ASPE
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OFFICE OF BEHAVIORAL HEALTH, DISABILITY, AND AGING POLICY

ISSUE BRIEF

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EVALUATING LONG-TERM SERVICES AND SUPPORTS REFORM OPTIONS FROM FRONT TO BACK

KEY POINTS

- The financial cost of long-term services and supports (LTSS) is high and the responsibility for this cost often falls on individuals and the Medicaid program. The overall financial cost in the United States is expected to grow as the proportion of individuals aged 65 and older increases.
- Several public programs have been proposed at the federal and state level that would provide individuals with an LTSS benefit to address a portion of LTSS costs. Two examples of such programs include the enacted **Washington State Cares (WA Cares) Fund** and the federally proposed **Well-Being Insurance for Seniors to be at Home (WISH) Act**.
- Starting from the WA Cares Fund and WISH Act designs, the actuarial firm Milliman Inc. estimated the cost of the WISH Act and two alternative benefit designs that provide eligible individuals with either limited front-end or back-end LTSS coverage.
- All plans modeled would be funded in whole or in part through a new payroll tax. Designs featured either a front-end design (providing a more limited benefit to a larger number of beneficiaries) or a back-end design (providing a more robust benefit to a smaller number of beneficiaries with a longer and more costly LTSS need).
- Milliman estimated that the baseline cost of the WISH Act is 2.2% of taxable payroll and the range of costs for the alternatives is 0.3% to 1.2%. The alternative programs would cover between 6% and 17% of individuals' average projected LTSS costs.

The Office of the Assistant Secretary for Planning and Evaluation, through a subcontract with RTI International, retained Milliman Inc. to prepare a technical report analyzing three LTSS reform proposals (the WA Cares Fund, WISH Act, and Medicare LTSS Act).[a] This Issue Brief focuses on the WA Cares Fund, WISH Act, and selected alternatives, and summarizes the major assumptions, methodology, and findings associated with these analyses presented in the longer technical report. The information should be considered in its entirety in combination with the technical report. It is important to note that estimates of required program revenue are for feasibility purposes only and are not intended to be final program costs and sources of funding.

For the purposes of this Issue Brief, the terms long-term services and supports (LTSS) and long-term care (LTC) are used interchangeably. LTSS is a range of services and supports for individuals who need assistance with daily living tasks, such as eating, bathing, dressing, toileting, mobility, medication administration or assistance, personal hygiene, transportation, and other health-related tasks and social supports. Often, this type of assistance is needed by individuals who experience functional limitations or cognitive impairment due to chronic medical conditions associated with aging.

[a] Actuarial Analysis of Long-Term Services and Supports Reform Proposals is available at https://aspe.hhs.gov/reports/long-term-services-supports-reform.

BACKGROUND ON LONG-TERM SERVICES AND SUPPORTS AND FINANCING

It is projected that most Americans turning age 65 today will require LTSS during their remaining lifetime. Specifically, ASPE and the Urban Institute estimate that 57% of 65-year-olds will have LTSS needs at the threshold for benefits under a tax-qualified long-term care insurance (LTCI) policy, set in the Health Insurance Portability and Accountability Act (HIPAA).[1] Under HIPAA, a person is eligible to receive LTSS benefits if they are unable to perform two or more activities of daily living (ADLs) without personal assistance for 90 days or more, or have severe cognitive impairment. With a more expansive definition of LTSS need (e.g., one or more ADLs or moderate cognitive impairment), the number of people with LTSS needs would be higher.

The cost of LTSS varies greatly by geographic region and setting and can be very expensive with annual median costs ranging from approximately $75,000 for home health aide services to over $104,000 for a semi-private room in a nursing home.[2] Most individuals require care for longer than one year--the average duration of disability is expected to be 3.6 years for women and 2.5 years for men.[1] However, 26% of women and 17% of men will need five or more years of care. Most of the responsibility of paying for these services falls on individuals paying out-of-pocket and the Medicaid program.[3] As the United States population continues to age,[4] spending by individuals and Medicaid on LTSS is expected to increase.

This Issue Brief describes approaches using a social insurance structure that set aside money sooner for future LTC needs, reduce the strain on state and federal Medicaid budgets, and pool risk across larger groups of people. In addition to Washington state's WA Cares Fund and Representative Suozzi's Well-Being Insurance for Seniors to be at Home Act, several alternative designs for addressing LTSS financing are presented.

Current LTSS Financing in the United States

Before discussing LTSS financing proposals, it is important to understand the current LTSS financing landscape. Medicaid is the primary payer of LTSS in the United States, covering approximately 50% of LTSS costs.[3] Medicaid is jointly funded by states and the Federal Government and pays for the LTC services of persons with very low incomes and limited assets. Given the significant cost of paid care, some individuals who are non-poor may "spend down" their assets and become Medicaid eligible. Research suggests nearly 10% of the previously non-Medicaid population aged 50-and-over spent down to Medicaid eligibility.[5]

Other LTSS payers include the following:

- Individuals paying out-of-pocket are responsible for approximately 15% of LTSS costs.[3] A portion of this cost comes from individuals whose income is too high to qualify for Medicaid and may not be able to afford or qualify for private LTCI.
- Approximately 10% of national LTSS expenditures are financed through the private insurance market.[3] Although LTC is a risk with high frequency (as previously note, more than half of 65-year-olds will need formal LTC in their lifetimes) and is potentially very costly, less than 8% of the adult population age 60 and older purchased a LTC only insurance policy as of 2022.[6]
- Other sources of funding for LTSS include worksite health care, other private revenues, Indian Health Service, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, other federal programs, Substance Abuse and Mental Health Services Administration, other state and local programs, and school health.[3]

The distribution of costs by payer described above is based on National Health Expenditure Accounts (NHEA) data produced by the Centers for Medicare & Medicaid Services (CMS). Total LTSS expenditures exclude spending on nursing care, home health care, or personal care paid by Medicare because this spending is mostly

for post-acute care. NHEA data also does not include private financing for home care and includes some post-acute care costs paid by Medicaid, which could result in overstated Medicaid costs and understated out-of-pocket costs. Research performed by the Urban Institute using different data and methods found that over one-third of LTSS spending by persons turning age 65 today will be paid out-of-pocket.[1]

FINDINGS FOR PROPOSED DESIGNS

LTSS Reform Proposals: WA Cares Fund and WISH Act

Two examples of public insurance aimed at addressing the growing need for, and costs of, LTSS are Washington state's WA Cares Fund and the proposed WISH Act. While these examples address the common issues of LTSS financing, they take different approaches with different implications for stakeholders. Plan specifications for these programs can be found in the Supplemental Tables (***Table 4***), but we include a summary of the programs below.

- **WA Cares Fund**. In Washington state, the passage of the LTSS Trust Act in 2019 established the WA Cares Fund[7] (RCW 50B.04[8]), which provides a limited public LTCI benefit for workers. In 2026, the total value of the LTC benefit is $36,500. The WA Cares Fund is financed by a payroll deduction paid by employees (not to exceed 0.58%) on all wages and self-employment income as applicable. Coverage is limited to workers and does not include spousal coverage. The program began collecting payroll deductions July 1, 2023, and benefits will become available for qualified individuals starting July 1, 2026. Per the WA Cares Fund website, the program "provides working Washingtonians a way to earn access to LTC benefits that will be available when they need them. It will cover most of the need for some people, while for others it will provide breathing room during one of life's most challenging stages, giving the family time to develop a plan."

- **WISH Act**. The proposed WISH Act, introduced by Congressman Thomas Suozzi in 2021, would create a new federal LTC social insurance plan financed by a payroll tax on wages paid equally by employees and employers. The cash benefit available under the WISH Act is based on the government's calculation of the median cost of six hours per day of paid personal assistance, which is currently about $3,600 per month. Depending on one's lifetime earned income, payment of benefits would begin 1-5 years following the need for LTSS and continue as long as a person needs assistance. Individuals with higher lifetime incomes would have to wait up to five years before payment of benefits begins. The WISH Act assumes that an aggregate payroll tax of 0.6% would cover the costs of program benefits for individuals with high (catastrophic) LTSS costs. According to Representative Suozzi, throughout his childhood all four of his grandparents lived in his house, with his mother the primary caregiver to three. These past experiences, along with the growing elderly population, were motivators for Suozzi to introduce the WISH Act,[9] and the legislation's design and origin is based on a paper written by Feder, Cohen, and Favreault in 2018.[10]

Alternative Program Designs

ASPE constructed alternative program designs to address potential concerns related to the cost and complexity of the WA Cares Fund and the WISH Act. The proposed designs keep the general framework of the WA Cares Fund program and the WISH Act, including a social insurance framework funded through a payroll tax with, in some cases, additional premiums. Milliman modeled alternative designs with a payroll tax/premium financing approach to better integrate with the current health care and LTSS financing system. This Issue Brief focuses on two of the alternative plan designs. Other designs analyzed can be found in the full technical report.

Both of the alternative proposals have consistent general program features (e.g., participation, benefit, vesting, and revenue structures), but then offer either a front-end or back-end ("catastrophic") benefit design. The program design features are summarized in ***Table 1*** below.

Table 1. Summary of Alternative Program Designs		
Plan Parameter	**General Program Features**	
Participation	Mandatory	
Benefit Structure	Reimbursement	
Minimum Age for Benefits	65	
Benefit Eligibility	HIPAA	
Vesting Requirements	10 years for full benefits; partial benefits for certain individuals	
Program Revenue Source	Payroll tax	
	Proposed Front-End Design	**Proposed Back-End Design**
Daily/Monthly Benefit Maximum	$100 daily limit, with 3.6% compound inflation	$150 daily limit, with 3.6% compound inflation Additional $10,000 cash benefit available after 1-year EP
Lifetime Benefit Maximum	Limited to 1-year benefit period (i.e., $36,500 starting pool of money)	Limited to 3-year benefit period (i.e., $164,250 starting pool of money)
Elimination Period (EP)	90-day	2-year
Additional Revenue Source	None	Monthly premium for ages 65+

EP = Elimination Period; HIPAA = Health Insurance Portability and Accountability Act.

We describe the general program features for both designs below and the rationale for selecting these features. Please see Milliman's full technical report for a more detailed discussion of the choices and tradeoffs associated with each plan parameter.

- **Core financing through a mandatory payroll tax**. Both alternative programs require all workers to pay a payroll tax without exception. The advantage of a mandatory design is broad risk spreading and the avoidance of adverse selection (and resulting financing uncertainty) associated with voluntary programs.

- **Reimbursement benefit**. Reimbursement benefits pay the cost of covered services up to a maximum daily, weekly, or monthly amount, as opposed to a cash structure where the beneficiary receives a cash payment that can be used for any purpose as long as the beneficiary meets eligibility requirements. Programs with reimbursement benefits can be significantly less expensive than cash benefits because they only pay for approved LTC services.

- **Minimum age for benefits of 65**. Under both alternative proposals individuals would pay the payroll tax as workers and be eligible to receive LTSS benefits at age 65. Limiting eligibility to persons ages 65 and older ensures that benefits are paid after individuals' key working years (during which they will contribute to the program's financing) and better aligns with the increased age-related risk of LTSS.

- **HIPAA benefit eligibility trigger**. Benefit eligibility refers to the criteria used to determine when a beneficiary is eligible to receive benefits. Most individuals with private LTCI policies are eligible to

receive benefits if they require assistance with two of six ADLs that are expected to last at least 90 days, or if they have severe cognitive impairment. These eligibility criteria are specified in the 1996 HIPAA and are commonly referred to as the "HIPAA eligibility" criteria. Both alternative program designs use HIPAA eligibility triggers because the criteria are commonly used, understood, and consistent across states, which removes some potential administrative complexity. Additionally, using eligibility criteria consistent with the private market could facilitate the development of wrap-around and other complementary products.

- **Ten-year vesting for full benefits**. Like Medicare and Social Security, under both alternative program designs workers must work and contribute to the programs for ten years (40 creditable quarters) to be eligible for full benefits. Both designs also include transitional vesting that applies to older workers at the beginning of the program to avoid situations where certain individuals pay into the program but leave the workforce before being eligible for benefits. The transitional benefit structure is as follows:
  - Individuals ages 55-59 in 2023 would also be eligible for partial, pro-rated benefits if they contribute between 20 and 40 quarters.
  - Individuals ages 60 and over in 2023 would not pay the payroll tax and would not be eligible to receive benefits.

Proposed Front-End Design

Table 2. Summary of Program Features for Front-End Design

Plan Parameter	WA Cares Fund	Proposed Front-End Design
Participation	Mandatory with voluntary features	Mandatory
Benefit Structure	Reimbursement	Reimbursement
Minimum Age for Benefits	18	65
Benefit Eligibility	3 ADLs	HIPAA
Daily/Monthly Benefit Maximum	No daily or monthly benefit maximum	$100 daily limit, with 3.6% compound inflation
Lifetime Benefit Maximum	$36,500 starting lifetime maximum, indexed to CPI	1-year benefit period (i.e., $36,500 starting pool of money)
Elimination Period	None	90-day
Vesting Requirements	3 of the last 6 or 10 years for full benefits; partial benefits for those born before 1/1/1968	10 years for full benefits; partial benefits for certain individuals
Program Revenue Source*	Payroll tax, gross wages	Payroll tax, Medicare tax wages
Estimated Payroll Tax Point Estimate	**0.58%**	**0.4%**
Estimated Payroll Tax Range		**0.3% - 0.6%**
LTC Actuarial Value (Male, Age 82)		**10%**
LTC Actuarial Value Range		**6% - 12%**

* WA Cares Fund will assess premiums on gross wages, including on additional wages (such as employee wages used for 125 cafeteria plan contributions) that are not subject to the Medicare tax and are not assumed to be assessed under ASPE's proposed designs.

ADL = Activity of Daily Living; CPI = Consumer Price Index; HIPAA = Health Insurance Portability and Accountability Act; LTC = Long-Term Care; WA Cares Fund = Washington State Cares Fund.

The first of the two proposed program designs features a front-end benefit. The intention of front-end coverage is usually to provide a more limited benefit to a larger number of beneficiaries, typically through a

smaller pool of money ($36,500) with a shorter elimination period (90 days). The front-end design was inspired by the WA Cares Fund design, which also provides front-end coverage. Below we show the main plan parameters for both programs (see ***Table 2***) and describe the changes and rationale for designing the proposed front-end design.

Beyond the plan parameters included in the general program feature commentary above, there were two major changes to the WA Cares Fund design:

- **$100 daily limit**. Both programs have a starting lifetime maximum amount of $36,500, but while the WA Cares Fund has no daily or monthly benefit maximum, the proposed design includes a $100 daily limit. Because individuals could only get $100 per day of LTSS reimbursed, the length of time to exhaust program benefits could be extended, which, all things equal, reduces overall program costs.

- **90-day elimination period**. An elimination (or deductible) period is the length of time that a person who meets the eligibility requirements would have to wait before their LTSS would be reimbursed under the program. As opposed to the WA Cares Fund benefit, which has no elimination period, the proposed front-end design has a 90-day elimination period because this parameter is consistent with the chronic disability requirement under HIPAA, is aligned with the private LTCI market, and would reduce costs relative to no elimination period.

The proposed front-end design would require a payroll tax of approximately 0.4% over a 75-year period. Sensitivity testing key assumptions produced a range of payroll taxes from 0.3% to 0.6% for this plan design (see the full report for detailed results of sensitivity testing). To cover program costs beyond 75 years, a different (potentially higher) tax rate could be required, once the population receiving benefits has stabilized. These results rely upon projections many years into the future. Actual expenses and required revenue will inevitably vary from the estimates described herein. Information on the methodology and assumptions can be found in the ***Methodology and Assumptions*** section below, as well as the full technical report.

The proposed front-end design covers approximately 10% of total expected LTSS costs for a male at claim age 82, a metric that Milliman refers to as Long-Term Care Actuarial Value (LTC AV).[11] Estimates of LTC AV for the front-end design ranges from 6% to 12% for males and females across different claim ages. The LTC AV represents an average; however, for many individuals the proposed front-end design would cover less than 10% of their actual LTSS costs and for many individuals the design would cover more. On average, other sources--such as Medicaid, private savings and other resources, private LTCI, and other payers--would be responsible for the remaining LTSS costs. When using the LTC AV to evaluate a program, it is important to consider what LTC AV level may be optimal for a particular program given other available funding sources and the amount of expected LTSS expenditures. The estimate of LTC AV presented here are the percentage of total expected LTSS costs covered by the proposed insurance option. If out-of-pocket costs were the relevant reference (i.e., the denominator in the calculation), then the LTC AVs for the various options would be larger.

Back-End (Catastrophic) Design

The second of the two proposed program designs feature a back-end (catastrophic) benefit. The intention of catastrophic coverage is usually to provide a more robust benefit to a smaller number of beneficiaries with a longer and more costly LTSS need, typically through a larger pool of money and longer elimination period. The back-end design was inspired by the WISH Act, which also provides catastrophic coverage. Below we show the plan parameters for both programs (see ***Table 3***) and describe the changes and rationale for designing the proposed catastrophic design.

Table 3. Summary of Program Features for Catastrophic Designs		
Plan Parameter	**WISH Act**	**Proposed Back-End Design**
Participation	Mandatory	Mandatory
Benefit Structure	Cash	Reimbursement
Minimum Age for Benefits	Social Security retirement age	65
Benefit Eligibility	HIPAA	HIPAA
Daily/Monthly Benefit Maximum	$3,600 monthly benefit, indexed to wages	$150 daily limit with Additional $10,000 cash benefit available after 1-year EP
Lifetime Benefit Maximum	No lifetime maximum	3-year benefit period (i.e., $164,250 starting pool of money)
Elimination Period	1-5 years depending on lifetime income earned	2-year
Vesting Requirements	10 years for full benefits; partial benefits for those with 5-40 quarters of work credit	10 years for full benefits; partial benefits for certain individuals
Program Revenue Source	Payroll tax	Payroll tax and monthly premium for individuals aged 65+
Estimated Payroll Tax Point Estimate	**2.2%**	**1.0%**
Estimated Payroll Tax Range		**0.7% - 1.6%**
LTC Actuarial Value (Male, Age 82)		**16%**
LTC Actuarial Value Range		**12% - 17%**

EP = Elimination Period; HIPAA = Health Insurance Portability and Accountability Act; LTC = Long-Term Care; WISH Act = Well-Being Insurance for Seniors to be at Home Act.

Beyond the plan parameters noted above, there were four major changes to the WISH Act design to arrive at the proposed catastrophic design.

- **Two-year elimination period**. The WISH Act has a variable elimination period that ranges from 1 year to 5 years depending on an individual's lifetime income earned. The proposed catastrophic design instead uses a single two-year elimination period that applies to all individuals regardless of income.

- **Three-year benefit period**. The WISH Act's benefit has no limit once past the waiting (deductible) period. The proposed back-end design limits the benefit to a three-year period ($164,250 total benefit amount) to reduce financing costs. Lifetime benefits are more expensive and can lead to pricing instability as uncapped benefits are more susceptible to unexpected higher costs.

- **Additional cash benefit**. The proposed catastrophic design includes an additional benefit of $10,000 (indexed to wages) after a one-year elimination period. This limited cash benefit provides transitional support before an individual would meet their two-year elimination period. For modeling purposes, Milliman made the simplifying (and conservative) assumption that the benefit would be paid immediately in the form of a cash lump sum upon completing the initial elimination period.

- **Income-related monthly premium**. The proposed back-end design includes an income-related monthly premium (indexed to wages) that enrollees would pay once they turn age 65. The costs of the alternatives assume an average monthly premium amount of $35. Milliman made the simplifying

assumption that all enrollees pay the premium, although individuals with low lifetime earnings would pay no/small premiums, and those with higher lifetime earnings would pay more. Milliman assumed 100% of vested individuals age 65+ pay this premium, including those who are still working, those who are currently receiving program benefits, and those who have exhausted program benefits. Milliman assumed individuals age 60+ as of 2023 will not be eligible to pay premiums or receive benefits. The monthly premium provides additional revenue to the program, as well as a mechanism for keeping track of individuals who may be retired and no longer contributing to the program via the payroll tax.

The proposed back-end design would require a payroll tax of approximately 1.0% over a 75-year period. Sensitivity testing key assumptions produced a range of payroll taxes from 0.7% to 1.6% for this plan design (see the full report for detailed results of sensitivity testing). Again, a different (potentially higher) tax rate could be required once the population receiving benefits has stabilized. As noted above, we expect that actual expenses and related required revenue will inevitably vary from the estimates described herein.

The back-end design has a LTC AV of 16% for a male at claim age 82. Estimates of LTC AV for this program design ranges from 12% to 17% for males and females across different claim ages. The LTC AV represents an average; however, for many individuals the proposed back-end design would cover less than 16% of their actual LTSS costs and for many individuals the design would cover more. As noted above, other sources such as Medicaid, personal income and savings, private LTCI, and other payers would be responsible for the remaining LTSS costs, and it is important to consider what LTC AV level may be optimal for a particular program given other available funding sources and the amount of expected LTSS expenditures.

METHODOLGY AND ASSUMPTIONS

Estimation of the LTC AV

The LTC AV is calculated as the cost of LTSS expected to be covered by an insurance plan divided by the total expected cost of LTSS. The underlying applicable costs and services used to determine the AV need to be consistent to provide meaningful comparisons of plans. For purposes of this analysis, it is assumed applicable services include paid, formal LTC services commonly covered by a private market comprehensive insurance policy after an individual satisfies benefit eligibility requirements. Notably, this includes the cost of room and board in a facility setting. LTC AV may not capture all aspects of a program's value (i.e., the AV would not be impacted by coverage of additional services outside of the applicable services included in the calculation).

To calculate the expected costs of applicable services the following was assumed:

- LTSS costs include comprehensive covered services provided in a skilled nursing facility, assisted living facility, or home care setting reimbursed at commercial rates. The daily cost of care in each of these settings is estimated using nationwide averages from the 2021 Genworth Cost of Care survey and other applicable sources. Future annual cost of care is projected assuming annual increases of 4% for facility care and 3% for home care.

- LTSS costs begin when an individual meets HIPAA eligibility criteria, or when an individual is unable to perform two of six ADLs, expected to last at least 90 days, or severe cognitive impairment.

Milliman used their proprietary LTC Guidelines (Guidelines) to estimate expected length of care need, varying by setting of care. The Guidelines provide frequencies, continuance curves, utilization assumptions, and claims costs developed from many product designs based on private insurance data from the past two decades. The Guidelines are updated triennially to reflect the most comprehensive and current information available in the market. Adjustments are applied to the Guidelines insured data to reflect a nationwide, general population.

Estimation of Required Payroll Tax

To project a program's required payroll tax, Milliman's model produces year-by-year cash flow projections, such that the value and scope of the program can be estimated for any of the years in the 75-year projection period. Revenue collected under the program is assumed to be placed into a trust fund for the sole purpose of paying expected program benefits and expenses. The cash flow consists of income to the program from taxes and interest earned from the fund balance. Outgo from the program consists of benefit payments in institutional or home and community-based care settings and administrative expenses.

LTC beneficiaries and costs are projected using Milliman's modeling software, MG-ALFA®. The projection starts with the 2016 population of the United States by age, sex, and region, and is projected forward through 2097. The projected nationwide population is estimated based on the number of births, deaths, and net immigration in each future year. To calculate the LTC beneficiaries and costs for the projected population in each year, the model utilizes the Guidelines calibrated from an insured basis to the estimated nationwide population characteristics.

The projection is for the 75-year period 2023 through 2097. A 75-year projection has been established by the Social Security Administration and CMS as the standard projection period for determining the financial status of a public insurance program. The 75-year period covers the expected lifetime of most residents just entering their working ages. Thus, a 75-year projection period covers all working years and all benefit years of those just beginning their participation. The model produces year-by-year cash flow projections, such that the value and scope of the program can be estimated for any of the years in the 75-year projection period.

Revenue to the program consists of taxes, premiums, and interest earned on the account balance. Expenditures to the program consist of benefit payments for covered services and administrative expenses. Milliman projected each of these items on a year-by-year basis for 75 years. The technical report provides further details on the demographic, economic, morbidity, and other assumptions used in the analysis contained in this Issue Brief.

DISCUSSION

The cost of LTSS is high and the responsibility for this cost often falls on individuals and the Medicaid program. This cost is expected to grow as the country ages. Several public programs have been proposed at the federal and state level that would provide individuals with a LTSS benefit, including Washington's WA Cares Fund and the federally proposed WISH Act.

In this Issue Brief, we estimate the cost and value of two alternative public program designs that would be funded via a mandatory payroll tax and provide eligible individuals with either a limited front-end or back-end (catastrophic) level of LTSS coverage. The proposed designs would require a payroll tax of approximately 0.4% and 1.0% to fund projected future benefits, and that these programs would cover 10% and 16% of individuals' average projected LTSS costs.

In addition to financing, the distributional impacts of program options and interaction with the current LTSS system--both paid and unpaid--need to be considered. For example, the benefits of insurance coverage for different income groups relative to cost (i.e., the expected value of the insurance compared to lifetime payments) should be evaluated as well as the interaction with existing public and private sources of LTSS coverage. Medicaid is the primary payer of LTSS for lower income individuals and a new social insurance program could lead to savings to the Medicaid program. These savings could be used to reduce future Medicaid expenditures, reduce payroll taxes and/or premiums for the new program, or a combination of the

two. Savings could also be re-allocated to Medicaid to expand currently optional benefits such as home and community-based services. In any case, policymakers should carefully consider program interactions so that Medicaid continues to provide robust services to persons eligible for the program.

CAVEATS AND LIMITATIONS

This report compares program parameters and tradeoffs across specific LTSS reform proposals and provides illustrative payroll tax rate impacts under different assumptions. Many assumptions were used to construct the estimates in this report. Results will differ from the estimates to the extent that alternative assumptions are used. Estimates may not be appropriate, and should not be used, for other purposes such as the evaluation of program designs not explicitly contemplated herein. In completing this work, we relied on publicly available information describing existing reform proposals Our summary may not be appropriate if this information is not accurate.

SUPPLEMENTAL TABLES

Table 4. Summary of Program Features for WA Cares Fund and WISH Act		
Plan Parameter	**WA Cares Fund**	**WISH Act**
Participation	Funded through payroll tax applying to all Washington workers except for certain exempt populations that have voluntary choice to participate.	Mandatory design where all workers are required to fund the program through a payroll tax, and after a number of years be eligible to receive benefits per program specifications.
Benefit Structure	Benefit units paid by DSHS to a LTSS provider as reimbursement for approved services provided to an eligible beneficiary.	Cash structure
Minimum Age for Benefits	Minimum age for benefits is 18.	Only individuals that have reached the Social Security retirement age would be eligible to receive benefits.
Benefit Eligibility	Eligibility determination will include an evaluation that the individual requires assistance with at least 3 ADLs (where 3 ADLs have yet to be defined).	HIPAA eligibility trigger (i.e., require assistance with 2 of 6 ADLs for a period that is expected to last at least 90 days, or if they have severe cognitive impairment).
Benefit Maximum	Benefit unit of $100, where an eligible beneficiary may not receive more than the dollar equivalent of 365 benefit units over the course of the eligible beneficiary's lifetime. 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. The benefit unit must be adjusted annually at a rate no greater than the Washington state CPI, as determined solely by the council. Any changes adopted by the council shall be subject to revision by the legislature.	$3,600 monthly benefit, indexed to wages. $3,600 monthly cash benefit indexed to wages with no lifetime maximum.
Elimination Period	DSHS must make benefit determination within 45 days from receipt of a request by a beneficiary to use a benefit; there is no language specifying whether beneficiary will be responsible for paying for services during the determination period.	EP of 1-5 years depending on lifetime income earned, where those with lifetime incomes in the lowest 40th percentile will receive benefits after one year and for every 1.25 percentiles of lifetime income beyond the 40th, the waiting period will extend for 1 month.

Table 4 (*continued*)		
Plan Parameter	**WA Cares Fund**	**WISH Act**
Vesting Requirements	Individual has paid the premium assessment, either: (a) A total of 10 years without interruption of 5+ consecutive years. (b) Nee3 years within the last 6 years from the date of application for benefits. Individual must have worked 500+ hours during each year from (a) or (b). Individuals born before 1/1/1968 may receive 1/10 of benefit units for each year of premium payments up to 100%.	Workers must work and contribute to the program for 10 years to be eligible for full benefits. Individuals who have worked between 5 quarters and 10 years are eligible for pro-rated partial benefits.
Program Revenue Source	Beginning 7/1/23, ESD will assess a premium of 0.58% of an individual's wages. Beginning 1/1/26, and biennially thereafter, the premium rate shall be set by the pension funding council at a rate no greater than 0.58%.	The WISH Act would charge everyone earning wages the same rate--a 0.6% payroll tax, with 0.3% from employees and 0.3% from employers.

ADL = Activity of Daily Living; CPI = Consumer Price Index; DSHS = ?; EP = Elimination Period; ESD = ?; HIPAA = Health Insurance Portability and Accountability Act; LTSS = Long-Term Services and Supports; WA Cares Fund = Washington State Cares Fund; WISH Act = Well-Being Insurance for Seniors to be at Home Act.

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