A STUDY TO USE CAPTIVE INSURANCE COMPANIES TO REDUCE PREMIUM RATE INCREASES FOR CONNECTICUT PARTNERSHIP LONG-TERM CARE INSURANCE POLICIES AND PEER-TO-PEER CAR SHARING

A Joint Study By

The Connecticut Insurance Department and The Office of Policy and Management

in Accordance with Public Act 2022-107

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PA 22-107 Report

Evaluation of the use of a Captive Insurance Company to reduce premium rate increases for policyholders with long-term care insurance policies purchased through the Connecticut Partnership for Long-Term Care and any other recommendations to reduce premium rate increases in Partnership Long-Term Care policies

General Long-Term Care (LTC) Background

LTC policies have been sold in Connecticut as far back as the mid-80's and continue to be sold today but at a much slower rate. LTC policies were originally priced using non-insurance data, primarily from nursing home studies in the 1980's. The main pricing assumptions are as follows:

1. Morbidity: the probability of going into claim, the probability of staying in claim status commonly referred to as the average claim duration and benefit utilization which represents the percentage of daily benefit used as most LTC polices are expense incurred. This means the benefit paid is the lesser of actual expenses incurred and the daily benefit amount purchased.
2. Mortality: the probability of death in addition to the probability of death while in claim status.
3. Voluntary Lapse: the likelihood an individual will lapse their policy on a voluntary basis. Most often mortality and voluntary lapse are combined.
4. Interest Rates: interest rates are used to create a present value of future claims and premiums which assume a certain rate of return earned by the insurance company.

Unfortunately, as the experience developed over time, all aspects of morbidity were much higher than expected, mortality and voluntary lapse were lower than expected and interest rates, until recently, have been at or near historical lows for a significant amount of time. This generated historical, current, and projected future LTC claims much higher than the original premiums were able to support and led to significant rate increases across the country and here in Connecticut.

The discrepancy between pricing assumptions and actual experience directly resulted in one LTC carrier going through liquidation. All affected policyholders now reside within their respective state guaranty funds. Another LTC carrier is involved in a court ordered rehabilitation which may or may not lead to a future liquidation.

Other LTC insurance carriers are raising solvency concerns, this has resulted in the National Association of Insurance Commissioners (NAIC) establishing a LTC Insurance Executive Task Force. The 2023 proposed charges are as follows:

Recognizing the gravity of the threat posed by the current long-term care insurance (LTCI) environment both to consumers and our state-based system of insurance regulation, the mission of the Long-Term Care Insurance (EX) Task Force is to: 1) monitor and evaluate the LTCI rate review process; 2) monitor and evaluate options to help consumers manage the impact of rate increases; and 3) monitor work performed by other NAIC groups to review the financial solvency of long-term care (LTC) insurers.

The Long-Term Care Insurance (EX) Task Force will:

1. Monitor and evaluate the progress of the multistate actuarial (MSA) rate review process as outlined in the *Long-Term Care Insurance Multistate Rate Review Framework* (MSA Framework) document, and make modification, as appropriate. Monitor state insurance department rate review actions subsequent to the implementation of the MSA Framework and MSA rate review recommendations.
2. Monitor and evaluate options to help consumers manage the impact of rate increases, including an evaluation of the use and impact of previously adopted guidance for states regarding reduced benefit options (RBOs).
3. Monitor the work performed by other NAIC solvency working groups and assist in the timely multistate coordination and communication of the review of the financial condition of LTC insurers.
4. Monitor the work performed by other NAIC committees, task forces, and working groups, as well as federal regulators, related to the LTCI industry.

The Connecticut Insurance Department is an active member of the LTC Insurance Executive Task Force, as well as the following NAIC LTC work groups and subgroups:

- Long-Term Care Actuarial Working Group
- Long-Term Care Pricing Subgroup
- Long-Term Care Valuation Subgroup
- Valuation Analysis Working Group – AG 51 Filing Review Group

At the peak of LTC sales there were well over 100 hundred carriers selling LTC policies across the country, many of those sold policies in CT. We currently have approximately 8 to 10 companies selling LTC insurance across the country and in CT. Additionally, in CT only two of those carriers are selling CT Partnership LTC policies.

As of 12/31/2020, there were a total of 101,848 people who were covered by a long-term care insurance policy issued in Connecticut. Of these 101,848 people, 38,873 were covered by a Connecticut Long-Term Care Partnership policy. This represents approximately 38% of the total people who purchased an LTC policy in Connecticut as of 12/31/2020.

Captive Background

A captive is a licensed self-insurance company. It is owned and controlled by its owners and affiliates who are also the insured beneficiaries. Pure captives, sponsored captives and association captives are the three most common types of captives: a pure captive is owned and capitalized by a single entity with all risk co-mingled within one structure; a sponsored captive is typically established and capitalized by a third party. The sponsored captive can host different cells for different insurance coverage or insureds. Each insured including the third party can rent a cell to insure its own risks; an association captive insures risks of the member organizations of an association and the affiliated companies of those members.

Captive solutions are used to fill coverage gaps in the commercial markets due to available or affordability issues such as for Connecticut crumbling foundations. Captives can also be commonly used by businesses for retained risks, such as deductibles, retentions, coinsurance, or uninsured liabilities. A captive can provide owners with flexibility, cost control, potential underwriting profits, data collection, payment vehicle, cash flow, own policy terms, risk financing or accelerated loss reserve federal tax savings. However, Captive owners need to pay fees and taxes (much lower than commercial insurers) to contracted service providers, such as captive managers, actuaries, auditors, brokers, claim adjusters and consultants, regulators, and state revenue services. To succeed, Captives need regulatory oversight and good corporate governance, owners' commitment, and capital contribution. Captives may go insolvent due to risk volatility or poor loss projections. If insolvent, policyholders who are also captive owners can't get claims fully paid, and captives are not protected by state guaranty funds. Even insolvent, unpaid claims remain the captive owner "family" obligation, therefore, captives are regulated with more flexibility and less restriction under captive laws by all captive domiciles.

While a Captive Insurance company can be an effective tool to manage an operation, as was the case for the crumbling foundation issue, generating revenue in-order-to reduce premium rate increases in Partnership Long-Term Care (LTC) policies is the heart of the issue.

If we were to apply principles like those used for crumbling foundations a fee would be applied to each Non-Partnership LTC policy which would then be used to partially offset the premium of Partnership LTC policies. In essence, increasing the premiums for 62,975 CT issued LTC policies while reducing 38,873 Partnership policyholder premiums, a form of subsidization.

While Public Act 22-107 specifically speaks to premium rate increases for CT Partnership for Long-Term Care policies, as is noted above, the majority of existing active policyholders in CT own what are referred to as Non-Partnership, or traditional, policies. More importantly, in almost every instance when an insurer has requested a premium rate increase for their Partnership policies, the insurer also requests a similar

increase for their Non-Partnership policies and when an increase is approved by the Connecticut Insurance Department it is almost always the same for an insurer's Partnership and Non-Partnership policies.

The Connecticut Partnership for Long-Term Care

Overview, History, and Affordability Options

Overview of the Connecticut Partnership for Long-Term Care Program

The Connecticut Partnership for Long-Term Care (Partnership) is a joint effort by State government and private industry to create an option to help Connecticut residents plan to meet future long-term care needs without depleting all their assets to pay for care. Under the Connecticut Partnership, private insurance companies sell special long-term care insurance policies. Similar to traditional long-term care insurance plans, Partnership policies offer benefits to pay for long-term care costs, and the cost of Partnership policies is identical to the amount of a non-Partnership plan for the same insurer for like benefits at the time of sale. But, unlike other policies, Partnership policies offer the added benefit of a Medicaid asset protection provision should the policyholder ever need to apply to Connecticut's Medicaid Program for continued long-term care assistance. Connecticut was the first state in the nation to offer its residents a way to plan to meet their long-term care needs without the fear of impoverishment, and laid the groundwork for three other states, New York, Indiana, and California to implement Partnership programs. Currently, forty-one (41) additional states have received approval from the federal government to implement Partnership for Long-Term Care programs[1].

The Medicaid asset protection feature is at the core of what makes a Partnership policy different from all other long-term care insurance products. It allows the policyholder to earn one dollar of Medicaid asset protection for every dollar that the policy pays out in qualified services for the policyholder's care. Typically, under the Medicaid program an individual must spenddown their assets to $1,600 in countable assets[2] and become impoverished to qualify, however, Medicaid asset protection requires the State to disregard the amount of a policyholder's assets that are equal to the amount the Partnership policy already paid out for the individual's care. For example, a policyholder who uses $300,000 in benefits under their Partnership policy is able to protect $300,000 of their own assets if they apply to Medicaid. The amount that a policyholder can

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[1] Office of Policy and Management, *Connecticut Partnership for Long-Term Care Progress Report to The General Assembly*; January 1, 2022, *https://portal.ct.gov/-/media/OPM/HHS/LTC/ANNRPT--JAN-2022.pdf*.

[2] Countable assets are any assets that have a principal attached to them and the Medicaid applicant has legal access to and can make liquid, such as cash, stocks, bonds, certain retirement accounts (IRAs, 401Ks, etc.) CDs, etc. Exempt assets are items that have no principal and cannot be cashed in, such as Social Security benefits and some pensions, as well as the individual's primary residence if they are applying for home care or their spouse is living in the home if they reside in a nursing home, term life insurance, burial plots and funeral contracts (up to certain limits).

protect is determined by what their Partnership policy pays in benefits. If the policyholder has assets that exceed the amount of Medicaid asset protection earned, the individual will have to spend down the difference between their total assets and the protected amount before being eligible for Medicaid. Once a policyholder has earned an amount of Medicaid asset protection equal to or greater than their actual assets, they are then eligible for Medicaid, assuming they meet all other Medicaid eligibility requirements.

Medicaid asset protection benefits both the State and the policyholder. It makes private long-term care insurance policies more affordable by allowing individuals to purchase a policy only up to the amount of assets they are seeking to protect. Otherwise, they would need to buy a more costly unlimited benefits policy[3] to ensure their assets are protected. One of the goals of developing this innovative asset protection feature was to entice more Connecticut residents to purchase private long-term care insurance through the Partnership program and delay or eliminate their need to access the State's Medicaid program.

As of September 2021, it is estimated that the Partnership program has saved the State's Medicaid program $77.5 million in long-term care expenses (half of these savings would accrue to the Federal Government) since its inception in 1992. The asset protection accumulated by policyholders as of September 2021 was over $665 million while $208 million of that will never be used since the policyholders who earned that Medicaid asset protection died before applying to Medicaid. Policyholders who have accessed Medicaid after using their Partnership policies have protected, as of September 2021, over $81 million in assets[4]

History of the Connecticut Partnership for Long-Term Care Program

In the late 1980s, then Governor O'Neill made note of shifting demographics in the state and nationally. The population was aging, and due to medical advances people would be living longer with chronic health conditions resulting in an increasing number of individuals needing long-term services and supports. In response, Governor O'Neill created a Blue-Ribbon Commission to examine how individuals, families and state government were going to pay for the high cost of long-term care. At the time, and still true today, Medicaid was the major payor of long-term care services and supports in Connecticut, with long-term care accounting for the majority of the state's Medicaid budget[5]. The Commission was seeking ways to constrain the growth of the State's Medicaid long-term care expenditures. It quickly became apparent that neither the private sector nor the public sector could adequately address the growth of Medicaid long-term services and supports spending on their own, therefore, the Commission developed numerous proposals focused on the development of a public/private alliance. In the end, the proposal that garnered the most support was a public/private partnership

[3] An Unlimited policy allows for an unlimited time period for benefits to be paid out, only limited by the daily/monthly benefit amount.
[4] Office of Policy and Management, *Connecticut Partnership for Long-Term Care Progress Report to The General Assembly;* January 1, 2022, *https://portal.ct.gov/-/media/OPM/HHS/LTC/ANNRPT--JAN-2022.pdf*
[5] Office of Policy and Management, *2022 Long-Term Care Plan: Balancing the System; January 1, 2022, https://portal.ct.gov/-/media/OPM/HHS/LTC_Planning_Committee/2022-LTSS-Plan_FINAL_Submission.pdf*.

that involved linking private long-term care insurance and the State's Medicaid program, and thus the Connecticut Partnership for Long-Term Care was created.

Most of the initial funding to develop and implement the Partnership program came from the Robert Wood Johnson Foundation (RWJF), the largest health care foundation in the country, and a smaller portion came from donations made by some private insurance companies. The original intent for the Partnership was to receive federal authorization and passage of national legislation allowing for the establishment of Partnership programs across the country. Ultimately, the bill stalled in Congress removing the immediate hope of establishing a national program. Undeterred, Connecticut pursued approval at the state level through an administrative route by securing approval of a Medicaid State Plan Amendment through the then Health Care Financing Administration (now known as the Centers for Medicare and Medicaid Services or CMS) to offer the Medicaid asset protection feature as part of a Partnership long-term care policy. Connecticut received federal approval of the State Plan Amendment at the beginning of Governor Lowell Weicker's term in 1991. In December 1991, the Connecticut Insurance Department (CID), in conjunction with the Office of Policy and Management (OPM) and the Department of Income Maintenance (now the Department of Social Services (DSS), approved the first three policies to be sold under the Connecticut Partnership program. In April 1992, the Partnership program became fully operational and sales of those three policies began.

A public information and consumer education campaign was fully initiated by the then State Department on Aging (now the Department of Aging and Disability Services) to accompany the launch of the Partnership program. As part of this educational effort, the Partnership's consumer counseling program utilized trained volunteers as information specialists for those interested in learning about their long-term care financing options, with the Partnership being one of them. Additionally, agents selling Partnership policies were required to be highly trained and educated on the product prior to engaging in sales so they could adequately explain options to clients. To this day, agent training consists of, at a minimum, seven hours of training on long-term care insurance in general, and the Partnership in particular, to meet the requirements found in the CID's regulations. Equally as important as educating consumers and agents was the need for State staff to engage in ongoing study of the effectiveness of the Partnership program. Therefore, OPM began an extensive research and evaluation component of the program by surveying those who purchased and dropped policies, those accessing benefits, as well as those denied coverage, to learn more about the characteristics of individuals who were participating in the program and why some individuals were being denied insurance.

Goals of the Connecticut Partnership for Long-Term Care Program[6]

[6] Office of Policy and Management, *Connecticut Partnership for Long-Term Care Progress Report to The General Assembly*; January 1, 2022, *https://portal.ct.gov/-/media/OPM/HHS/LTC/ANNRPT--JAN-2022.pdf*.

2022 was the 30th full year that Partnership policies were available for purchase by Connecticut residents. The Partnership was developed with the following four major goals[7]:

- Provide Connecticut residents with a way to plan for their future long-term care costs without the risk or fear of impoverishment;
- Enhance the standards of private long-term care insurance products available to Connecticut residents;
- Provide public education to residents about the importance of planning ahead for future long-term care costs; and
- Conserve public Medicaid funds by delaying or negating the need for individuals to access the benefit to cover the cost of long-term care.

Target Population

The Partnership was designed primarily to assist those who have built up enough resources to be self-reliant, but not enough to privately pay for their long-term care needs for an extended period. Connecticut residents who may not have enough means to pay for long-term care out-of-pocket and find themselves at risk of needing to spend down their assets and impoverish themselves to qualify for Medicaid to pay for their continued long-term care needs. Individuals with lower incomes may qualify for financial assistance through Medicaid and other state and federal programs and wealthy residents can likely afford to pay for their care with private resources. The middle-class, however, lacks a financial safety net when the time comes to pay for high cost of long-term care. The average annual cost of a nursing home stay in 2021 was $168,000 and the average annual inflation rate for nursing home care from 1988-2021 was 4.7%[8]. A middle-class individual cannot finance such an expense for an extended period. As a result, the Partnership was designed with the following features to allow middle-income residents the ability to purchase a meaningful benefit in a more affordable manner.

Features of the CT Partnership Program

- Provides Medicaid asset protection at NO additional cost,
- Includes the following benefits and protections:
    - Detailed, clearly defined benefit triggers to access the policy,
    - Extensive coverage of home and community-based services including care management to ensure consumers receive care in the setting of their choice,
    - Minimum Daily Benefit Amount (DBA) requirements and automatic inflation protection without increases in the premium to ensure a meaningful benefit at time of utilization,
    - Guaranteed 5% rate discount in Connecticut nursing homes,

[7] Ibid.
[8] Office of Policy and Management, *Cost of Long-Term Care in Connecticut;* March 2022, https://portal.ct.gov/-/media/OPM/HHS/LTC/Cost-of-LTC-in-CT---2022.pdf.

    - A coverage reduction option for those in danger of lapsing a policy,
    - Coverage of ancillary services, (i.e., laundry, PT and OT) in a nursing home are covered in addition to room and board (if the cost does not exceed the DBA of the policy).
- Requires Insurance Agents/Producers to complete special Partnership specific training, and
- Provides unbiased consumer education and support through a toll-free phone line, dedicated website, and print materials.

National Expansion of the Partnership Model

Original Four Partnership States: In 1998, the Connecticut General Assembly passed legislation that gave Connecticut the authority to enter into reciprocal agreements with other Partnership states for the granting of Medicaid Asset Protection (see the following section for detailed information on the National Reciprocity Compact). Initially, Connecticut developed such a reciprocal agreement with the state of Indiana and in 2001, it became effective when CMS granted final approval. The agreement allows a Connecticut Partnership policyholder to receive Medicaid Asset Protection from Indiana's Medicaid program and vice versa for purchasers of Indiana Partnership policies[9].

National Expansion: On February 8, 2006, the Deficit Reduction Act (DRA) of 2005 went into effect. The DRA repealed the requirement imposed by Congress in 1993 that new Partnership programs would have to attempt to recover assets protected through the Partnership after the Medicaid client had died. After the four initial Partnership programs (CA, CT, IN & NY) were started in 1992 and 1993, Congress imposed the new recovery provisions which ostensibly kept new states from developing Partnership programs. Only Illinois had gotten approval as a Partnership state since 1993, but the asset recovery requirement proved to be an insurmountable obstacle and the Illinois Partnership did not survive. With the repeal of the 1993 recovery requirement, there was tremendous interest from states to develop a Partnership program. Since 2006, forty-one states have received federal approval to implement Partnership programs. In addition to the four original states (CA, CT, IN & NY), there are a total of 45 states operating Partnership programs. Only Alaska, Hawaii, Massachusetts, Mississippi, and Vermont do not currently operate a Partnership program. All the new Partnership programs are required to utilize the dollar-for-dollar Medicaid asset protection model first implemented in Connecticut (as opposed to total asset protection available in New York and Indiana)[10].

National Reciprocity Compact and the Partnership

[9] Office of Policy and Management, *Connecticut Partnership for Long-Term Care Progress Report to The General Assembly*; January 1, 2022, https://portal.ct.gov/-/media/OPM/HHS/LTC/ANNRPT--JAN-2022.pdf.
[10] Ibid.

As noted above, due to the passage of the federal Deficit Reduction Act in 2006, many more states have developed Partnership programs. Effective January 1, 2009, the federal government enacted a Reciprocity Compact (Compact) for Medicaid asset protection between Partnership states. The Compact requires that any state in the Compact agrees to have reciprocity with any other state in the Compact. On March 27, 2009, Connecticut received approval from the federal government to join the Compact. The approval was retroactive to January 1, 2009. However, all Connecticut Partnership policyholders are covered under the Compact, regardless of when they purchased their Partnership policy. Under the terms of the Compact, Connecticut Partnership policyholders who relocate to another state may be eligible to receive dollar-for-dollar Medicaid asset protection just as they would when they apply to Connecticut's Medicaid program. In addition, the original reciprocity agreement between Connecticut and Indiana remains in effect.

States are permitted to opt in and out of the Compact at any time. Consequently, the list of states participating in the Compact may change over time. Currently, all 41 new Partnership states, along with Connecticut, Indiana, and New York, are participating in the Reciprocity Compact. California is currently the only state with a Partnership program that is not participating in the Reciprocity Compact. For a list of states currently participating in the Reciprocity Compact, go to the following website - **https://nyspltc.health.ny.gov/reciprocitymap.htm[11].**

Key Facts About the Connecticut Partnership

As of September 30th, 2021:

- 60,596 policies have been purchased statewide.
- 57 is the average age of purchasers of individual Partnership policies.
- 5,190 Partnership policyholders have qualified to receive benefits under their policies.
- $665 million in insurance payments have earned Medicaid Asset Protection.
    - Over $208 million of this Medicaid asset protection amount will never be used since it was earned by policyholders who passed away before applying to the Medicaid program.
- 326 policyholders have accessed CT's Medicaid program after using their Partnership benefits while protecting over $81 million in assets.

Medicaid Cost Savings Attributed to the Connecticut Partnership

One of the core goals of the Connecticut Partnership is to generate savings to the Medicaid program today and well into the future. It has already had a positive impact on current Medicaid expenditures resulting in a cumulative $77.5 million in savings[12]. The savings are the result of the following:

[11] Office of Policy and Management, *Connecticut Partnership for Long-Term Care Progress Report to The General Assembly*; January 1, 2022, *https://portal.ct.gov/-/media/OPM/HHS/LTC/ANNRPT--JAN-2022.pdf*.
[12] Ibid.

- Individuals have an incentive to plan for their future long-term care needs so they can receive services and retain the ability to pass on their hard-earned assets to their children or other loved ones, rather than having to undertake estate or Medicaid planning techniques that may involve transferring or sheltering assets.
- Care management assistance and provider discount arrangements under private insurance have the potential to control unnecessary utilization of services and cost which can help individuals stretch and conserve scarce resources and delay, or eliminate, an individual's need for Medicaid coverage.
- Policyholders may never need to access Medicaid if their coverage under their private Partnership policy proves sufficient to meet their long-term care needs. Important to note, the majority of individuals who have used their Partnership benefits have never needed to apply to Medicaid, primarily because they died before utilizing all their insurance benefits.

Long-Term Care Insurance Rate Increases

Rate increases are not unique to Partnership policies. Typically, any rate increase filed by a company for a Partnership policy is also filed for the equivalent non-Partnership policy. In fact, under no circumstances can premiums between Partnership plans and comparable non-Partnership policies be different at the point of sale when the actuarial assumptions are the same. The one caveat is that the claims experience could be different on Partnership versus non-Partnership policies and in those cases, different rate increases could be justified. Since rate increases impact both Partnership and non-Partnership policies in Connecticut, any cost mitigation strategies must apply to both Partnership and non-Partnership policies to help reduce the initial premium cost and need for and/or cost of future rate increases for all long-term care insurance policyholders.

Potential State Solutions to Address the Affordability of Long-Term Care Insurance

Since solutions to the rising costs of long-term care have been an area of intense discussion for many years, there have been state and federal initiatives which have attempted to reduce the impact on Medicaid budgets and help individuals plan for future care needs. Some of these programs have already been repealed, others are still in the initial stages of implementation. Below are examples of two programs that sought to address the affordability and sustainability of long-term care costs. However, both the federal CLASS Act and the Washington, WA Care Fund, hit substantial roadblocks to implementation.

Attempted Federal Action

The Community Living Assistance Services and Supports (CLASS) Act was enacted as Title VIII of the Patient Protection and Affordable Care Act (ACA), P.L. 111-148 (March 23, 2010), which amended the Public Health Service Act, 42 U.S.C section 201 et seq., by adding the CLASS Act as Title XXXII. The law was designed to establish a voluntary

national insurance program for American workers to help pay for long-term services and supports they may need in the future. The CLASS program sought to help enrollees live independently in the community and give them considerable freedom to determine and purchase the necessary services and supports they purchase with their coverage. CLASS benefits were to be funded entirely through enrollee premiums; there was no taxpayer subsidy.

The CLASS Act was repealed January 1, 2013. The reason it was repealed was that the ACA required the CLASS program to be self-sufficient and that actuaries had to certify that for at least the next 75 years, it would be able to pay for itself. The CLASS Act was a voluntary self-insurance program. Therefore, individuals had to choose to contribute towards the program and for how long, in addition there was no underwriting feature as a gate keeper. The actuaries determined that because of the voluntary nature of the program there was no way to guarantee that enough people would participate, and for long enough, to cover the benefits promised to be paid under the program, and eventually the federal Treasury would have to bail out the program. The result was the repeal of the CLASS Act[13].

Current Public Program Efforts: The State of Washington – WA Cares Fund[14]
The WA Cares Fund is the result of years of research on how to make long-term care affordable for everyone in Washington. Before creating the program, the state studied data and worked with experts to explore public and private solutions. Based on that research, WA Cares Fund was designed to offer every resident a modest benefit at an affordable cost. People who want more can buy supplemental private insurance, much like how Social Security and 401(k) plans work together.

The WA Cares Fund, established through SHB 1087 and signed into law by Washington State Governor Jay Inslee on May 13, 2019, is a state program designed to provide qualifying Washington residents up to $36,500 (adjusted annually for inflation) to purchase a wide range of long-term services and supports. Workers would contribute $0.58 per $100 of earnings through payroll deductions and the collected premiums would go into a dedicated trust fund that can only be used for this program. Self-employed individuals and federally recognized tribes are not required to participate but may elect coverage and workers may request exemptions.

On December 28, 2021, Governor Jay Inslee placed a temporary hold on the collection of the WA Cares Fund. On January 27, 2022, Governor Inslee signed House Bill 1732 and House Bill 1733 which made several changes to the WA Cares Program and pushed back the original implementation timeline. The changes include:

1. Offering near retirees an ability to earn partial benefits for each year they work; and

[13] U.S. Department of Health and Human Services, A Report on the Actuarial, Marketing, and Legal Analyses of the CLASS Program; October 2011, https://web.archive.org/web/20111014231815/http:/aspe.hhs.gov/daltcp/Reports/2011/class/index.shtml
[14] All information in this section is taken from various sources on the WA Cares Fund website; August 2022 https://wacaresfund.wa.gov/.

2. Establishes that certain workers who would be unlikely to qualify or use their benefits can request an exemption, such as workers who live out of state, military spouses, workers on non-immigrant visas and veterans with a service-connected disability rating of 70% or more.

The revised implementation timeline for the WA Cares Fund is as follows:

Effective Date	Program Provision
January 1, 2023	Groups/Workers may begin applying for exemptions from participation in the program.
July 1, 2023	Worker contributions to the Fund begin.
January 1, 2026	Benefits become available for utilization by eligible individuals.

Based on public reports regarding this program, there have been numerous obstacles that face the Fund including lawsuits from various employers, eligibility for military personnel who are deployed to different states, residents who choose to retire out-of-state, and operational challenges in overall stand-up and implementation. The State of Washington has not shared any specific information on program challenges in a public resource that could be found online.

Federal Action Resulting in Minimal Impact

To date, the federal government has taken little action to incentivize the purchase of long-term care insurance or to aid in its affordability and address the matter of rate increases. One notable action taken in 1996 was the passage of the Health Insurance Portability and Accountability Act (HIPAA), that created tax-qualified policies. As a result of HIPAA, long-term care expenses and long-term care insurance premiums can be counted as unreimbursed medical expenses for the purposes of qualifying for a federal tax deduction. However, this action has had very limited impact on the affordability of long-term care policies since it requires individuals to itemize their deductions in order to receive any benefit. Additionally, even those who itemize their federal tax deductions must have incurred unreimbursed medical expenses that exceed 10% of their adjusted gross income. Typically, the financial profile of a long-term care policyholder is that they have good health insurance and, therefore, usually don't meet the 10% threshold. In addition, the federal Tax Cuts and Jobs Act of 2017 (Public Law 115-97) increased the threshold to qualify for the standard deduction, therefore, fewer individuals are opting to itemize their federal deductions.

Potential Options for Consideration

At the outset, it is important to recognize that a state level solution may not be best positioned to deliver significant impact. While insurance is generally regulated on a state level, the federal government is the more appropriate place to initiate sweeping and effective policy to address matters related to long-term care insurance affordability.

The federal government has the ability to take potentially meaningful actions around tax incentives and other rate reduction measures across the industry.

This is not to say the State does play any role in controlling long-term care insurance costs. The following actions, merit further exploration, and could have a positive impact for policyholders. The recommendation is that any of the following cost mitigation mechanisms be implemented for both Partnership and non-Partnership policies.

(1) Consider options to address affordability for current and potential policyholders such as:
    a. Offer premium tax credits/deductions.
    b. Explore the option of requiring insurance companies to offer a wide range of inflation protection options (e.g. 0.5% - 5.0%) that will allow policyholders affected by rate increases the option to reduce their inflation rate to a lower, more affordable level without jeopardizing their policy's Partnership status/Medicaid asset protection. Such options should allow that current benefit levels, such as the daily benefit, not be reduced but increase from their current level based on the reduced inflation protection level.
    c. Examine the possibility of requiring insurance companies to implement "landing spot" inflation protection options, that allow the reduction of the inflation protection provision as a means of offsetting the rate increase. This would give consumers additional tools to design a product that meets their current and expected needs at different points in life.

(2) Explore Implementing Additional Rate Increase Transparency and Policyholder Education Devices such as:
    a. Considering insurance companies provide all policyholders with certain educational materials about the future possibility of rate increase at time of policy purchase.
    b. Enhance consumer outreach and education efforts conducted by the Office of Policy and Management as part of the administration of the Partnership program.

(3) Consider Further Affordability Measures for Overall LTC Insurance Access and Affordability including:
    a. Explore options to expand the LTC marketplace, with specific attention towards employer-based offerings.