Universal Family Care

Designing State-Based Social Insurance Programs for Long-Term Services and Supports, Paid Family and Medical Leave and Early Child Care and Education

Study Panel of the National Academy of Social Insurance

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Research Director
Caring Across Generations
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About the Study Panel
Overview

- **Convened:** December, 2017
- **Funding:** the Ford Foundation and Caring Across Generations
- **Task:** Design Policy Options for *State-Based Social Insurance* Programs for Long-term Services and Supports (LTSS), Paid Family and Medical Leave (PFML), and Early Child Care and Education (ECCE)
- **Panel Co-Chairs:** Marc Cohen and Heidi Hartmann
- **Project Staff:** Benjamin Veghte (Director) and Alexandra Bradley
- **Panel Members:** 30 experts in three working groups
  - **LTSS Working Group:** Chaired by Marc Cohen
    - Staff support by Eileen J. Tell, ET Consulting LLC
  - **ECCE and PFML Working Group:** Chaired by Heidi Hartmann
  - **UFC Working Group:** Benjamin Veghte and Alexandra Bradley
LTSS Working Group Members (1/2)

- **Marc Cohen**, Working Group Chair; Co-Chair, Professor, McCormack Graduate School of Policy and Global Studies, University of Massachusetts, Boston; Co-Director, LeadingAge LTSS Center @UMass Boston; Research Director, Center for Consumer Engagement in Health Innovation, Community Catalyst
- **Eddie Armentrout**, Consulting Actuary, Actuarial Research Corporation
- **Brian Burwell**, Vice President, Health Policy and Data Analytics, IBM Watson Health
- **Henry Claypool**, Policy Director, Community Living Policy Center, University of California, San Francisco
- **Robert Espinoza**, Vice President of Policy, PHI (Paraprofessional Healthcare Institute)
- **Judith Feder**, Professor of Public Policy, McCourt School of Public Policy, Georgetown University
- **Howard Gleckman**, Senior Fellow, The Urban Institute
- **David Grabowski**, Professor of Health Care Policy, Harvard Medical School
LTSS Working Group Members (2/2)

- **Michael Miller**, Director, Strategic Policy, Community Catalyst
- **Rebecca Owen**, Consulting Actuary, HealthCare Analytical Solutions, Inc.
- **Patrick Reeder**, Senior Vice President, Government & Industry Relations, Genworth Financial
- **Heinz Rothgang**, Professor of Health Economics, SOCIUM Research Center on Inequality and Social Policy, University of Bremen
- **Allen Schmitz**, Principal and Consulting Actuary, Milliman, Inc.
- **Mary Sowers**, Director of Special Projects, National Association of State Directors of Developmental Disabilities Services (NASDDDS)
- **David Stevenson**, Associate Professor, Health Policy, Vanderbilt Univ. School of Medicine
- **Eileen J. Tell**, President and CEO, ET Consulting, LLC
- **Anne Tumlinson**, CEO, Anne Tumlinson Innovations LLC
ECCE/PFML Working Group Members (1/2)

- **Heidi Hartmann**, Working Group Chair; President and CEO, Institute for Women’s Policy Research; Research Professor, The George Washington University; MacArthur Fellow
- **Indivar Dutta-Gupta**, Co-Executive Director, Economic Security and Opportunity Initiative, Georgetown Center on Poverty and Inequality
- **Kathryn Edwards**, Associate Economist, RAND Corporation; Professor, Pardee RAND Graduate School
- **Joan Entmacher**, Senior Fellow, National Academy of Social Insurance
- **Jocelyn Frye**, Senior Fellow, Center for American Progress
- **Jeffrey Hayes**, Program Director, Job Quality and Income Security, Institute for Women’s Policy Research
ECCE/PFML Working Group Members (2/2)

- **Elaine Maag**, Senior Research Associate, Urban-Brookings Tax Policy Center, The Urban Institute
- **Aparna Mathur**, Resident Scholar, Economic Policy, American Enterprise Institute
- **Michelle McCready**, Chief of Policy, Child Care Aware of America
- **Ray Pepin**, Temporary Disability Insurance (TDI) Administrator, Rhode Island Department of Labor & Training
- **Erik Rettig**, Director, Northeast/Mid-Atlantic, Small Business Majority
- **Christopher Ruhm**, Professor of Public Policy and Economics, Frank Batten School of Leadership and Public Policy, University of Virginia
- **Marci Ybarra**, Associate Professor, School of Social Service Administration, University of Chicago
UFC Working Group Members

- **Benjamin Veghte**, Project Director, Academy Study Panel on Caregiving
- **Alexandra Bradley**, Lead Policy Analyst, Academy Study Panel on Caregiving
- **Marc Cohen**, Professor, UMass/Boston; Co-Director, LeadingAge LTSS Center @UMass Boston; Research Director, Center for Consumer Engagement in Health Innovation, Community Catalyst
- **Heidi Hartmann**, President and CEO, Institute for Women’s Policy Research; Research Professor, The George Washington University; MacArthur Fellow
- **Eddie Armentrout**, Consulting Actuary, Actuarial Research Corporation
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- **Joan Entmacher**, Senior Fellow, National Academy of Social Insurance
- **Mary Sowers**, Director of Special Projects, NASDDDS
- **Rebecca Owen**, Consulting Actuary, HealthCare Analytical Solutions, Inc.
Process and Timeline

- **Process**
  - LTSS Working Group formed four subgroups:
    - Structure
    - Financing
    - Integration (with current LTSS payment and delivery systems)
    - Implementation
  - LTSS Working Group met four times in plenum over year
  - Subgroups held calls between plenum meetings
  - Project staff developed new report drafts in advance of each plenum meeting

- **Timeline**
  - Report will be completed in February and released in late March
About the UX Design Project
Process and Insights

● Process
  o Funding from Pivotal Ventures (Investment and Incubation Company)
  o Partnering with IDEO.com, leading practitioners of User Experience (UX) design
  o 6-week design sprint mid-November 2018 to first week of January 2019
  o Starting point: 15 semi-structured interviews explore needs of sandwich generation caregivers and care workers; 6 interviews with policy experts and practitioners
  o We developed narratives around support needs expressed by interview partners
  o We developed WebApp grounded in those needs and informed by study panel policy design parameters

● Insights
  o Goals for policy design look different if conceived in functional vs. relational terms
  o UX perspective surfaces unexpected support needs
  o We highlight these in stylized form using four families
Esmeralda

24-year old mom of a three-year old daughter and full-time caregiver for her epileptic and schizophrenic 54-year old mother.

Theresa

45-year old mom of three adult children, legal guardian of a two-year old granddaughter, and part-time caregiver for her 65-year old mother. Works full time as an executive admin at a university.

Leah

30-year old pregnant mother (expecting in May) of a 2-year old son and part-time caregiver for her 78-year old father. Works full time as a marketing manager.

Sally

53-year old mother of two teenagers and part-time caregiver for her 89-year mother, who has needed 24-hour, live-in professional care for the past 10 years. Works part time as a travel agent.
Families will need each of these things at different moments of life.

- Confidence
- Variety
- Flexibility
- Access

“I need guidance to confidently do care right.”

“I need the right variety of support.”

“I need flexible care options.”

“I need care to be accessible to me.”
Human-Centered Policy Design
Bringing together User Experience and Policy Design

What citizen experiences

service  program  policy

What government says

Process focus: Functional
People focus: Relationship
LTSS Policy Options
The Case for Action (1/2)

- LTSS needs are growing as families are becoming less able to meet them
  
  ![Figure 1: Majority Turning 65 Today Will Need LTSS](image)
  
  Among those turning 65 in 2015-19

- LTSS needs can exist at any age
  
  - 40% of those needing LTSS today are working-age
    
    - Intellectual/developmental, mental-health, or physical disabilities; often lifelong
  
- Caregiver support ratio declining
  
  - Ratio of people 45-64 to 80+ projected to decline from 7:1 in 2015 to 3:1 in 2050
The Case for Action (2/2)

- **LTSS can be costly**
  - Average cost of LTSS for the 52% of Americans with significant need: $266,000
  - In addition to lost earnings and career growth for family caregivers

- **Individual Savings insufficient to finance LTC needs for most Americans**
  - Half of working-age households projected to be unable to maintain living standards
  - Typical household approaching retirement has $10,000 in 401(k)/IRA savings
  - Median balance among 58% of households with some retirement savings: $108,000

- **Private insurance helpful to some, but not broad-based solution**
  - About 7% of households 50 or older have private LTCI; market shrinking
  - Enactment of social insurance could revitalize market (front-end/wraparound)

- **Problem of lack of insurance mechanism for LTSS is not going away**
  - Cost of inaction is greater than the cost of action
Figure 5: Barriers to Access to Home and Community-Based Services (HCBS) under Medicaid

Categorical Eligibility Requirements

Do I meet the categorical eligibility requirements for Medicaid?

Federal Requirements

Am I age 65+, disabled, medically needy*, or have other specified medical conditions?

State Requirements

NO Not eligible

YES Does my state limit HCBS access to certain eligibility groups?

NO Do I meet the financial eligibility requirements?

YES I may or may not be eligible depending on my eligibility pathway.
Financial Eligibility Requirements

Federal Requirements

Do I meet the financial eligibility requirements for Medicaid?

Do I receive SSI? Or did I formerly receive SSI but become ineligible due to increased earnings or age?

State-Level Requirements

NO
Does my state have a waiver to allow people with higher earnings to receive benefits and/or to buy in to Medicaid?

NO
Not eligible

YES
and I meet my state financial eligibility requirements

NO
and I do not meet them

Do I meet clinical level of care criteria?

Do I meet clinical level of care criteria?

Not eligible

YES
Does my state have more restrictive financial eligibility requirements?

NO
and I meet my state financial eligibility requirements

YES
and I do not meet them
Functional Eligibility Requirements

Do I meet the functional eligibility requirements for Medicaid?

Federal Requirements

Do I meet the level of care requirements (e.g. ADLs)?

State Requirements

NO
Not eligible, unless my state has a buy-in option

YES

Does my state cover optional HCBS benefits (e.g., personal care)?

NO
Not eligible

YES
I am entitled to those benefits, which may or may not be sufficient to meet my care needs

Are the services that I need covered under my state’s 1915(c) waiver (or, in rare cases, 1115 waiver) for HCBS?

NO
Not applicable to my care needs.

YES
Does my state have a wait list for HCBS coverage?

NO
I am likely eligible for HCBS coverage, which may or may not be sufficient to meet my care needs.

YES
Depending on my position on the wait list, I may or may not get Medicaid HCBS coverage.
Why State-Based Social Insurance?

● Why Social Insurance?
  ○ As strains on Medicaid grow, very risky to rely on future access to Medicaid HCBS
  ○ Risk-pooling is needed to relieve financial pressure on families when most vulnerable
  ○ Universal program would enable families to keep loved ones at home, working-age pwd to live in community, seniors to age in place
  ○ Social insurance could fill enormous coverage gap for broad middle class, guarantee access to HCBS and protect against impoverishment due to LTSS needs
  ○ Provides peace of mind

● Why state-based?
  ○ Relieve pressure on state’s Medicaid budget
  ○ Support development and quality of state’s LTSS providers
  ○ Stimulate economic growth by increasing LFP and creating quality jobs
  ○ Most countries have strong local component in LTSS financing/admin/delivery
  ○ Washington state/Hawaii already moving, others on path
Decision Points for States

- **Program Structure**
  - Eligible population
  - Timing and duration of coverage

- **Program Financing**
  - Sources of funding
  - PAYGO vs. pre-funded
  - Program Cost

- **Program Integration**
  - Coordination with Medicaid and private insurance
  - Integration of LTSS and health care

- **Program Implementation**
  - Workforce development, provider credentialing, revenue collection/management, eligibility determination, cash-service reimbursement continuum, care coordination
Program Structure

- Eligible population
  - Only those who have paid in and vested vs. everyone
  - Generational transition issues (Current and future disabled vs. only future)

- Start and duration of coverage
  - Front-end
  - Back-end (Catastrophic)
  - Comprehensive (unlimited)
Timing and Duration of Coverage

Figure 8: Projected Duration of LTSS Need among Seniors with Need

<table>
<thead>
<tr>
<th>Duration of Need</th>
<th>Share of Persons Turning 65 in 2015-19 with LTSS Need</th>
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<tbody>
<tr>
<td>&lt; 1 Year</td>
<td>36.1%</td>
</tr>
<tr>
<td>1-2 Years</td>
<td>14.9%</td>
</tr>
<tr>
<td>2-5 Years</td>
<td>22.4%</td>
</tr>
<tr>
<td>&gt; 5 Years</td>
<td>26.6%</td>
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Projected Duration of LTSS Need at HIPAA-Level
## Comparison of Front/Back-end, Comprehensive

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<th></th>
<th>Front-end</th>
<th>Back-end (Catastrophic)</th>
<th>Comprehensive</th>
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<tr>
<td><strong>Who is covered?</strong></td>
<td>Everyone with an LTSS need receives some benefits.</td>
<td>Targets funding to those with the greatest LTSS needs (longest duration).</td>
<td>Everyone with an LTSS need receives benefits.</td>
</tr>
<tr>
<td><strong>Program costs</strong></td>
<td>More predictable program costs and more affordable premiums, all else equal.</td>
<td>Costs may be more unpredictable, as life span increases over time or as duration of morbidity increases.</td>
<td>Most expensive (all else being equal) because both front- and back-end needs are covered and duration of needs is unpredictable.</td>
</tr>
<tr>
<td><strong>Impact on family caregivers</strong></td>
<td>Helps all families cope with initial period of care need, giving them time to identify appropriate planning and resources for continuing to meet needs (e.g., apply for Medicaid if needed to cover longer term need)</td>
<td>Reduces need for family care during phase when family care resources are “burnt out” or high-level care needs at longer care durations exceed what family can support.</td>
<td>Reduces family care burden throughout entire duration of need.</td>
</tr>
<tr>
<td><strong>Private market gap-filling</strong></td>
<td>More difficult for private market to supplement because private market unlikely to cover back-end risk.</td>
<td>Easier for private market to gap-fill with affordable front-end coverage for those who want it.</td>
<td>Private market might gap-fill with a benefit that adds to the daily benefit amount.</td>
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Program Financing

- Potential financing approaches
  - Social Security tax base
  - Medicare Part A tax base (with higher earners paying higher rate)
  - Medicare Net Investment Income Tax (NIIT) base
  - Combination of Medicare Part A and NIIT tax bases
  - Medicare Parts B and D approach
  - Income tax base
  - Sales surtax
  - Estate tax
  - Provider fees
  - General revenues
Funding Considerations

● Funding Considerations
  ○ Size of tax base
  ○ Fiscal sustainability
  ○ Political sustainability
  ○ Affordability
  ○ Connection with program benefits

● PAYGO vs. Prefunding
  ○ PAYGO implications
  ○ Prefunding implications
  ○ Blended approach (DE)
## LTSS Funding in Practice

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<th>Revenue Source</th>
<th>Scope of Coverage</th>
<th>PAYGO or Prefunded</th>
</tr>
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<tr>
<td><strong>United States</strong></td>
<td></td>
<td></td>
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<tr>
<td>Medicaid program</td>
<td>General revenues</td>
<td>Means-tested</td>
</tr>
<tr>
<td>Washington state proposal*</td>
<td>Payroll tax on all earned income</td>
<td>Universal</td>
</tr>
<tr>
<td>Cohen-Feder proposal**</td>
<td>From age 40 onward: Payroll tax on all earned income (split between employers and employees); Tax on investment income of high earners (above $200k/$250k)</td>
<td>Universal (after income-related waiting period)</td>
</tr>
<tr>
<td><strong>International</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td>Payroll tax on earned income; Pensioners pay full contribution; Childless workers pay supplementary contribution; UI pays contributions for unemployed</td>
<td>Universal</td>
</tr>
<tr>
<td>Netherlands</td>
<td>Contributory for institutional care and 24-hour home care (with general revenue funding for other home care and LTSS)</td>
<td>Universal</td>
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## Tax Rates Required to Fund Some LTSS Programs

### 75-Year Rates Based on a $100 Daily Benefit

<table>
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<tr>
<th>Tax Base</th>
<th>Washington Front-End</th>
<th>Home Health Program</th>
<th>Cohen-Feder Catastrophic or Back-end</th>
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<tr>
<td></td>
<td></td>
<td>$36,500 Benefit Maximum</td>
<td>$73,000 Benefit Maximum</td>
</tr>
<tr>
<td>Social Security</td>
<td>0.75%</td>
<td>1.08%</td>
<td>1.73%</td>
</tr>
<tr>
<td>Income Tax</td>
<td>0.58%</td>
<td>0.83%</td>
<td>1.33%</td>
</tr>
<tr>
<td>Medicare Payroll</td>
<td>0.62%</td>
<td>0.89%</td>
<td>1.43%</td>
</tr>
<tr>
<td>Medicare Investment</td>
<td>13.68%</td>
<td>19.67%</td>
<td>31.53%</td>
</tr>
<tr>
<td>Medicare Total</td>
<td>0.59%</td>
<td>0.85%</td>
<td>1.37%</td>
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Existing LTSS Systems Abroad

- **Social Insurance Programs**
  - Germany, Japan, Netherlands, South Korea
  - U.S. proposals: Washington state, Cohen-Feder

- **Universal-Comprehensive Systems**
  - Sweden, Denmark, Finland

- **Residual**
  - England, United States (Medicaid)

- **Hybrid**
  - France

- **Pervasive challenges**
  - Funding, labor-market participation and health of family caregivers, integration of LTSS with health and social services, quality of jobs for LTSS workforce
A Universal Family Care program
What if Esmeralda had access to care for her mom and daughter?

In-home care for her mom and day care for her daughter would allow her to go back to school and ultimately work and contribute financially to her family and build a career.
What if Esmeralda had access to care for her mom?

What if Theresa had an affordable daycare with flexible hours for her granddaughter?

Child care subsidy allows her to enroll in daycares that match her work schedule. The reduced reliance on her mom removes stress and prevents her from missing as much time at work.

In-home care for her mom and day care for her daughter would allow her to go back to school and ultimately work and contribute financially to her family and build a career.
What if Esmeralda had access to care for her mom?

What if Theresa had an affordable daycare with flexible hours for her granddaughter?

What if Leah had a variety of support for her dad?

Service marketplace connects her dad to speciality supports, like walking partners, that help him with his health and socialization. This removes some of her care burden, allowing her more time to focus on her young children and career.

Child care subsidy allows her to enroll in daycares that match her work schedule. The reduced reliance on her mom removes stress and prevents her from missing as much time at work.

In-home care for her mom and day care for her daughter would allow her to go back to school and ultimately work and contribute financially to her family and build a career.
What if Sally had a way to feel financially confident in her mom’s care?

In-home care subsidy supports payment for her mom’s care, allowing her financial peace of mind and allowing her more time with immediate family and to find work.

What if Leah had a variety of support for her dad?

Service marketplace connects her dad to speciality supports, like walking partners, that help him with his health and socialization. This removes some of her care burden, allowing her more time to focus on her young children and career.

What if Theresa had an affordable daycare with flexible hours for her granddaughter?

Child care subsidy allows her to enroll in daycares that match her work schedule. The reduced reliance on her mom removes stress and prevents her from missing as much time at work.

What if Esmeralda had access to care for her mom?

In-home care for her mom and daycare for her daughter would allow her to go back to school and ultimately work and contribute financially to her family and build a career.
Pillars of a Universal Family Care program

Work is the foundation & funding mechanism.
Everyone pays into it through a payroll deduction, and the program enables people to work.

Flexible and portable.
Accessible throughout your lifetime, as your needs change.

Access to a variety of services.
Including those that are non-medical and might delay the need for intensive care.

Combines disparate programs.
Into a connected and easily navigable program.

Elevates care work.
Provides growth paths and careers for caregivers, alongside the regulations surrounding it.