must file evidence with the commissioner that the association or associations have at the time of such filing at least 100 persons who are members and that the association or associations have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and bylaws that provide that:

(A) The association or associations hold regular meetings at least annually to further the purposes of the members;

(B) Except for credit unions, the association or associations collect dues or solicit contributions from members; and

(C) The members have voting privileges and representation on the governing board and committees of the association.

(ii) Thirty days after filing the evidence in accordance with this section, the association or associations will be deemed to have satisfied the organizational requirements, unless the commissioner makes a finding that the association or associations do not satisfy those organizational requirements; or

(d) A group other than as described in (a), (b), or (c) of this subsection subject to a finding by the commissioner that:

(i) The issuance of the group policy is not contrary to the best interest of the public;

(ii) The issuance of the group policy would result in economies of acquisition or administration; and

(iii) The benefits are reasonable in relation to the premiums charged.

(6) "Policy" includes a document such as an insurance policy, contract, subscriber agreement, rider, or endorsement delivered or issued for delivery in this state by an insurer, fraternal benefit society, health care service contractor, health maintenance organization, or any similar entity authorized by the insurance commissioner to transact the business of supplemental long-term care insurance.

(7) "Qualified supplemental long-term care insurance contract" or "federally tax-qualified supplemental long-term care insurance contract" means:

(a) An individual or group insurance contract that meets the requirements of section 7702B(b) of the internal revenue code of 1986, as amended; or

(b) The portion of a life insurance contract that provides supplemental long-term care insurance coverage by rider or as part of the contract and that satisfies the requirements of sections 7702B(b) and (e) of the internal revenue code of 1986, as amended.

(8) "Supplemental long-term care insurance" means an insurance policy, contract, or rider that is advertised, marketed, offered, or designed to provide coverage for at least 12 consecutive months for a covered person after benefits provided under chapter 50B.04 RCW have been exhausted. Supplemental long‑term care insurance may be on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. Supplemental long-term care insurance includes any policy, contract, or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity that supplements benefits provided in chapter 50B.04 RCW.

(a) Supplemental long-term care insurance includes group and individual annuities and life insurance policies or riders that provide directly or supplement long-term care insurance and that supplements benefits provided in chapter 50B.04 RCW. However, supplemental long-term care insurance does not include life insurance policies that: (i) Accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement; (ii) provide the option of a lump sum payment for those benefits; and (iii) do not condition the benefits or the eligibility for the benefits upon the receipt of long-term care.

(b) Supplemental long-term care insurance also includes qualified supplemental long-term care insurance contracts.

(c) Supplemental long-term care insurance does not include any insurance policy, contract, or rider that is offered primarily to provide coverage for basic medicare supplement, basic hospital expense, basic medical-surgical expense, hospital confinement indemnity, major medical expense, disability income, related income, asset protection, accident only, specified disease, specified accident, or limited benefit health. These may not be marketed to consumers as providing coverage that is supplemental to the long-term care benefits provided in chapter 50B.04 RCW.

NEW SECTION. **Sec.**  A group supplemental long-term care insurance policy may not be offered to a resident of this state under a group policy issued in another state to a group described in section 17(5)(d) of this act, unless this state or another state having statutory and regulatory supplemental long-term care insurance requirements substantially similar to those adopted in this state has made a determination that such requirements have been met.

NEW SECTION. **Sec.**  (1) A supplemental long-term care insurance policy or certificate may not define "preexisting condition" more restrictively than as a condition for which medical advice or treatment was recommended by or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person, unless the policy or certificate applies to group supplemental long-term care insurance under section 17(5) (a), (b), or (c) of this act.

(2) A supplemental long-term care insurance policy or certificate may not exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within six months following the effective date of coverage of an insured person, unless the policy or certificate applies to a group as defined in section 17(5)(a) of this act.

(3) The commissioner may extend the limitation periods for specific age group categories in specific policy forms upon finding that the extension is in the best interest of the public.

(4) An issuer may use an application form designed to elicit the complete health history of an applicant and underwrite in accordance with that issuer's established underwriting standards, based on the answers on that application. Unless otherwise provided in the policy or certificate and regardless of whether it is disclosed on the application, a preexisting condition need not be covered until the waiting period expires.

(5) A supplemental long-term care insurance policy or certificate may not exclude or use waivers or riders to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period.

NEW SECTION. **Sec.**  (1) No supplemental long-term care insurance policy may:

(a) Be canceled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;

(b) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder;

(c) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care;

(d) Condition eligibility for any benefits on a prior hospitalization requirement;

(e) Condition eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care;

(f) Condition eligibility for any benefits other than waiver of premium, postconfinement, postacute care, or recuperative benefits on a prior institutionalization requirement;

(g) Include a postconfinement, postacute care, or recuperative benefit unless:

(i) Such requirement is clearly labeled in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits"; and

(ii) Such limitations or conditions specify any required number of days of preconfinement or postconfinement;

(h) Condition eligibility for noninstitutional benefits on the prior receipt of institutional care;

(i)(i) Provide for a deductible that is greater than the maximum dollar equivalent provided in RCW 50B.04.060(3)(b), including inflation adjustments provided in RCW 50B.04.010(3), without the limitation provided in RCW 50B.04.050(2). The issuer may provide for a deductible that is less than the maximum dollar equivalent provided in RCW 50B.04.060(3)(b), especially for a policyholder born before 1968;

(ii) The issuer must accept notice from the department of social and health services that the policyholder has exhausted the benefits provided under chapter 50B.04 RCW as evidence of satisfying the deductible. However, for a policyholder born before 1968, the department must provide the amount of benefits paid under chapter 50B.04 RCW as evidence of payment toward the deductible;

(j) Include an elimination period of greater than 12 months. Any period of time the policyholder is considered an eligible beneficiary as defined in RCW 50B.04.010 must count toward any elimination period in a supplemental long-term care insurance policy. If the policy includes a deductible and an elimination period, the policy may provide that the elimination period is satisfied after the later of when the deductible or the elimination period has been met; and

(k) Require a policyholder to undergo a functional assessment to satisfy a benefit trigger to determine that the elimination period has begun or ended. However, the issuer may require the policyholder to undergo a functional assessment and apply a benefit trigger for purposes of approving a claim and authorizing benefits.

(2) A supplemental long-term care insurance policy or certificate may be field-issued if the compensation to the field issuer is not based on the number of policies or certificates issued. For purposes of this section, "field-issued" means a policy or certificate issued by a producer or a third-party administrator of the policy pursuant to the underwriting authority by an issuer and using the issuer's underwriting guidelines.

NEW SECTION. **Sec.**  (1) Supplemental long-term care insurance applicants may return a policy or certificate for any reason within 30 days after its delivery and to have the premium refunded.

(2) All supplemental long-term care insurance policies and certificates must have a notice prominently printed on or attached to the first page of the policy stating that the applicant may return the policy or certificate within 30 days after its delivery and to have the premium refunded.

(3) Refunds or denials of applications must be made within 30 days of the return or denial.

(4) This section does not apply to certificates issued pursuant to a policy issued to a group defined in section 17(5)(a) of this act.

NEW SECTION. **Sec.**  (1) An outline of coverage must be delivered to a prospective applicant for supplemental long-term care insurance at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and its purpose.

(a) The commissioner must prescribe a standard format, including style, arrangement, overall appearance, and the content of an outline of coverage. The outline of coverage must also include a disclosure:

(i) Of how the supplemental long-term care insurance interacts with benefits provided in chapter 50B.04 RCW and any potential gaps in coverage or discontinuities of care between benefits provided under chapter 50B.04 RCW and the policy;

(ii) That the premiums may increase over time and an explanation of the conditions that may result in an increase in premiums;

(iii) If the policyholder's circumstances change or premiums increase and the policyholder is unable or unwilling to pay the increased premiums, the options available to the consumer, including a reduction in benefits and nonforfeiture of premiums;

(iv) That premiums continue after retirement;

(v) When premium payments are no longer required under the policy, known as a waiver of premiums; and

(vi) That the purchase of the policy does not qualify the policyholder to apply to be exempt from premium assessments under RCW 50B.04.085.

(b) When an insurance producer makes a solicitation in person, the insurance producer must deliver an outline of coverage before presenting an application or enrollment form.

(c) In a direct response solicitation, the outline of coverage must be presented with an application or enrollment form. The disclosures required under (a) of this subsection are required in any marketing materials.

(d) If a policy is issued to a group as defined in section 17(5)(a) of this act, an outline of coverage is not required to be delivered, if the information that the commissioner requires to be included in the outline of coverage is in other materials relating to enrollment. Upon request, any such materials must be made available to the commissioner.

(2) If an issuer approves an application for a supplemental long-term care insurance contract or certificate, the issuer must deliver the contract or certificate of insurance to the applicant within 30 days after the date of approval. A policy summary must be delivered with an individual life insurance policy that provides supplemental long-term care benefits within the policy or by rider. In a direct response solicitation, the issuer must deliver the policy summary, upon request, before delivery of the policy, if the applicant requests a summary.

(a) The policy summary must include:

(i) An explanation of how the supplemental long-term care benefit interacts with other components of the policy, including deductions from any applicable death benefits;

(ii) An illustration of the amount of benefits, the length of benefits, and the guaranteed lifetime benefits if any, for each covered person;

(iii) Any exclusions, reductions, and limitations on benefits of supplemental long-term care;

(iv) A statement that any supplemental long-term care inflation protection option required by section 28 of this act is not available under this policy; and

(v) If applicable to the policy type, the summary must also include:

(A) A disclosure of the effects of exercising other rights under the policy;

(B) A disclosure of guarantees related to long-term care costs of insurance charges; and

(C) Current and projected maximum lifetime benefits.

(b) The provisions of the policy summary may be incorporated into a basic illustration required under chapter 48.23A RCW, or into the policy summary which is required under rules adopted by the commissioner.

NEW SECTION. **Sec.**  A supplemental long-term care insurance policy, contract, or rider must:

(1) Allow the policyholder options for reduction of benefits or nonforfeiture of premiums as provided in section 29 of this act if the premiums increase or the policyholder's circumstances change and the policyholder is unable or unwilling to pay the increased premiums;

(2) Allow for continuity of coverage of care settings and providers, including family providers, that the policyholder was receiving as benefits under the program provided in chapter 50B.04 RCW unless there is substantial clinical or other information showing that the current care setting or provider cannot meet the care and safety needs of the policyholder. If the issuer makes a determination that the care setting or providers are not suited to meeting the care and safety needs of the policyholder, the issuer may require a change of care setting or provider under the policy, effective 90 days after the transition from the benefits provided under chapter 50B.04 RCW. The policyholder may appeal the determination through an independent third-party review as tracked by the commissioner. The issuer may audit for fraudulent claims where the care being claimed is not being provided; and

(3) Cover family providers, provided they are suited to meet the care and safety needs of the policyholder.

NEW SECTION. **Sec.**  (1) When a policyholder purchases a supplemental long-term care insurance policy, the issuer must request written consent from the policyholder to share information with the department of social and health services. If the policyholder provides written consent, the issuer must inform the department of social and health services that the policyholder has purchased a supplemental long-term care insurance policy and share any information with the department for the purposes of any potential care coordination.

(2) Only basic demographic information that would allow a person to be identified in the program provided in chapter 50B.04 RCW may be shared if the individual consents to sharing information. No health care information as defined in RCW 70.02.010 or data on claims may be shared.

NEW SECTION. **Sec.**  If a supplemental long-term care benefit funded through a life insurance policy by the acceleration of the death benefit is in benefit payment status, a monthly report must be provided to the policyholder. The report must include:

(1) A record of all supplemental long-term care benefits paid out during the month;

(2) An explanation of any changes in the policy resulting from paying the supplemental long-term care benefits, such as a change in the death benefit or cash values; and

(3) The amount of supplemental long-term care benefits that remain to be paid.

NEW SECTION. **Sec.**  All supplemental long-term care denials must be made within 30 days after receipt of a written request made by a policyholder or certificate holder, or the policyholder's representative. All denials of supplemental long-term care claims by the issuer must provide a written explanation of the reasons for the denial and make available to the policyholder or certificate holder all information directly related to the denial.

NEW SECTION. **Sec.**  (1) An issuer may rescind a supplemental long-term care insurance policy or certificate or deny an otherwise valid supplemental long-term care insurance claim if:

(a) A policy or certificate has been in force for less than six months and upon a showing of misrepresentation that is material to the acceptance for coverage; or

(b) A policy or certificate has been in force for at least six months but less than two years, upon a showing of misrepresentation that is both material to the acceptance for coverage and that pertains to the condition for which benefits are sought.

(2) After a policy or certificate has been in force for two years it is not contestable upon the grounds of misrepresentation alone. Such a policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

(3) An issuer's payments for benefits under a supplemental long-term care insurance policy or certificate may not be recovered by the issuer if the policy or certificate is rescinded.

(4) This section does not apply to the remaining death benefit of a life insurance policy that accelerates benefits for supplemental long-term care that are governed by RCW 48.23.050 the state's life insurance incontestability clause. In all other situations, this section applies to life insurance policies that accelerate benefits for supplemental long-term care.

NEW SECTION. **Sec.**  (1) The commissioner must establish minimum standards for inflation protection features.

(2) An issuer must comply with the rules adopted by the commissioner that establish minimum standards for inflation protection features.

(3) In addition to complying with the rules adopted under this section, no issuer may offer a supplemental long-term care insurance policy in this state unless the issuer also offers to the policyholder, in addition to any other inflation protection, the option to purchase a policy that provides for benefit levels to increase by at least three percent annually.

NEW SECTION. **Sec.**  (1) Except as provided by this section, a supplemental long-term care insurance policy may not be delivered or issued for delivery in this state unless the policyholder or certificate holder has been offered the option of purchasing a policy or certificate that includes a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. If a policyholder or certificate holder declines the nonforfeiture benefit, the issuer must provide a contingent benefit upon lapse that is available for a specified period of time following a substantial increase in premium rates.

(2) If a group supplemental long-term care insurance policy is issued, the offer required in subsection (1) of this section must be made to the group policyholder. However, if the policy is issued as group supplemental long-term care insurance as defined in section 17(5)(d) of this act other than to a continuing care retirement community or other similar entity, the offering must be made to each proposed certificate holder.

(3) The commissioner must adopt rules specifying the type or types of nonforfeiture benefits to be offered as part of supplemental long-term care insurance policies and certificates, the standards for nonforfeiture benefits, and the rules regarding contingent benefit upon lapse, including a determination of the specified period of time during which a contingent benefit upon lapse will be available and the substantial premium rate increase that triggers a contingent benefit upon lapse.

NEW SECTION. **Sec.**  A person may not sell, solicit, or negotiate supplemental long-term care insurance unless the person is appropriately licensed as an insurance producer and has successfully completed supplemental long‑term care coverage education that meets the requirements of this section.

(1) All supplemental long‑term care education required by this chapter must meet the requirements of chapter 48.17 RCW and rules adopted by the commissioner.

(2)(a) Before soliciting, selling, or negotiating supplemental long‑term care insurance coverage, an insurance producer must successfully complete a one‑time education course consisting of no fewer than eight hours on long‑term care coverage, the provisions of chapter 50B.04 RCW and any rules adopted to implement the program, long‑term care services, other state and federal regulations and requirements for long‑term care and qualified long‑term care insurance coverage, changes or improvements in long‑term care services or providers, alternatives to the purchase of long‑term care insurance coverage, the effect of inflation on benefits and the importance of inflation protection, and consumer suitability standards and guidelines.

(b) In addition to the one-time education and training requirement set forth in (a) of this subsection, insurance producers who engage in the solicitation, sale, or negotiation of supplemental long‑term care insurance coverage must successfully complete no fewer than four hours every 24 months of continuing education specific to supplemental long‑term care insurance coverage and issues. Supplemental long‑term care insurance coverage continuing education must consist of topics related to long-term care insurance, long-term care services, and, if applicable, qualified state long-term care insurance partnership programs, including, but not limited to, the following:

(i) State and federal regulations and requirements and the relationship between benefits offered under chapter 50B.04 RCW, qualified state long-term care insurance partnership programs, and other public and private coverage of long-term care services, including medicaid;

(ii) Available long-term care services and providers;

(iii) Changes or improvements in long-term care services or providers;

(iv) Alternatives to the purchase of private long-term care insurance;

(v) The effect of inflation on benefits and the importance of inflation protection;

(vi) This chapter and chapters 48.84 and 48.85 RCW; and

(vii) Consumer suitability standards and guidelines.

(3) The insurance producer education required by this section may not include training that is issuer or company product-specific or that includes any sales or marketing information, materials, or training, other than those required by state or federal law.

(4) Issuers must obtain verification that an insurance producer receives training required by this section before that producer is permitted to sell, solicit, or otherwise negotiate the issuer's supplemental long-term care insurance products.

(5) Issuers must maintain records subject to the state's record retention requirements and make evidence of that verification available to the commissioner upon request.

(6)(a) Issuers must maintain records with respect to the training of its producers concerning the distribution of its long-term care partnership policies that will allow the commissioner to provide assurance to the state department of social and health services, medicaid division, that insurance producers engaged in the sale of supplemental long-term care insurance contracts have received the training required by this section and any rules adopted by the commissioner, and that producers have demonstrated an understanding of the partnership policies and their relationship to benefits offered under chapter 50B.04 RCW and public and private coverage of long-term care, including medicaid, in this state.

(b) These records must be maintained in accordance with the state's record retention requirements and be made available to the commissioner upon request.

NEW SECTION. **Sec.**  (1) Issuers and their agents, if any, must determine whether issuing supplemental long-term care insurance coverage to a particular person is appropriate, except in the case of a life insurance policy that accelerates benefits for supplemental long-term care.

(2) An issuer must:

(a) Develop and use suitability standards to determine whether the purchase or replacement of supplemental long-term care coverage is appropriate for the needs of the applicant or insured, using a best interest standard. The issuers and their agents must act in the best interests of the applicant or policyholder under the circumstances known at the time the recommendation is made, without putting the issuer or agent's financial interests ahead of the interests of the applicant or policyholder;

(b) Train its agents in the use of the issuer's suitability standards; and

(c) Maintain a copy of its suitability standards and make the standards available for inspection, upon request.

(3) The following must be considered when determining whether the applicant meets the issuer's suitability standards:

(a) The ability of the applicant to pay for the proposed coverage and any other relevant financial information related to the purchase of or payment for coverage;

(b) The applicant's goals and needs with respect to supplemental long-term care and the advantages and disadvantages of supplemental long-term care coverage to meet those goals or needs; and

(c) The values, benefits, and costs of the applicant's existing health or long-term care coverage, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.

(4) The sale or transfer of any suitability information provided to the issuer or agent by the applicant to any other person or business entity is prohibited.

(5)(a) The commissioner must adopt rules on forms of consumer-friendly personal worksheets that issuers and their agents must use for applications for supplemental long-term care coverage.

(b) The commissioner may require each issuer to file its current forms of suitability standards and personal worksheets with the commissioner.

NEW SECTION. **Sec.**  A person engaged in the issuance or solicitation of supplemental long-term care coverage may not engage in unfair methods of competition or unfair or deceptive acts or practices, as such methods, acts, or practices are defined in chapter 48.30 RCW, or as defined by the commissioner.

NEW SECTION. **Sec.**  An issuer or an insurance producer who violates a law or rule relating to the regulation of supplemental long-term care insurance or its marketing is subject to a fine of up to three times the amount of the commission paid for each policy involved in the violation or up to $10,000, whichever is greater.

NEW SECTION. **Sec.**  (1) The commissioner must adopt rules that include standards for full and fair disclosure setting forth the manner, content, and required disclosures for the sale of supplemental long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definitions of terms. The commissioner must adopt rules establishing loss ratio standards for supplemental long-term care insurance policies. The commissioner must adopt rules to promote premium adequacy and to protect policyholders in the event of proposed substantial rate increases, and to establish minimum standards for producer education, marketing practices, producer compensation, producer testing, penalties, and reporting practices for supplemental long-term care insurance.

(2) The commissioner must adopt rules establishing standards protecting patient privacy rights, rights to receive confidential health care services, and standards for an issuer's timely review of a claim denial upon request of a covered person.

(3) The commissioner must adopt by rule prompt payment requirements for supplemental long‑term care insurance. The rules must include a definition of a "claim" and a definition of "clean claim." In adopting the rules, the commissioner must consider the prompt payment requirements in long-term care insurance model acts developed by the national association of insurance commissioners.

(4) The commissioner may adopt reasonable rules to carry out this chapter.

NEW SECTION. **Sec.**  (1) The commissioner must:

(a) Develop a consumer education guide designed to educate consumers and help them make informed decisions as to the purchase of supplemental long-term care insurance policies provided under this chapter; and

(b) Expand programs to educate consumers as to the supplemental long-term care insurance policies provided under this chapter, with a focus on the middle-income market. If allowable under federal law, the commissioner must expand the statewide health insurance benefits advisor program to provide the consumer education.

(2) The guide and programs should:

(a) Provide additional information and counseling for consumers born before 1968. This information and counseling should educate these consumers as to potential out-of-pocket costs they may be subject to before supplemental long-term care insurance will begin paying claims and strategies for managing the gap between benefits payable under chapter 50B.04 RCW and coverage under supplemental long-term care insurance.

(b) Support consumers in assessing the tradeoffs between various elimination period options and premium rates.

(c) Educate consumers on budgeting any benefits available under chapter 50B.04 RCW carefully to reduce the likelihood and size of any potential gap between those benefits and the supplemental long-term care insurance.

NEW SECTION. **Sec.**  A new section is added to chapter 48.83 RCW to read as follows:

This chapter does not apply to supplemental long-term care insurance as defined in section 17 of this act.

NEW SECTION. **Sec.**  RCW 50B.04.040 (Long-term services and supports council—Benefit unit adjustment) and 2019 c 363 s 5 are each repealed.

NEW SECTION. **Sec.**  Sections 15 through 35 of this act constitute a new chapter in Title 48 RCW.

NEW SECTION. **Sec.**  If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec.**  This act is not a conflicting measure dealing with the same subject as Initiative Measure No. 2124 within the meaning of Article II, section 1 of the state Constitution, but if a court of competent jurisdiction enters a final judgment that is no longer subject to appeal directing the secretary of state to place this act on the 2024 ballot as a conflicting measure to Initiative Measure No. 2124, this act is null and void and may not be placed on the 2024 ballot.

NEW SECTION. **Sec.**  This act takes effect January 1, 2025, only if Initiative Measure No. 2124 is not approved by a vote of the people in the 2024 general election. If Initiative Measure No. 2124 is approved by a vote of the people in the 2024 general election, this act is null and void.

**--- END ---**