SENATE BILL REPORT
SB 5344

As of January 28, 2025

Title: An act relating to establishing the essential worker health care program.

Brief Description: Establishing the essential worker health care program.

Sponsors: Senators Riccelli, Harris, Lovick, Cleveland, Lovelett, Liias, Saldaña, Frame, Hasegawa, Nobles, Trudeau, Valdez and Wilson, C..

Brief History:
Committee Activity: Health & Long-Term Care: 1/28/25.

Brief Summary of Bill

- Establishes an essential worker health care program by July 1, 2026, to help participating nursing home employers provide nursing home workers with health coverage if the federal Centers for Medicare and Medicaid Services approves a state plan amendment or waiver for the program.

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Staff: Julie Tran (786-7283)

Background: Taft-Hartley Benefit Trusts. Taft-Hartley Benefit Trusts (Trusts) are formed and operated according to the federal law originally called the Labor Management Relations Act of 1947. Trusts are typically formed through agreements between multiple collective bargaining units and employers. Pension benefits are most often provided by Taft-Hartley plans, but they also may provide health, occupational, unemployment, and other benefit programs. Trusts must be governed by a board of trustees with equal employee and employer representation. Collective bargaining agreements typically provide that employers contribute a specific amount to the trust fund for their bargaining unit employees, rather than provide the employees with specific benefits. For Trusts, trustees then carry out

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the terms of the Trusts to provide members with benefits from the fund.

Multiple Employer Welfare Arrangement. A Multiple Employer Welfare Arrangement (MEWA) is a form of group purchasing arrangement defined by the federal Employee Retirement Income Security Act of 1974, as an employee welfare benefit plan, or any other arrangement established or maintained for the purpose of offering or providing medical, surgical, or hospital care or other benefits to the employees of two or more employers or to their beneficiaries. To obtain and maintain the ability to do business as a MEWA in Washington State, the MEWA must comply with the following regulations:

- MEWA must obtain a certificate of authority from the Office of the Insurance Commissioner (OIC);
- MEWA members must be employers in a bona fide association that provides health care services to at least 20 employers, not a mere conduit for the collection of insurance premiums;
- the association must have been in existence for at least ten years, as of December 31, 2003;
- MEWAs must deposit $200,000 with OIC and maintain a surplus of $2 million or more; and
- MEWAs must meet numerous technical requirements for disclosure of financial status, plan operation, and management competence, integrity, and bondability.

Report on Essential Worker Health Benefits Program. In 2024, the Legislature directed the Department of Social and Health Services (DSHS) to work with OIC and the Health Care Authority to develop an implementation plan for a phase-in of an essential worker health benefits program for nursing facility employees and submit the report to the Legislature by December 2024. DSHS was directed to evaluate the feasibility of such a program, determine financial requirements, develop materials for workers, and establish procedures for enrollment.

In the December 2024 assessment report to the Legislature, DSHS concluded that the implementation of the concept of a health benefits trust is feasible and DSHS provided the Legislature with three options to setting up insurance through a health benefit trust for nursing facility employees and these options are not exclusive and more than one can be pursued. It is unknown during the time of the report as to how many employers would ultimately be interested in participation in the program to enhance employee benefits but the success of each of the health plans is based on a sufficient number of participating employers and employees to ensure solvency.

The report noted that regardless of the option pursed by the Legislature, statutory and regulatory change would be needed for DSHS to implement this supplemental payment to participating facilities in proportion to their Medicaid occupancy. DSHS would need to calculate the payments so the entire appropriation from the Legislature for this purpose would be spent each year. As a result, the payment's actual figure would vary each year depending on the total appropriation, number of participating employers, and Medicaid

occupancy percentage at each participating facility.

The report also noted that there would likely only be rules around including health plan information on the cost report for participating employers and depending on the option chosen by the Legislature, a lot of the oversight would fall to the OIC.

Report Recommendations. The three options provided by the report: (1) utilization of the existing home care trust, (2) establish a self-funded MEWA in the style of the Oregon model, or (3) establish a fully insured association health plan in partnership with a related nursing home or long-term care association currently operating in Washington State.

Utilization of the Existing Home Care Trust. This option is to expand the product lines offered by an existing large-scale multi-employer fund in the home care industry. The current benefit group covers home health caregivers and is funded according to hours worked. This expansion would be a new benefit design based on a monthly premium model that can be offered as employer-based coverage.

This type of trust can provide insurance to any and all union employees of a participating employer. There is no requirement for union employees to belong to a specific union. The fund may also insure a certain number of non-union employees of participating employers. The number of non-union employees that may be insured through the existing plan is determined as a percentage of total insured individuals. Current law sets this limit at 15 percent. The implementation of this option as the only source would limit participation to employers who are fully or majority unionized.

Establish a Self-Funded Multi-Employer Welfare Arrangement Similar to Oregon State. In 2023, Oregon established a Multi-Employer Essential Workers Healthcare Trust and required all employers to participate in the single self-funded MEWA. It was designed to offer coverage to 3500 to 7500 low wage workers who are currently unable to afford their employer's current health plan or are Medicaid-ineligible.

To pursue this option, the Legislature needs to statutorily authorize the establishment of this self-funded MEWA and then, once established, the state can allow employers to join. The state is recommended to adopt most, if not all, of the protections added by the Oregon Legislature to ensure that the entity remains solvent and meets its obligations. Currently in statute, operation of self-funded MEWAs is restricted to entities that have been in existence or operated actively for a period of not less than ten years as of December 2003.

Establish a Fully Insured Association Health Plan in Partnership With a Related Nursing Home or Long-Term Care Association Currently Operating in Washington State. If establishing this type of health plan, the state would need to comply with federal regulations, specifically the Employee Retirement Income Security Act (ERISA), and meet three general criteria for the formation of a bona fide association health plan:

- the entity has business or organizational purposes and functions unrelated to the

provisions of benefit;
- the employers share a commonality and genuine organizational relationship unrelated to the provision of benefits; and
- the employers that participate in a benefit program, either directly or indirectly, exercise control over the benefit program both in form and substance.

Any proposed entity structure would need to be subject to prior approval by DSHS and OIC to ensure compliance with the program requirements and with state insurance laws or is exempt from these laws under ERISA. These entities should be required to seek approval from a designated state agency for any changes to premiums, premium shares, and plan design in advance of open enrollment. DSHS should monitor health care benefit spending to ensure spending is not supplanted by any additional funds.

Medicaid Rate Methodology for Nursing Homes. The Medicaid nursing home payment system is administered by DSHS. The Medicaid rates in Washington are unique to each facility and reflect the client acuity of each facility's residents. Medicaid payments for nursing home residents are shared by the state and federal governments at the state's Federal Matching Assistance Percentage rate.

Summary of Bill: The Essential Worker Health Care Program (program) is established within DSHS, by July 1, 2026, to help provide nursing home workers with high quality, affordable health coverage through participating nursing home employers.

Supplemental Payments. DSHS must distribute a supplemental payment to participating nursing home employers and seek any necessary approvals from the federal Centers for Medicare and Medicaid Services (CMS). The supplemental payment must be distributed annually in proportion to each program participating nursing home employer's Medicaid bed days in the previous calendar year.

Program Requirements. To participate in the program, employers must operate at least one licensed nursing home in the state that participates in Medicaid and enter into a memorandum of understanding (MOU) with DSHS, committing to:
- participate in an OIC-certified qualified health fund;
- allocate substantially all of the funds distributed through the program to the qualified health fund;
- provide documentation to DSHS that shows the spending on employee health care benefits in the state in the two years prior to the employer's entry into the program;
- maintain spending on employee health care benefits in the first year of the program participation at least equal to the average of the spending in the two years prior to program entry and maintain spending in subsequent years at least equal to this level plus the United States' Bureau of Labor Statistics' Consumer Price Index for health insurance. The spending must flow through the certified qualified health fund. For qualified health funds offered through a Trusts fund in which union representatives occupy at least 50 percent of board seats, a certification from each participating union

is sufficient to comply with the health care benefits spending requirement needed to participate in the program;
- provide DSHS with information concerning its employee health care benefits, employer's health plan's covered employee uptake, the employer and covered employees' cost, and employer's employee retention in the two years prior to its program entry, and provide updates to this information at the end of each year of participation in the program;
- demonstrate at least annually, or more frequently at DSHS' request, that it has used all of the supplemental payments received through the program to significantly improve the quality of employee health care benefits offered to covered employees; and
- meet any other conditions or requirements specified by DSHS in rule to achieve the program's goals.

Covered Employees. Only covered employees may participate in the program.

A covered employee is any permanent employee of a company that operates a participating facility who works primarily in the state including, but not limited to:
- employees providing direct care to nursing home residents;
- employees indirectly involved in resident care;
- employees providing dietary, housekeeping, laundry, or environmental services on location;
- administrative employees and management; and
- corporate office employees, or any subcontractor of such a company who works on a full-time, permanent basis in a nursing home.

DSHS may take any authorized enforcement action or terminate any participating employer that fails to comply with the requirements established in the MOU and any related rules adopted by DSHS.

Qualified Health Fund. OIC must annually certify a proposed health care benefit arrangement as a qualified health fund if it meets the requirements. Supplemental payments to participating employers in the program may be disbursed by DSHS only to employers that offer employee health care benefits solely through a qualified health fund that:
- includes at least two distinct and unrelated employers in each program year. For the operation's initial plan year, the entity seeking certification must provide sufficient information to confirm that at least two distinct and unrelated employers will be offering employee health care benefits through the fund. For subsequent years, the entity seeking certification must provide information showing that at least two distinct and unrelated employers participated in the fund during the previous plan year;
- operates or provides health coverage through a fully-insured MEWA or an association health plan or operates as a self-insured Trust with equal union and employer participation;
- for a qualified health fund operated under a fully-insured MEWA or an association

health plan, offered benefits to at least 5000 employees in the long-term care industry in the state during the previous plan year. For the operation's initial plan year, the entity seeking certification must provide sufficient information to confirm anticipated enrollment of at least 5000 long-term care employees;
- offers a benefit package that is either equivalent to an Affordable Care Act Platinum Plan in actuarial value, covered benefits and cost sharing, or, if the plan is offered by a Trust or a plan approved by the board of Trusts;
- certifies each year that participating employers are complying with the terms of the program including the maintenance of the spending requirement;
- with exception for Trusts plans, demonstrates for the operation's initial year and annually that it has provided opportunity for substantive input on plan design, including covered services and how they will be delivered from substantially all covered employees;
- with exception for Trusts plans, demonstrates for the operation's initial year and annually that it has a robust enrollment process in place to ensure that covered employees fully understand their benefits; and
- complies with any other requirements determined by OIC in rule to further the program's goals.

OIC may take any authorized enforcement action or revoke a qualified health fund's certification that fails to meet the program's requirements or any related rules adopted by OIC.

Noncompliance and Recoupment. For employers participating in a qualified health fund that loses the certified qualified health fund status for noncompliance, DSHS must recoup any program supplemental payments received during the period in which the qualified health fund was out of compliance with the program's requirements and any related program rules adopted by DSHS or OIC.

For participating employers terminated by DSHS for noncompliance, DSHS must recoup any supplemental payments from the participating employer that was out of compliance with the program's requirements and any related program rules adopted by DSHS for the fiscal years in which the employer was out of compliance.

DSHS must establish and administer a process for the recoupment of supplemental payments disbursed under the program. The recoupment process must include:
- a review and audit of expenditures by participating employers and qualified health funds at least once every two years;
- written notice to employers or funds found noncompliant, detailing the reasons for recoupment and providing an opportunity for appeal within 30 days;
- recovery of funds by offsetting future payments, direct reimbursement to DSHS, or other means as determined by DSHS in rule; and
- reporting all recoupment activities to the Legislature annually, including details of amounts recovered and the basis for recoupment.

Federal Approval of the Program. DSHS must submit the necessary state plan amendment or waiver application to CMS by July 1, 2025. The program's implementation is contingent upon CMS' approval of a state plan amendment or waiver providing federal financial participation for the program's supplemental payments.

DSHS must provide a report to the Legislature on the status of approval by no later than December 1, 2025.

If CMS does not provide approval by July 1, 2026, DSHS and OIC must:
- delay program implementation until approval is received;
- provide an updated implementation timeline to the Legislature; and
- identify and recommend potential state funding alternatives to ensure compliance with the intent of this act.

Any supplemental payments made under the program prior to CMS' approval are contingent on retroactive approval of federal matching funds or subject to the outlined recoupment process.

Rulemaking. DSHS and OIC may adopt rules to administer and implement this program.

Appropriation: None.

Fiscal Note: Requested on January 20, 2025.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: The bill contains several effective dates. Please refer to the bill.