

FINAL BILL REPORT

ESSB 5291

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Synopsis as Enacted

Brief Description: Implementing the recommendations of the long-term services and supports trust commission.

Sponsors: Senate Committee on Labor & Commerce (originally sponsored by Senators Conway, Saldaña, Cleveland, Frame, Nobles, Stanford, Valdez and Wilson, C.).

Senate Committee on Labor & Commerce
House Committee on Early Learning & Human Services
House Committee on Appropriations

Background: Long-Term Services and Supports Trust Program—General. In 2019, the Long-Term Services and Supports (LTSS) Trust Program (Program) was enacted. The Program provides long-term care benefits to persons who paid premiums for a specified period of time and have been assessed as needing a certain amount of assistance with activities of daily living (ADLs).

The Program is administered jointly by the Department of Social and Health Services (DSHS), the Employment Security Department (ESD), and the Health Care Authority (HCA). The Office of the State Actuary performs certain audits and other functions. The LTSS Commission, which includes legislators, agency directors, and stakeholders, meets and makes recommendations to the Governor, certain state agencies, and the Legislature. The LTSS Council, which will include legislators, agency directors, and stakeholders, will meet annually to determine any necessary adjustments to the benefit unit to ensure adequacy and solvency of the LTSS Account (Account).

Premiums. The Program is funded by a premium of 0.58 percent assessed on employees' wages, with assessments beginning on July 1, 2023. The premiums are deposited by the Employment Security Department into the Account.

Exemptions. Certain individuals are eligible for voluntary exemptions from the Program, including employees who:

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- are U.S. military veterans with a 70 percent service-connected disability rating or higher;
- are spouses or registered domestic partners of active-duty service members;
- have non-immigrant temporary work visas; or
- are employed by a Washington employer, but live outside Washington.

In addition, there is a voluntary exemption for employees who attested by December 31, 2022, that they had long-term care insurance purchased before November 1, 2021.

Elective Coverage. Self-employed persons may elect coverage under the Program before July 1, 2026, or within three years of becoming self-employed for the first time. Self-employed persons who elect coverage must pay premiums and may not withdraw from coverage. Beginning July 1, 2026, employees or self-employed persons who leave Washington may elect to continue participating in the Program if they were assessed premiums for at least three years in which they worked at least 500 hours in each of those years.

Eligibility for Benefits. A person is deemed a qualified individual if the person has paid the Program premiums for either a total of ten years without interruption of five or more consecutive years; or three years within the last six years from the date of application for benefits. The person must also have worked at least 500 hours during each of the ten years or three years.

A qualified individual, who is 18 years or older, may become an eligible beneficiary beginning on July 1, 2026, for individuals residing in Washington and beginning on January 1, 2030, for out-of-state individuals. To become an eligible beneficiary, the qualified individual must file an application with DSHS and undergo an eligibility determination, including an evaluation that the individual residing:

- in Washington, requires assistance with at least three ADLs; or
- outside of Washington, either is unable to perform, without substantial assistance from another individual, at least two of the following ADLs for a period of at least 90 days due to a loss of functional capacity—eating, toileting, transferring, bathing, dressing, or continence; or requires substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairments.

Benefits. Benefits are available beginning on July 1, 2026, for eligible beneficiaries in Washington and beginning on July 1, 2030, for out-of-state eligible beneficiaries. The maximum lifetime benefits are currently \$36,500—\$100 benefit units multiplied by 365. The benefit unit must be adjusted annually at a rate no greater than the Washington State Consumer Price Index (CPI), as determined solely by the LTSS Council.

Other Provisions. Discrimination against persons based upon race, gender, age, or preexisting condition is prohibited under the Program. There are special rules for persons born before January 1, 1968.

Long-Term Care Insurance. Long-term care (LTC) insurance pays for care generally not covered by regular health insurance or Medicare. LTC insurance policies include an elimination period which is the number of days that the policyholder is financially responsible for their own care before benefits start. Elimination periods can range from 0 to 180 days. LTC policies do not guarantee coverage unless the policyholder satisfies certain requirements. These are called benefit triggers, which vary by policy. LTC insurance provides a daily benefit, which is the maximum daily amount the insurance policy will pay in any single day for the policyholder's care. The daily benefit may include room and board, home care, adult day care, hospice, respite care, and so on. It can vary based on the dollar amount selected when the policy is purchased and the type of care that is received.

Washington law provides standards and requirements for LTC insurance policies and their sale in Washington.

Long-Term Care Partnership Program. Under the Long-Term Care Partnership Program, people who purchase qualified long-term care partnership insurance policies may apply for long-term care Medicaid under special rules for determining financial eligibility. These special rules generally allow the person to protect assets up to the insurance benefits received from a partnership policy so that such assets will not be taken into account in determining financial eligibility for long-term care Medicaid and will not subsequently be subject to estate recovery for Medicaid and long-term care services paid.

Summary: Out-of-state Participants. An out-of-state participant who has elected coverage may not withdraw from the Program after electing coverage. ESD must cancel the out-of-state elective coverage if the participant fails to make the required payments or submit the required reports.

Qualified Individuals. The requirement that an individual may be deemed a qualified individual by paying premiums for ten years is modified to remove the requirement they be paid without interruption of five or more consecutive years. The additional option to qualify by paying the premiums for three years within the last six years from the date of the application is still available. An out-of-state participant whose coverage was cancelled may not be a qualified individual.

Exemptions. An active-duty service member who is concurrently working off duty civilian employment is automatically exempt from the Program. An employee who holds a nonimmigrant visa for temporary workers, as recognized by federal law, is automatically exempt from the Program, unless the employee notifies the employee's employer that the employee would like to participate. If an employee who holds a nonimmigrant visa for temporary workers becomes a permanent resident or citizen employed in Washington, the exemption no longer applies. Exemptions will be discontinued when an exempt individual who resided outside of Washington and moves to Washington or who was in the military and is discharged or separates from service. An exempt employee who previously attested

to having LTC insurance may rescind the exemption prior to July 1, 2028.

Benefits. The ADLs required to become an eligible beneficiary residing in Washington State are those ADLs defined by DSHS and they must be expected to last for at least 90 days.

Definitions. Certain definitions are modified, including eligible beneficiary and qualified family member. The term benefits units is modified to include an automatic adjustment for inflation by the CPI, rather than the CPI as determined by the LTSS Council. The bill repeals the provisions related to the LTSS Council and transfers the limited duties to the LTSS Commission. A consumer directed employer and an entity contracted by DSHS as a financial agency who serves only clients of in-home LTC workers who are qualified family members are added to the list of exceptions to regulation under the In-home Services Agencies laws.

Administration. HCA must assist DSHS with leveraging existing payment systems for paying of approved services. DSHS may contract with a third party to administer payments to providers. DSHS must establish appropriate and efficient payment methods and procedures. The provisions that CBAs existing on October 19, 2017, do not need to be reopened or apply the program responsibilities until reopened is removed. Delinquent premiums, penalties, interest, Medicare or Medicaid waiver savings must be deposited into the Account. A process regarding delinquent payments is provided. Employers must provide certain reports and keep specified records. Penalties for willfully failing to provide the required reports and pay premiums are provided.

Employment sector is removed from the list of demographic information required in the annual Commission report to the Legislature.

If a federal waiver for Medicare or Medicaid results in shared savings, it must be deposited in the Account.

Pilot Program. DSHS, ESD, and HCA may conduct a pilot program from January 1, 2026, to June 30, 2026, with no more than 500 participants to assess the processes and system capacities to manage eligibility and payment distribution to providers.

Supplemental Long Term Care Insurance. A new chapter is provided for standards and requirements for supplemental LTC insurance policies, designed for coverage after LTSS benefits are exhausted. The provision includes current requirements for LTC insurance with the following additional requirements:

- prohibits issuing a policy and using rates unless they are filed with the LTSS Commissioner;
- prohibits providing a deductible greater than the Program maximum dollar equivalent benefit;
- requires the issuer to accept notice from DSHS that the policyholder has exhausted

- benefits under the Program as evidence of satisfying the deductible;
- prohibits providing an elimination period of greater than 12 months;
- prohibits requiring a policyholder to undergo a functional assessment to satisfy a benefit trigger for the elimination period—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;
- requires the outline of coverage to include additional disclosures of how the policy interacts with Program benefits, about premium increases and options, that premiums continue after retirement, and that the policy does not exempt the policyholder from Program premiums;
- mandates the policy allow for continuity of care settings and providers, including family providers with limited appealable exceptions;
- requires DSHS to ask qualified individuals when applying for WA Cares benefits whether they have supplemental LTC insurance and request written consent to share information with the policy issuer; and if consent is provided, to notify the policy issuer that the individual has applied for benefits and may share information;
- requires the issuer to request written consent from the policyholder to share limited information with DSHS for care coordination when a policyholder purchases a supplemental LTC policy; and
- requires the issuer to comply with rules establishing minimum standards for inflation protection features.

The Office of the Insurance Commissioner must develop a consumer education guide and expand existing consumer education programs for supplemental LTC insurance. The guide and counseling should provide additional information for consumers born before 1968.

Supplemental LTC insurance policies are included in the Long-Term Care Partnership Program, which allows for exclusion of certain assets in the determination of Medicaid eligibility for individuals purchasing qualifying long-term care policies and meeting other criteria.

Votes on Final Passage:

Senate	38	11	
House	78	16	(House amended)
Senate	35	13	(Senate concurred)

Effective: January 1, 2026

May 1, 2026 (Sections 17 through 39, 47 and 48)

January 1, 2027 (Sections 12 through 14)