Market Study of Liability Insurance for Washington State Adult Family Homes

Prepared for the Washington State Office of the Insurance Commissioner

Prepared by Davies Actuarial, Audit & Consulting, Inc.

June 20, 2025

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June 20, 2025

The Honorable Patty Kuderer
Insurance Commissioner, Washington State
302 Sid Snyder Ave. SW
Olympia WA 98504-0258

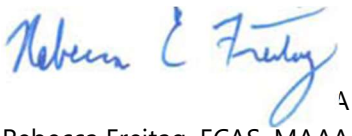
Re: Market Study of Liability Insurance for Washington State Adult Family Homes ("AFHs")

Dear Commissioner Kuderer:

Please find attached our market study of liability insurance for Washington State Adult Family Homes.

We appreciate the opportunity to work with you and the Washington Office of the Insurance Commissioner and to assist the Legislature. Please do not hesitate to contact us with any comments or questions.

Sincerely,



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Executive Summary

In Washington, adult family homes ("AFHs") are an important part of the state's long-term care system. AFHs provide an alternative to institutional care and promote a high degree of independent living for residents. AFHs serve people with functional limitations who have broadly varying capacities and service needs. They serve a variety of residents, including the elderly, developmentally disabled individuals, and individuals with behavioral health needs. They provide care within the residents' communities.

WAC 388-76-10000 defines an "adult family home" as "a residential home in which a person or an entity is licensed to provide personal care, special care, room, and board to more than one but not more than six adults who are not related by blood, adoption, or marriage to a provider, entity representative, resident manager, or caregiver, who resides in the home. An adult family home may be licensed to provide care to up to eight adults if the home receives approval under WAC 388-76-10031 or 388-76-10032."[1]

According to the Washington State Department of Social & Health Services ("DSHS"), AFHs serve approximately 15% of Medicaid long term care clients.[2] AFHs in Washington State are regulated by DSHS.

WAC 388-76-10191 requires that AFHs maintain commercial general liability insurance and professional liability insurance as a condition of licensure. WAC 388-76-10192 then specifies that this coverage must include:

- Errors or omissions of the AFH or its employees or volunteers;
- Bodily injury, property damage, and contractual liability; and
- Premises, operations, products-completed operations, personal injury, advertising injury, and liability assumed under an assumed contract.

According to the above-cited WAC, the required minimum liability limits are $500,000 per occurrence and $1,000,000 in aggregate. The governing statute also requires that such policies provide coverage for the State of Washington, its officials, agents, and employees for claims relating to acts or omissions of an AFH.

This liability insurance is important in that it:

- Provides security for the payment of damages to an injured party (including a resident) if damages occur as a result of the AFH's acts or omissions (or acts or omissions of its employees or volunteers during the course of their work at the AFH);
- Provides security for the payment of damages to an injured party (including a resident) in the event that the AFH is liable for other damages that are unrelated to acts or omissions during the course of its work; and
- Provides financial protection for the AFH, including defense of claims.

[1] See also RCW 70.128.010 and 70.128.066.

[2] See https://www.insurance.wa.gov/adult-family-home-liability-market-study-work-group, June 26 meeting, "DSHS, Department of Social and Health Services, June 26 presentation."

AFH operators and other market participants raised concerns regarding the availability and affordability of the required liability insurance. These are important issues because if liability insurance meeting the regulatory requirements cannot be readily obtained, the public purposes underlying the insurance mandate would not be met, AFHs might lose their licenses or cease operations, and their residents and the public generally might be adversely affected.

Accordingly, in the 2024 supplemental operating budget (ESSB 5950), the Washington State Legislature ("Legislature") directed the Washington State Office of Insurance Commissioner ("OIC") to convene a work group to:

- Review the availability and cost of liability insurance for AFHs;
- Identify obstacles to AFHs' access to liability insurance including underwriting restrictions, market conditions, as well as legal and regulatory requirements;
- Evaluate the financial risk to AFHs, their residents, the state Medicaid program, and others that exist as a result of the increased cost of insurance, or in the event AFHs are uninsured due to a lack of access to coverage; and
- Make policy recommendations to improve access to liability insurance coverage for AFHs.
- Submit a preliminary report to the Legislature by December 31, 2024 and a final report by June 30, 2025

The OIC retained Davies Actuarial, Audit & Consulting, Inc. ("Davies", "we", or "us") to assist the work group in research, actuarial analysis, and the preparation of this study. Attorneys from Davis, Malm & D'Agostine, P.C. were also engaged to assist with research and analysis.

In the course of our work, we conducted interviews with market participants, reviewed AFH-type facilities and insurance requirements in other states, cooperated with the OIC in the issuance of a data call to insurers, analyzed the results of the data call, reviewed AFH liability insurer underwriting guidelines, and cooperated with the Washington Adult Family Home Council ("AFHC") in the issuance of a survey to its members.

Based on our study, we found that the key challenges related to AFH liability insurance include:

- The very restrictive budgets of many AFH owners, which can make even relatively low premiums or relatively small premium increases difficult for AFH owners to manage;
- Relatively high premium charged to a small subset of AFHs for liability insurance;
- Tension between the demands of risk management - experienced by AFH owners in the form of premium increases and underwriting restrictions associated with higher risk residents - and the interest of certain residents in aging in place; and,
- In some cases, lack of business management or healthcare experience before undertaking ownership and licensure of an AFH.

Policy options which we submit for consideration by the Legislature and which are presented near the end of this report include:

- Suggestions which may make the Washington AFH market more appealing to a wider variety of insurers, potentially increasing market competition, with more choice available to insureds and potentially with more favorable pricing outcomes;
- Thoughts on enhancing the education of potential and current AFH owners regarding insurance, risk management training, operating a small business, and other best practices;

- Considerations regarding the average daily bed rate paid to AFHs compared with the daily bed rate paid for other types of facilities; and,
- Suggestions on certain DSHS administrative items, such as the positive effects of timely annual inspections and the conformance of the standard AFH contracts to statute and market conditions.

Conditions and Limitations

The actuarial review conducted in this study involves the estimation of outcomes of future uncertain events. As such, results are subject to variation from expected values.

The data set from which we conducted these projections was limited in size, as described further in the "Data Call and Actuarial Analysis" section. Furthermore, we did not conduct an audit of this data; instead, we reviewed it for reasonability and issued follow-up questions to the insurance companies. Some of the insurance companies responded to our inquiries while others did not.

Due to the nature and degree of uncertainty involved in these actuarial projections, there can be no guarantee that these independent estimates will prove adequate or not excessive. However, the assumptions and methodologies we used in our analysis are, in our opinion, reasonable under the circumstances.

The policy options recommended for consideration are based on our research. Although we have attempted to identify potential consequences of each policy option, it is not possible to identify every consequence. Furthermore, the Legislature may choose to execute some options in a manner not contemplated by this study. The outcome of any option or combination of options cannot be guaranteed.

This report should be read and distributed in its entirety, as opposed to parts thereof. Evaluation of the actuarial projections should be conducted by an actuary experienced in the relevant lines of business and markets.

Washington AFH Background

Legislative and Administrative Background

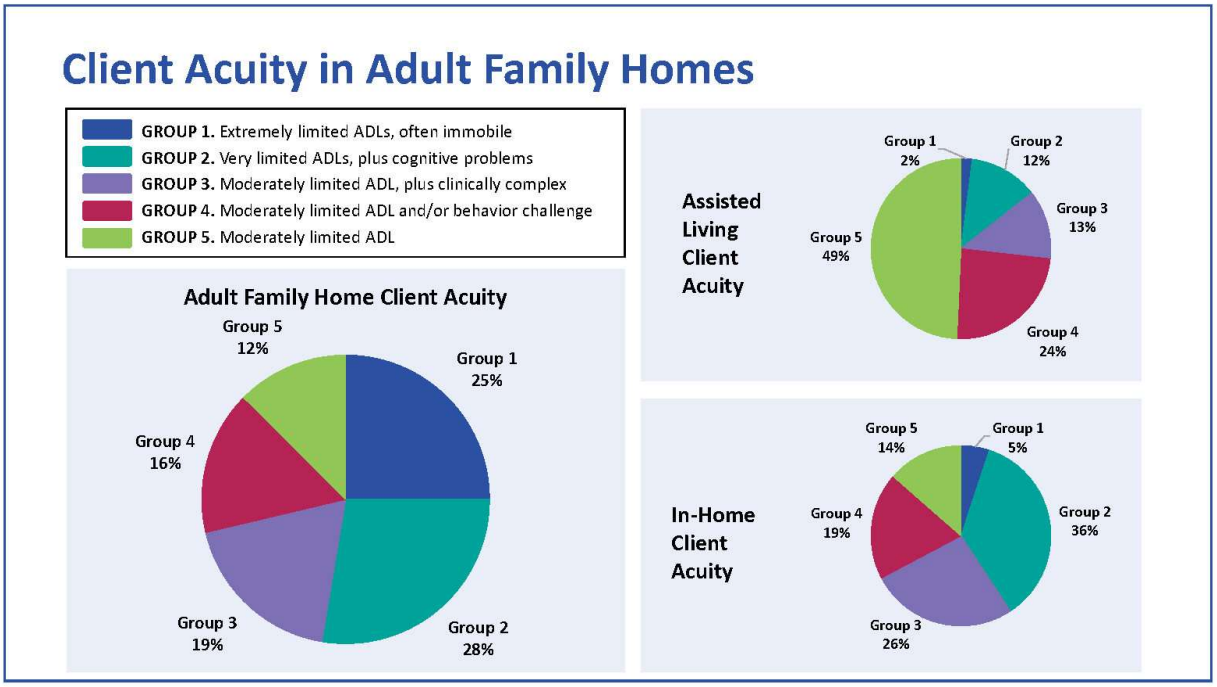
The Legislature has found that "the development and operation of adult family homes that promote the health, welfare, and safety of residents, and provide quality personal care and special care services should be encouraged." At the same time, the Legislature recognized that many residents of community-based long-term care facilities are vulnerable, that their health and well-being are dependent on their caregivers, and that residents' health, safety, and well-being are of paramount concern in the licensing and regulation of AFHs. DSHS, which oversees such licensing, is therefore directed to "more aggressively promote protections for the vulnerable population" that the long-term care system serves.[3]

To these ends, AFHs are licensed in Washington as residential homes in which one or more resident caregivers provide room, board, and services to between one and eight adults not related by blood or marriage to the caregiver(s).[4] The services rendered by a caregiver may include personal care (physical assistance, prompting, and supervising direct personal care tasks excluding tasks performed by a licensed health professional), special care (care "beyond personal care services"), skilled nursing (subject to appropriate staffing and licensure), and nurse-delegated care.[5] Special training is required for AFHs serving residents with special needs such as dementia, developmental disabilities, mental illness, traumatic brain injury, and bariatric care.[6]

Residents of Washington AFHs

Washington AFHs provide services to residents with diverse needs. Residents may be grouped based on the intensity of care required – a classification approach often described in the healthcare context as a patient, resident, or client's "acuity".[7] The Aging and Long-Term Support Administration ("ALTSA"), which is a division of DSHS, provided the following graphic in its June 26, 2024 presentation to the OIC AFH work group.[8] The graphic classifies AFH client acuity based on the level of assistance required to perform activities of daily living ("ADLs"):[9]

[3] See RCW 70.128.005
[4] See RCW 70.128.010.
[5] See WAC 388-76-10000 and 388-76-10400.
[6] See RCW 70.128.060; 70.128.230; and 70.128.040(4).
[7] The Department of Developmental Disabilities, for example, uses a number of "acuity scales" to develop an "objective assessment of a person's support needs." See WAC 388-828-1020 (defining "Accuity Scale"); see also RCW 71.24.648 (Behavioral health treatment facilities to "[e]stablish staffing requirements that provide an appropriate response to the acuity of the residents"); RCW 49.95.005 (Legislative finding that "[t]he average needs and acuity levels of people [receiving long term care] in their homes has increased and become more diverse.")
[8] See https://www.insurance.wa.gov/adult-family-home-liability-market-study-work-group, "DSHS, department of social and health services, June 26 presentation."
[9] ADLs generally include self-care activities including bathing, dressing, eating, personal hygiene, transferring (e.g. from bed to chair), toileting, ambulation/mobility, and medication assistance. See RCW 18.20.310 (Defining ADLs regarding assisted living facilities).



The average acuity in AFHs is substantially higher than the average acuity in assisted living facilities or for those receiving services in-home. The combined acuity of Groups 1 and 2, the acuities with the highest needs, represents more than 50% of residents in AFHs.

The nature of AFHs as defined by Washington's legislative and administrative code differs in certain respects from "adult family homes" in other states. Appendix A presents a review of regulatory structures in other jurisdictions, analyzing areas of similarity or difference with the Washington regulatory structure. The review suggests, for example, that Washington AFHs are permitted to serve residents with relatively high acuity (e.g. residents requiring feeding tubes or ventilation) who might be required to transition to more intensive care settings (e.g. skilled nursing facilities) in some other jurisdictions. Similarly, some other jurisdictions may have narrower licensing categories – regulating homes with elderly residents under a different regime than homes with residents who are developmentally disabled – than Washington's single broad license which permits a single AFH to serve a wide range of clients. Finally, some jurisdictions may require that the regulatory body overseeing AFHs authorize every individual resident as appropriate for a specific home; Washington has no similar rule.

The diverse needs and higher average acuity of Washington AFHs may be factors in the availability and affordability of liability insurance.

DSHS Contracts, Daily Bed Rates, and Economics of AFHs

DSHS offers a variety of contracts to AFH operators who serve Medicaid-eligible residents.[10]

[10] See https://www.dshs.wa.gov/altsa/residential-care-services/afh-sample-contracts

The contracts note that the "Contractor [AFH operator] shall. . . accept the rates agreed upon in the current and future collective bargaining agreements between the Governor of the State of Washington and the Washington State Residential Council in accordance with RCW 41.56." They also note that AFHC is "the sole and exclusive representative for Contractors of AFH care services who receive payments from Medicaid and State-funded long-term care programs."[11]

We gained the following understanding from conversations with DSHS representatives as well as AFHC representatives regarding daily bed rates for residents who are eligible for Medicaid, other state, and/or federal funding:

- There are annual negotiations between DSHS and AFHC regarding the maximum DSHS daily bed rate for AFHs.
- Each resident is assessed by DSHS personnel using the "CARE" (Comprehensive Assessment Reporting Evaluation) tool, both at initial entry and subsequently at annual renewals, to determine the functionality of the resident and the care needed for that resident. The CARE assessment will determine the daily bed rate for that individual.
- Residents may be eligible for Medicaid or other state or federal funds based on income. In some circumstances, depending on income, the resident may be Medicaid-eligible but may also be required to pay a certain portion of the daily bed rate directly to the AFH operator. In these cases, DSHS pays the portion of the daily bed rate for which the resident is not responsible.
- The final negotiated maximum daily bed rate may not be sufficient to account for all costs associated with the resident's care and their representative portion of operational costs at the AFH.

Note that the agreed-upon daily bed rate is paid to the AFH operator on a monthly basis, based on the number of days during the month for which the resident has resided at the AFH.

Low-income residents may also be eligible for additional Medicaid-funded services that are not provided by the AFH providers, including nurse delegated care, skilled nursing care, therapies, and adult day health.[12]

The majority of Washington AFH residents are Medicaid-eligible. DSHS provided us the following table:

[11] See "AFH Sample Contract" as well as other AFH contracts at https://www.dshs.wa.gov/altsa/residential-care-services/afh-sample-contracts

[12] See https://www.insurance.wa.gov/adult-family-home-liability-market-study-work-group, June 26 meeting, "DSHS, Department of Social and Health Services, June 26 presentation."

Adult Family Home Medicaid Occupancy	
State Fiscal Year	Percent of Licensed Beds Occupied by Medicaid Clients*
FY20	52.2%
FY21	53.4%
FY22	52.0%
FY23	52.3%
FY24	51.0%
FY25	52.3%
*Represents snapshot of Medicaid clients authorized for AFH personal care services over the total number of licensed beds at Medicad-contracted AFHs at the beginning of each fiscal year.	

Note that the table above **understates** the percentage of *occupied* beds related to Medicaid clients, as the denominator of each percentage is **total licensed beds**. According to information from brokers as well as DSHS, there are many AFHs which are licensed for more beds than the number of current residents. One interviewee estimated that the portion of AFH residents receiving Medicaid assistance, as opposed to private pay, may be as much as 80%. For this reason, any deficiency in funding of the daily bed rate may materially impact the fiscal viability of AFHs.

AFHs provide a number of public benefits including keeping residents in community settings and permitting many residents to age-in-place. In addition, AFHs provide care to elderly and other residents at a cost that, in many cases, is substantially below the cost that would be incurred in alternative facilities. DSHS representatives noted these benefits in the course of a June 26, 2024, presentation to the working group.[13] DSHS subsequently provided data comparing the monthly cost of providing care to residents in various facilities:

Type of Facility	Monthly Per Capita Funding
Adult Family Homes	$5,694[14]
Nursing Homes	$10,601[14]
State Psychiatric Hospital	$25,200[15]

[13] See https://www.youtube.com/watch?v=t4JYRs__D8I, recording of presentation, approximately minute 22.
[14] Based on ALTSA FY 25 data for elder care. The Developmental Disability Administration ("DDA") amount for adult family homes for FY 25 is $5,604, a similar figure to the ALTSA metric. DDA does not show a nursing home amount.
[15] Based on State psychiatric hospital daily bed rate of $840, multiplied by 30 days. Private psychiatric hospitals daily bed rate was $860.

It is interesting to note that the adult family home per capita monthly funding could be materially raised and still be substantially less expensive than the nursing home monthly per capita funding.[16] Certainly, skilled nursing facilities provide greater professional and operational capabilities than AFHs. However, given the diversity of population served by AFHs, including high-acuity residents, and the concerns voiced by the AFHC that the current financial realities are not sustainable for many AFH operators, this may be a matter for further consideration.

We noted two additional items of interest when reviewing sample DSHS AFH contracts:

- As noted above, WAC 388-76-10192 states that the liability requirements for AFHs are limits of $500,000 per occurrence and $1,000,000 annual aggregate. In contrast, the sample DSHS contracts require a minimum limit of $1,000,000 per occurrence and $2,000,000 annual aggregate. Furthermore, we understand from DSHS personnel that most DSHS contracts were recently updated to require $2,000,000 per occurrence and $4,000,000 annual aggregate coverage, but that the AFH contracts were held at $1,000,000 per occurrence and $2,000,000 annual aggregate limits until June 30, 2026 because of affordability concerns.
- Additionally, the contracts state, "the Contractor shall obtain insurance from insurance companies identified as an admitted insurer/carrier in the State of Washington, with a current Best's Reports' rating of A-, Class VII, or better." [17] As will be noted further in this report, there are no admitted carriers currently offering AFH liability insurance in Washington with the only sources for AFH liability insurance being non-admitted or non-traditional carriers such as risk retention groups ("RRG").[18] (See the "Providers of Insurance" section later in this report for further explanation of these types of insurance entities.)

These contract conditions - which are in excess of WAC requirements – are either impossible to achieve in current market conditions or would tend to decrease the availability and affordability of liability insurance in comparison with conditions that matched the WAC minimum requirements.

[16] The monthly AFH per capita funding in the table above appears to represent an average of funding across all ALTSA residents. As funding differs by resident needs, some residents' monthly funding is presumably greater than this amount and some is less than this amount. We were not provided specific data to determine the monthly funding for an Acuity 1 or 2 resident, for instance. Nevertheless, consideration of this funding in comparison with nursing home funding is likely a worthwhile exercise.

[17] See https://www.dshs.wa.gov/altsa/residential-care-services/afh-sample-contracts, specific contracts, under "Insurance" section.

[18] A small number of Washington AFHs may be receiving liability insurance from an admitted carrier through their affiliation with certain large non-profit organizations. Specifically, it appears that one admitted carrier has historically been willing to include coverage for such affiliated AFHs as part of an overall insurance program offered to a larger non-profit entity. This coverage is not available in the general market.

Liability Insurance Environment for Washington AFHs

Providers of Insurance

The following entities were identified in public work group meetings and in our interviews with insurance producers as the primary entities providing liability insurance to Washington AFHs:

- Huntersure LLC
- Nationwide E&S and Specialty Insurance (f.k.a. Scottsdale Insurance Company)
- James River Insurance Company
- Kinsale Insurance Company
- Hamilton
- Richmond National
- PCH Mutual Insurance Company, Inc., an RRG, which serves as the insuring entity for Washington AFHs written by Personal Care and Assisted Living Insurance Center ("PCALIC")

Huntersure is a program manager[19] that works with certain Lloyd's syndicates, which are excess and surplus lines ("E&S") insurers. Nationwide E&S and Specialty Insurance,[20] James River Insurance Company,[21] Kinsale Insurance Company,[22] Hamilton,[23] and Richmond National[24] are all E&S insurers. PCALIC[25] is a program manager that places insurance through PCH Mutual, an RRG.[26] Both PCALIC and PCH Mutual are owned by Tangram Insurance Services.

All of the identified insurance companies are E&S companies or an RRG which means that they are not "admitted" insurance companies.

It is important to distinguish between the regulation of traditional "admitted" insurance and the regulation of insurance written on an E&S basis or by an RRG ("non-admitted"). Admitted insurance is written by an insurance company licensed to do business in the state in which the insurance exposure is located.[27] In accordance with WAC 284-20B-030 and WAC 284-24-011, as well as the OIC property and casualty filing instructions, all liability forms and rates, respectively, written on admitted basis for Washington insureds must be filed with the OIC.

If a potential insurance customer cannot obtain insurance coverage in the admitted market, they may be able to obtain it in the E&S market. E&S insurance coverage is intended for specialty, unusual, or riskier

[19] https://www.huntersure.com.
[20] https://nationwideexcessandsurplus.com.
[21] https://jrvrgroup.com/james-river-insurance.
[22] https://www.kinsaleins.com.
[23] https://www.hamiltongroup.com/about.
[24] https://www.richmondnational.com.
[25] https://tangramins.com/programs/personal-care-and-assisted-living.
[26] https://pchmutual.com/contact.
[27] https://www.irmi.com/term/insurance-definitions/admitted-insurance.

business that insurance companies will not cover on an admitted basis. E&S business is excluded from state guaranty funds.[28]

The OIC does not have direct regulatory authority over forms or premium rates written on an E&S basis. Insurance companies operating on an E&S basis are not required to maintain rate manuals or standard forms nor submit publicly available rate & form filings to the state for insurance written on this basis.[29]

RRGs -- which are formed pursuant to the federal Liability Risk Retention Act and therefore "exempt from any State law, rule regulation, or order to the extent that such law, rule, regulation or order would . . . make unlawful, or regulate, directly or indirectly, the operation of a risk retention group" are owned by their policyholder members.[30] An RRG must have a state of domicile but is not required to file forms or rates in the other states in which it is doing business. The federal laws that authorize the creation of RRGs prohibit them from participating in state guaranty funds.[31]

As all the identified insurance companies currently providing coverage to Washington AFHs are E&S companies or RRGs, the OIC has no direct authority over their forms or rates. Additionally, the absence of admitted companies in this space may indicate that liability insurance for this class of business is perceived as difficult to price or riskier in some way.

Based on interviews, we understand that some admitted insurance companies historically provided AFH liability coverage in Washington, but no longer do so. These include Hanover and Philadelphia.

Some AFH providers expressed concerns that certain disclosures on the DSHS website (including allegation reports that had not yet been investigated, and de minimis citations issued during inspections) may have been unintentionally impacting the availability and affordability of insurance. These concerns may have been addressed, however, by Chapter 235, Laws of 2024 (amending RCW 70.128.280 effective June 6, 2024) which excludes de minimis citations or allegation reports from the DSHS consumer-oriented website. Deficiency reports are still included on the website, as are enforcement actions. Additionally, DSHS now posts deficiency-free inspection letters and notices of return to compliance.

Underwriting of AFH Liability Policies

Underwriting Guideline Information – Introduction

Presenters at the working group meetings on July 24, 2024[32] and June 26, 2024,[33] highlighted the importance of underwriting guidelines and their impact on certain AFHs. The subject was also raised in subsequent interviews with insurance producers, insurance company executives, and AFH-interested

[28] https://www.insurance.wa.gov/surplus-line-insurance
[29] *ibid*
[30] 15 U.S.C. § 3902(a)(1)
[31] 15 U.S.C. § 3901(a)(2)
[32] See https://www.insurance.wa.gov/adult-family-home-liability-market-study-work-group, "July 24, Liability and property presentation."
[33] See https://www.insurance.wa.gov/adult-family-home-liability-market-study-work-group, "June 26 meeting" recording.

parties. Because not all insurance companies who responded to our data call provided underwriting guidelines, we present some summary information based on these presentations and interviews below. The statements in this "Introduction" section should be understood to represent parties' experience and subjective understanding rather than objective findings made after review or audit.

A small sample of some underwriting guidelines, as represented in presentations and interviews, is provided below:

- Insurers rate liability policies based on **licensed**, not **occupied** beds. This is important because the number of occupants can change during the course of the policy year, but the premium cannot be changed. (Note that this statement was confirmed based on subsequent data received in the data call).

- Most insurance companies review DSHS inspection reports at initial application and upon every annual renewal.

- One insurance company primarily offers coverage to AFHs that provide elder care. It may not write coverage for AFHs where any resident's primary diagnosis is related to mental illness or where any resident has a developmental disability. It also may exclude AFHs in which any resident is permanently confined to bed.

- A second insurance company accepts AFHs that provide elder care, developmental disability, and behavioral services. However, it will not accept AFHs with residents with elevated risk of physical violence or self-harm. It also will not accept AFHs that include residents in need of skilled nursing care. It performs very careful underwriting of any AFH that has one or more residents who are bedridden or are in later stages of Alzheimer's disease.

- A third insurance company accepts AFHs that provide elder care, developmental disability, and behavioral services; however, it requires a staff member to always be awake (known as "24/7 awake staff"). It also requires no historical liability losses in the period reviewed.

- A fourth insurance company accepts AFHs that provide elder care, development disability, and behavioral services but requires no historical liability losses in the period reviewed. It does not write coverage if any of the residents require skilled nursing care. It will accept residents with a mental health issue as the primary diagnosis but will not accept residents with substance use disorder or who have been released directly from prison or involuntary confinement.

As residents' medical or cognitive conditions may change over time, AFHs may encounter challenges with their insurance policies upon renewal if residents no longer meet the underwriting requirements of the insurance company. For instance, at a certain point in time, an AFH may have one or two residents with mild dementia and may qualify for coverage with a specific insurer. However, by the time a renewal application is completed, those residents may be at a later stage of dementia which may disqualify the AFH from that insurer's underwriting guidelines. Similarly, residents may progress from being ambulatory to being non-ambulatory or from being able to eat to being fed via tube. In these events, the AFH may face a substantial increase in premium or even a non-renewal from its insurer.

In this context, it should be noted that RCW 70.129.110 prohibits an AFH from discharging or transferring a resident except in limited circumstances. Even when discharge or transfer is statutorily permitted, the resident has certain rights, such as a minimum 30-day notice, and notification of the location to which the resident is being discharged or transferred. The circumstances that allow an AFH to discharge or transfer a resident do not include changes in acuity that may impact the AFH's ability to renew liability insurance or secure replacement coverage. This can create a difficult situation for all involved and a potential conflict between the legal obligation to maintain liability insurance and the requirement to allow a resident to remain at an AFH.

It should also be noted, in this context, that premium for AFH liability coverage is typically set for a 12-month period based on the number of licensed beds while the Medicaid daily bed rate applies only when a resident is occupying a bed and is adjusted depending on that specific resident. As a result, acuity-driven increases in insurance premium can last well beyond the period during which increases to the daily bed rate may provide a corresponding increase in AFH reimbursement. For instance, a high-acuity resident may pass away and there may be a delay before the AFH can admit a new resident, and/or the new resident may be eligible for a lower daily-bad rate reimbursement.

Underwriting Guidelines – Provided by Insurance Companies

As part of the data call issued by the OIC in cooperation with us, the OIC requested, "copies of underwriting guidelines or manuals and rating guidelines or manuals, if applicable."

Three companies provided underwriting guidelines. One of the three companies is a large current writer of Washington AFH liability policies. This large writer has been noted by brokers as an insurer that charges relatively lower insurance premiums relative to many of the other companies in the market. The other two responding companies have been in the Washington market historically but have either completely or almost completely exited several years ago. (One of these two companies has not written AFH liability policies in Washington for several years; the other has only two continuing policies). We reviewed the underwriting guidelines of the company currently providing substantial coverage as well as those of the other two companies.

Insurer with Substantial Washington AFH Liability Insurance Market Share

The company that continues to provide substantial AFH liability insurance coverage in Washington focuses (among other items) on:

- Strong employee screening to make abuse claims less likely
- Minimal transportation of residents to avoid auto claims
- Risk mitigation procedures which the insured must implement
- Copies of most recent state inspections
- For new facilities, a minimum of 3 years of clinical experience or healthcare administration
- Historical loss runs for 3-5 years for facilities in business for that length of time (or for a shorter period for newer facilities)
- For AFHs with a substantial portion of wheelchair-dependent residents, requirements for those residents to be on the ground floor, for the facility to have sufficient ground floor exits, and awake staff overnight or adequate alarm systems
- AFHs with "wanderer" residents can be accepted only if strong risk mitigation systems (such as door alarms and missing resident protocols) are in place.

- Various therapies (occupational, speech, physical), wound care, pain management and IV care are not covered by this policy; instead, the professionals who administer this care must have their own professional liability policies.

The underwriting guidelines explain why each of these items can correlate with risk. And indeed, in reviewing these items, many appear to align with the best interest of the residents: favorable state inspection results would likely indicate a safe and orderly environment; employees that have passed background checks are less likely to abuse the residents; accessible emergency egress for wheelchair-dependent residents; controls in place to prevent elopement if "wanderer" residents are accepted; and the requirement that licensed professionals provide certain types of skilled care.

We note that delays in DSHS inspections may result in the rejection of certain risks as the insurance company may not have an adequate record that previous deficiencies have now been corrected.

Additionally, the structures in which many AFHs operate may make it difficult to meet some of the underwriting guidelines listed above.[34] Further, because many AFH providers speak English as a second language and because many AFH residents come from immigrant communities with language barriers, there may be increased challenges in generating and maintaining documentation of compliance with certain underwriting guidelines. This does not necessarily mean that the guidelines are problematic or not serving valuable purposes (e.g. encouraging safer facilities and diffusing best practices) but instead may suggest that AFH providers may benefit from additional training in the type of residents they can and should accept given the nature of their buildings.

We also note that this insurer requires a minimum of three years of clinical experience or healthcare administration for new facilities. In discussions with brokers, they noted that the lack of management and/or healthcare experience for many new facilities is a strong impediment to obtaining affordable insurance. It is possible that proactive education of potential new entrants into the market regarding this issue would create a more successful entry for them.

Finally, this insurer will not cover liability for wound care in its policy, and does not allow an unlicensed individual to provide this care. Wound care arose as an item of interest in interviews and also in the survey of AFHC members below. Many AFH providers are frustrated that wound care is not covered as it is often a practical necessity for residents who choose to age in place. However, in our actuarial and insurance experience, various wounds may worsen, lead to difficult and undesirable outcomes, and are frequently the subject of liability claims even in a skilled nursing setting. AFH providers may need to be instructed that accepting a resident with wounds, in the absence of skilled nursing care from a practitioner with their own professional liability ("PL") insurance, may be inadvisable and may reduce the likelihood of obtaining affordable insurance. (Alternatively, affordability could be addressed on the revenue side through increased daily bed rates for patients requiring wound care and electing not to transition to a nursing home or skilled nursing facility.)

Insurers that have Exited or Materially Exited the Washington AFH Liability Insurance Market

One of the companies that has materially exited the Washington AFH liability insurance market does not accept insureds:

[34] Many AFHs operate from standard residential structures rather than purpose-built facilities. While this is consistent with the concept of a "family home" and with the preferences of many residents, it does mean that expensive retrofits may be necessary to meet some underwriting guidelines.

- Providing any skilled nursing or medical care services;
- Operating developmental disability group homes with nursing services that exceed "minimal"
- Offering any residential services to sexual offenders, violent offenders, fire starters, or participants in alternative to incarceration programs; and,
- Admit any residents with behavioral issues

It is possible that the broad nature of the Washington AFH licensure, which allows many of the above classification of residents to reside in one home, may have been one factor for the material withdrawal of this insurer from the state as its national underwriting guidelines evolved over time.

The insurer which previously had a strong presence in Washington but has since completely withdrawn does not currently write any GL/PL/Abuse coverage for any elder care homes across the United States. It also will not consider homes "licensed for 100% non-ambulatory regardless of the actual percentage [of non-ambulatory residents]." Our understanding is that all Washington licensed AFHs are in theory licensed for up to 100% non-ambulatory residents. For these and other reasons, this carrier is likely no longer a good fit for Washington AFHs as its underwriting guidelines have evolved.

Data Call and Actuarial Analysis

Pursuant to the direction in the Legislature's 2024 supplemental operating budget (ESSB 5950) to review the cost of liability insurance for AFHs, we assisted the OIC in the issuance of a data call. The data call was issued to insurance companies that had been identified by various brokers as providers of this insurance.

Data Call Instructions

The data call instructions are attached as Appendix C. The following are a few explanatory notes related to the data request:

- Our intent was to perform an actuarial analysis based on the 2019 – 2024 period.
- We requested information as of 9/30/2024, instead of 12/31/2024, as we did not want to delay insurer responses in early 2025 in the event that their 2024 financials had not yet closed.
- We requested policy and premium data beginning in 2018 so that we could have information necessary to calculate earned premium for the entirety of the 2019 year. Note that, as is commonly understood in insurance accounting, "[e]arned premium is the amount an insurance entity has recognized as revenue for the coverage provided under the insurance contract to date."[35] As an example, an annual policy effective on July 1, 2018 will earn approximately half of its premium in 2018 and half in 2019. For this reason, we needed to obtain 2018 policies in order to have a complete earned premium set for 2019.
- We requested historical losses with incurred dates in the 1/1/2015 – 9/30/2024 period, including the 2015 – 2018 years, in case that loss experience might help us trace transitions between insurance companies or increased rating.
- We requested underwriting and rating guidelines or manuals, if applicable. The items we received were discussed above (see "Underwriting Guidelines – Provided by Insurance Companies").
- The data call clearly referenced "liability insurance policy covering adult family home providers" and that the "liability coverages included are as defined in WAC 388-76-10192."
- As noted in Appendix C, "all data submitted as a part of this data call are confidential by law and privileged and not subject to public disclosure under chapter RCW 42.56. The Commissioner may prepare and publish reports, analysis, or other documents using the data received from individual property and casualty companies so long as the data in the report is in the aggregate form and does not permit the identification of information related to individual companies."

Data Call Responses

The data call was issued on February 13, 2025, and the insurance companies were requested to provide data no later than March 18, 2025. A number of insurance companies requested extensions to the March 18, 2025 deadline, and they were granted such extensions.

We did not audit the data, but we did check it for reasonability. We sent questions regarding the data to a number of insurance companies. Questions included issues such as:

- Losses listed in the data without any matching premium record for the loss policy number.
- Apparently duplicated records.

[35] See https://viewpoint.pwc.com/dt/us/en/pwc/accounting_guides/insurance-contracts/Insurance-Contracts/Chapter-4--Short-duration-contract-liabilities/4_2-Premium-recognition-and-unearned-premium-liability.html (Summary definition of earned premium from a prominent accounting firm).

- Cause of loss descriptions that appeared to indicate non-liability coverages.
- Situations in which we were uncertain as to whether the insured was an AFH or some other type of facility. According to the Washington Administrative Code, a Washington AFH will have eight or fewer licensed beds. There were instances in which companies provided us data with more than eight licensed beds per policy. This can occur if a number of AFHs are operated by one business; we followed up to ascertain whether this was the case or whether non-AFH policies had been inadvertently included in the data.

Some of the insurance companies responded to our initial inquiries and explained the data or provided corrected data. Some noted that the data may have been incorrect or missing some information, but that they did not have the ability to correct it. One company noted that some of the policies with more than eight beds were AFHs and some were instead assisted living facilities, and that there was no way to differentiate these in their data. Some companies did not respond to our inquiries at all.

As described above, the responding companies are generally E&S insurers or an RRG. It is important to note that such companies may not be as accustomed to responding to data calls as admitted insurers.

After processing any corrected data provided by the companies, we reached out to each of the insurers individually, presenting summarized information by year (2018 – 2024) and in total that included:

- Policy Count
- Written Beds
- Written Premium
- Average Premium Per Bed (calculated by Davies and equal to Written Premium divided by Written Beds)
- Earned Beds (calculated by Davies based on effective dates of policies and Written Beds)
- Earned Premium (calculated by Davies based on effective dates of policies and Written Premium)
- Claims Counts
- Reported Loss & Defense and Cost Containment Expense ("DCC") (Reported amounts are equal to Paid amounts plus Case Reserve amounts)
- Reported Loss Ratio (calculated by Davies and equal to Reported Loss & DCC divided by Earned Premium)

The email to each insurer stated, "Prior to issuing any report or findings, we wanted to allow you to review our summary of the data you provided for [your company] to ensure that it is consistent with your company's understanding of the loss and premium amounts for this exposure in Washington state." In addition, we presented any outstanding questions on the data to provide a final opportunity for an insurer to note issues with data interpretation/aggregation.

No company objected to the presentation of its data. Several companies requested explanations on the calculations of earned premium; we explained that this was performed using a traditional actuarial methodology, but that we primarily needed the companies to validate the non-calculated fields provided by them. The data used in our analysis represents the final data available, after any company-provided revisions to their data based on our inquiries.

We compared the written beds by year provided in the data responses to the licensed beds listed by DSHS in its June 26, 2024 working group meeting presentation.[36] We found that for the 2021 – 2023 years, the beds in our data set represented over 80% of the DSHS licensed beds. The metric was smaller for the 2019 and 2020 years, with the ratio of beds in the dataset to DSHS licensed beds slightly over 50% for 2019 and slightly over 70% for 2020.[37] These ratios indicate that for most of our data, we have captured a very sizeable percentage of the market information.

Actuarial Analysis

Due to confidentiality considerations, we present all data in the aggregate, across all companies that responded to the data call.

Loss and Premium Snapshot

We initially aggregated the premium and loss and DCC "point in time" data and produced Table 1 below.

Loss and DCC are frequently combined in actuarial analyses. For the remainder of this report, in the interest of brevity, any reference to "loss" will refer to "loss and DCC" and any reference to "loss ratios" will refer to "loss and DCC ratios."

The data in Table 1 relies on "reported" (paid plus case reserves) loss.

The "ultimate" value of loss is equal to the final value that will have been paid when all claims have closed. Until that time, actuaries estimate the ultimate loss value using a variety of techniques and methods. In most circumstances, the "reported," or paid plus case reserve loss, will understate the ultimate value of the claims in aggregate until all claims are closed. For this reason, companies generally add a provision for "Incurred but not Reported" ("IBNR") or "bulk" reserves to the liabilities presented in their financial statements.

Based on this understanding, the reported loss ratios in the table below likely represent ultimate loss ratios for years 2021 and prior, where it appears that claims are closed, but likely understates the ultimate loss ratio for years 2022 and subsequent. (Note that 93% of the premium submitted under this data call was associated with claims-made policies instead of occurrence policies. For this reason, further development on years 2021 and prior seems unlikely).[38] Nevertheless, Table 1 presents helpful information in the form

[36] See https://www.insurance.wa.gov/sites/default/files/2024-11/dshs-afh-june-26-meeting.pdf

[37] We round these figures to recognize imprecision in the data. For example, as noted above, we have indications that the bed count may be underrepresented in certain regards (losses appear with no matching policies, thus indicating missing policy records) and may be overrepresented in others (assisted living facilities may have been included in the data, and we have no ability to reliably remove these). Similarly, it is possible that our data for 2019 is somewhat incomplete, as perhaps the key market participants have shifted since 2019. We do not provide this ratio for 2024 as the 2024 data we received was valued as of September 30 and did not represent a full year.

[38] As the trigger for claims-made policies is the date of report of the claim, new claims are unlikely to be reported materially after the year in question has ended. For this reason, if all reported claims are closed, we can assume that there are no unknown claims for which we must establish an IBNR reserve. In contrast, new claims can arise on occurrence policies for some time after the close of the given time period, because the trigger for an occurrence policy is when the underlying incident occurred. Occurrence policy claims can sometimes be reported many years later but still attach to the year of occurrence; thus, when examining occurrence policies, actuaries may establish a bulk reserve for a given year for claims that are unknown, even when all known claims have closed. See Appendix B for further explanation of occurrence and claims-made policies.

of a "snapshot" of premium and loss data. Please note that Table 1 and Table 2, the notes within the rectangles surrounding the tables and much of the narrative in this "Actuarial Analysis" section of the report are actuarial in nature. Consistent with our Actuarial Standards of Practice, this section must be sufficiently technical and detailed such that another practicing actuary would be able to review the reasonability of our statements. In the interest of readability for a general audience, we have preceded each key finding in the narrative below with a **bold summary statement** regarding our findings.

Table 1

Washington State Office of the Insurance Commissioner
Davies' Study of Adult Family Homes
Summary of Industry Liability Insurance Coverage
All Companies Combined

Year	Policy Count (1)	Written Beds (2)	Written Premium (3)	Average Premium Per Bed (4)	Earned Beds (5)	Earned Premium (6)	Reported Non-Zero Claim Counts (7)	Reported Loss (8)	Reported Loss Ratio (9)
2019	1,371	8,683	2,761,034	318	8,483	2,495,869	11	4,119,450	165%
2020	2,071	13,203	4,649,188	352	10,584	3,624,381	8	2,430,089	67%
2021	2,547	16,486	6,350,507	385	14,900	5,433,398	6	1,298,709	24%
2022	2,818	18,000	8,016,549	445	17,115	7,030,803	8	1,502,757	21%
2023	3,063	19,860	9,612,100	484	18,936	8,823,759	10	1,293,258	15%
2024*	2,876	19,037	9,005,460	473	17,941	8,373,950	8	519,958	6%
Totals	14,746	95,269	40,394,838	424	87,958	35,782,160	51	11,164,222	31%

*2024 represents data through 9/30, except for one company which provided loss and premium data through 12/31.
(1) - (3), (7) - (8) from data provided by data call respondents.
Reported loss is gross of deductible as respondents' treatments of deductibles were inconsistent. We note that most policies have a $0 deductible and that the deductibles for other policies were small.
(4) = (3) / (2)
(5), (6) calculated based on effective dates, parallelogram method, and (2) and (3) respectively
(9) = (8) / (6)

We note the following observations based on Table 1:

- **Strong AFH bed growth year over year – see Column (2)** - Consistent with DSHS reports, the number of AFH licensed beds in the dataset demonstrates strong growth from year to year. Please see Column (2) for the number of insured beds by year in our dataset. (Note that 2024 represents a partial year of data).

- **The average premium per bed over all years is $424. See the "Totals" number in Column (4). With an expectation of 6 licensed beds per facility, this translates to an average premium of $2,544 per facility.**

  Additionally, the year-over-year change in premium per bed as shown in Column (4) appears generally reasonable given industry information.

  Note that average premium per bed appears to be increasing at an average rate of 8% annually when viewed across the 2019 – 2024 period, or approximately 7% annually when viewed across the 2021 – 2024 period. (A longer period may be advantageous in providing more stable results; however, as the number of AFH beds increases so rapidly by year and insurers enter and exit the market, a shorter period may be more instructive about the present). This trend is similar for both beds written at $500,000 per occurrence limits and beds written at $1 million per occurrence limits, although the trend is slightly higher for the $1 million limits beds. The slightly higher trend at higher limits is to be expected.

  Marsh McLennan produces a semi-regular actuarial study[39] regarding liability insurance for senior living and long-term care exposures. The most recent two reports "separated the claims and exposure data into long-term care: those exposures relating to skilled nursing facilities; and senior living: those exposures relating to independent living, assisted living, and memory care providers." Washington AFHs appear to include both types of exposures. In its September 2024 report,[40] upon review of ten years of data, Marsh determines that the countrywide annual loss rate trend for senior living is +4.4% and that the corresponding countrywide annual trend for long term care is +4.0%. Although this trend is smaller than the trend shown in our study, the Marsh trend is not exactly comparable to the Washington AFH market because it:
  - does not take into account specifics of the AFH environment;
  - is a countrywide trend instead of a Washington-specific trend; and
  - is developed over a much larger dataset and period of time. (The Marsh dataset represents 10,300 closed claims; in contrast our dataset represents thirty-eight closed claims). The trend demonstrated in our study may warrant further review, but is not unreasonable in comparison with the Marsh report given the specific nature of this data call.

- **The profitability of this business for insurers is noteably variable from year to year. See Loss ratios in Column (9) for 2019-2021 which, are equal to "reported loss" (as described above) divided by premium.** (We do not evaluate this metric for 2022 and subsequent as these years are too immature, as described above; for 2022 and subsequent, we will evaluate ultimate loss ratios). **Lower loss ratio values indicate higher insurer profitability; higher values indicate less profit or an unprofitable year**. **This is to be expected in an environment in which even a small number of claims can require payments approaching or exceeding total premium collected**

[39] Generally published every 1-2 years.
[40] See "2024 General and Professional Liability Benchmark Report for Senior Living and Long-Term Care Providers" available for download at https://www.marsh.com/en/industries/senior-living-long-term-care/insights/gl-pl-benchmark-report.html

and in which there are a limited number of policies.[41] The loss experience in the Washington AFH liability insurance market - measured by the reported loss ratio in Column (9) (reported loss in Column (8) divided by earned premium in Column (6)) - is subject to substantial volatility. This may be due, in part, to the size of the market and the relative infrequency of losses.

In a hypothetical scenario in which premiums are perfectly priced, the loss plus associated non-DCC underwriting expenses for the policies in question should be equal to the earned premiums.[42] Thus, pricing actuaries use a target loss ratio materially below 100%, as other non-DCC underwriting expenses also represent a material portion of the premium. (We do not have sufficient data to project the target loss ratio for this line of business and market; however, for purposes of comparison, in some lines of business and in some markets the target loss ratio may represent approximately 65% of earned premium, with other underwriting expenses representing approximately 35% of earned premium).

The 2019 reported loss ratio was 165%, which is clearly unprofitable. This ratio indicates that $1.65 of loss was incurred by the insurance company for every $1.00 of premium that was paid by the insureds. Additionally, amounts were certainly spent on other underwriting expenses, thus making the business even more unprofitable.

The 2020 reported loss ratio was 67%, which is much closer to a profitable ratio, and the 2021 reported loss ratio was 24%, which is a strongly profitable loss ratio. (Note again that reported loss ratios for 2022 and subsequent do not represent ultimate claims value; we will examine projections to ultimate shortly).

This volatility is to be expected given the nature of this market. In all years that were studied, almost 100% of the premium was written at either $500,000 per occurrence limits (generally with an annual aggregate limit of $1 million) or at $1 million per occurrence limits (generally with an annual aggregate limit of $2 million), with an average of 67% of the beds written at $500,000 per occurrence limits and an average of 33% of the beds written at $1 million per occurrence limits. The total earned premiums for the 2019 and 2020 years are approximately $2.5 million and $3.6 million, respectively. Even in an environment with relatively few claims, a small number of claims at or near policy limits could create an unprofitable loss ratio.

As the AFH market continues to grow, the insurance market may stabilize somewhat; however, with the size of premiums in play, results may remain volatile from year to year. Insurance companies will take into account the possibility of a small number of claims having a large impact on results when pricing this business.

[41] Compare approximately 4,500 Washington licensed AFH providers (per DSHS) in 2024 with the millions of annual private passenger auto policies in a state. Per actuarial science, results tend to be more variable when there is a smaller base of policies.

[42] Note that this hypothetical scenario is unlikely in the real world, as insurance by its nature represents an unknown liability at the time that it is issued. Also note that in a small market like the one reviewed in our study, it is highly unlikely that we would see consistency in loss ratio from year to year; instead, we would tend to focus on a loss ratio over a number of years.

Scale may also be a significant issue with regard to AFH liability insurance. For example, at the level of the individual policy there will be certain expenses associated with delivering insurance (underwriting, policy preparation/delivery, premium processing, and others) that are either fixed or grow very slowly in comparison with policy or premium size. These expenses may be insignificant in the context of industries with larger insureds purchasing very expensive policies, generating economies of scale. By design, however, an AFH will never have more than 8 beds such that it will not generate industrial scale and fixed costs will necessarily push the expense ratio up. Similarly, at the level of the overall market, in lines of business with millions of policies, the insurers themselves can generate economies of scale even if individual policies produce relatively little premium. The AFH market is much smaller. According to DSHS, there were only 4,272 Washington AFH providers in 2023.[43] Carriers writing such coverage will not, therefore, have the opportunity to generate the scale and efficiency that might be possible in larger consumer or commercial markets

Projection of Ultimate Loss

After accumulating our "point in time" observations about loss ratio volatility and average premium per bed, we wished to create an actuarial projection of ultimate loss amounts and ultimate loss ratios. Given the diverse nature of our dataset, with eight companies represented, each with their own loss development patterns, as well as the small number of claims in our dataset,[44] we did not find that traditional actuarial techniques such as the loss development method would be sufficiently predictive. Instead, we projected ultimate loss based on estimates of IBNR for each open claim.[45] These estimates were derived by reviewing the policy limits that apply to each claim as well as the nature of the claim and any insights into the case reserving policy of the company which we could glean based on the data. We sensitivity tested various scenarios and produced the projection in Table 2 below. Note that this methodology does not account for unreported claims that could emerge for the small percentage of occurrence policies. Note also that results may be inaccurate; there may be many claims that close at significantly lower or higher IBNR amounts than we project. Actuarial projections rely on the "law of large numbers"[46] to approach accuracy; the statistical reliability of such projections with a small claims dataset is lower than with a larger dataset. Notwithstanding the above caveats, we produce Table 2 below:

[43] See DSHS June 26, 2024 working group presentation at https://www.insurance.wa.gov/sites/default/files/2024-11/dshs-afh-june-26-meeting.pdf

[44] As shown in Table 1, our dataset consists of 51 reported claims with loss amounts greater than $0. As a matter of comparison, a standard of 1082 claims are used in many actuarial studies to determine whether a dataset has full statistical significance. Actuarial projections rely on large datasets. Our dataset is by nature small because of the limited number of AFH beds, premiums, and claims in Washington State.

[45] We determined "open" claims based on claims that had some associated case reserve; it is possible that other claims are open with a zero-case reserve.

[46] See https://www.investopedia.com/terms/l/lawoflargenumbers.asp which states, "The law of large numbers, in statistics, states that the results of a test on a sample get closer to the average of the whole population as the sample size grows."

Table 2

Washington State Office of the Insurance Commissioner
Davies' Study of Adult Family Homes
Projections of Ultimate
Loss
All Companies Combined

Year	Policy Count (1)	Earned Beds (2)	Earned Premium (3)	Reported Non-Zero Claim Counts (4)	Ultimate Loss (5)	Ultimate Loss Ratio (6)	Ultimate Severity (7)	Reported Frequency (8)
2019	1,371	8,483	2,495,869	11	4,119,450	165%	374,495	1.297
2020	2,071	10,584	3,624,381	8	2,430,089	67%	303,761	0.756
2021	2,547	14,900	5,433,398	6	1,298,709	24%	216,451	0.403
2022	2,818	17,115	7,030,803	8	1,852,757	26%	231,595	0.467
2023	3,063	18,936	8,823,759	10	2,413,258	27%	241,326	0.528
2024*	2,876	17,941	8,373,950	8	2,269,958	27%	283,745	0.446
Totals	14,746	87,958	35,782,160	51	14,384,222	40%	282,044	0.580

*2024 represents data through 9/30, except for one company which provided loss and premium data through 12/31
(1), (4) from data provided by data call respondents
(2), (3) calculated based on data provided by respondents
(5) projected based on reported loss, open claims, policy limits, claim descriptions, and observations on case reserving practices by company.
(6) = (5) / (3)
(7) =(5) / (4)
(8) =(4) / (2) x 1000. Note that since the vast majority of policies are claims-made, reported frequency should be similar to ultimate frequency.

Based on this methodology, we project the overall ultimate loss ratio at approximately 40%. Note again the potential volatility from year to year as well as the potential for underprojection of the most recent years, where the least information is known regarding individual claims. (These claims are generally not as mature in the settlement and/or litigation process). There is the possibility that some claims with $0 payments and $0 case reserves may eventually convert to more substantive claims, especially those in the 2024 year. Finally, we observe that ultimate severities (average cost per claim) shown in Column (7) and frequencies shown in Column (8) are projected based on reported claims. Given that approximately 93% of the premium is claims-made and our small dataset, we made the assumption that reported claims equal ultimate claims; this assumption may or may not be correct.

Our actuarial projections across all years indicate overall insurer profitability, but given the nature of the market, rates do not appear unreasonable.

A 40% ultimate loss ratio is on the lower end of typical loss ratios. However, given the volatility in the market, the potential for a few claims to create strong impacts, and the possibility that the nature of the AFH market may require unusually high expense ratios, a 40% ultimate loss ratio may not be unreasonable. Additionally, the E&S market which currently provides insurance for this exposure in Washington State is designed for "hard to place" risks. They may experience lower loss ratios than admitted insurers because they are willing to write exposures that admitted insurers will not, and they require financial compensation in order to take that risk.

We considered whether the creation of a government-sponsored insurance entity might be a worthy policy option, given the somewhat low projected ultimate loss ratio. **We decided that a government-sponsored insurance entity was not a recommended policy option** for a number of reasons:

- Should a government-sponsored option be offered, the likelihood of adverse selection is high.[47] This entity, potentially without the benefit of many years of underwriting experience, will likely offer an average rate to many insureds. The insureds who are currently being underwritten as the best risks with the most affordable premiums will likely stay with their current insurance company. Most of the insureds who opt to purchase insurance with the new entity will likely be those with higher-than-average premiums. In the event that these premiums meaningfully correlate with risk, the entity will be charging a too-low premium for the risks that are drawn to it.

- The relatively small premium volume of our dataset (likely slightly over $10 million of written premium for the complete 2024 year) may make the initiation of any type of government-sponsored insurance entity difficult to manage. The current carriers can diversify their risk and spread their expenses to other states and/or lines of business. A premium base of $10 million may be insufficient to pay for all of the operating expenses of an insurance entity in addition to paying claims and could lead to higher expense ratios (and lower loss ratios) than observed in our dataset.

Based on our discussions with brokers and even based on the June 2024 AFHC presentation, we have not determined that a true "availability" problem exists in the sense that it is impossible to find insurance for a given AFH. Instead, we have learned that the problems more focus on "affordability" of insurance given the high premiums charged to certain types of risk and the very restricted budgets experienced by most AFH providers. Policy options related to these challenges are discussed in the Policy Options section of this report.

Average Bed Rates

We also utilized the data call to review the distribution of rates (premium per licensed bed) for the policy data received. We restricted our review to policies with effective dates in 2023, as this was the most recent

[47] According to Investopedia, "in the insurance industry, adverse selection refers to situations in which an insurance company extends insurance coverage to an applicant whose actual risk is substantially higher than the risk known by the insurance company. The insurance company suffers adverse effects by offering coverage at a cost that does not accurately reflect its actual risk exposure." See https://www.investopedia.com/articles/insurance/082516/examples-adverse-selection-insurance-industry.asp

complete year of policy data. By performing our review on one year of data, we avoid ambiguity because of rate changes over time and instead present an "apples to apples" rate comparison.

As over 70% of the policies reviewed had 6 licensed beds, we present the information below both on a per-bed basis, and on a 6-bed basis, where the 6-bed basis is representative of a typical policy.

The average rate in 2023 was $480, indicating an average 6-bed policy premium of $2,880. Based on our industry knowledge regarding this type of exposure, this appears to be a reasonable average premium.

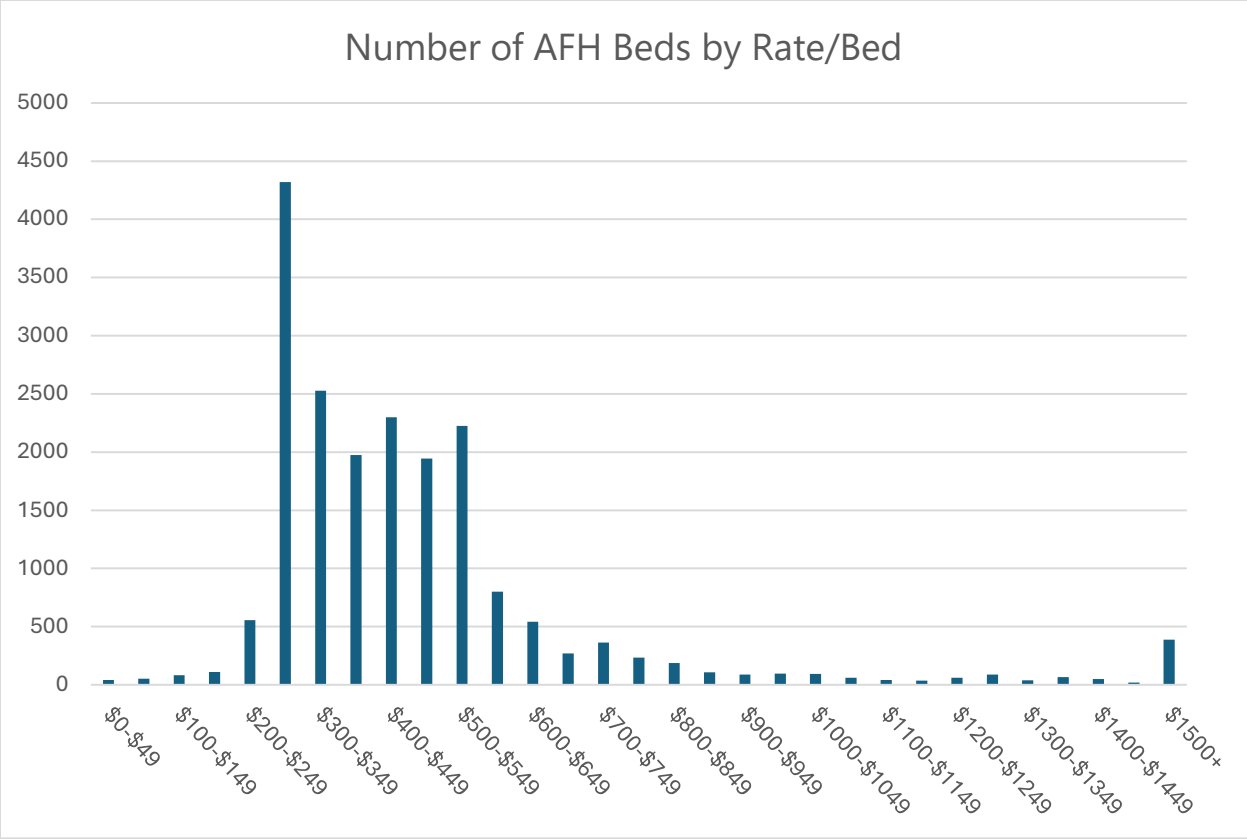
Over 80% of the beds had a rate of less than $550, representative of a total premium of less than $3,300 for an exemplar 6-bed policy. In our opinion, and based on industry knowledge, this premium is also within a reasonable range for the exposures written.

Over 94% of the insured beds had a rate of less than $900 per bed, representative of a total premium of less than $5400 for an exemplar 6-bed policy. We note that there may be substantial differences in exposure between AFHs due to patient acuity, facility layout (difficulty of egress for certain residents), worrisome inspection reports or loss history, provider experience, and other rating and underwriting factors. The rates in the $550 to $899 range may be reasonable if they are representative of greater liability insurance risk.

We note that for the 5.7% of beds for which rates exceed $900 per bed, the premiums can indeed be very high. Of the 10 policies with a per bed rate of $3750 or higher, 8 of them were written by companies identified to us by brokers as ones that are willing to write higher risks. The lowest policy premium in this rate category was $12,500 (3 licensed beds) while the highest was slightly over $50,000 (6 licensed beds). We do not have information specific to these AFHs but understand that some homes do provide very high levels of care (e.g. residents on ventilators or reliant on feeding tubes) such that the associated liability risks may be more comparable to a skilled nursing facility than a typical AFH.

Although we understand that many AFH owners are working on very tight budgets, the figures above do not appear to indicate an availability or affordability insurance crisis on the whole. Rather, they indicate that the insurance market perceives certain types of AFHs or their residents to present greater risk. Our Policy Options section presents some potential avenues that may be of assistance to AFH owners.

The graph below shows a presentation of rate per bed for policies in the data call with an effective date in 2023:



Data Call – Summary of Findings

In summary, our key findings from our analysis of the data received in the data call were:

- More than 80% of the policies with 2023 effective dates were charged annual bed rates less than $550 per bed, which based on our industry knowledge, is reasonable.
- Approximately 14% of the policies were charged annual bed rates in the $550 - $899 range per bed. This rate may be reasonable for insureds that present a higher risk, because of complexity of patient care, potentially worrisome inspection reports or loss experience, physical characteristics of the home that could create liability issues (for instance, slower egress in emergency), or other factors.
- Approximately 5% of the policies have daily bed rates of $900 or more. Many of these beds, especially the ones with the most expensive rates, were written by insurers which are recognized by brokers as accepting risks that other insurers will not.
- The year-to-year increase in premiums does not appear excessive based on industry information.
- Our aggregate ultimate projected loss ratio, although not unreasonable, indicates strong profitability for the insurance companies. However, we note:

- Admitted carriers are currently not engaged in this market; non-admitted carriers will expect stronger profitability in exchange for taking on risk;
- A small number of total-limits losses, which are not uncommon in this industry, could make loss ratios much higher and even result in underwriting losses;
- Lack of economies of scale may increase the expense ratio for this business, reducing the implicit profitability.

Based on these findings, our policy options will focus on creating a more efficient and appealing market to encourage new entrants, and will also focus on educational and other environmental factors that may improve outcomes.

Potential Coverage Issues

One of the mandates of the working group required by the 2024 supplemental operating budget (ESSB 5950) was to "evaluate the financial risk to AFHs, their residents, the state Medicaid program, and others that exist as a result of the increased cost of insurance, or in the event AFHs are uninsured due to a lack of access to coverage."

This section does not address AFHs that are uninsured because, while we did not specifically seek to identify uninsured AFHs, we also did not encounter such facilities in the course of our research. Financial risks identified therefore appear to arise primarily from gaps in coverage that may result from misunderstanding or lack of education on the part of the insured.

Gaps in Insurance Coverage - Timing

The liability policies sold to AFHs are essentially small commercial policies; however, the nature of the AFH market is that many of the owners are not familiar with the importance and mechanics of insurance or in some cases may not be experienced in timely submission of documentation. Additionally, based on a number of interviews, we understand that AFH owners are frequently on a very restrictive budget. The combination of these two factors can sometimes result in situations in which AFH owners experience gaps in coverage based on timing.

A gap in coverage for even a short time can cause substantial problems for the AFH owner, the claimant, and/or the state Medicaid program if a claim is triggered during the gap. The owner may lose all of their savings in attorneys' fees and/or in ultimately paying the claim. Claimants are at risk of not receiving compensation in the event of injury or death of a resident or visitor and Medicaid may be unable to recover third-party liability payments.

This section documents a number of scenarios which can result in a gap in coverage:

- An AFH owner may not respond promptly to broker information requests regarding insurance renewal applications. The AFH owner may not realize that the insurance company requires time after the submission of a renewal application to review inspection reports; updated medical, ambulatory, or other needs of residents; and updated loss information. The AFH owner may also not fully appreciate that the admission of certain new residents, the decline in abilities of existing residents, or a change in the insurer's underwriting guidelines, may require the broker to submit an application to a different insurance company. For these reasons, the AFH owner may delay responding to broker inquiries until very close to the renewal date of the policy. In this case, especially if the broker needs to search for a new insurer, the broker may be unable to place insurance in advance of the renewal date, and the insured may suffer a gap in coverage.

- Based on interviews and some survey results, it appears that some AFH owners perceive liability insurance as a regulatory requirement rather than an important consideration in their own fiscal security. Where AFH owners are highly price sensitive, this may lead to financial decisions that expose the owner, third-party claimants, and the state Medicaid program to coverage gaps. For example:

- AFH owners on restrictive budgets who encounter cash flow challenges may opt to prioritize payment of immediate operating expenses over liability insurance premium. This may cause policies to lapse, opening a coverage gap.

- AFH owners switching from claims-made coverage with one insurer to similar coverage with another may elect to forgo "prior acts" or "extended reporting period" coverage to reduce expenses, sometimes against the advice of insurance brokers. This creates an opportunity for claims to arise that are covered by neither insurer Please see Appendix B for further detail on this scenario.

- One person or entity may obtain a new AFH license and then sell the AFH to another owner. This is commonly called a Change in Ownership or "CHOW." We understand that in some instances, after the purchase and sale agreement is executed, the original owner will allow the insurance to lapse before the new owner procures coverage or is named as the licensee.

Gaps in Insurance Coverage - Sublimits

For some AFH liability policies, there may be sublimits on the policy for certain types of coverage. For instance, a policy that provides $500,000 per claim limits may provide a sublimit of $100,000 for elopement claims. (An "elopement" is when a resident wanders off or otherwise exits the premises without the knowledge of the AFH staff. This may happen for residents with dementia and can present severe risks.) There also may be coverage limits that apply to bedsores or to sexual abuse. These sublimits can expose the AFH owner to unanticipated liability and could also have financial consequences for claimants and the state Medicaid program to the extent that they reduce the assets available to fund recoveries or third-party liability claims. In many cases, higher sublimits can be purchased for additional premium.

AFH Owner Feedback

Based on work group meeting and interviews with AFHC staff, we learned that many AFHs were operating on very limited budgets, and that relatively small insurance premium increases could have outsize effects on an AFH's financial condition.

In our review of AFH and related insurance systems in other states (see Appendix A), we noted that the California Behavioral Health Planning Council had produced a March 2018 paper entitled, "Adult Residential Facilities (ARFs): Highlighting the Critical Need for Adult Residential Facilities for Adults with Serious Mental Illness in California."[48] The paper presents several exemplar income statements for a variety of California ARFs to demonstrate specific financial challenges the ARFs may face in the context of overall financial operations. We hoped to gather similar exemplar income statements that might help to understand the overall financial structure of select AFHs and demonstrate how affordable/unaffordable liability insurance may be for certain anonymized entities. We requested assistance from the AFHC in the fall of 2024 and revisited the possibility in the spring of 2025.

The AFHC did not solicit collection of full income statements but did issue a survey. There were 41 respondents out of approximately 4,300 providers. The information generated by the survey represents a small percentage of the population and is anecdotal, subjective, self-reported, and not externally validated. It may, nevertheless, be interesting and informative. For example:

- 23 of the respondents said that they accept "mostly Medicaid" payments with another 12 saying that they accept "Mixed Medicaid and Private Pay."
- 26 respondents stated that they accept a wide variety of residents. Some entries reported significant resident diversity (even within an 8-bed home) including AFHs admitting the following mixes of residents:
    - HIV, Dementia, Developmental Disabilities, Mental Health, Behavioral Health (ECS, SBS)
    - Ventilator Use, Private Duty Nursing, Medically Complex, Developmental Disabilities,
    - Dementia, Developmental Disabilities, Mental Health, Behavioral Health (ECS, SBS)
    - Ventilator Use, Developmental Disabilities, Mental Health, Behavioral Health (ECS, SBS)
    - Dementia, Developmental Disabilities, Mental Health
- One AFH provider with significant self-reported liability premium (stated as approximately $36,000) provides "medically complex private duty nursing care for the highest acuity. . . residents" and requires a high level of "24/7 nursing care." The respondent stated, "this [DSHS] fee structure does not cover all the nursing care, physical therapy, or operational costs that it takes to cover the care we provide". Although the self-reported insurance premium is indeed high compared to other AFHs, it may not be unreasonable given the level of care described and accompanying risk profile for the liability insurer.
- Another AFH provider noted that they provide "a high level of nursing care and some [residents] require more staffing due to behaviors." That operator noted a self-reported annual liability premium of $23,000.

[48] See https://www.dhcs.ca.gov/services/MH/Documents/Legislation-Committee/2018-ARF-Final.pdf

- Some AFHs self-reported premiums less than $4,000 and stated that the premium is too expensive and is crowding out other operating costs. Additionally, it appears that some AFH providers may not realize that they will be rated and underwritten based on their licensed beds, not based on their current number of occupants.[49]

- Two providers described how self-reported premiums of $12,000 or $30,000, respectively, are impacting their businesses.
- Some AFH providers recognize that their premiums are directly related to the types of residents whom they accept, and have had to make some painful decisions about whom to admit in order to keep premiums to an affordable level. This may not necessarily indicate that premiums are too high; it may instead (or additionally) indicate that compensation is too low to cover the operational expenses (including insurance) for certain types of risk.

[49] It should be noted, in this regard, that insurance companies do not change premiums mid-year, nor do they check on the number or status of the residents mid-year. The insurers therefore rate on the number of beds for which the facility is licensed as well as the profile of the residents as of the application date.

Policy Options

Below, we present a variety of policy options for consideration with the Legislature that align with the categories in our Executive Summary at the beginning of this report. These policy options are based on our research and observations.

We have not identified a problem with true availability of insurance and therefore are reluctant to suggest options which could potentially disrupt the current market and cause market exits. Our options instead focus on creating a more flexible and responsive insurance market, education of AFH owners, AFH owner compensation, and factors external to the AFH owners which may impact their premiums.[50]

Policy Option Category 1

Implement licensing changes which may make the AFH liability insurance market more appealing to new market participants, and/or may allow the current market participants to price policies with greater confidence

Policy Option 1.A

Create narrower DSHS licensure definitions for AFHs

As described in greater detail in Appendix A, many states that we reviewed have more specific licensing categories for their AFH-type facilities, or the AFH-type facility is restricted from providing some of the higher risk services that are allowed in Washington AFHs:

- The California Department of Social Services licenses a broad category of residential facilities providing 24-hour non-medical residential care to the elderly, children and adults with mental, physical, or developmental disabilities, those who require assistance recovering from mental illness, or who have HIV/AIDS or terminal illness. But those facilities are then specially licensed (Levels 1 through 4) based on the intensity and level of care and supervision required by residents.
- In Hawaii, regulations subdivide ARCH facilities by type (I and II) and also require specific licensure for E-ARCH facilities providing higher levels of care. Developmental Disabilities Domiciliary Homes which provide supervision or care, but not nursing services, to five or fewer adults with developmental disabilities in a home setting with a resident caregiver are licensed separately.
- In Oregon, the Oregon Department of Human Services issues licenses in three classes, depending on the provider's and caregivers' training/experience, including Class 1 (residents requiring assistance with 4 or fewer ADLs), Class 2 (residents who require assistance in all ADLs, but require full assistance in no more than three ADLs), and Class 3 (residents requiring assistance with 4+ ADLs, to include one resident who is bedridden or dependent on all ADLs). Other agencies separately license foster homes for adults with intellectual or developmental disabilities or with qualifying mental illnesses.

[50] Please see our narrative towards the end of the Actuarial Analysis section of this report, describing why the initiation of a government-sponsored insurance entity may be undesirable.

- In Idaho and Texas, the licensing does not appear to be very specific, but the regulator must approve each resident to ensure that the services available in the home are consistent with the resident's needs.
- In Florida, AFH-type facilities typically do not provide medical care, though there are exceptions, and they may not admit or retain residents requiring higher levels of care (e.g. bedridden individuals, those with stage 2+ pressure sores). There are separate residential treatment facilities which provide a long-term homelike environment for individuals suffering from mental illness (excluding, among other things, substance use disorders) and are licensed at different levels based on the level of care/supervision required.

Insurance professionals identified the broad Washington licensure as a point of concern for some insurance companies. When an AFH is first licensed and is seeking insurance, the owner may have an idea of who they are seeking as residents. However, based on the broad Washington AFH licensure structure, the insurance company has no guarantee that the residents admitted during the course of the annual policy will be similar to the profile initially envisioned. This creates reluctance on the part of insurance companies, as they cannot be sure of the type of risks they are insuring. It can also create challenges for the insured and brokers upon renewal, when the residents who have been admitted do not meet the insurer underwriting guidelines. This same scenario can arise for long-established AFHs who admit new residents during the policy year, although the risk of a completely unanticipated profile is likely greatest at the AFH inception.

Insurance professionals have also expressed concern regarding residents with vastly different profiles residing in the same AFH. It may be more risky for a non-ambulatory elderly resident to be residing in the same AFH as a resident with behavioral or mental health challenges.

The Legislature may wish to consider creating more specific licensure categories for Washington AFHs, such that insurance companies have a clearer understanding of the types of residents that will reside in the AFH.

Potential Advantages:

- Insurance companies may be able to price AFHs more confidently based on the more defined licensure requirements. This may lead to more refined pricing by current insurance companies, may increase the appetite for affordable pricing of new AFHs, and may even encourage new entrants to the market.
- AFH residents may benefit as they would be better able to identify AFHs specific to their needs and would have confidence that the AFH will not reorient its focus after they are admitted.
- Over time, AFH owners may gain a better understanding of the insurance premiums that are associated with certain types of residents (ones needing skilled nursing care, ventilator care, wound care, "wanderers", non-ambulatory, etc).

Potential Disadvantages:

- Many of the currently licensed AFHs serve a wide variety of residents, and the unnecessary disruption of current residents would be undesired, as well as disallowed by Washington Administrative Code. As a possible workaround/solution to this problem, perhaps current residents could be "grandfathered" into the AFH, but when accepting new residents, an AFH would be

restricted to its stated license category. Similar consideration should be given to tension between the objectives of matching residents to suitable AFHs and allowing them to age in place even if their acuity increases.

- With the greater clarity on insurance premiums obtained by more specific licensure categories, certain types of AFHs may see their premium increase as risks are concentrated in those homes. (Note that this is already occurring on a practical level, but currently AFH owners are surprised by their changes in premium, whereas with more clarity, they could make an informed decision from the outset). Washington may have to meet this challenge by allotting more funds or a higher daily bed rate towards residents that are associated with a higher operational (insurance) cost.
- Narrower licenses would mean reduced options for some residents (i.e. they would be limited to selecting from a subset of AFHs).
- One attendee at our June 17, 2025 presentation on research and draft findings observed that narrower licenses may tend to cause similarly situated individuals to concentrate in particular homes. This could have social and operational effects (e.g. an increase in the average level of acuity).

Policy Option 1.B

Enhance the Licensure Requirements for New AFH Owners

Based on our understanding of insurer underwriting guidelines as presented by insurance professionals and based on our review of specific underwriting guidelines provided in the data call, some insurers will not provide coverage to AFH owners with less than three years of experience in clinical experience or healthcare administration. This lack of hands-on experience is considered by these insurers to be a higher liability risk. Thus, inexperienced new AFH owners may be forced to purchase more expensive insurance.

The Legislature may consider requiring prospective AFH owners to gain three years of clinical experience or healthcare administration (including serving as residence manager for an existing AFH) before becoming licensed themselves.

Potential Advantages:

- Prior to embarking on ownership of an AFH, the prospective owner would obtain hands-on experience to better understand the demands. According to several professionals in the industry, there are many newer AFHs with a license for six beds but only one or two residents. (Note that insurance premiums are determined based on the number of licensed beds, not the number of residents). The greater length of time and the experience before eligibility for a license may benefit both the individual AFH owners and the market.
- There is potential for better risk management and resident outcomes for AFHs, which should also correlate with a lower risk profile and lower insurance premiums.
- One insurance professional noted that AFHs frequently receive poor DSHS inspection reports on the first annual inspection because the owners do not appreciate the gravity of some items that they may perceive as insignificant. This can greatly affect their insurance premiums, and is also less than optimal from a resident-care standpoint. Were they to have experienced their first inspection in an existing AFH, they would have a greater appreciation of the process and the necessary attention to detail.

Potential Disadvantages:

- Slowdown of time-to-market which may be problematic depending on the AFH needs in the coming years.
- This option may replace one barrier to entry (expensive insurance premium) with another (increased experience requirements).

Policy Option Category 2

Enhancing AFH Owner Education and Awareness

During the course of our survey of AFH-type facilities in other states (see Appendix A), we became aware that Portland State University publishes an annual study on Oregon Adult Foster Homes (a close equivalent to Washington AFHs).[51] Further, the Portland State University team has worked with Oregon regulators to train and educate current and prospective providers on technical aspects of owning and operating an AFH.[52] Although we are aware that the AFHC encourages education of its members, **the Legislature may wish to grant funds to one or more educational institutions to partner with DSHS, AFHs, the AFHC, or others to conduct ongoing research and education aimed to improve AFH fiscal sustainability, quality of care, and best practices.**

Education that could be of immediate use to AFH owners as it relates to this study includes:

- Small business budget planning and management, incorporating DSHS bed rates, other income, and operational costs. This could include training in the various insurance and other operational costs that arise from the care of different types of residents.
- Risk management training, including the importance of risk mitigation, compliance and documentation, the benefits and workings of insurance coverage, and the role of the tort system.
- Training in DSHS compliance, including keeping the AFH inspection-ready
- Understanding of the physical qualities of a residence that make it more or less insurable (location and accessibility of exits, fire safety, age of electrical systems, etc).
- An introduction to human resources including hiring, employee retention, benefits, overtime, workplace safety, antidiscrimination/harassment law, and related issues
- Self-care and strategies for managing work/life balance in a career where work occurs in the home.

Policy Option Category 3

Raising Daily Bed Rates for AFH Residents

Affordability of AFH liability insurance is ultimately a question of how the premium charged compares with revenue and other expenses. We were unable to obtain exemplar financial statements that might have provided direct evidence but it is nevertheless clear that Washington AFHs operate under restrictive budgets with very modest profit margins (please see "AFH Owner Feedback" section of this report) and that the challenge in making the budget work for many AFHs is broader than insurance cost alone. The most direct

[51] See recent study at https://archives.pdx.edu/ds/psu/42492
[52] See https://www.pdx.edu/institute-on-aging/afhworkshopseries

method of improving affordability would be to make more resources available to AFHs through increased revenue in the form of raising daily bed rates.[53]

As noted in the "DSHS Contracts, Daily Bed Rates, and Economics of AFHs" section of our report, the average daily bed rate for AFHs is significantly lower than for skilled nursing facilities or state psychiatric hospitals. Certainly, there are residents of AFHs who need a lower level of care. However, given that more than 50% of AFH residents have Acuity 1 or 2 as measured by DSHS, **it may be appropriate for the Legislature and/or DSHS to consider providing more robust funding to the AFHs, especially to high acuity residents, to ensure the continued fiscal viability of AFHs**. Given the disparity between the average bed rate for AFHs and for other facilities, it is likely that the AFH bed rate could be raised substantially and still provide savings over alternate facility placements.

Additionally, DSHS may wish to consider insurance operational costs when determining daily bed rate. For instance, a non-ambulatory resident may not have a very high acuity in terms of medication management or nursing staff needed, but the insurance cost associated with that resident may be high.

Policy Option Category 4

Administrative DSHS Items

Policy Option 4.A

Eliminate Inspection Backlogs

Based on conversations with insurance professionals, AFH owners, and personnel from DSHS, we understand that during COVID-19, many AFH inspections were necessarily postponed. This resulted in a backlog of inspections.

Our understanding is that although DSHS has made efforts to resume inspections on their scheduled annual timelines, the inspection personnel are understaffed, and that inspections may still not occur on their annual inspection timelines.

All underwriting guidelines we reviewed, as well as discussions with insurance professionals, confirmed that the DSHS inspection report is a key item used by underwriters to determine AFH acceptability to be underwritten and also in determination of price. Accordingly, an inspection report with noted deficiencies would present a red flag to underwriters and the AFH owner may have difficulty procuring insurance (and soliciting customers) until corrections are confirmed by a follow-up DSHS report. It is therefore extremely important that the follow-up inspections be conducted and reported timely. In this way, the AFH can present documentation that the deficiencies have been addressed and can present a "clean" report. Similarly, delays between standard scheduled inspections can make it difficult for AFH owners to demonstrate that they are superior risks, leading to rejection by preferred insurance companies and substantially increased AFH liability premiums.

[53] One attendee at the June 17, 2025 presentation on research and draft findings suggested that the Legislature might consider supplementing caregiver wages --– perhaps through a tax credit. We were unable to conduct detailed research on this idea prior to the issuance of this report.

The Legislature may wish to consider addressing this issue, perhaps by providing funding to DSHS to enhance their inspection-related staffing.

Policy Option 4.B

Conforming the Standard AFH Contract to Statute and Market Conditions

As noted above in "DSHS Contracts, Daily Bed Rates, and Economics of AFHs," the liability insurance requirements in standard DSHS AFH contract exceed those set forth in WAC 388-76-10192. Whereas the WAC requires limits of $500,000 per occurrence and $1 million annual aggregate, the standard contracts require limits of $1 million per occurrence and $2 million annual aggregate. (Note that we understand this is set to rise to minimum limits of $2 million per occurrence and $4 million annual aggregate as of July 1, 2026). Higher limits necessarily require higher premium, creating the potential for decreases in the availability and affordability of AFH liability insurance.[54]

The standard contract also requires that liability insurance be provided by "an admitted insurer/carrier in the State of Washington, with a current Best's Reports' rating of A-, Class VII, or better." As discussed earlier in this report, AFH liability insurance is currently not offered by admitted carriers. It is pragmatically impossible for the AFH owner to comply with the terms of the DSHS contract.

Consideration should be given to conforming legislation and the standard AFH contract, leaving flexibility in the statute or contract to adapt to market conditions, and to creating flexibility in either the statute or contract that recognizes market realities, and to balancing minimum limit requirements against affordability/availability concerns.

[54] It may be helpful to note, in this context, that several of the peer jurisdictions studied (Florida, Idaho, and Texas) do not require the purchase of liability insurance as a condition of licensure, that the scope of any such requirement is unclear in other states (Hawaii and Oregon), and that only in California were we able to identify specific minimum limits ($1 million occurrence/$3 million aggregate).

Appendix A –Study of Peer Jurisdiction Regulatory Structures & Insurance Markets

To place the market for AFH liability coverage in context, better understand market dynamics, and develop policy options to improve insurance access in Washington, we examined the regulatory structure and market experience in other jurisdictions with analogous long-term care facilities. A fifty-state survey would be beyond the scope of this market study so, after review of available literature and preliminary investigation, six states -- California, Florida, Hawaii, Idaho, Oregon, and Texas -- were selected for further review based on their regions and regulatory structures.

California

The California Department of Social Services licenses a broad category of residential facilities providing 24-hour non-medical residential care to the elderly, children and adults with mental, physical, or developmental disabilities, those who require assistance recovering from mental illness, or who have HIV/AIDS or terminal illness.[55] Certain facilities are then specially licensed (Levels 1 through 4) based on the intensity and level of care and supervision required by residents. Additionally, an assisted living waiver program is available for elderly residents of certain facilities -- Residential Care Facilities for the Elderly ("RCFE") and Adult Residential Care Facilities ("ARF") -- to permit them to maintain independence and receive care in a social-based setting rather than a healthcare facility.[56] RCFEs are required by statute to maintain liability insurance coverage with limits of $1,000,000 per occurrence and $3,000,000 in aggregate.[57]

Review of publicly available sources did not disclose information about the availability and affordability of liability coverage for residential facilities analogous to Washington AFHs. In 2018, however, the California Behavioral Health Planning Council published a study addressing the need for ARFs (including ARFs serving seniors and those with mental illness) and focusing in significant part on the financial challenges that these facilities faced.[58] The study did not specifically analyze liability insurance costs but the exemplar financial statements in the report show that insurance (exclusive of workers compensation) was generally a significant expense and large fraction of net income.

Generally speaking, the population served by AFHs in Washington might be served in California by a range of facilities with narrower or more specialized licenses. Notably, these facilities are typically prohibited from providing "medical care" (though others may provide such care on-premises) which has two significant

[55] CDSS regulations are available at https://www.cdss.ca.gov/inforesources/letters-regulations/legislation-and-regulations/community-care-licensing-regulations/residential. Narrative description of certain facilities (excluding Residential Care Facilities for the Elderly and Adult Residential Care Facilities) is also available at https://www.cdss.ca.gov/inforesources/adult-care-licensing/resources-for-residents-and-families#:~:text=Social%20Rehabilitation%20Facilities%20(SRF)%3A,need%20assistance%2C%20guidance%20or%20counseling.

[56] https://www.dhcs.ca.gov/services/ltc/Pages/Residential-Care-Facility-and-Adult-Residential-Facility-Provider-Enrollment.aspx.

[57] Cal. Health & Safety Code, § 1569.605.

[58] https://www.dhcs.ca.gov/services/MH/Documents/Legislation-Committee/2018-ARF-Final.pdf.

implications. First, the residents of California facilities may have less acute care needs than some residents of Washington AFHs.[59] Second, the fact that California facilities may provide lower levels of care in some instances may mean there is also a lower risk of liability claims.

Florida

The Florida Agency for Persons with Disabilities and Agency for Health Care Administration license a number of facilities serving populations similar to those served by Washington AFHs including:

- Group homes that offer supervision and care for the physical, emotional, and social needs of 4 to 15 residents in a family living environment;[60]
- Adult family care homes ("AFCH") in which a resident caregiver provides personal care (but not skilled nursing) services to up to 5 individuals in a home environment.[61] Residents may include persons with physical/mental disabilities, young adults aging out of foster care, seniors, individuals experiencing homelessness, and individuals with HIV/AIDs;
- Assisted living facilities ("Florida ALF") which may be larger facilities but which are operated and regulated as residential environments and which provide routine personal care service and may (with "specialty licenses") offer more intensive care with the objective of permitting residents to age in place;[62] and
- Residential treatment facilities which provide a long-term homelike environment for individuals suffering from mental illness (excluding, among other things, substance use disorders) and are licensed at different levels based on the level of care/supervision required.[63]

These Florida facilities typically do not provide medical care, though there are exceptions, and they may not admit or retain residents requiring higher levels of care (e.g. bedridden individuals, those with stage 2+ pressure sores). AFCH may be the facilities most analogous to a Washington AFH and Florida has a comparatively small number of these entities (fewer than 300). In contrast, however, there are a large number of Florida ALF (nearly 3,000) which, due to their greater size, serve a significant population.[64] For both categories, there is a legislative focus on regulatory flexibility and the avoidance of obstacles to establishment.[65]

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[59] California regulations specifically prohibit adults with certain health conditions -- naso-gastric or naso-duodenal tubes, active/communicable TB, conditions that require 24-hour monitoring, stage 3/4 dermal ulcers, and any other conditions requiring licensure as a health facility -- may not be admitted to or retained in any community care facility. See Cal. Code Regs., tit. 22, § 80091.

[60] See Fla. Stat. Ann., § 393.063 *et seq.*; Fla. Admin. Code 65G-2.

[61] See Fla. Stat. Ann., § 429.060 *et seq.*; Fla. Admin. Code 59A-37.

[62] See Fla. Stat. Ann., § 429.01 *et seq.*; Fla. Admin. Code 59A-36.

[63] See Fla. Admin. Code 65E-4.016.

[64] Facility search returns (https://quality.healthfinder.fl.gov/Facility-Search/FacilityLocateSearch) show 217 licensed AFCH and 2,972 Florida ALF as of November 2024.

[65] See Fla. Stat. Ann. § 429.63 ("Regulations governing adult family-care homes must be sufficiently flexible to allow residents to age in place if resources are available to meet their needs and accommodate their preferences" and "Rules of the agency relating to adult family-care homes shall be as minimal and flexible as possible to ensure the protection of residents while minimizing the obstacles that could inhibit the establishment of adult family-care homes."); Fla. Stat. Ann. § 429.01 ("In support of the goal of aging in place… assisted living facilities should be

It does not appear that there are any publicly available formal studies as to the health of the liability insurance market for AFCH or Florida ALF. With regard to AFCH, this is unsurprising given that these providers are not required to maintain professional liability insurance.[66] Florida statutes do require Florida ALFs to maintain liability insurance but the minimum limits are unclear.[67]

While Florida licenses a number of facilities providing care to targeted populations, it also licenses AFCH which may serve a broad population similar to that of a Washington AFH. Florida regulations, however, limit the acuity level of residents in all community residential homes – requiring bedridden individuals and those requiring higher levels of care to transition to facilities subject to medical regulation. As discussed with regard to California, this may mean that Florida residential care facilities have a lower overall risk profile than some Washington AFHs.

Hawaii

The Hawaii Department of Health licenses several facility types that are, to some degree, analogous to a Washington AFH including:

- Adult Residential Care Homes ("ARCH") are facilities serving adults who require at least minimal assistance with ADLs but not the professional health services of an intermediate, skilled, or acute care facility. ARCHs are divided into Type I (five or fewer residents) and Type II (six or more residents). In addition there are "Expanded ARCHs" ("E-ARCH") which offer some care consistent with an intermediate care or skilled nursing facility. All ARCHs must have a primary care giver present at all times. Type I ARCHs must have a resident care giver and may have up to two non-ambulatory residents if they meet certain staffing and fire safety criteria.[68]
- Community Care Foster Family Homes in which a resident caregiver provides accommodations, personal care, and homemaker services for no more than two adults (three under special license), both of whom are SSI recipients (if eligible) and at least one of whom is a Medicaid recipient requiring a level of care equivalent to that provided in an intermediate or skilled nursing facility.[69]
- Developmental Disabilities Domiciliary Homes which provide supervision or care, but not nursing services, to five or fewer adults with developmental disabilities in a home setting with a resident caregiver.[70]

operated and regulated as residential environments with supportive services and not as medical or nursing facilities" and "Regulations governing these facilities must be sufficiently flexible to allow facilities to adopt policies that enable residents to age in place when resources are available to meet their needs and accommodate their preferences."). See also Fla. Stat. § 419.001(1)(a) (Regarding zoning/siting of "community residential homes").

[66] https://www.afchtraining.com/faq. https://ahca.myflorida.com/content/download/7236/file/Adult_Family_Care_Home_ST_F.pdf (Regulation set for AFCH does not reference insurance).

[67] Fla. Stat. Ann. § 429.275 (insurance requirement); Fla. Admin. Code 59A-36.013(4) (Documentation of liability insurance must "include the name and street address of the facility, a reference that the facility is an assisted living facility, the facility's licensed capacity, and the dates of coverage"; there is no reference to minimum limits.)

[68] Haw. Admin. Rules 11-100.1.

[69] Haw. Admin. Rules 11-800.

[70] Haw. Admin. Rules 11-89.

The number of each type of facility licensed in Hawaii is not clear but, in 2023, the Hawaii Long-Term Care Ombudsman reported that the total number of nursing homes, assisted living facilities, ARCH (and E-ARCH), and community care foster family homes was approximately 1,790 with nearly 13,000 beds.[71] ARCH facilities appear to constitute approximately 450 of these facilities with nearly 2,700 beds.[72] Hawaii statutes require that operators of certain community-care homes (including all of the entities listed above, except Assisted Living Facilities) maintain liability and auto insurance but the required limits of that insurance are unclear.[73]

The regulatory structure for Hawaii community-based care facilities appears similar to that in Washington with the notable exception that Hawaii regulations subdivide ARCH facilities by type (I and II) and also require specific licensure for E-ARCH facilities providing higher levels of care. This subdivision may be relevant to the affordability and availability of liability insurance if the regulatory differentiation permits insurers to better understand the nature of the risks presented by each facility. (An E-ARCH, for example, provides service to residents with greater medical needs such that it may present a greater severity risk than some other facilities.)

Idaho

The Idaho Department of Health and Welfare ("Idaho DHW") licenses more than 2,500 Certified Family Homes ("Idaho CFHs") which aim to provide safe, family-style living environments to adults who require assistance with daily living activities, but who do not need a more restrictive, institutional setting.[74] Residents of Idaho CFHs include adults who are elderly, who have mental illnesses, developmental disabilities, or physical disabilities, or who are otherwise unable to live alone without personal assistance and whose mental, emotional and physical condition can be met by his or her care provider.[75]

Idaho CFHs typically house one or two residents (in addition to the provider who must be a resident) but variances to house up to four residents may be requested on a case-by-case basis.[76] Care may be provided to one resident who requires "nursing facility level of care" or, with a variance, up to two such residents.[77] Prior approval from Idaho DHW is required before any resident is admitted.[78] There is no requirement that Idaho CFHs maintain professional liability insurance but homeowner's or renter's insurance on the premises is necessary for issuance and renewal of facility certification.[79]

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[71] https://health.hawaii.gov/opppd/files/2024/03/16_EOA-Annual-Legislative-Report-SFY2023_Final.pdf.
[72] https://health.hawaii.gov/ohca/state-licensing-section/ (The total count of capacity reported in the August 2024 "Combined ARCH-Expanded ARCH Vacancy Report-By Area" was 2,690).
[73] The insurance requirement is established in Haw. Rev. Stat., § 321-11.8 but it does not appear that accompanying regulations have been adopted for ARCHs, Community Care Foster Homes, or Developmental Disabilities Domiciliary Homes. Regulations applicable to a separate license category -- Adult Foster Homes, which provide care for up to two developmentally disabled adults in a private family home – require minimum liability insurance of $1 million occurrence/$2 million aggregate and automobile liability coverage of $100,000 occurrence/$300,000 aggregate. Haw. Admin. Rules § 11-148.1-8. The State of Hawaii must be named as an additional insured on such policies. Id.
[74] See Idaho DHW Certified Family Home overview site; Idaho DHW Certification & Recertification site.
[75] I.C. § 39-3501.
[76] IDAPA 16.03.19.140.
[77] IDAPA 16.03.19.130.
[78] IDAPA 16.03.19.260.
[79] IADAPA 16.03.19.101.07; IADAPA 16.03.19.111.02.

The licenses issued to an Idaho CFH and a Washington AFH both have broad scope – authorizing care for residents with varying needs and functional capacity. The Idaho DHW's prior approval and variance process may, however, be used to manage resident acuity and therefore establish a degree of facility specialization. While specialization would affect a facility's risk profile, this would affect insurance affordability/availability only if it were known to/relied upon by underwriters. More broadly, the fact that Idaho CFHs (2-4 licensed beds) are substantially smaller than Washington AFHs (6-8 licensed beds) means that facilities in the two states are likely to have very different operations, staffing, and cost structure. In addition, the market for professional liability insurance is likely to be materially different in Idaho (where purchase is voluntary) and Washington (where purchase is mandatory).

Oregon

The Oregon Department of Human Services ("OR DHS"), through its Aging and People with Disabilities Program, licenses adult foster homes ("Oregon AFH") which are single-family residences where 24-hour care is offered in a homelike setting to adults who are older or have physical disabilities.[80] Other agencies separately license foster homes for adults with intellectual or developmental disabilities or with qualifying mental illnesses.[81] There may also be substantial local variation to the extent that agencies for individual counties are authorized to establish parallel regulatory frameworks for licensing and inspecting adult foster homes in their jurisdictions.[82] Though regulated by different agencies, providers for all types of adult foster homes collectively bargain with the State as a single unit.[83] As of Fall 2022, there were 1,329 Oregon AFHs with a licensed capacity of approximately 6,100 beds.[84]

An Oregon AFH may provide care to five or fewer residents.[85] The care provided by an Oregon AFH is not necessarily medical or nursing and may include services to promote maximum independence and an enhanced quality of life.[86] Licenses may be issued in three classes, depending on the provider's and caregivers' training/experience, including Class 1 (residents requiring assistance with 4 or fewer ADLs, Class 2 (residents who require assistance in all ADLs, but require full assistance in no more than three ADLs), and Class 3 (residents requiring assistance with 4+ ADLs, to include one resident who is bedridden or dependent on all ADLs).[87]

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[80] General licensing information is available at https://www.oregon.gov/odhs/licensing/adult-foster-homes/pages/default.aspx and a consumer guide describing Oregon adult foster homes is available at https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/de9033.pdf. Portland State University also publishes annual studies on Oregon AFHs, the most current of which is available at https://archives.pdx.edu/ds/psu/42492 ("2023 PSU Study").

[81] Adult foster homes for residents with intellectual and developmental disabilities are licensed under OAR 411-360 and administered by the Oregon DHS Office of Developmental Disability Services (https://www.oregon.gov/odhs/licensing/idd-foster-homes/pages/afh-overview.aspx) while adult foster homes for individuals with qualifying mental illness are licensed under OAR 309-40 and administered by the Oregon Health Authority (https://www.oregon.gov/oha/hsd/amh-lc/pages/afh.aspx).

[82] Or. Rev. Stat. § 443.780.

[83] 2023-25 Collective Bargaining Agreement.

[84] See 2023 PSU Study at p. 7-9 (Fall 2022 figures reflect a 14% decline from peak capacity in 2015).

[85] See OAR 411-049-0102(6).

[86] See OAR 411-049-0102(14).

[87] See OAR 411-049-0105(9)-(16). Variances may be granted where doing so may (among other things) permit a resident to remain in place without jeopardizing care, health, and safety. Special licensure is required to provide ventilator care. See OAR 411-049-0155.

OR DHS regulations include requirements that caregivers receiving initial training/orientation as well as subsequent training on an annual or biennial basis.[88] License applicants must demonstrate that they have sufficient financial resources to operate a home, including having liquid assets, letters of credit, or other financial guarantees.[89] Some Oregon AFHs may be required to purchase professional liability insurance but the nature of any such requirement (e.g. policy limits) and its scope (e.g. how many Oregon AFHs are affected) are unclear.[90]

Oregon facilities equivalent to Washington AFHs appear to have narrower licenses, limiting the acuity of both potential and current residents. This may have some benefit from the perspective of insurance underwriting but could have implications for other objectives, including the ability of residents to age-in-place. The Oregon regulatory structure also separates populations (e.g. elderly/physically disabled and developmentally disabled) that may not be formally distinguished in licensing Washington AFHs. Where there does not appear to be a clear universal coverage mandate, there are likely to be significant differences between the Oregon and Washington markets for adult family home professional liability insurance.

Texas

The Texas Health and Human Services Commission ("TX HHS") licenses adult foster care homes ("AFC Homes") which provide care for people unable to continue living independently in their own homes because of physical, mental, or emotional limitations.[91] Similar facilities serving individuals with intellectual disabilities in a home and community-based setting are licensed by TX HHS as group or host homes.[92]

AFC Homes are typically licensed for up to four residents who share a household and common living area with the provider.[93] Historically, an AFC Home seeking to provide care to more than four people was required to qualify as a Type C assisted living facility but that requirement has been eliminated.[94] Expanded licenses may now permit up to eight residents in an AFC Home.[95] There does not appear to be a publicly available directory of Texas AFC Homes but TX HHS does maintain a directory of assisted living facilities that showed a total of 365 entities with licensed capacity of between 1 and 8 beds (2,486 total beds).[96] A number of entities listed in the directory are AFC Homes but it is unclear how many of the 1-8 bed facilities operated under such licenses.

The provider seeking a license must be the primary caregiver for residents in his or her AFC Home and must demonstrate financial stability independent of anticipated HHS payments.[97] It does not appear that Texas law requires an AFC Home to maintain professional liability insurance but providers must demonstrate

[88] OAR 411-049-0125(2)(g) and (4)-(11).
[89] See OAR 411-049-0125(3); See also OAR 309-040-0360(1)(k) (similar regulation for developmentally disabled adult foster homes).
[90] See, e.g., "So, You are Thinking of Opening an Adult Foster Home…" (Lane County booklet for prospective OR AFH providers, noting that "final preparations for operation" include "obtain[ing] insurance coverage (homeowners, liability, auto, and workers' compensation)"); OR DHS Business Records training.
[91] See Texas HHS AFC site.
[92] See Texas HHS site for Home and Community-Based Services.
[93] See 26 TAC § 278.103 (Provider qualifications).
[94] See 26 TAC § 553.5(d) ("HHSC no longer issues Type C licenses and Type C licensure is no longer a requirement…").
[95] 26 TAC § 278.111(b).
[96] HHS Assisted Living Providers Directory (updated as of May 27, 2025).
[97] 26 TAC § 278.103(a).

financial stability (independent of State provider payments) and the ability to meet existing financial obligations.[98] HHS Regulations do not include prescribed limits addressing the acuity of potential residents. However, AFC Homes may only serve residents approved by HHS "to ensure the provider can meet the needs of all residents."[99]

Texas regulations separately categorize homes for developmentally disabled residents and homes for those who are elderly or have physical, mental, or emotional limitations. Through the prior approval process, however, HHS may effectively control resident acuity and a consistency of risk profile within any particular AFC Home. Such sorting would not be apparent from facility license, however, such that it may have minimal impact on underwriting and the affordability/availability of professional liability insurance.

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Resources for further research regarding residential long-term care include:

- *Compendium of Residential Care and Assisted Living Regulations and Policy* (2015).[100] This report (prepared by the Office of Disability, Aging and Long-Term Care Policy for the U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation) focuses on group residential care settings that serve a population of older adults or working-age adults with physical disabilities. The compendium provides a digest of the regulatory structure in each jurisdiction and a helpful nationwide overview. Though focusing primarily on assisted living facilities, the compendium contains helpful information regarding adult foster care, a category which substantially overlaps with Washington AFHs though Washington AFHs do, notably, serve a broader population including those with mental illness and developmental disabilities.

- *Adult Family Care: A Viable Alternative to Nursing Homes* (2021).[101] This whitepaper, published by the AARP Public Policy institute describes the history of adult family care and key features for potential residents to consider in various jurisdictions. The report also includes appendices with tables comparing/contrasting regulatory approaches across multiple jurisdictions.

- *Adult Residential Facilities* (2018).[102] This report, issued by the California Behavioral Health Planning Council, addressed the barriers to and need for increased access to appropriately staffed and maintained Adult Residential Facilities in the State of California. The study demonstrates some of the challenges faced by facilities that are analogous, at least in part, to Washington AFH with particular focus on the challenging finances of a business model with significant labor costs and revenue constrained by the benefits available under Social Security and State Supplemental Payment programs.

- *Long-Term Care in Hawaii* (S. Suzuki, Hawaii Bar Journal vo. 19, no. 13, 2015). This journal article, while focusing on a single state's experience, provides a helpful history of the development of

[98] Id.
[99] 26 TAC 278.111(a)(2).
[100] https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//73501/15alcom.pdf
[101] https://ltsschoices.aarp.org/sites/default/files/documents/doi/adult-family-care.doi.10.26419-2Fppi.00128.001.pdf
[102] https://www.dhcs.ca.gov/services/MH/Documents/Legislation-Committee/2018-ARF-Final.pdf

formal and informal long-term care facilities, the types of facilities now available, and financing considerations.

- Portland State University Institute on Aging. A multidisciplinary team at Portland State University has been researching best practices in housing and long-term care including annual reports on Oregon AFHs (see, supra, n. 80) and broader studies regarding staffing levels, admission/discharge practices, family involvement, resident characteristics, and other issues involving the experience of residents, staff, and owners of adult family homes. These publications are collected on the university's website -- https://pdxscholar.library.pdx.edu/aging_pub/. In collaboration with the Oregon Department of Human Services, the Institute on Aging has also developed a series of training and technical assistance webinars addressing topics from resident care to operation of a small business.

Appendix B – Claims-Made "Prior Acts" and "Tail"

Insurance policies are typically written on either an "occurrence" or a "claims-made" basis. "Occurrence" policies generally provide coverage for incidents that "occur" during the policy period regardless of when the incident is discovered or the claim for coverage is reported to the insurer. In contrast, a "claims-made" policy will provide coverage only for claims first reported during the policy period regarding incidents that occurred during a defined period. Because occurrence policies generally do not have a cut-off for the filing of claims, they provide broader coverage than claims-made policies and are often more expensive.

Most Washington AFH liability policies are written on a claims-made basis. In our data set, for example, approximately 93% of the written premium in the 2019 – 2024 years was for claims-made policies, instead of occurrence policies.

To illustrate the difference in coverage, consider an AFH which purchases a series of policies which are issued on January 1 every year. An AFH resident suffers an injury on December 20, 2023, and the injury is reported on February 5, 2024. If the policy is an occurrence policy, then the claim will attach to the 2023 policy (date of occurrence).

Claims-made policies are always accompanied by a "retroactive date". A retroactive date is the earliest date of occurrence that will be covered by the policy. Suppose that in our example, the policy is a claims-made policy with a retroactive date of January 1, 2016. Then the claim will be covered under the 2024 policy because it was reported in 2024 and occurred after January 1, 2016.

When an insured renews a claims-made policy with the same carrier, the retroactive date will remain unchanged. **However**, when an insured moves to a new carrier, there is a risk of a coverage gap because the new carrier will not necessarily offer the same "retroactive date" as the previous carrier. In order to maintain unbroken coverage, the AFH must therefore either a) purchase "prior acts" coverage from the new insurer, such that the same retroactive date is maintained or b) purchase an "extended reporting" or "tail" endorsement from the prior insurer. (The "tail" endorsement allows future reporting for any claim that occurs between the retroactive date and the expiration date of the policy.) If the insured does not implement either of those options, it will be left with a gap in coverage.

As an example, suppose that the policyholder in the example above moves from Insurer A to Insurer B as of January 1, 2025 and does not purchase "prior acts" or "tail" coverage. In this instance, the retroactive date for Insurer B is January 1, 2025. Suppose a claim that occurred on October 15, 2024 is reported on March 1, 2025. Insurer A will not cover the claim because no extended reporting endorsement or "tail" was purchased; the last policy it provided covered claims reported in the 2024 year, not in 2025. Insurer B will not cover the claim either because "prior acts" coverage was not purchased; only acts occurring after January 1, 2025 will be covered. If the insured is unaware of this risk, it may be left with an unexpected gap in insurance coverage. It should also be noted that, even if the gap is chosen intentionally by the AFH owner (so as to minimize the cost of liability insurance), the purposes of a liability insurance mandate would not be served because injured residents may have limited sources of recovery while Medicare/Medicaid may be unable to recover from a third-party payer.

Appendix C – Data Call Instructions

Washington state data call relating to Adult Family Homes

At the direction of the Washington state Legislature, Insurance Commissioner Patty Kuderer must collect certain data regarding the availability and cost of liability insurance for adult family homes. Pursuant to the 2024 supplemental operating budget (ESSB 5950), the Washington State Legislature directed the Insurance Commissioner to collect the information required from entities transacting insurance with adult family home providers. Please respond to the following two requests. Please note that the first request relates to the provided data template.

Confidentiality statement: Pursuant to RCW 48.02.065(8), all data submitted as a part of this data call are confidential by law and privileged and not subject to public disclosure under chapter RCW 42.56. The Commissioner may prepare and publish reports, analysis, or other documents using the data received from individual property and casualty companies so long as the data in the report is in the aggregate form and does not permit the identification of information related to individual companies.

Submission

Due: WORKSHEET AND ADDITIONAL DATA ARE DUE BY COB MARCH 18TH, 2025.

- If your company transacts insurance with adult family home providers within the time frames described below, please complete the worksheet and return to datacall@oic.wa.gov.
- If after your review your company has NOT transacted insurance with adult family home providers within the time frames described below, complete the contact information, leave the other tabs blank and return to datacall@oic.wa.gov.
- When you email your worksheet, please change "NAME" in the .xlsx file "NAME_Adult_Family_Home_Data_Call_Template" to your company name or group.

Worksheet instructions

Tab 1 Contact information

- Please complete the contact information in "Company Info" tab of attached template.

Tab 2 Policy and Premium

The following request applies to each liability insurance policy covering adult family home providers with policy effective dates in the 1/1/2018 – 9/30/2024 period; liability coverages included are as defined in WAC 388-76-10192.

The liability coverages requested defined in WAC 388-76-10192 are:

- Errors or omissions of the AFH or its employees or volunteers;
- Bodily injury, property damage, and contractual liability; and
- Premises, operations, products-completed operations, personal injury, advertising injury, and liability assumed under an assumed contract.

We anticipate that all respondents providing this business during the specified time period should be able to complete the first 13 fields of the template for all policies (Insured, DSHS license number, zip code, policy number, effective date, expiration date, licensed beds, premium, policy limit – per occurrence/claim, policy limit – annual aggregate, policy deductible/SIR, claims made or occurrence policy, and retroactive date if claims-made form). The completion of these fields is required.

Please note that "claims-made or occurrence form" field has drop-down response options.
Many policies may have no deductible or SIR. If this is the case, then please complete the "policy deductible/SIR" field with a $0 entry.

The additional 14 fields of data (beginning from "minimum premium?") may be readily available for certain insurance companies and less readily available for others. Please complete the fields for which you have readily available data.

The "minimum premium?" field, which is a yes or no question to indicate whether the premium charged for the policy is a minimum premium, has a drop-down response option.

"Total debit/credit" should be populated as a positive or negative percentage. For instance, if the home would have typically been charged premium of $4000, based on the number of beds, but based on favorable historical loss experience or underwriting characteristics it was instead charged $3000, the debit/credit field entry would be -25% ($1000 premium discount/ $4000 base).

All fields should represent the information provided for the underwriting and pricing of the policy. For instance, [number of residents] should be a snapshot of what was provided at the time of the insurance application.

Tab 3 Loss and Claims

For each loss with incurred dates in the 1/1/2015 – 9/30/2024 period, please complete the "Loss" tab of the attached template.

Incurred date references accident date for occurrence policies and report date for claims made policies.

There may be more than one row (loss) per policy number.

All numeric fields should be valued as of 9/30/2024 (or if an alternate recent valuation date is used, please inform us of the date).

Please note that the "Coverage" and "Type of Claimant" fields have drop-down response options.

"Direct loss" refers to the loss paid by the insurance company, without regard to any cessions to reinsurers.

"Expense" refers to Defense & Cost Containment Expenses, as defined in the Annual Statement Instructions.

Please ensure that the loss description includes a description of cause of loss (e.g. fall, elopement, medication issue, etc).

Additional Information Requested

Non-Worksheet items

Please provide the following non-worksheet items relating to underwriting/pricing background. Please send these items to datacall@oic.wa.gov.

a. Please provide copies of underwriting guidelines or manuals and rating guidelines or manuals, if applicable.

b. When providing copies of items in subsection a., please submit a list any debits or credits in use. For example, there may be debits or credits for prior loss experience (or lack thereof), for number of exits, for certain types of residents with more complex care needs, for results of inspections, etc.