SENATE BILL REPORT
SB 5599

As of February 20, 2017

Title: An act relating to requiring unused state funds for the health care benefits of long-term care workers to be returned to the state.

Brief Description: Requiring unused state funds for the health care benefits of long-term care workers to be returned to the state.

Sponsors: Senators Rivers, Baumgartner, Bailey and Braun.

Brief History:
Committee Activity: Ways & Means: 2/14/17.

Brief Summary of Bill

- Requires all recipients of long-term care worker health benefit funds to fulfill annual reporting requirements and return unused funds for health benefits to the state.

SENATE COMMITTEE ON WAYS & MEANS

Staff: James Kettel (786-7459)

Background: The Department of Social and Health Services (DSHS) provides publicly funded personal care to approximately 50,000 eligible clients who are elderly or have developmental disabilities and live in their own home. Personal care services include assistance with various tasks such as toileting, bathing, dressing, ambulating, meal preparation, and household chores. There are two ways in which personal care services may be provided in a client's home: (1) by an individual provider, or (2) by an employee of a home care agency (agency provider).

Individual Providers. Individual providers are hired and supervised by the client they care for and each worker is paid through a direct contract with the DSHS. The client is responsible for verifying the hours of service an individual provider provides. Individual providers who contract with the DSHS have collective bargaining rights regarding wages, health benefits, and other issues. Pursuant to the collective bargaining agreement, all

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individual providers are paid on the same seniority-based wage scale and receive their health benefits through a Multiemployer Health Benefits Trust.

Agency Providers. There are approximately 100 licensed home care agencies with which DSHS contracts to provide publicly funded in-home care. Each agency is responsible for hiring, supervising, and compensating its own employees. The agency works with a client to determine a work schedule and then provides an agency employee, herein referred to as the agency provider, to care for the client. Agencies are paid through contracted vendor rates. Each agency is responsible for its own wage scale and for the provision of health benefits to its employees. Some agencies are on the same wage scale as individual providers; some are not. Some agencies purchase health care through a Multiemployer Health Benefits Trust; others do not.

Health Benefits. The 2015-17 collective bargaining agreement for individual providers requires the state to contribute $3.46 per DSHS-paid hour worked to fund health benefits purchased through a Multiemployer Health Benefits Trust. The state contribution to the agency vendor rate for health care benefits is also $3.46 per DSHS-paid hour worked, which is the same rate as negotiated and funded in the collective bargaining agreement for individual providers.

About 30 percent of homecare agencies either purchase health benefits for employees independently, or do not provide health benefits for employees. If one of these agencies does not fully utilize funding for health benefits, then the unused funds must be returned to the state.

The remaining 70 percent of homecare agencies, and all individual providers who qualify for benefits and elect to receive benefits, receive health benefits from a Multiemployer Health Benefits Trust. The Multiemployer Health Benefits Trust, as a Taft-Hartley trust, falls under the oversight of the U.S. Department of Labor and its operations are governed by federal statute—the Employee Retirement Income Security Act. The Multiemployer Health Benefits Trust is not currently required to provide information about unused funds to the state, and is not required to return unused funds to the state.

Summary of Bill: All recipients of long-term care worker health benefit funds, including the Multiemployer Health Benefits Trust, would be required to keep monthly records of revenue and expenditures. Each year, all recipients of long-term care worker health benefit funds would receive an independent audit of financial information. After completing the annual audit within 30 days, all recipients of long-term care workers health benefit funds would be required to return unused funding for health benefits to the state. If the funds are not returned, then the DSHS is directed to treat the situation as a vendor overpayment and commence financial recovery procedures. If the funds are still not recovered, then the DSHS must terminate its contact with the entity.

Appropriation: None.

Fiscal Note: Available.

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

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: PRO: Medicaid funds should be used for their designated purposes. Funds that have been allocated to pay for health benefits for caregivers should be spent accordingly. Funds not spent for this purpose should be returned to the state to safeguard the use of tax dollars. Non-union homecare agencies already document the use of funding and must return excess funds to the state. Passing this bill would give agencies a framework to utilize for administrative hearings and disputes. Unionized agencies and the SEIU health benefits trust should be held to the same standard. From the years 2013 through 2016, the DSHS collected a total of $5 million from the non-union agencies, an average of about $1.2 million each year. In the same time period, the SEIU health benefits trust had an average of about $4.7 million each year in unused health benefits funding. The revenue and health benefit expenditures for the trust have increased since 2011. Administrative expenditures for the trust have increased by more than 100 percent since 2011. Much of the trust administrative expenditures are paid directly to SEIU 775 and the SEIU training partnership. Some funds paid to the SEIU 775 are used for political activity. The prior method of funding health benefits was a reimbursement method. There was no excess funding for health benefits in the prior method. There needs to be some sort of reconciliation of the funding. If not, the union will never have an incentive to utilize the funding for its intended purpose. The accumulation of excess funding creates a slush fund of Medicaid money. Setting aside excess money is inviting trouble.

CON: The health benefits trust is responsible for providing medical, dental, and vision benefits to approximately 17,000 long-term care workers. The trust is a self-funded purchaser, which saves money and also allows for flexibility in benefit design. As a self-funded purchaser, the trust needs to build and maintain a reserve. The reserve must be available to pay for fluctuation in cost drivers, such as claims costs. The trust keeps administrative costs low, and reinvests savings to cover more workers. The trust has been able to reduce wait time to obtain coverage, keep premium costs low, keep co-pays low, and reduce barriers to care. The trust also funds health and wellness programs that have resulted in decreasing unnecessary emergency room visits by 17 percent, increasing primary care visits by 24 percent, and decreasing hospital admission rates by 14 percent. Targeted population health programs improve the management of chronic diseases and improve the overall health of long-term care workers. The size of the reserve is currently about $75 million.

OTHER: The health benefits trust is a separate entity from SEIU 755. The health benefits trust is a Taft Hartley trust. The governing board for the health benefits trust is comprised half of worker representatives and half of employer representatives. SEIU 775 is always looking for common ground and shares a common goal with much of the intent languages. SEIU 775 is also looking for ways to maximize the number of workers covered by health insurance and the quality of such benefits. Although, it is unclear how sweeping funds out of the trust would accomplish the goals outlined in the intent language. The Office of Financial Management has recognized the need for self-funded plans, like the health benefits trust, to maintain a reserve. OFM recommends that the reserve cover at least 16 weeks of expenditures. The reserve may be used for terminal liability, claims fluctuation, and catastrophic events. It is normal and usual for the health benefits trust to have this much reserve.

Persons Testifying: PRO: Loren Freeman, Freeman & Associates; Jennifer Kemper, Kemper Services.

CON: Merissa Clyde, SEIU 775 Benefits Group.

OTHER: Galen Li, DiMartino Associates, Inc; Luke Esser, SEIU 775.

Persons Signed In To Testify But Not Testifying: No one.