



Designing Universal Family Care

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

2019

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William J. Arnone

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Preface

ABOUT THE REPORT

This report explores strategies that states could pursue to better support families in meeting evolving care needs over the lifespan. The first three chapters of the report explore the challenges families face in the realms of early child care and education (ECCE), paid family and medical leave (PFML), and long-term services and supports (LTSS). For each care domain, the panel identifies policy options along with the tradeoffs associated with specific policy choices; this is done within the context of assuring universal access, affordability, and financial stability through well-defined financing mechanisms. The concluding chapter explores how an integrated approach to care policy might be designed—one offering families a single point of access to ECCE, PFML, and LTSS benefits—under an umbrella program called Universal Family Care. Each chapter outlines challenges that states would need to navigate regarding how a new social insurance program would relate to existing federal and state care programs. Each chapter also addresses implementation considerations.

This analysis was developed over a year of deliberations by a Study Panel of 29 experts in care policy from a variety of perspectives. The report does not include recommendations but instead identifies the building blocks and tradeoffs associated with a range of options in the design of a state-based social insurance program. While there are other approaches for improving care supports, this report focuses specifically on social insurance solutions. As well, while there is nothing that precludes such approaches from being adopted at the national level, the focus of this analysis is on the potential for state action. Although addressed primarily to state policymakers, our analysis should be of interest to providers, advocacy organizations, insurers, administrators, and federal policymakers, as well as to any person interested in these issues.

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EXECUTIVE SUMMARY

The dynamics of work and family life have shifted over the past several decades, but public policy has not kept pace with working families' changing needs. As households increasingly rely on the income of all working-age adults to make ends meet, many families now lack a stay-at-home caregiver. Moreover, our disparate programs are not well-designed or integrated to address the reality that family caregiving needs—including those related to early child care and education (ECCE), paid family and medical leave (PFML), and long-term services and supports (LTSS)—overlap and change over the life course.

A patchwork of federal programs exists to help poor and low-income families pay the costs of early child care and education. These programs are chronically underfunded, however, and fail to serve a significant share of even the fraction of families with sufficiently low income to qualify.

In the absence of a national PFML policy, four states—California, New Jersey, New York, and Rhode Island—have implemented PFML social insurance programs, and four more jurisdictions—the District of Columbia, Washington, Massachusetts, and Connecticut—have recently enacted bills that currently await implementation. In the vast majority of states, however, most workers—when they need time away from work to care for a loved one and/or cope with a health problem of their own—lack access to paid leave. If they take leave to recover from an illness or care for a loved one, they risk significant wage or even job loss.

Long-term services and supports (LTSS) needs are growing, and for a variety of reasons families are becoming less able to meet them. One in two of those turning 65 today will need LTSS. Around 40 percent of those needing LTSS today are under 65; many will require lifelong services and supports. LTSS can be costly for both those needing care and family caregivers.

Each chapter in this report analyzes these care policy challenges and presents policy options for states to consider in addressing them. All options are based on an underlying presumption of universality, that is, care supports that are not means-tested. Thus, the report is focused on state-based, social insurance approaches. The first chapter presents three approaches states could take to provide universal access to early child care and education: (1) comprehensive universal ECCE, which would place ECCE more on par with primary and secondary school education by entitling all children to publicly funded ECCE; (2) employment-based, contributory ECCE, which would entitle all children to ECCE if their parent(s)/guardian(s) are sufficiently attached to the labor force; and (3) a universal ECCE subsidy, which would entitle all families to a subsidy to cover a portion of the cost of ECCE for their children.

The second chapter presents three policy options for states interested in developing a PFML program: (1) The first is a universal, contributory social insurance program with an exclusive state fund; where, all workers would contribute to a state social insurance fund

out of which all benefits would be paid; (2) a contributory social insurance program with regulated opt-outs, where employers would be required to offer a certain level and type of coverage and to comply with specified anti-discrimination and other consumer protections, but would be free to choose between utilizing the state fund, self-insuring, or purchasing a private plan for coverage; and (3) an employer mandate, where employers would be obligated to provide paid leave benefits directly to their workers, either by self-insuring or by purchasing private coverage.

The third chapter analyzes four key decision points for states considering introducing an LTSS social insurance program, such as the one Washington State introduced in 2019. A primary consideration relates to program structure, i.e., who will be eligible for the program's benefits, how will generational transition issues be addressed, and will front-end, back-end (catastrophic), or temporally unlimited coverage be offered? The second design choice is the financing approach: Will the program be funded through payroll contributions, an income tax, or some other dedicated revenue source? And will it be financed on a pay-as-you-go or prefunded basis? The third decision point concerns program integration. How will the new program mesh with Medicaid LTSS and private long-term care insurance? Finally, what implementation challenges must be navigated? How will the program

be administered, revenues collected and managed, eligibility determined, and program integrity ensured?

The concluding chapter of the report explores what an integrated approach to supporting families in meeting their care needs might look like. We refer to this approach as Universal Family Care (UFC), and present several options for how this might be structured, should a state decide to move in this direction. In this approach, all workers would contribute to a care insurance fund which would pay out ECCE, PFML, and LTSS benefits when these needs arise. The fund would provide these benefits through a single, integrated access point for families. In crafting a UFC program, states would need to make design choices about a variety of issues including who is covered and for what, the sources of funding, eligibility requirements, benefit adequacy, and qualifying events. To understand tradeoffs in design choices, we present four illustrative UFC designs, each expressed as packages of ECCE, PFML, and LTSS benefits. The choices vary primarily by their benefit generosity and by whether the program is funded solely by contributions or also by additional revenues to achieve universal coverage. Once a state has decided upon a structural design approach, choices would remain concerning the degree of internal UFC integration across its ECCE, PFML, and LTSS components, as well as the relationship of UFC benefits to existing ECCE programs and Medicaid LTSS.

INTRODUCTION

Families have always coped with the risk of needing to receive or provide care—whether care for children, people with disabilities, or parents or grandparents with functional or cognitive support needs. But in the wake of decades of wage stagnation and changes in family structure, the share of families with a stay-at-home caregiver has sharply declined.¹ Most of today's families need all parents' earnings to make ends meet; 64 percent of mothers bring in at least one quarter of family earnings, including 41 percent who bring in half or more.² With regard to care for older adults, demographic factors compound the challenge: over the coming decades, growth in the population 80 and older will far outpace growth in potential caregivers ages 45-64.³ To meet the needs of today's families, a paradigm shift is needed—one that better enables family caregivers to balance work and family responsibilities.

As the need for family care supports has grown, our care infrastructure has not kept pace. Our systems for providing affordable early child care and education (ECCE) and

long-term services and supports (LTSS)—the services and supports needed by some older adults and people with disabilities to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications—are fragmented. As well, because they are targeted at the poor, they leave the broad middle class largely on their own. Paid family and medical leave (PFML)—which makes it possible for workers to care for a loved one, bond with a new child, or recover from a medical condition without significantly compromising the family finances—is broadly available in only four states: Rhode Island, California, New Jersey, and New York.⁴ At the same time, jobs in child care and long-term care are poorly compensated, which limits the size and skills of the care workforce, compromising the quality and reliability of care and resulting in many needs being unmet.⁵

The costs associated with early and long-term care needs are beyond the means of many families. On average, families can expect to pay roughly \$9,000 annually for center-based care for a four-year-old, nearly \$10,000

¹ Liana Fox, Wen-Jui Han, Christopher J. Ruhm, and Jane Waldfogel, "Time for Children: Trends in the Employment Patterns of Parents, 1967-2009," *Demography*, Vol. 49, No. 4, 2013, <https://ideas.repec.org/a/spr/demogr/v50y2013i1p25-49.html>.

² Sarah Jane Glynn, "Breadwinning Mothers Continue to be the U.S. Norm," Center for American Progress, May 10, 2019, <https://www.americanprogress.org/issues/women/reports/2019/05/10/469739/breadwinning-mothers-continue-u-s-norm/>.

³ Donald Redfoot, Lynn Feinberg, and Ari Houser, "The Aging of the Baby Boom and the Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers," AARP Public Policy Institute, August 2013, <https://www.aarp.org/home-family/caregiving/info-08-2013/the-aging-of-the-baby-boom-and-the-growing-care-gap-AARP-ppi-ltc.html>.

⁴ In the near future, PFML will also be available in Connecticut, the District of Columbia, Massachusetts, and Washington State.

⁵ Robert Espinoza, "Workforce Matters: The Direct Care Workforce & State-Based LTSS Social Insurance Programs," PHI, 2019 (Forthcoming); Nina Dastur, Indivar Dutta-Gupta, Laura Tatum, Peter Edelman, Kali Grant, and Casey Goldvale, "Building the Caring Economy: Workforce Investments to Expand Access to Affordable, High-Quality Early and Long-Term Care," Creative Commons, 2017, http://www.georgetownpoverty.org/wp-content/uploads/2017/05/Building-the-caring-economy_hi-res.pdf.

for a toddler (age 1-3), and roughly \$11,600 for an infant (age 0-1).⁶ These figures vary widely across states, and they do not take into account additional expenses for extra services such as extended or flexible hours. LTSS most often is needed for less than two years, but it is expensive. Among the roughly half of Americans 65 and older who will have significant LTSS needs, the average cost will be \$266,000 in today's dollars, and a little more than half of that will have to be paid out of pocket.⁷ The affluent can pay for LTSS from their income and savings; a few people (only about 7 percent of adults 50 or older) have private long-term care insurance.⁸ The vast majority of the population, those in the broad middle class, either forgo paid care (relying on family members), pay for it out of limited income and savings until they deplete their assets and qualify for Medicaid, or simply go without needed care altogether.

For many families, care needs can become unmanageable, or manageable only at significant cost to family members' health, well-being, income, and careers. Improvements to our care infrastructure could go far in easing these strains. Access to paid leave could make it easier for a working parent to take care of a newborn or sick child or help an aging parent cope with the aftermath of a fall or medical emergency—without being forced to leave the workforce. Similarly, if affordable child care, elder care, and supports for people

with disabilities were universally available, family caregivers across the income spectrum could continue to work and advance in their careers, bolstering both their own families' economic security and the nation's economy. Public care supports would not replace family members' care for one another, but they could give family caregivers more flexibility to manage care and career responsibilities.

Social insurance is a policy approach designed to achieve universal, affordable coverage for risks that are often expensive and sometimes infrequent. Typically, when financed by workers (and/or their employers), there is a statutorily defined share of each paycheck that is contributed throughout their careers in return for a benefit in times of need. Everyone contributes, and everyone is eligible to benefit, without a means test. Social Security and Medicare Part A (Hospital Insurance) are examples of this. This report fleshes out the design of different options for social insurance approaches to child care, paid leave, and long-term care benefits.

A social insurance approach to care supports is designed to make them affordable to everyone across the income spectrum. Like Social Security, PFML is a wage replacement benefit, and seeks to replace enough wages to make leave-taking affordable. Like Medicare Part A, ECCE and LTSS are service benefits; social insurance approaches to ECCE

⁶ Child Care Aware of America, *The US and the High Cost of Child Care: 2018 Report*, 2018, <http://usa.childcareaware.org/advocacy-public-policy/resources/research/costofcare/>.

⁷ Melissa Favreault and Judith Dey, "Long-Term Services and Supports for Older Americans: Risks and Financing Research Brief," Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Washington, D.C., February 2016, <https://aspe.hhs.gov/basic-report/long-term-services-and-supports-older-americans-risks-and-financing-research-brief>.

⁸ Life Insurance and Market Research Association (LIMRA), "Combination Products Giving Life Back to Long-term Care Market," 2017, https://www.limra.com/Posts/PR/Industry_Trends_Blog/Combination_Products_Giving_Life_Back_to_Long-term_Care_Market.aspx.

and LTSS are designed to make child care and long-term care more affordable for all. Social insurance programs are designed to achieve affordability by including the entire workforce under the coverage umbrella and collecting modest contributions from each paycheck for the duration of a worker's career. This model contrasts dramatically with the status quo for child care and elder care, where a family faces tens of thousands of dollars of ECCE and LTSS costs, typically over a period of only a few years, and often at a time when they are least able to afford it, because too often, when the need arises, breadwinners must reduce their work hours or leave the workforce entirely.

The concluding chapter of this report explores an integrated approach to care supports: Universal Family Care (UFC). UFC would provide ECCE, PFML, and LTSS benefits through one integrated program with a joint funding mechanism and a single access point for families. UFC represents one way to achieve the goal of modernizing our care infrastructure, making it possible for family caregivers to handle both work and care responsibilities. The vision of UFC can be operationalized in a variety of ways, and this chapter details a range of approaches that states could take, if they chose to move in this comprehensive fashion. States seeking to adopt UFC will ultimately choose a policy design that best matches their unique constellation of goals, preferences, and

constraints. Much of the information provided in our analysis of UFC policy options is also relevant for federal policymakers who may seek a national approach to these issues, which could be similar to the UFC program put forward here for states to consider.

Any effort to expand access to family care supports must include a workforce strategy. Child care and long-term care jobs are poorly compensated, which limits the size and skills of the care workforce and reduces the quality and reliability of care. While this report highlights the need to improve the quality and supply of care jobs, both in the ECCE and LTSS fields, it is beyond the scope of this report to go into depth on this issue. Excellent research has been conducted on this elsewhere, and we refer the reader to that literature.⁹

We focus on state efforts because, to some degree, states have acted as “laboratories of democracy and social policy” and are likely to continue to do so. States led the way in creating social insurance protections in Workers’ Compensation, Unemployment Insurance, and Paid Family and Medical Leave, and Washington State recently passed the nation’s first LTSS social insurance program. Moreover, state and local governments have decades of experience administering ECCE and LTSS programs. They already perform functions such as defining and assessing benefit eligibility, certifying qualified

⁹ For example, see Nina Dastur, Indivar Dutta-Gupta, Laura Tatum, Peter Edelman, Kali Grant, and Casey Goldvale, “Building the Caring Economy: Workforce Investments to Expand Access to Affordable, High-Quality Early and Long-Term Care,” Creative Commons, 2017, http://www.georgetownpoverty.org/wp-content/uploads/2017/05/Building-the-caring-economy_hi-res.pdf; Robert Espinoza, “Workforce Matters: The Direct Care Workforce and State-Based LTSS Social Insurance Programs,” PHI, 2019 (Forthcoming); Joanne Spetz, Robyn I. Stone, Susan A. Chapman, and Natasha Bryant, “Home And Community-Based Workforce for Patients with Serious Illness Requires Support to Meet Growing Needs,” *Health Affairs*, Vol. 38, No. 6, June 2019, <https://doi.org/10.1377/hlthaff.2019.00021>.

providers, and reimbursing providers. States have a wealth of knowledge and experience that can easily serve as a foundation for a Universal Family Care program. Finally, a UFC social insurance program with dedicated financing would fund much of a state's paid LTSS needs, relieving pressure on its Medicaid budget, which is funded by general revenues. Thus, there is no reason that, absent federal solutions, states must "sit on their hands" and wait; in fact, they already have valuable experience on which to base such an approach.



Designing a State-Based Social Insurance Program for Early Child Care and Education

2019

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Preface

ABOUT THE CHAPTER

This chapter explores social insurance solutions to challenges states face in providing affordable, quality early care and education for young children. It was developed during a year of deliberations by a Working Group of 13 child and family policy experts with a variety of expertise and perspectives. It is part of a larger Study Panel project on Universal Family Care. The chapter focuses exclusively on programs for children ages 0 to 5—or, more specifically, those who have not yet reached the traditional age of entrance into a state’s formal education system, as the precise age of entrance into public education varies by state.

This chapter focuses on state-level policy options regarding program design and funding. Funding for child care and education in the United States is remarkably complex. Mandatory public education programs—typically beginning around age 5—are largely funded through state and/or local resources. In contrast, the very limited existing public funding for early child care and education (ECCE), particularly for children ages 0 to 3, has traditionally come primarily from the federal government. Changes to federal ECCE policy are beyond the scope of this report, though the report notes where added federal funding or guidance could be particularly helpful to states.

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EXECUTIVE SUMMARY

The dynamics of work and family life have shifted over the past several decades, but public policy has not kept pace with the changing needs of workers and their families. As households increasingly rely on having all adults working to make ends meet, a full-time stay-at-home parent is no longer achievable for many families. At the same time, the lack of affordable early child care and education (ECCE) poses a significant challenge for families trying to balance the need to provide safe, stimulating care for children with financial security. Women—especially women of color—face particularly stark disadvantages in terms of financial security and labor force attachment when meaningful access to affordable early child care and education is lacking.

A variety of federal-level programs exist to provide assistance with the cost of early child care and education. However, because these programs are vastly underfunded, they fail to serve a substantial proportion of families who meet the very strict eligibility requirements. Financing and implementing education systems has historically been the purview of states, but most states have failed, as yet, to treat early child care and education with the same attention as primary and secondary school education. A robust state-level ECCE program could substantially improve child health, development, and well-being, increase the financial security of families, and reduce inequities in access to high-quality care.

This chapter discusses three policy options for states interested in developing an early child care and education program:

1. Comprehensive universal early child care and education—which would place early care and education on par with primary and secondary school education by entitling all children access to publicly funded early care and education.
2. Employment-based, contributory early child care and education—which would entitle all children to early care and education if their parent(s)/guardian(s) are sufficiently attached to the labor force.
3. Universal early child care and education subsidy—which would entitle all families to a subsidy or voucher to cover a portion of the cost of early care and education for their children.

For each of these policy options, states will need to consider a variety of program design factors, including how the program is financed and the nature of the benefits that families receive. States will also need to address integrating a new state ECCE program with existing federal and state ECCE programs, building up the ECCE workforce and improving the quality of ECCE jobs, and lifting up the quality of care. Ultimately, a carefully designed ECCE program has the potential to make a substantial positive impact on children, families, communities, and the economy.

Section I.

INTRODUCTION

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The dynamics of work and family life have shifted over the past several decades, yet public policy has not fully adapted to the changing needs of workers and their families. With women now representing a substantial proportion of the workforce,¹ more mothers are working outside the home.² As the vast majority of children are growing up in households where every parent is working,³ the need for children to have access to safe, quality early care and education outside the home has increased over time. These trends are not likely to reverse. Mothers' earnings are critical to most families' ability to make ends meet. Nearly two-thirds (64 percent) of mothers are breadwinners or co-breadwinners, bringing home at least a quarter of the family's earnings, including more than 4 in 10 (42 percent) who are primary breadwinners, bringing home half or more of the family's earnings. Women of color are also more likely to be the primary source of economic support for their families.⁴

For most families trying to earn sufficient income both to provide for their families and

to provide safe, stimulating care for their children, access to high-quality, affordable early child care and education (ECCE) is lacking. Roughly 60 percent of the circa 24 million children between the ages of 0 and 5 in the United States⁵ are in some form of regular care arrangement.⁶ Yet, in contrast to free, public primary and secondary education, families typically bear a substantial financial responsibility in paying for ECCE. On average, families pay more than half the cost of ECCE out of pocket,⁷ and many families pay the full cost of care without any public financial support. Early care and education for a child aged 0 to 4 years costs between \$9,000 and \$9,600 per year, on average, though there is substantial geographic variation.⁸ There is also substantial variation in the cost of care by age, as infant care is roughly \$1,000-\$2,000 more expensive per year than the cost of care for four-year-olds.⁹ Further, the financial

On average, families pay more than half the cost of ECCE out of pocket.

¹ U.S. Department of Labor, "Table 4. Families with Own Children: Employment Status of Parents by Age of Youngest Child and Family Type, 2017-2018 Annual Averages," Washington, DC: U.S. Department of Labor Bureau of Labor Statistics, 2019, <https://www.bls.gov/news.release/pdf/famee.pdf>.

² Lynda Laughlin, "Who's Minding the Kids? Child Care Arrangements: Spring 2011," *Household Economic Studies*, pp. 70-135, Washington, DC: U.S. Census Bureau, 2013, <https://www2.census.gov/library/publications/2013/demo/p70-135.pdf>.

³ Eileen Patten, "How American Parents Balance Work and Family Life When Both Work," Pew Research Center, 2015, <http://www.pewresearch.org/fact-tank/2015/11/04/how-american-parents-balance-work-and-family-life-when-both-work/>.

⁴ Sarah Jane Glynn, "Breadwinning Mothers Continue to be the U.S. Norm," Center for American Progress, May 10, 2019, <https://www.americanprogress.org/issues/women/reports/2019/05/10/469739/breadwinning-mothers-continue-u-s-norm/>.

⁵ U.S. Census Bureau, "POP1 Child Population: Number of Children (in Millions) Ages 0-17 by Age, 1950-2017 and Projected 2018-2050," 2017, <https://www.childstats.gov/americaschildren/tables/pop1.asp>.

⁶ The majority of children with no regular care arrangement is under the supervision of a stay-at-home parent/guardian, while others have inconsistent or unstable sources of care. [See: Lynda Laughlin, "Who's Minding the Kids? Child Care Arrangements: Spring 2011," *Household Economic Studies*. P70-135. Washington, DC: U.S. Census Bureau, 2013, <https://www2.census.gov/library/publications/2013/demo/p70-135.pdf>.]

⁷ BUILD Initiative, "Finance and Quality Rating and Improvement Systems," Boston, MA, 2017, <http://www.buildinitiative.org/Portals/0/Uploads/Documents/Resources/QRIS%203/FinanceQRIS.pdf>.

⁸ Child Care Aware of America, "The US and the High Cost of Child Care: 2018 Report," 2018, https://cdn2.hubspot.net/hubfs/3957809/COCreport2018_1.pdf.

⁹ Ibid.

burden of ECCE is distributed unequally; lower-income families spend a substantially higher proportion of their income on these services than do higher-income families.¹⁰

While a patchwork of federal funding sources is available to help finance ECCE programs, even among children eligible for those programs, many do not receive benefits due to insufficient funding. For example, only about 1 in 6 eligible children (typically those in the lowest-income families) benefits from the Child Care and Development Block Grant (CCDBG)—one of the largest federal child care programs.¹¹ Most early care and education

programs are designed and administered at the state and local level. As a result, the quality, accessibility, and affordability of early child care and education resources vary greatly by location.

Child Health, Development, and Well-being

Children's brains develop rapidly before the age of five—more rapidly than at any other period of life.¹² The first five years are rich with cognitive, linguistic, social, emotional, and motor development. Children's experiences and life circumstances in these early years

¹⁰ La Rue Allen and Emily P. Backes (eds.), "Transforming the Financing of Early Care and Education," Committee on Financing Early Care and Education with a Highly Qualified Workforce, Washington, DC: The National Academies Press, 2018, <https://www.nap.edu/catalog/24984/transforming-the-financing-of-early-care-and-education>.

¹¹ Nina Chien, "Factsheet: Estimates of Child Care Eligibility & Receipt for Fiscal Year 2015," Office of the Assistant Secretary for Planning & Evaluation, U.S. Department of Health and Human Services, January 2019, <https://aspe.hhs.gov/system/files/pdf/260361/CY2015ChildCareSubsidyEligibility.pdf>.

¹² Center on the Developing Child, "Five Numbers to Remember About Early Childhood Development (Brief)," 2009, <https://developingchild.harvard.edu/resources/five-numbers-to-remember-about-early-childhood-development/#note>.



may affect their health, development, and well-being long into the future.¹³

Children who attend high-quality early education programs have improved outcomes in long-term academic achievement, socio-emotional development, poverty, lifetime earnings, and incarceration rates.

As a result, the quality of care for the youngest children in our society can have a particularly significant impact on long-term developmental outcomes. In fact, most of the achievement gaps and disparities in socio-emotional development that are found among school-aged children and adolescents were actually present prior to their entry into the formal education system.¹⁴ Numerous studies have found that high-quality early care and education programs can have lasting effects on a child's long-term educational achievement.¹⁵

But the benefits of quality early childhood education are not limited to academic achievement: Children who attend high-quality early education programs have improved outcomes on factors ranging from socio-emotional development¹⁶ to poverty, lifetime earnings, and incarceration rates.¹⁷ Evidence suggests that even physical health is improved through participation in high-quality early child care and education programs; one study in particular found significant reductions in cardiovascular and metabolic diseases among children who attended a high-quality early childhood education program compared to their peers who did not.¹⁸

To the extent that high-quality ECCE programs reduce a range of negative outcomes, their costs can be viewed as an investment in the nation's citizenry and future workforce. Estimates of the return on that investment range from \$4 to \$16 for every dollar spent on high-quality early childhood programs.¹⁹

¹³ Vincent J. Felitti, Robert F. Anda, Dale Nordenberg, David F. Williamson, Alison M. Spitz, Valerie Edwards, Mary P. Koss, and James S. Marks, "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study," *American Journal of Preventative Medicine*, vol. 14, no. 4, 1998, [https://www.ajpmonline.org/article/S0749-3797\(98\)00017-8/abstract](https://www.ajpmonline.org/article/S0749-3797(98)00017-8/abstract).

¹⁴ James J. Heckman, "Schools, Skills, and Synapses," *Economic Inquiry*, vol. 46, no. 3, 2008, http://jenni.uchicago.edu/papers/Heckman_2008_EI_v46_n3.pdf.

¹⁵ For a review of the literature on the impact of early childhood education, see: Sneha Elango, Jorge Luis García, James J. Heckman, and Andrés Hojman, "Early Childhood Education," 2015, <https://heckmanequation.org/assets/2017/01/FINALMoffitt-ECE-Paper2015.pdf>.

¹⁶ James J. Heckman, "Schools, Skills, and Synapses," *Economic Inquiry*, vol. 46, no. 3, 2008, http://jenni.uchicago.edu/papers/Heckman_2008_EI_v46_n3.pdf.

¹⁷ Arthur Rolnick, "Investing in Early Childhood Development is Smart Economic Development," *The Science of Early Brain Development: A Foundation for the Success of Our Children and the State Economy: First Edition*, Wisconsin Family Impact Seminars, 2014, https://www.purdue.edu/hhs/hdfs/fii/wp-content/uploads/2015/07/s_wifis32report.pdf.

¹⁸ Frances Campbell, Gabriella Conti, James J. Heckman, Seong Hyeok Moon, Rodrigo Pinto, Elizabeth Pungello, and Yi Pan, "Early Childhood Investments Substantially Boost Adult Health," *Science*, vol. 343, 2014, <https://heckmanequation.org/assets/2017/01/Science-2014-Campbell-1478-85.pdf>.

¹⁹ Arthur Rolnick, "Investing in Early Childhood Development is Smart Economic Development," *The Science of Early Brain Development: A Foundation for the Success of Our Children and the State Economy: First Edition*, Wisconsin Family Impact Seminars, 2014, https://www.purdue.edu/hhs/hdfs/fii/wp-content/uploads/2015/07/s_wifis32report.pdf.

The Cost of Early Child Care and Education, Family Financial Security, and Inequities in Access

Investing in the success and well-being of our future citizenry is one rationale for financing high-quality ECCE programs, but access to affordable ECCE can also affect family economic security and labor force attachment in the present. As the proportion of families with a stay-at-home caregiver has declined relative to previous generations, families increasingly rely on some outside source of care for their pre-school-aged children.²⁰

The average cost of ECCE represents 37 percent of the earnings of the average single parent.

Despite this increasing demand for early child care and education, its cost is well beyond the means of many families in the United States,²¹ particularly for high-quality center-based programs. On average, families with a four-year-old in a legally operating child care facility can expect to pay roughly \$9,000 for center-based care or around \$8,300 for home-based care.²² For a toddler, the cost of center-based care rises to around \$10,000, and for an infant to roughly \$11,600. Across

all ages (below the age of eligibility for public K-12 education), states, and both types of care settings, the average annual cost of child care runs between \$9,000 and \$9,600. These cost figures vary tremendously across states, and do not take into account additional expenses for extra services such as extended or flexible hours.

The average cost of early care and education represents over one-third (37 percent) of the earnings of the average single parent, and 10 percent of the average earnings of married co-parent households with minor children.²³ According to standards established by the U.S. Department of Health and Human Services, child care should take up no more than 7 percent of a family's income in order to be considered affordable.²⁴ Thus, for many families, high-quality care for young children is unaffordable in the current early care and education landscape across the U.S. Additionally, the affordability of many existing early child care and education resources is dependent on the fact that professional care providers are often receiving very low—even poverty-level—wages. The cost of providing adequate compensation for high-quality care is even higher than the often already overwhelming cost of care.²⁵ As programs pursue the goal of improving the quality of care, it will be

²⁰ Heather Boushey, *Finding Time* (Boston, MA: Harvard University Press, 2016).

²¹ Elise Gould and Tanyell Cooke, "High-Quality Child Care Is Out of Reach for Working Families," Economic Policy Institute, Issue Brief #404, 2015, <https://www.epi.org/files/2015/child-care-is-out-of-reach.pdf>.

²² Child Care Aware of America, "The US and the High Cost of Child Care: 2018 Report," 2018, <http://usa.childcareaware.org/advocacy-public-policy/resources/research/costofcare/>.

²³ Ibid.

²⁴ Office of Child Care (OCC), Administration for Children and Families (ACF), Department of Health and Human Services (HHS), "Child Care and Development Fund (CCDF) Program," 2016, <https://www.federalregister.gov/documents/2016/09/30/2016-22986/child-care-and-development-fund-ccdf-program>.

²⁵ For a state-by-state breakdown of the cost of high-quality early care and education, see: <https://www.costofchildcare.org/>.



necessary to also invest in increasing wages and training for child care and education providers.²⁶

While the presence of a stay-at-home caregiver has declined over the past several decades, the rate of stay-at-home motherhood has increased slightly in recent years, with roughly three in ten children cared for by a stay-at-home mother.²⁷ Today's stay-at-home mothers are significantly more likely to be women of color, to live below the poverty line, and to have lower educational attainment than working mothers.²⁸ These

disparities suggest two possible—and interrelated—narratives. On the one hand, mothers of certain demographic backgrounds may simply show a greater preference for staying home and raising their children. On the other hand, societal trends suggest that a second reason for the disparity may be the more likely, or at least more common, rationale—that women are staying home with their children due to a lack of supportive workplace policies in the United States, such as broad access to affordable child care and paid family and medical leave.²⁹ Additionally, families may be making their own cost-

²⁶ For an extensive discussion of this topic, see: Nina Dastur, Indivar Dutta-Gupta, Laura Tatum, Peter Edelman, Kali Grant, and Casey Goldvale, "Building the Caring Economy: Workforce Investments to Expand Access to Affordable, High-Quality Early and Long-Term Care," Creative Commons, 2017, http://www.georgetownpoverty.org/wp-content/uploads/2017/05/Building-the-caring-economy_hi-res.pdf.

²⁷ D'Vera Cohn, Gretchen Livingston, and Wendy Wang, "After Decades of Decline, A Rise in Stay-at-Home Mothers," Pew Research Center, 2014, <http://www.pewsocialtrends.org/2014/04/08/after-decades-of-decline-a-rise-in-stay-at-home-mothers/>.

²⁸ Ibid.

²⁹ Sarah Jane Glynn and Danielle Corley, "The Cost of Work-Family Policy Inaction: Quantifying the Costs Families Currently Face as a Result of Lacking U.S. Work-Family Policies," Washington, DC: Center for American Progress, 2016, <https://cdn.americanprogress.org/wp-content/uploads/2016/09/22060013/CostOfWorkFamilyPolicyInaction-report.pdf>.



benefit analyses in regards to accessing paid child care and education services; if a parent's earnings are insufficient to balance out the cost of enrolling their child in an early care or education program, they may view the tradeoff between labor force participation and the financial burden of out-of-home care differently from more affluent families. Indeed, research on the introduction of universal pre-K in Washington, D.C. suggests that the District's free, public early education program resulted in sizeable increases in labor force participation among disadvantaged mothers (and others).³⁰

Working families in the U.S. experience an estimated \$8.9 billion loss in earnings annually due to a lack of access to affordable child care.

Working families in the U.S. experience an estimated \$8.9 billion loss in earnings annually due to a lack of access to affordable child care.³¹ As other similarly wealthy nations have implemented family-friendly work policies, their women's labor force participation has grown. In the United States, by contrast, women's labor force participation

³⁰ Rashid Malik, "The Effects of Universal Preschool in Washington, D.C.: Children's Learning and Mothers' Earnings," Center for American Progress, 2018, <https://www.americanprogress.org/issues/early-childhood/reports/2018/09/26/458208/effects-universal-preschool-washington-d-c/>.

³¹ Sarah Jane Glynn and Danielle Corley, "The Cost of Work-Family Policy Inaction: Quantifying the Costs Families Currently Face as a Result of Lacking U.S. Work-Family Policies," Washington, DC: Center for American Progress, 2016, <https://cdn.americanprogress.org/wp-content/uploads/2016/09/22060013/CostOfWorkFamilyPolicyInaction-report.pdf>.

has been stagnant or declining, falling further behind other OECD countries.³² This could be compromising U.S. economic growth and competitiveness; one study estimates the cost to the nation to be \$57 billion in lost earnings, productivity, and revenue.³³ Increasing families' access to affordable ECCE³⁴ and increasing public expenditures on ECCE programs,³⁵ on the other hand, could significantly increase maternal employment.

³² Francine D. Blau and Lawrence M. Kahn, "Female Labor Supply: Why Is the United States Falling Behind?," *American Economic Review*, vol. 103, no. 3, 2013.

³³ Sandra Bishop-Josef, Chris Beakey, Sara Watson, and Tom Garrett, "Want to Grow the Economy? Fix the Child Care Crisis," Ready Nation: Council for a Strong America, 2019, <https://www.strongnation.org/articles/780-want-to-grow-the-economy-fix-the-child-care-crisis>.

³⁴ Taryn W. Morrissey, "Child Care and Parent Labor Force Participation: A Review of the Research Literature," *Review of Economics of the Household*, vol. 15, no. 1, March 2017.

³⁵ María E. Enchautegui, Nina Chien, Kimberly Burgess, and Robin Ghertner, "Effects of the CCDF Subsidy Program on the Employment Outcomes of Low-Income Mothers," U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, December 2016, <https://aspe.hhs.gov/system/files/pdf/253961/EffectsCCSubsidiesMaternalLFPTechnical.pdf>.

Section II.

**THE LANDSCAPE
OF EARLY CHILD
CARE AND
EDUCATION
POLICIES IN THE
UNITED STATES**

NATIONAL
ACADEMY
OF SOCIAL
INSURANCE



Caring for children and nurturing their development has long been viewed as women's work. It is generally performed by women in their own homes without pay—and by some women, especially women of color and immigrants, for other families' children at low pay. Child care work has long been undervalued and viewed as a private—rather than a public—responsibility. These views have shaped the patchwork of child care and early education policies that still prevails across the nation today.

Brief History of Early Child Care and Education Programs in the United States

In response to the crises of the Great Depression and the Second World War, the federal government made its first investments in child care—but abandoned those initiatives

as the crises passed. “Emergency nursery schools” were established in the 1930s as part of the New Deal’s Works Progress Administration (WPA), primarily to provide employment to unemployed teachers, nurses, and others. However, many of the centers were closed as private employment increased. When women were needed during the Second World War to work in defense-related industries, some WPA centers were revived and new child care centers were created in war production areas. Federal and state funds made care available at a modest fee, regardless of income, to about 600,000 children at over 3,000 centers between 1942 and 1946. After the war ended, Congress withdrew funding and most centers closed.³⁶

The doubling of mothers’ labor force participation between the end of the Second World War and 1970, together with new

³⁶ For a broader discussion of the history of child care policy in the United States, as well as original citations, see: Julie Vogtman, “Undervalued: A Brief History of Women’s Care Work and Child Care Policy in the United States,” National Women’s Law Center, 2017, https://nwlc.org/wp-content/uploads/2017/12/final_nwlc_Undervalued2017.pdf.

research on the importance of children's early development, led to renewed interest in public child care policy. The Head Start program was created in 1965 as part of the War on Poverty to provide preschool education and health, nutrition, and other services to young children in poor families.³⁷

A universal national child care program was nearly enacted more than 40 years ago. The Comprehensive Child Development Act of 1971 passed Congress with bipartisan support.

A universal national child care program was nearly enacted more than 40 years ago. The Comprehensive Child Development Act of 1971 passed Congress with bipartisan support. It would have provided substantial funding for child care centers that would be open to all on a sliding fee scale, reflecting the view that "comprehensive child development programs should be available to all children."³⁸ The bill mandated free care for families with the lowest income and additional services to promote healthy child development for low-income children. President Richard M. Nixon vetoed the bill, declaring that it would "commit the vast moral authority of the National Government to the side of communal approaches to child rearing over against [sic] the family-centered approach."³⁹

³⁷ Ibid.

³⁸ H.R. 1083, *Comprehensive Child Development Act of 1971*, Finding of Congress, <https://www.congress.gov/bill/93rd-congress/house-bill/1083/all-info>.

³⁹ Richard Nixon, "Veto of the Economic Opportunity Amendments of 1971," Dec. 9, 1971 (Transcript available at the American Presidency Project: <http://www.presidency.ucsb.edu/ws/?pid=3251>).

⁴⁰ Sharon K. Long, Gretchen G. Kirby, Robin Kurka, and Shelley Waters, "Child Care Assistance under Welfare Reform: Early Responses by the States," Washington, DC: The Urban Institute, 1998, <http://webarchive.urban.org/publications/308043.html>.

⁴¹ Congressional Research Service, "The Child Care and Development Block Grant: Background and Funding," 2014, https://www.everycrsreport.com/files/20140917_RL30785_523d234ca8f11b399d2adf7d0609aa077586fe95.pdf.

Following the veto, universal child care policies fell off the national agenda. Instead, federal policies focused on child care as a means to promote work, particularly among low-income single parents. Until 1990, the welfare program known as Aid to Families with Dependent Children (AFDC) was connected to three separate federal child care programs. Families who were receiving AFDC and who were either working or in an education or training program were entitled to child care. Families leaving AFDC were entitled to one year of subsidized child care under the separate Transitional Child Care Program. The At-Risk Child Care program provided capped funding to states to serve working families at risk of needing welfare without child care assistance.⁴⁰

In 1990, the Child Care and Development Block Grant program (CCDBG) was enacted to provide child care assistance to low- and moderate-income working families not connected to AFDC whose incomes did not exceed 75 percent of state median income. The CCDBG program did not create an individual entitlement to child care and was funded by annual appropriations.⁴¹ The program is now funded under the broader Child Care and Development Fund (CCDF), which includes a mandatory entitlement for states (the Child Care Entitlement to States) and the discretionary Child Care and Development Block Grant, which provides funds for eligible families.



The 1996 law that repealed AFDC also eliminated its three associated child care programs and any individual entitlement to child care. Instead, the law created one new consolidated child care block grant to be administered by the state agency managing the CCDBG, subject to CCDBG rules.⁴²

More recently, federal and state initiatives have devoted more attention to improving the quality of early care and education for children. In 2018, Congress allocated an additional \$2.4 billion in discretionary funding for the CCDBG, as well as increasing funding for other, smaller early care and education programs. While funding is still far

from adequate, this investment was a critical step in the right direction.

Overview of Current Early Child Care and Education Programs

This section briefly describes current programs that focus on providing care and education services to young children.⁴³ It does not address broader social policies for families and children that may be used to support early care and education, such as Temporary Assistance to Needy Families (TANF), the Social Services Block Grant (SSBG), Elementary and Secondary Education Act (ESEA), and the Child Tax Credit (CTC).⁴⁴

⁴² Ibid.

⁴³ The primary resource used to inform this overview is: Congressional Research Service, “Early Childhood Care and Education Programs: Background and Funding,” 2016, https://www.everycrsreport.com/files/20160516_R40212_7109fd6a323108f119477ff9818cfb50481a8469.pdf.

⁴⁴ For a summary of federal spending, by program, on early child care and education, see Figure 12 on page 37 of: Nina Dastur, Indivar Dutta-Gupta, Laura Tatum, Peter Edelman, Kali Grant, and Casey Goldvale, “Building the Caring Economy: Workforce Investments to Expand Access to Affordable, High-Quality Early and Long-Term Care,” Creative Commons, 2017, http://www.georgetownpoverty.org/wp-content/uploads/2017/05/Building-the-caring-economy_hi-res.pdf.

Nor does this section include programs that support young children’s healthy development in other ways, such as the Children’s Health Insurance Program (CHIP); Medicaid; the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program; the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); and the Supplemental Nutrition Assistance Program (SNAP).

Child Care and Development Block Grant (CCDBG)

The Child Care and Development Block Grant (CCDBG) provides federal funds to every state to provide direct child care assistance to low- and moderate-income families who have children under 13 and/or older children with disabilities. A portion of the funding also must be used to improve the quality and accessibility of care. States must match a portion of the federal funds and can develop their own policies under broad federal parameters.⁴⁵

Since the number of families in need of financial support for ECCE is so much higher than current funding levels can cover, states typically rely on key program design levers to prioritize the limited ECCE subsidy resources that are available. Under federal law, CCDBG funds may be used to assist families with income up to 85 percent of the state median income. Because federal funds are insufficient

to serve all children eligible under federal law, states may—and do—set lower eligibility limits. In nearly one-third of the states, families with income above 150 percent of the federal poverty guidelines (\$30,630 a year for a family of three in 2017) could not qualify for child care assistance. In nearly three-quarters of states, families with income above 200 percent of poverty (\$40,840 a year for a family of three in 2017) would be ineligible for assistance.⁴⁶

States also determine the copayment required of eligible families. Federal regulations recommend that parents not be required to pay more than seven percent of their income on child care. However, most states do not meet this standard. Over half the states require families at 150 percent of poverty to pay copayments that account for more than seven percent of their income for child care; nearly a quarter of the states require families at the poverty line to pay more than seven percent of their income.⁴⁷

Under federal law, the parents with whom the child resides must be “working or attending a job training or educational program” or the child must be receiving or in need of protective services.⁴⁸ States have some flexibility in setting eligibility standards. For example, federal law does not mandate how many hours parents must work to qualify for the CCDBG, but nearly

⁴⁵ Congressional Research Service, “The Child Care and Development Block Grant: Background and Funding,” 2014, https://www.everycrsreport.com/files/20140917_RL30785_523d234ca8f11b399d2adf7d0609aa077586fe95.pdf.

⁴⁶ Karen Schulman and Helen Blank, “Persistent Gaps: State Child Care Assistance Policies 2018,” National Women’s Law Center, 2018, <https://nwlc.org/resources/overdue-for-investment-state-child-care-assistance-policies-2018/>.

⁴⁷ Ibid.

⁴⁸ U.S. Code Title 42, “The Public Health and Welfare,” Chapter 105, Community Services Programs, Subchapter II–B, Child Care and Development Block Grant, Section 9858c, <https://www.law.cornell.edu/uscode/text/42/9858c>.

Although federal regulations recommend that parents not be required to pay more than seven percent of their income for child care, most states do not meet this standard.

half of the states do.^{49,50} Parents working in unstable, low-wage jobs may have difficulty

meeting the minimum hours requirements, and thus may not qualify for assistance.⁵¹ Recognizing that it is difficult to search for and start a job without child care in place, the 2014 federal reauthorization of the law requires states to allow families to qualify for and begin receiving assistance while a parent looks for work if they become unemployed, and some states have their own, more generous allowances.^{52,53} The

⁴⁹ States that do not set a minimum number of parent/guardian work hours for eligibility may still base the amount of the subsidy on the number of hours worked.

⁵⁰ Victoria Tran, Sarah Minton, Sweta Haldar, and Kelly Dwyer, “The CCDF Policies Database Book of Tables, Key Cross-State Variations in CCDF Policies as of October 1, 2017,” OPRE Report 2018-106, Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2018, https://www.acf.hhs.gov/sites/default/files/opre/ccdf_policies_database_2017_book_of_tables_final_10_09_18_508.pdf.

⁵¹ Kimberly Burgess, Colin Campbell, Nina Chien, Taryn Morrissey, and Sharon Wolf, “Income and Employment Fluctuations Among Low-Income Working Families and Their Implications for Child Care Subsidy Policy,” Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, <https://aspe.hhs.gov/system/files/pdf/255481/incomefluct.pdf>.

⁵² The reauthorization of CCDBG in 2014 requires states to allow families who have been receiving child care assistance to continue receiving it for at least three months while a parent looks for a job.

⁵³ Karen Schulman and Helen Blank, “Persistent Gaps: State Child Care Assistance Policies 2018,” National Women’s Law Center, 2018, <https://nwlc.org/resources/overdue-for-investment-state-child-care-assistance-policies-2018/>. A larger share of states has job search policies for families receiving or leaving Temporary Assistance to Needy Families, see Tables 2 and 3: https://www.acf.hhs.gov/sites/default/files/opre/ccdf_policies_database_2016_book_of_tables_final_12_05_17_b508.pdf.



2014 reauthorization also requires states to implement 12-month eligibility re-determination periods for CCDF families, regardless of changes in a family's income (unless their income doesn't exceed the federal threshold of 85 percent of the state's median income) or any temporary changes in parent/guardian participation in work, training, and/or education activities.⁵⁴

Parents may choose any provider that meets basic health and safety standards, including centers, licensed family child care homes, and, in most states, providers who are exempt from licensing requirements under state law because of the small number of children served, their relationship to the children, or other reasons.⁵⁵ Congress strengthened those standards in its 2014 CCDBG reauthorization (see text box), but states' implementation has been uneven.⁵⁶

Quality-Related Requirements for States under the Child Care and Development Block Grant Reauthorization of 2014

The Act requires states to:

- Establish and enforce minimum health and safety standards covering 11 broad areas, such as the prevention and control of infectious diseases, building and premises safety, and emergency preparedness;
- Ensure that all providers receiving funds from the CCDBG complete pre-service and ongoing training on health and safety topics;
- Set age-specific standards for group size limits and child-to-provider ratios;
- Conduct pre-licensure and annual unannounced licensing inspections for all licensed CCDBG providers, as well as annual inspections for unlicensed (or "license-exempt") CCDBG providers;

- Establish qualifications and training for licensing inspectors and set inspector-to-provider ratios; and
- Conduct criminal background checks on applicable child care providers and staff members.

In addition,

- All providers receiving funds from the CCDBG must complete pre-service and ongoing training on health and safety topics; and
- Minimum state spending on general quality activities increases incrementally from 4 percent of CCDBG spending under prior law to 9 percent by FY2020, plus states must spend an additional 3 percent on quality activities for infants and toddlers.

Source: Congressional Research Service (CRS), "Early Childhood Care and Education Programs: Background and Funding," 2016, <https://crsreports.congress.gov/product/pdf/R/R40212>.

⁵⁴ Administration for Children and Families, Office of Child Care, "CCDF Reauthorization Frequently Asked Questions," U.S. Department of Health and Human Services, 2015, <https://www.acf.hhs.gov/occ/resource/ccdf-reauthorization-faq-archived>.

⁵⁵ National Center on Early Childhood Quality Assurance, "Supporting License-Exempt Family Child Care (No. 302)," Department of Health and Human Services: Administration for Children & Families: Office of Child Care, 2015, https://childcareta.acf.hhs.gov/sites/default/files/public/supporting_exempt_fcc.pdf.

⁵⁶ Karen Schulman, "The Child Care and Development Block Grant Act of 2014: Uneven State Implementation of Key Policies," National Women's Law Center, 2015, <https://nwlc-ciaw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2017/09/NWLC-report-on-state-implementation-of-CCDBG-reauthorization.pdf>.



State payment rates for CCDBG child care providers can help determine the quality of services that providers will be able to offer. However, since public funding for ECCE is relatively limited compared to the amount families pay out of pocket, the quality of care generally more closely reflects the income of the communities served by that particular service provider. To give families access to 75 percent of the providers in their communities, federal regulations recommend that states set payment rates for providers at the 75th percentile of current market rates. However, just two states set their payment rates at the 75th percentile of current market rates, and multiple states have set their payment rates at less than the 50th percentile of current

market rates.⁵⁷ States operate resource and referral agencies that help parents locate providers, but parents/guardians may be unable to find providers who will provide the care they need for the rates offered.

The CCDBG provides vital assistance to families who receive it—but many families in need do not. Children who meet all state eligibility requirements are not guaranteed assistance. Nearly two-fifths of states have waiting lists or frozen intake—meaning they simply turn families away without even putting their names on a waiting list.⁵⁸ The number of children receiving CCDBG assistance dropped by over 373,000 between 2006 and 2015;⁵⁹ only 16 percent of children

⁵⁷ Karen Schulman and Helen Blank, “Persistent Gaps: State Child Care Assistance Policies 2018,” National Women’s Law Center, 2018, <https://nwlc.org/resources/overdue-for-investment-state-child-care-assistance-policies-2018/>.

⁵⁸ Ibid.

⁵⁹ CCDBG funds are available for families with children up to age 13 who have child care and education needs. [Christine Johnson-Staub and Hannah Matthews, “CCDBG: A Critical Support for Working Families,” CLASP, 2017, <https://www.clasp.org/sites/default/files/public/resources-and-publications/publication-1/CCDBG-A-Critical-Support.pdf>.]



through age 13 eligible for assistance under federal guidelines were estimated to be receiving it as of 2015.⁶⁰ The recent infusion of federal funds for the CCDBG could have an impact on those numbers, with one estimate suggesting that an additional 670,000 children could be served as a result of the 2018 funding increase.⁶¹ However, states may also prioritize using those funds for other investments, such as quality improvement, which in turn would translate into a lower impact on increasing enrollment than anticipated.

Head Start / Early Head Start

Head Start is a federal program that provides funds directly to local grantees, rather than

states, to provide comprehensive early childhood development services to low-income children, including educational, health, nutritional, social, and other services.⁶² Although Head Start programs may serve any child up to compulsory school age, they principally serve three- and four-year-olds. The smaller Early Head Start component, added in 1994, serves children under age three, including during pregnancy. A network of about 1,600 public and private (nonprofit and for-profit) agencies administers Head Start programs.⁶³

Head Start gives grantees flexibility to design programs to meet local needs, consistent with federal requirements. In general, families

⁶⁰ Committee on Ways and Means, U.S. House of Representatives, *2018 Green Book*, Chapter 9: Child Care, Additional Tables and Figures, "Figure 9-5, Percent of Children Eligible under State Rules Who Were Served by the CCDF in 2015," 2018, <https://greenbook-waysandmeans.house.gov/2018-green-book/chapter-9-child-care>.

⁶¹ CLASP, "\$5 Billion Child Care Increase Would Help Hundreds of Thousands," Fact Sheet, March 2019, <https://www.clasp.org/sites/default/files/publications/2019/03/State%20by%20State%20Impact%20of%20%245%20Billion%20FY2020.pdf>.

⁶² Congressional Research Service, "Head Start: Background and Funding," 2014, https://www.everycrsreport.com/files/20140102_RL30952_9de5df5a6c4debc9131eea76fb96ade27155c351.pdf.

⁶³ Ibid.

served must be below the federal poverty line, or the child must be homeless, in foster care, or participating in public assistance. Programs may fill up to 35 percent of their slots with children from families with income between 100 and 130 percent of the poverty line, provided that priority populations have been served first.⁶⁴

Head Start regulations specify staff qualifications and training requirements. For example, at least 50 percent of Head Start teachers must have a bachelor's or advanced degree in early childhood education; all Head Start teacher assistants must have at least a Child Development Associate (CDA) credential, be enrolled in an associate's or bachelor's degree program, or be enrolled in a CDA program to be completed within two years. A portion of Head Start funding is reserved to encourage partnerships between Early Head Start grantees and center-based and family child care providers who agree to meet the Head Start performance standards.⁶⁵

Nationwide, Head Start served 732,711 preschool-aged children (31 percent of all eligible children) and Early Head Start served 154,352 children under age three (7 percent

of all eligible children).⁶⁶ Among children in poverty, Head Start programs served 35 percent of three- and four-year-olds and seven percent of children under three.⁶⁷ Access varies widely by state.⁶⁸ For example, Nevada enrolls 17 percent of poor four-year-olds, while North Dakota enrolls 100 percent. Enrollment of poor children under age three ranges from three percent in Nevada to 13 percent in the District of Columbia.⁶⁹ Additionally, while states can contribute additional funds to Head Start, over three-quarters of states do not invest beyond the federal dollars received.⁷⁰

State preschool programs

State-funded preschool education programs have expanded rapidly in recent years. In 2002, just three states and the District of Columbia served more than one-third of four-year-olds; in 2017, serving one-third of four-year-olds has become the national average, and nine jurisdictions enrolled more than 50 percent. Two jurisdictions (DC and VT) have also succeeded in enrolling more than half of three-year-olds in a state preschool program. In 2002, 13 states had no state-funded preschool programs; that

⁶⁴ For example, 10 percent of slots are reserved for children with disabilities.

⁶⁵ U.S. Department of Health and Human Services, Administration for Children and Families, "Head Start Program Performance Standard Excerpts, 45 CFR Chapter XIII, Subchapter B: The Administration for Children and Families, Head Start Programs," 2016, <https://eclkc.ohs.acf.hhs.gov/sites/default/files/docs/pdf/staff-qualifications.pdf>.

⁶⁶ National Head Start Association, "Access to Head Start in the United States of America," 2019, <https://www.nhsa.org/national-head-start-fact-sheets>.

⁶⁷ Child Trends Databank, "Head Start," December 27, 2018, <https://www.childtrends.org/indicators/head-start>.

⁶⁸ W. Steven Barnett and Allison H. Friedman-Krauss, "State(s) of Head Start," National Institute for Early Education Research (NIEER), Rutgers Graduate School of Education, 2016, http://nieer.org/wp-content/uploads/2016/12/HS_Full_Reduced.pdf.

⁶⁹ Ibid.

⁷⁰ Bipartisan Policy Center, "Creating an Integrated Efficient Early Care and Education System to Support Children and Families: A State-by-State Analysis," December 2018, <https://bipartisanpolicy.org/wp-content/uploads/2019/01/Creating-an-Integrated-Efficient-Early-Care-and-Education-System-to-Support-Children-and-Families-A-State-by-State-Analysis.pdf>.

number declined to seven in 2017.⁷¹ Total state spending on preschool education has increased since 2002, though spending per child has decreased in real terms.⁷²

Most programs use a state-specified income level in addition to age to determine eligibility, but even states with a goal of universal access generally prioritize low-income children and children with other risk factors when resources are insufficient to serve all children.⁷³

There is substantial variability across states regarding key structural design features of state preschool programs, and thus what it means for families in a practical sense to get a slot in one of those programs is relatively hard to define. State programs differ in regard to the settings in which children can receive care (e.g., public schools, community-based providers, or both), program hours (e.g., half-versus full-day), licensing standards (e.g., staff-to-student ratios), and curriculum quality.⁷⁴

State programs also vary widely in quality and workforce policies. The National Institute for Early Education Research—which evaluates

programs using ten quality benchmarks—found that, in 2017, just five state preschool programs met all ten benchmarks, while an additional 15 programs met nine. By contrast, nine programs, including several in states serving large numbers of children, met fewer than five benchmarks.⁷⁵ States also have different standards for workforce policies supporting early childhood educators and care providers, such as compensation, educational requirements, and professional development opportunities.⁷⁶

The federal Preschool Development Grant (PDG) Program provides some support for state preschool efforts. Initially, PDG funding for FY2014-FY2017 was used to support states in building or expanding access to high-quality preschool programs for low- and moderate-income four-year-olds. For the purposes of this program, the federal administering agencies defined the term “high-quality preschool program” in a way that addressed staff development, child-to-staff ratios, and health and safety standards. This legacy PDG program was later replaced by a new PDG program authorized in the “Every Student Succeeds Act of 2015.” The new law explicitly prohibited the administering

⁷¹ Allison H. Friedman-Krauss, W. Steven Barnett, G.G. Weisenfeld, Richard Kasmin, Nicole DiCrecchio, and Michelle Horowitz, “The State of Preschool 2017: State of Preschool Yearbook,” National Institute for Early Education Research (NIEER), Rutgers Graduate School of Education, 2018, http://nieer.org/wp-content/uploads/2018/04/YB2017_Executive-Summary.pdf.

⁷² Ibid.

⁷³ Megan E. Carolan and Lori Connors-Tadros, “Approaches to State Pre-K Eligibility Policy: Considerations for Policy Makers in Revising Policy to Increase Access for High Needs Children,” Center on Enhancing Early Learning Outcomes, 2015, http://ceelo.org/wp-content/uploads/2015/05/ceelo_policy_report_prek_eligibility_approaches.pdf.

⁷⁴ Ajay Chaudry, “The Promise of Preschool Education: Challenges for Policy and Governance,” *The Current State of Scientific Knowledge on Pre-Kindergarten Effects*, The Brookings Institution and Duke University Center for Child and Family Policy, 2017, https://www.brookings.edu/wp-content/uploads/2017/04/duke_prekstudy_final_4-4-17_hires.pdf.

⁷⁵ Allison H. Friedman-Krauss, W. Steven Barnett, G.G. Weisenfeld, Richard Kasmin, Nicole DiCrecchio, and Michelle Horowitz, “The State of Preschool 2017: State of Preschool Yearbook,” National Institute for Early Education Research (NIEER), Rutgers Graduate School of Education, 2018, http://nieer.org/wp-content/uploads/2018/04/YB2017_Executive-Summary.pdf.

⁷⁶ Ajay Chaudry, “The Promise of Preschool Education: Challenges for Policy and Governance,” *The Current State of Scientific Knowledge on Pre-Kindergarten Effects*, The Brookings Institution and Duke University Center for Child and Family Policy, 2017, https://www.brookings.edu/wp-content/uploads/2017/04/duke_prekstudy_final_4-4-17_hires.pdf.



federal agencies from defining the term “high-quality.”⁷⁷ Under the new PDG grants (first funded in FY2018), states are focusing on birth-through-five needs assessments, strategic planning, maximizing parental choice, sharing best practices, and improving overall quality of early childhood programs.⁷⁸

⁷⁷ CRS, “Early Childhood Care and Education Programs: Background and Funding,” 2016, https://www.everycrsreport.com/files/20160516_R40212_7109fd6a323108f119477ff9818cfb50481a8469.pdf.

⁷⁸ Ibid.

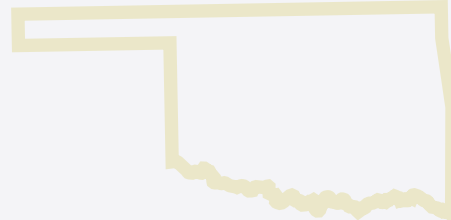
State Highlights: Universal Preschool Programs

District of Columbia:

The District of Columbia's preschool program serves children in all eight wards of the District. The program was established through the Pre-K Enhancement and Expansion Act of 2008. Federal and state-level public funding are supplemented by support from the DC Ed Fund, which acquires "high-impact, private investments" to support the growth of D.C. Public Schools.⁷⁹ To be eligible, a child must be three or four years old and a resident of the District. As of 2018, 86 percent of four-year-olds and 72 percent of three-year-olds were enrolled. Full-day preschool services are provided in traditional public schools, public charter schools, and community-based programs.⁸⁰

Oklahoma:

In 1993, Oklahoma gave all school districts the option to offer pre-K programs for four-year-olds. Five years later, a state law (HB 1657) began requiring school districts to provide half- or full-day preschool for four-year-olds in the state. Oklahoma allocates state and local tax money for preschool. School districts may also use funds from their federal Title I⁸¹ programs to fund preschool. One study found that the preschool program had impacts that lasted into middle school, including math achievement test scores, enrollment in honors courses, and grade retention.⁸²



⁷⁹ For more information, see: DC Ed Fund, <https://www.dcedfund.org/#dc-ed-fund>.

⁸⁰ District of Columbia Office of the State Superintendent of Education (OSSE), "Fiscal Year 2018 Pre-K Report," 2018, <https://osse.dc.gov/sites/default/files/dc/sites/osse/publication/attachments/OSSE%20Annual%20Pre-K%20Report%202018.pdf>.

⁸¹ "Title I, Part A (Title I) of the Elementary and Secondary Education Act, as amended by the Every Student Succeeds Act (ESEA), provides financial assistance to local educational agencies (LEAs) and schools with high numbers or high percentages of children from low-income families to help ensure that all children meet challenging state academic standards." <https://www2.ed.gov/programs/titleiparta/index.html>. As enacted in 1965, "[t]he purpose of this subchapter [Title I] is to provide all children significant opportunity to receive a fair, equitable, and high-quality education, and to close educational achievement gaps." Elementary and Secondary Education Act of 1965, 20 U.S.C. 6301 et seq., <https://www.law.cornell.edu/uscode/text/20/6301>.

⁸² William T. Gormley, Jr., Deborah Phillips, and Sara Anderson, "The Effects of Tulsa's Pre-K Program on Middle School Student Performance," *Journal of Policy Analysis and Management*, vol. 37, no. 1, 2018, <https://onlinelibrary.wiley.com/doi/pdf/10.1002/pam.22023>.



Child and Dependent Care Tax Provisions

The federal Child and Dependent Care Tax Credit (CDCTC) is a tax credit for employment-related expenses incurred for the care of a dependent child under age 13 or a dependent or spouse with disabilities. Congress enacted it in 1954 as a deduction for certain employment-related child and dependent care expenses. The measure was converted to a tax credit in 1976.⁸³ Currently, the maximum credit rate, for families with adjusted gross income of \$15,000 or less, is 35 percent of expenses up to \$3,000 for one child (for a maximum credit of \$1,050) and \$6,000 for two or more children (for a maximum credit of \$2,100). The credit rate declines with income

to 20 percent for families with income above \$43,000 (for a maximum credit of \$600 for one child and of \$1,200 for two or more children).

The federal CDCTC is non-refundable: it can only be used to offset federal income tax liability. Positive federal income tax liability is rare to non-existent for families with incomes at or below the poverty line. As a result, very low-income families—who in theory are entitled to the largest credit—receive little or no benefit.⁸⁴

Another federal tax provision is the Dependent Care Assistance Program (DCAP). If employers offer the DCAP, taxpayers can exclude from their income—for both income

⁸³ Act of Aug. 16, 1954, Pub. L. No. 83-591, §214, 68A Stat. 3, 70-71 (codified at I.R.C. §214); Tax Reform Act of 1976, Pub. L. No. 94-455.

⁸⁴ Margot L. Crandall-Hollick, “Child and Dependent Care Tax Benefits: How They Work and Who Receives Them,” Congressional Research Service: R44993, 2018, <https://crsreports.congress.gov/product/pdf/R/R44993>.

Because the federal Child and Dependent Care Tax Credit is non-refundable, very low-income families receive little or no benefit.

and payroll tax purposes—up to \$5,000 for the employment-related care expenses of one or more children under 13 or a dependent or spouse with disabilities. This exclusion from income is worth more to taxpayers with a higher marginal tax rate.⁸⁵ Additionally, families must still be capable of paying up-front for their child care expenditures, as the DCAP program simply reimburses for incurred expenses (akin to many health care Flexible Spending Account programs).

Half of the states and the District of Columbia have their own child and dependent care tax provisions, most of which are based on the federal CDCTC. In 12 states, the credits are refundable.⁸⁶

Other federally funded early child care and education programs

The Individuals with Disabilities Education Act (IDEA) authorizes grants to states to serve individuals with disabilities through age 21. IDEA specifically authorizes grants for infants and toddlers (birth through age two) experiencing developmental delays, as well as for children ages three to five with a disability who require special services to benefit from public education. Roughly 373,000 infants and toddlers and 760,000 preschool-age children participated in FY 2017.⁸⁷

The Child Care Access Means Parents in School (CCAMPIS) program awards grants to institutions of higher education to supplement or initiate campus-based child care services. Parents must be eligible for a Pell Grant. About 3,400 students were served in FY 2016,⁸⁸ but a recent increase in funding (from roughly \$15 million in FY2017 to \$33 million in FY2018⁸⁹) will almost certainly increase the number of families served by this program moving forward.

⁸⁵ Ibid.

⁸⁶ National Women's Law Center, "State Child and Dependent Tax Credit Provisions, Tax Year 2017, Fact Sheet," 2018, <https://nwlc-ciw49tixgw5lhab.stackpathdns.com/wp-content/uploads/2018/06/State-Child-Care-and-Dependent-Care-TY-2017-Final.pdf>.

⁸⁷ Committee on Ways and Means, U.S. House of Representatives, 2018 *Green Book*, Chapter 9: Child Care, Additional Tables and Figures, "Table 9-1. Characteristics of Selected Early Childhood Care and Education Programs and Tax Provisions," 2018, <https://greenbook-waysandmeans.house.gov/sites/greenbook.waysandmeans.house.gov/files/Chapter%209%20Child%20Care%20-%20Additional%20Tables%20and%20Figures.pdf>.

⁸⁸ Ibid.

⁸⁹ U.S. Department of Education, "Child Care Access Means Parents in School Program: Funding Status," January 9, 2019, <https://www2.ed.gov/programs/campisp/funding.html>.



The Family and Child Education Program (FACE) provides grants to tribes and tribal institutions for services for children under age six and their parents in home- and center-based settings. About 2,200 children were served in School Year 2016-2017.⁹⁰

⁹⁰ Committee on Ways and Means, U.S. House of Representatives, *2018 Green Book*, Chapter 9: Child Care, Additional Tables and Figures, "Table 9-1. Characteristics of Selected Early Childhood Care and Education Programs and Tax Provisions," 2018, <https://greenbook-waysandmeans.house.gov/sites/greenbook.waysandmeans.house.gov/files/Chapter%209%20Child%20Care%20-%20Additional%20Tables%20and%20Figures.pdf>.

Section III.

**POLICY OPTIONS
FOR STATE EARLY
CHILD CARE
AND EDUCATION
PROGRAMS**

NATIONAL
ACADEMY
OF SOCIAL
INSURANCE



This section outlines three approaches that a state could take to establish a social insurance program⁹¹ for early child care and education:

1. a comprehensive universal early child care and education program,
2. an employment-based early child care and education contributory program, and
3. a universal early child care and education subsidy program.

The panel does not recommend or advise against any of these options. Instead, it describes the core design features and unique considerations for each of these three options, outlines a range of vetted approaches states

could adopt in pursuing them, and describes the building blocks and tradeoffs involved.

If a state were to opt for one of the three broad policy options elaborated in this chapter, additional choices would then need to be made with regard to benefit design and funding mechanisms. These decision points are discussed broadly in the text boxes *Designing Program Benefits* (p. 40) and *Funding Sources* (p. 41), and more specifically within the elaboration of each of the three policy options below. Finally, we analyze the implications of each design approach for fiscal sustainability, program stability, political feasibility, administrative simplicity, and addressing inequality in access.

⁹¹ Social insurance programs are by design expansive in reach and typically financed through broad-based, contributory funding streams.

Designing Program Benefits

There are several factors to consider when deciding how to structure the benefits of an ECCE program.

How could benefits be structured and delivered to families?

There are three common ways that ECCE benefits can be delivered. The policy option(s) (listed above) that are compatible with each benefit delivery approach are indicated in parentheses.

- **Public provision:** An early child care and education program could expand the existing public education system to serve younger children. Local school systems might use state funds for both school-based and other qualified programs, or divide funding between school systems and collaboratives of community-based programs that function as part of the public system. (Option 1)
- **In-kind benefit:** An in-kind benefit is paid directly to a qualified early child care and education provider on behalf of an eligible family. Often provided to families in the form of subsidies or vouchers, these benefits could cover all or a portion of the cost of care. (Option 1, 2, or 3)
- **Cash benefit:** A cash benefit would be paid directly to eligible families to spend as they wished for child care and education. As with child and dependent care tax credits, families might be required to document that the benefits are being used to pay for ECCE. (Option 2)

What types of care qualify for coverage?

Presumably, any program would cover center-based care and licensed home-based care

facilities. A program also might cover license-exempt family, friend, and neighbor (FFN) care. Policymakers might require FFN providers to meet quality standards and could fund training, home visits, and other supports for such providers.

How much care would be covered?

- Should benefits include full-day or only half-day programs?
- Would a program cover care year-round or exclude summer months, as in many K-12 public school systems?
- What about additional subsidies or vouchers for services outside of regular program hours (e.g., early mornings, evenings, weekends)?
- Might benefits increase for families with lower incomes and/or greater levels of need?
- How can a program ensure providers receive sufficient compensation to provide high-quality care without further raising costs for families?
- Could benefits vary with the type of care selected (e.g., lower benefits for FFN care than licensed home-based and center-based care?)
- Should benefits increase for more highly-rated providers, perhaps using a state-level Quality Rating and Improvement System (QRIS) system?

Funding Sources

States have a variety of options for funding an early child care and education program. A program need not draw solely on one source of funding, but rather could blend funding streams and/or use different funding sources to pay for different program elements. Each of the following funding sources brings different advantages and challenges. Some are relatively more predictable and stable; are more regressive; or spread the costs more broadly.

Earmarked revenue sources

A state could opt to institute some form of earmarked tax to provide a primary or supplementary source of program funding. More than half of federal spending on programs supporting seniors and working-aged adults is funded through dedicated revenue sources, but dedicated revenue sources represent only about five percent of federal spending on children.⁹²

At the state level, dedicated funding sources are typically considered more reliable than general revenues. Because of state balanced budget requirements, earmarked taxes are largely removed from annual appropriations battles associated with general revenues. However, funding through an earmarked tax could still be unpredictable, particularly if the tax were based on property value or sales of a specific commodity. Some options for sources of earmarked taxes include:

- Personal income surtax, which could be calculated either as a flat proportion of income or progressively by requiring higher contribution rates from higher earners.
- Payroll tax, which could be paid exclusively by employees, shared between employees and employers, or paid exclusively by employers.

Though a state might cap taxable earnings, omitting a cap would generate more revenue and spread costs more equitably.

- Corporate income surtax.
- Unearned income tax.
- A state or local levy initiative.
- Property surtax.
- Sales (sur)tax, which—for states that already charge a sales tax—could be applicable to all items for which a sales tax is collected or exclusively for one or more specific types of item.

General revenues

States could fund an early child care and education program through general revenues. This mode of funding can be vulnerable to annual appropriations battles, but tying ECCE funding to K-12 formula grants—as several states do for their existing preschool programs—could provide greater stability.

Family contributions

A state could offer universal ECCE free of charge to families or require a co-payment from families not eligible for existing no-cost federal or state programs (e.g., Head Start). Some states already require such contributions from families for existing

⁹² Committee for a Responsible Federal Budget, “Budgeting for the Next Generation: Options to Improve Budgeting for Children,” 2018, http://www.crfb.org/sites/default/files/Budgeting_for_the_Next_Generation_Options_to_Improve_Budgeting_for_Children.pdf.

Continued on p.42

Funding Sources *(continued)*

subsidy or voucher programs. To enhance equity and promote accessibility for those with the greatest need, family contributions might be determined based on each family's means, through either a sliding scale design or a fixed percentage rate proportional to family earnings (e.g., no more than seven percent of a family's total income, which is the amount recommended by the Department of Health and Human Services for family contributions for child care). A state might consider requiring families earning above a certain income to pay the entirety of their child care costs, but such a program would likely exclude many middle- and upper-income households from receiving benefits, which would limit its universality and long-term political viability. An alternative option more in the

spirit of social insurance would be to have even higher-income households still receive a modest benefit from the program, which would increase the program's universality and, in tandem, broaden its base of support.

Philanthropic grants

While unlikely to provide a sufficiently consistent funding source to implement an entire ECCE program, philanthropic grants could provide a valuable source of additional resources for program development and enhancement. Grants might be especially useful for funding program startup costs, staff training, professional development, and infrastructure development.



Option 1. Comprehensive universal early child care and education program

A universal, comprehensive early child care and education program would cover all children, regardless of parent/guardian employment status. The program could supply early care and education to children through the public school program (essentially extending public K-12 education to younger ages), subsidies for qualified center- and/or home-based care (or even FFN care), or some combination of the two. Since many states are already providing access to pre-K programs for some or all three- and four-year-olds, policymakers might consider expanding the public education system to all older children first while relying on and supporting the private market to provide care services for younger children (ages 0-2). A comprehensive social insurance program would be primarily publicly funded, but could require contributions for families accessing these services to supplement public funds.

Such a program would entail significant costs, but would put early care and education on par with traditional public elementary and secondary education, which has been essentially universally available for more than a century. An increasing number of states and localities are already expanding their existing public education programs for preschool-aged children.

A universal, comprehensive early child care and education program would cover all children, regardless of parent/guardian employment status.

Eligibility: By definition, all children within the covered age range would be eligible for a universal and comprehensive ECCE program. A state might provide ECCE to all children below the age of entry into formal education, or it might limit eligibility to children of a certain age or age range. Further, a state might implement universal coverage immediately or in stages. For example, a program might first provide coverage only for four-year-olds, or for all pre-school-aged children but not infants and toddlers, with the ultimate goal of covering every child from (soon after) birth to the age of entry into formal education. It is important to note that targeting only the oldest children first may have unintended consequences for ECCE for younger children, however, as the cost of care for the youngest children is higher than for preschool-aged children and existing programs already strongly favor funding services for older children.

Benefits: A state could implement universal ECCE by expanding its existing universal public education programs to younger children. Alternatively, a state might combine expanded public education with a subsidy program, as described in Option 3 (see p. 50). For example, school systems and local provider collaboratives could expand their public school programs to serve preschool-aged children, and the program could rely on subsidies to serve infants and toddlers, for whom a greater proportion of parents may seek non-center care services.

Financing: Financing a universal, comprehensive ECCE social insurance program in a fair and efficient manner will

require nuance and thoughtful consideration. A comprehensive, universal program could be entirely state-funded, or could be designed more similarly to a standard social insurance program by requiring some form of direct contribution from families accessing the program. A substantial amount of public funding would likely be necessary to implement a universal ECCE program and to supplement any family contributions. Such funding could come from general revenues and/or dedicated funding stream(s) (e.g., earmarked surtaxes on income, property, or sales). A state program might provide comprehensive ECCE at no cost to families who are already eligible for no-cost early child care and education programs. Alternatively, a state could use general

revenues or other dedicated funding streams to fund the entire program, without requiring any family contributions, as is largely the case for K-12 public education.

Family contributions would likely be determined based on a sliding scale according to family income. Family contributions could not realistically be collected solely via payroll taxes, as some families may lack adults who have ties to traditional employment relationships. An alternative option would be to collect family contributions at the point of accessing benefits. To increase equity, family contributions might be set on a sliding scale linked to family income; alternatively, a state might select a fixed contribution rate (e.g., seven percent) applied to family income and/or assets.

Policy Assessment — Option 1. Comprehensive universal early child care and education program

Fiscal sustainability: The fiscal costs of expanding access to comprehensive universal care and education for children under the age of entry into the formal education system would be substantial. However, primary and secondary public education has been financed through state and local revenue streams for roughly a century, which demonstrates a strong case for this program's long-term fiscal sustainability. Some states have already expanded access to publicly funded education for preschool-aged children, as well.

Program stability: A comprehensive and universal ECCE program would, in many ways, closely resemble the existing public education system, which has remained relatively stable for a substantial amount of time. Such a program

may experience challenges at the outset in terms of building up ECCE provider capacity to accommodate a likely significant increase in the number of children receiving services. States could mitigate this initial instability by phasing in the program over time, such as by offering benefits to the oldest children first and then gradually extending coverage to younger children.

Political feasibility: Universal public education has, by and large, stood the test of time in terms of political feasibility. The benefits of early care and education to children, families, and society at large are substantial and make a strong case for such an investment. Several states have already adopted this model in developing their universal pre-K programs for four- and, in some

cases, three-year-olds, including the District of Columbia, Oklahoma, Vermont, and West Virginia. Additionally, universal programs tend to garner more widespread political support, which in turn enhances political feasibility.

For states concerned about maintaining choice in ECCE providers, or where there are regional concerns in terms of physical access to ECCE services (e.g., in rural and/or low-income communities), policymakers might consider building in some flexibility by offering subsidies to qualified private early care and education providers. Flexibility in terms of eligible service providers would also allow for the program to build on the existing infrastructure of ECCE services without undermining the availability of care. Without this flexibility, states risk a chilling effect on the availability of services for infants and toddlers, as providers often offset the substantially higher cost of care for younger children by serving children of a variety of ages and spreading those costs more broadly.

Administrative simplicity: A universal comprehensive program would remove many of the administrative burdens of some other and/or existing ECCE program designs. Families would not need to be screened and monitored for program eligibility, for example, because all children who live in the jurisdiction would be eligible. If family contributions were

required for accessing benefits, however, the state would need to develop protocols and systems for determining the amount of required contributions for each individual family and for collecting those contributions. Determining qualifications of and standards for ECCE service providers and centers would also be a substantial up-front administrative task, and the state would need to continue monitoring those providers in perpetuity, as they do with public K-12 providers currently.

Addressing inequality in access: Since all children would be eligible for benefits under a universal comprehensive program, this design would make a substantial impact on inequity in access to early care and education. As with the K-12 public education system, however, those inequities would not be reduced to zero, as there could still be variations in program access and quality by region, challenges with provider capacity building, or other disparities. Any universal public program would need to be carefully designed so as not to replicate the failings of the existing K-12 education landscape, where stark contrasts in quality of care and education exist based on where a child lives due, in large part, to how the system is financed (i.e., relying on local property taxes for funding). A program could attempt to tackle some of these disparities by allowing families to access services from both public and private ECCE providers.



Option 2. Employment-based early child care and education contributory program

The employment-based program design would entitle all families with children under the age of primary school education to early care and education services if their parent(s)/guardian(s) are sufficiently attached to the labor force. All workers would contribute to the program, regardless of whether or not they have children. Contributions could be complemented by public funds, family copayments, or both. Benefits would most likely be provided in the form of a subsidy or voucher for qualified center- or home-based care services.

Much like other benefits tied to employment—such as temporary disability insurance, paid family leave, unemployment insurance, paid sick time, etc.—the goal of an employment-based ECCE social insurance program is to support an individual's ability to maintain labor force attachment in the event of a temporary life event and reduce financial shock. Lack of access to and the

high cost of early child care and education can be significant barriers to parents/guardians maintaining consistent labor force attachment. An employment-based system might be an effective strategy for getting or keeping parents/guardians in the workforce.

Eligibility: A state might condition a child's eligibility on either 1) parent/guardian workforce participation or 2) parent/guardian work history.

- If the program's goal is exclusively to encourage and assist with parent/guardian workforce attachment, then eligibility should be based on current workforce participation. Working parents/guardians typically need child care regardless of their work history if they want to be able to keep their jobs. Similarly, parents/guardians who are seeking employment would also need child care.

- Social insurance programs typically limit benefit eligibility to those who have already contributed to the program. Such a requirement does not match the nature of the risk of needing ECCE, however, because the risk can arise before the parent has entered the labor market or generated a significant work and contribution history. Since the vast majority of parents/guardians will continue to pay into the social insurance program long after their children have aged out of eligibility for benefits, most parents/guardians would simply make their contributions to the program retroactively.

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Additional eligibility questions to consider include the following:

- When designing an employment-based program for ECCE, policymakers should seriously consider how to ensure that the program covers those in nonstandard work arrangements. Particularly if the program is entirely or even partially funded by a payroll tax, policymakers will need to carefully consider how to be inclusive of parents/guardians who are self-employed, independent contractors, or otherwise participate in non-traditional work arrangements.

- Policymakers will need to consider how to handle families where the employed parent(s)/guardian(s) cross state lines for work. A payroll tax might suggest that the child would be eligible in the state of the parent's employment, depending on the taxation policies of the individual state. However, eligibility for existing ECCE programs—including CCDBG, Head Start, and state pre-K—depend on the family's residence.
- States will also need to consider whether a family would be eligible for benefits if another parent/guardian who had no current attachment to the labor force was providing full-time, at-home care for the child(ren). If so, policymakers should consider if the child would be required to attend a qualified center- or home-based provider, or if the family could instead collect benefits as a form of compensation for the stay-at-home parent/guardian's caregiving. Such a policy could encourage lower-earning spouses to stay home and provide care rather than returning to or entering the workforce. However, many caregivers are already staying home to provide care—whether by choice or necessity—without any form of compensation for their caregiving labor. Providing benefits to family caregivers for children could thus enhance the economic stability and empowerment of stay-at-home parents/guardians and their families.

Benefits: The nature of the benefit for any ECCE social insurance program would depend on a variety of factors, but an employment-based program may be particularly suited to a cash or in-kind (subsidy-style) benefit. From an equity standpoint, creating a new contributory social insurance program for children of working parents/guardians while requiring

children with non-working parents/guardians to rely on the (limited and underfunded) existing landscape of resources raises important considerations for policymakers.

Financing: Employment-based social insurance programs in the United States—such as Social Security—have traditionally been financed primarily through payroll contributions made by both employees and employers, though some state-level social insurance programs (e.g., paid family leave⁹³) are funded exclusively through payroll

contributions from workers, while others still rely entirely on employer contributions. An ECCE program financed by payroll contributions could also draw from other, complementary funding sources (e.g., general revenues, a dedicated sales tax). It is important to note that, to the extent that a social insurance program relies on payroll contributions, it relies heavily upon relatively stable sources of funding. However, such a financing system would need to be carefully structured to ensure that the program covers independent contractors and self-employed workers.

Policy Assessment — Option 2. Employment-based early child care and education contributory program

Fiscal sustainability: A program funded primarily through dedicated payroll taxes has the inherent advantage of strong fiscal sustainability, since the program has access to a consistent and reliable source of income. The taxation rate and/or taxable wage base (if applicable) may need to be periodically adjusted in order to adjust to shifts in the state's birth rate amongst working families, as program costs will rise and fall with changes in the number of children being served.

Program stability: A contributory social insurance model offers a relatively stable option for states, as the funding and benefits are less likely to change significantly from year to year when spread across an entire state's workforce. This stability would be enhanced by ensuring that reserves are available in the program's trust fund to cushion against fluctuations in GDP and employment rates from year to year.

Political feasibility: Programs that prioritize and aim to incentivize participation in the labor force are often politically appealing. Many federal and state-level programs already condition access to benefits on parent/guardian employment or job search. However, a contributory program based on labor market participation could face challenges in terms of political feasibility. The patchwork of existing federal and state-level ECCE programs is already complicated and fragmented, and a program focused primarily on labor force attachment would create further fractures in terms of which families are receiving which benefits and types of services. Segregating access to benefits based on labor force participation may face particular political resistance considering that this is a program targeted at children, whose nurturing and development arguably should not depend on the workforce participation of

⁹³ The payroll taxes that fund state-level paid family leave programs are levied exclusively on employees in all but one jurisdiction (DC). For paid medical leave programs, costs are typically split between employees and employers (again, with the exception of DC).

their parents/guardians. Additionally, even for families with one or more working parents, labor force attachment can be inconsistent or unpredictable, which in turn could lead to turnover or instability for a child's attachment to early care and education. In this policy design option, families may see challenges similar to those that they currently see with consistency in access to health care, which can often also be attached to and contingent upon an individual's labor force participation.

Administrative simplicity: The employment-based model bears some similarity to other existing state-level programs (e.g., Unemployment Insurance), and hence its financial administration would be relatively familiar to states. In other respects, however, an employment-based model would increase administrative complexity. Unlike in Unemployment Insurance, ECCE benefits are typically much more complex than a simple cash transfer, as early care and education assistance varies tremendously across states and even regions within the same state. Unlike for a universal program, the agency administering this program would need to have systems and staff in place for determining whether or not a family is eligible to receive benefits (e.g., whether the worker has met any vesting

requirements for paying contributions into the program; incorporating both traditional and non-standard work arrangements into the program) and to what benefits they are entitled (e.g., full-day versus partial-day care). If families were required to send their child(ren) to a qualified provider, states would also need to approve and monitor child care and education providers for their eligibility to participate in the program.

Addressing inequality in access: A program that further divides family eligibility will not be a strong strategy for addressing inequities in access to early care and education. Many existing federal and state-level programs already have parent/guardian employment requirements, so such a program design will do little to target families whose needs are not currently being met. Additionally, if the program is funded by a flat (versus progressive) payroll tax, and particularly if the taxable wage base is capped and unearned income is excluded from taxation, the financing structure could place a disproportionate burden on lower-income families and potentially increase financial inequity. However, such a program will ultimately still likely increase the number of families receiving benefits and the amount of benefits that they receive, which is an improvement over the status quo.

Option 3. Universal early child care and education subsidy program

A universal subsidy-style program could provide coverage for all children, regardless of their caregivers' employment status or income. Families would be eligible to receive some form of subsidy or voucher that would cover a portion of the cost of early care and education services for their children. Under the CCDBG, states already provide child care assistance—generally in the form of subsidies—to a fraction of low- and moderate-income families with employment-related child care needs. A universal subsidy program would essentially extend a program akin to the CCDBG model to all families, though states may opt to prioritize providing coverage for lower-income families not already receiving benefits from one of the existing federal- or state-level programs first.

A universal subsidy-style program could provide coverage for all children, regardless of their caregivers' employment status or income. Families would be eligible to receive some form of subsidy or voucher that would cover a portion of the cost of early care and education services for their children.

A subsidy-style program might appeal to a state for a variety of reasons. Such a model could be administratively simpler than a comprehensive program, particularly if the state exercises limited oversight regarding who qualifies as an eligible provider.

A subsidy-style program might enable families to access care from a diverse array of providers in a broader range of settings. This flexibility might be particularly valuable for families with irregular schedules and children with special caregiving needs, and may be more accommodating to cultural differences in child-rearing perspectives. It is also important, however, to consider the tradeoffs between administrative simplicity and the quality of care that children are receiving.

Eligibility: By definition, all children below the age of formal entry into public education would be eligible for access to this universal subsidy program. A state might also provide benefits to older children if they require care outside of traditional school hours, such as if their parent(s)/guardian(s) are working during evenings, early mornings, weekends, or periods of school recess (e.g., summers, holidays, etc.).

Financing: A subsidy-style program could be funded in a variety of ways. Social insurance programs are typically at least partially contributory, so families with some ability to pay would likely be required to make some financial contribution to their child(ren)'s early care and education. A payroll tax or earmarked income surtax could fund a subsidy program, either in part or in full. Alternative or additional funding mechanisms could draw on general revenues or another type of earmarked tax (e.g., a sales or property surtax) in order to fund the program.



Benefits: A subsidy-style program could provide important flexibility to families needing assistance with early child care and education. If a state permitted eligible families to continue receiving federal assistance, adding benefits from a new subsidy-style social insurance program might provide more comprehensive care to families with the greatest levels of need.

State policymakers would face important decisions regarding the amount of a state-provided subsidy. A state could provide a flat amount to each qualifying child, which would significantly reduce administrative complexity. Alternatively, the state might link subsidy amounts to parent/guardian earnings, with progressive benefit structures providing higher benefits to families with lower incomes and/or assets. A state could also opt to tie the amount of a benefit to the number of parental work hours. For example,

a child whose parent/guardian works full-time could receive higher benefits than one whose parent/guardian works part-time. Benefit amounts also could vary based on the type or quality of the ECCE program accessed (e.g., center-based versus FFN care) and/or the costs of care in the area. Varying benefit amounts based on type or quality of care, however, would likely disproportionately reduce benefit amounts for lower-income families, as they more commonly rely on lower-quality service providers and FFN care.

Policy Assessment — Option 3. Universal early child care and education subsidy program

Fiscal sustainability: The fiscal sustainability of a universal subsidy program would depend in part on the financing mechanism selected to fund the program and the nature of the benefits provided. A flat benefit amount offers the stability of comparative consistency and predictability, since the amount of spending required would rise and fall based only on the number of children receiving benefits, not the level of need of the families. A progressive benefit structure could be a cost-saving measure in that higher-earning families would receive lower benefits. However, a progressive benefits structure could cause challenges for maintaining consistent and reliable program funding. If a higher proportion of the population were lower-income and therefore received higher benefits, then in turn there might also often be a smaller pool of state-level general revenues to finance those benefits. This is particularly relevant in cases of a local or national recession.

Program stability: A subsidy program could have mixed success in terms of program stability. On the one hand, such a program is comparatively simple to administer, and therefore may be more easily sustainable over time. However, unlike a universal comprehensive program—where families have a relatively more tangible and consistent benefit—the generosity and thus sufficiency of a subsidy program could wax and wane as state priorities and financial resources shift over time. This has been the case with other federal and state-level subsidy-style programs (e.g., housing assistance).

Political feasibility: A subsidy program has advantages and disadvantages in terms of political feasibility. On the one hand, the concept of offering families a greater sense of choice in their child(ren)'s ECCE provider is appealing, and a subsidy program offers that kind of flexibility. Policymakers may also view a subsidy program as more immediately achievable, since developing a more comprehensive program may be seen as financially overwhelming. However, a subsidy program may not be sufficient to meet the needs of all families, and, unless carefully designed, may not contribute to improving the availability and quality of ECCE providers, which means gaps in access will persist.

Administrative simplicity: A subsidy-style program benefits from relative administrative simplicity compared to other programs. Administrative complexity would modestly increase if states used a progressive benefits structure. For states that limit subsidies to state-certified providers, administrative capacity will need to be established and maintained to enroll and monitor provider quality standards.

Addressing inequality in access: A universal subsidy program does have the inherent advantage of universality, and therefore will undoubtedly address some of the issues families face in accessing ECCE services for their children. However, depending on the generosity and/or progressivity of benefits, a subsidy program may be insufficient for many families to fully access care, making it ineffective at reducing

inequality. In fact, if the amount of support that families receive is low enough that low-income families effectively cannot use the benefit, such a program may actually increase inequality, as many middle- and upper-income families will be able to utilize the subsidies while lower-income families will remain unable to afford the care services they require. Additionally, a subsidy program does

not inherently address regional differences in physical access to ECCE services or necessarily improve the quality of ECCE services locally available to any individual family. However, a program could be carefully crafted to achieve those goals, such as by calibrating child care payment rates based on the cost of providing quality child care and ensuring that providers are earning living wages.



Section IV.

INTEGRATION AND IMPLEMENTATION CONSIDERATIONS



Once a state has selected a policy design and funding approach for its early child care and education program, several other factors must be considered. These include the integration of a new state ECCE program with existing programs and policies, implementation issues, and consideration of the complexities surrounding eligibility for benefits. While an extensive discussion of each of these issues is beyond the scope of this report, this section aims to draw attention to some of the primary issues that states will need to consider further upon deciding to implement any of the three above policy options—or any other program to expand access to affordable early child care and education.

Integration with existing federal and state-level programs

As discussed in Section II of this Chapter, the existing landscape of programs for early child

care and education is broad and complex, and states will need to plan carefully to integrate any new program with the array of existing ECCE programs. From a pragmatic perspective, it is unlikely that most states developing a new ECCE program would seek to supplant existing federal ECCE funding. Federal programs provide critical infusions of funding, and existing state programs have often used a great deal of time, money, and effort to meet specific local needs. Rather, states are more likely to be attempting to fill the many gaps that exist for families who are ineligible for existing federal and state programs, or who are eligible but either do not receive benefits due to insufficient funding or require assistance beyond the benefits that they are currently receiving.

By carefully designing and implementing programs, states can combine multiple funding sources to achieve their goals such as through “blending” and/or “braiding” funds. “Blending”

refers to combining funds from different sources into one pot without allocating and tracking expenditures by funding source. “Braiding” refers to coordinating different funding sources, allocating revenues and tracking expenditures by funding source.⁹⁴

In order to achieve successful integration with existing federal and state programs, policymakers also need to carefully consider how factors such as licensing, quality standards and monitoring, data systems, and governance would be integrated across systems. Additionally, states would need to decide to what degree providers would be required to meet existing minimum federal and state quality standards, which would have both advantages and disadvantages. On the one hand, aligning a new program’s standards with existing ones would relieve some of the burden of having to develop and administer a new set of quality standards for providers, which in turn would relieve some complexity for providers, as well. On the other hand, states might have difficulty finding and recruiting sufficient qualified providers to meet demand, which could perpetuate disparities in access to services due to both the regional distribution and the aggregate supply of qualified providers.

State-run preschool programs: Existing state-run preschool programs would, in some ways, be the simplest to integrate with a new social insurance ECCE program. First, any of the three policy options discussed above (Section III) could simply be layered

on top of an existing state preschool program by filling in the remaining gaps in access to early child care and education for all children prior to the start of formal, mandatory public education. Second, states (or localities) with large-scale preschool programs could use existing infrastructure to make high-quality ECCE accessible to more children, either by expanding the age of eligibility or making the program closer to universally accessible for all children below school age. States or localities might also benefit from the experience of having previously implemented an existing preschool program. For example, those states likely already have experience with blending and braiding funding and would be familiar with the complexities of meeting federal quality standard requirements.

Head Start / Early Head Start: The Head Start / Early Head Start (HS/EHS) program will undoubtedly remain a critical program for low-income families, as well as a vital source of federal funding for ECCE programs. Because HS/EHS benefits include health, nutritional, social, and other services as well as education and child care, a state may choose different eligibility requirements for a new state-wide ECCE program.⁹⁵ Many children do not need the type and degree of supports provided by HS/EHS, and extending those benefits to all children may not be the most efficient use of often limited resources. In addition, or alternatively, a self-financed social insurance system providing funding for ECCE to all families could potentially enable states to use some HS/EHS funds to cover enhanced

⁹⁴ Child Care State Capacity Building Center, “Layering or Blending and Braiding Multiple Funding Streams,” <https://childcareta.acf.hhs.gov/systemsbuilding/systems-guides/financing-strategically/maximizing-impact-public-funding/blending-braiding-funding>.

⁹⁵ Congressional Research Service, “Head Start: Background and Funding,” 2014, https://www.everycrsreport.com/files/20140102_RL30952_9de5df5a6c4debc9131eea76fb96ade27155c351.pdf.



benefits for a greater proportion of eligible children. Some jurisdictions, including the District of Columbia,⁹⁶ have already grappled with integrating HS/EHS funds into a universal pre-K program and could provide examples of successful integration strategies.

Child Care and Development Block Grant (CCDBG): A state could blend and braid federal CCDBG funds with funding from the new social insurance program, and potentially other resources as well. By blending substantially increased state funding with federal CCDBG funds and taking advantage of the flexibility in federal regulations, states could provide child care assistance to more low- and moderate-income families; assist more parents

looking for work or in school, as well as those employed; and increase reimbursement rates to help improve the quality of care.

A fully state-funded program might provide assistance to families ineligible for CCDBG because of their income or ECCE needs unrelated to employment. To simplify administration for states, families, and providers, states could utilize the existing CCDBG infrastructure but could allocate to the separate state program a portion of shared overhead expenses, assistance provided to families or providers ineligible for CCDBG, and administrative costs specific to the state program. While this braided approach might present complexities, many states

⁹⁶ For a discussion of the District's integration of Head Start and non-Head Start students into combined classroom settings, see: Neela Banerjee, "All in One Classroom: Blending Head Start and Non-Head Start Students," *New America*, June 1, 2010, <https://www.newamerica.org/education-policy/early-elementary-education-policy/early-ed-watch/all-in-one-classroom-blending-head-start-and-non-head-start-students/>.

have experience with using braided funding to provide ECCE, health care, and public assistance programs (such as the Performance Partnership Pilots initiative).^{97,98}

Building up the ECCE provider workforce

Investments in high-quality care and education for the youngest children would do more than simply meet a need for families: such investments offer an opportunity to improve the quality of ECCE. Unlike many jobs, providing early child care and education cannot be easily automated or offshored—nor would many families want it to be.

Developing ECCE workforce skills and training would improve both the quality of jobs and

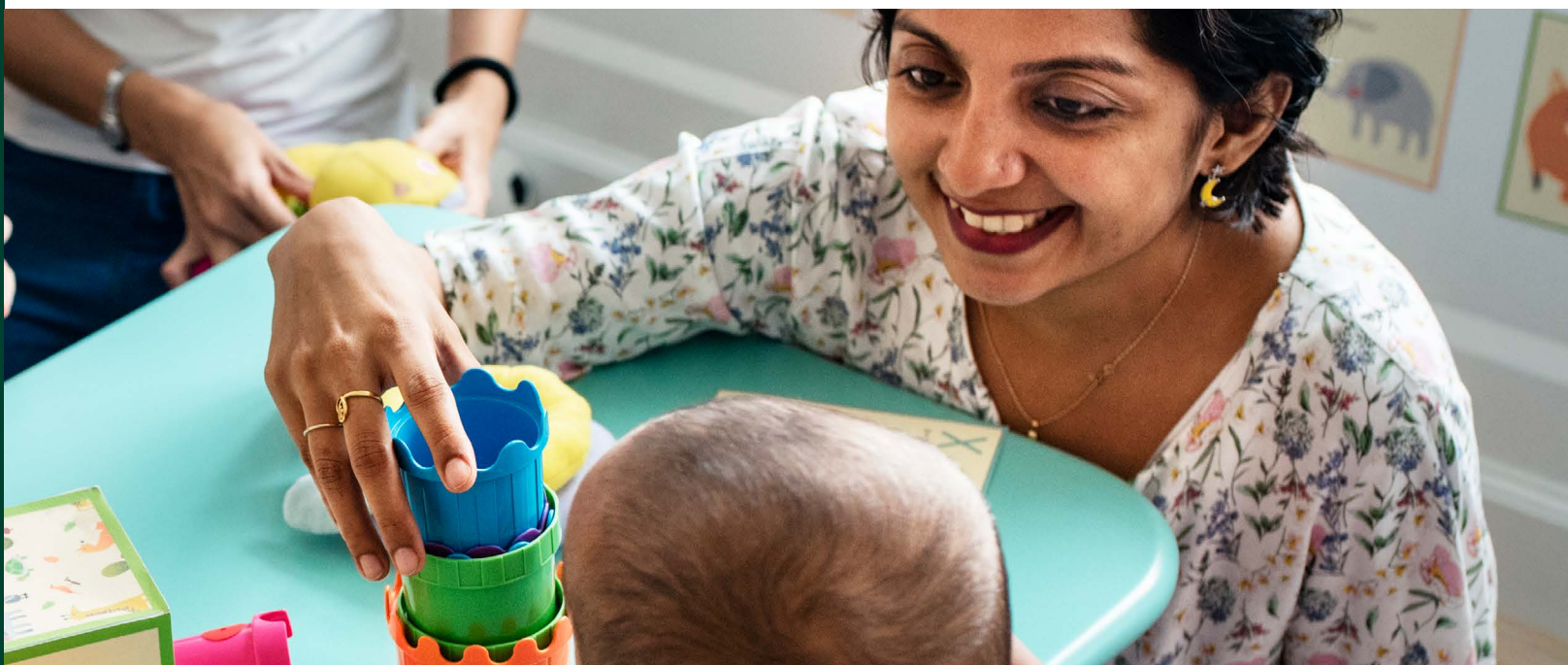
the quality of care. Current ECCE policies lack funding to expand the quantity or improve the quality of care. The infusion of new funds into this area to support a large-scale program would, with careful and intentional program design, enable the field to attract new talent to the ECCE provider workforce and improve the skills of the existing workforce. While an extensive discussion of policy strategies for developing the ECCE workforce is beyond the scope of this report, we briefly highlight a few key issues below and refer the reader to more comprehensive reports on this subject.⁹⁹

Compensation: Low wages prevent many workers from serving and remaining in

⁹⁷ Child Care State Capacity Building Center, “Layering or Blending and Braiding Multiple Funding Streams,” <https://childcareta.acf.hhs.gov/systemsbuilding/systems-guides/financing-strategically/maximizing-impact-public-funding/blending-braiding-funding>; Margie Wallen and Angela Hubbard, “Blending and Braiding Early Childhood Program Funding Streams Toolkit,” QRIS National Learning Network, 2013, <https://qrisnetwork.org/resource/2013/blending-and-braiding-early-childhood-program-funding-streams-toolkit>.

⁹⁸ Adrienne L. Fernandes-Alcantara, “Vulnerable Youth: Background and Policies,” Congressional Research Service, 2018, <https://fas.org/sgp/crs/misc/RL33975.pdf>.

⁹⁹ For an extensive discussion of expanding the care workforce, see: Nina Dastur, Indivar Dutta-Gupta, Laura Tatum, Peter Edelman, Kali Grant, and Casey Goldvale, “Building the Caring Economy: Workforce Investments to Expand Access to Affordable, High-Quality Early and Long-Term Care,” Creative Commons, 2017, http://www.georgetownpoverty.org/wp-content/uploads/2017/05/Building-the-caring-economy_hi-res.pdf.



the ECCE workforce. Care providers and teachers for the youngest children are paid considerably less than primary school, kindergarten, and school-sponsored preschool teachers—even among providers with equivalent levels of education. Low compensation for demanding work can lead to economic insecurity and, often, high turnover rates for those caring for young children. A state program that links program benefits to providers' qualifications and quality standards should also ensure that providers receive enough to pay ECCE workers adequately.

A state program that links program benefits to providers' qualifications and quality standards should also ensure that providers receive enough to pay ECCE workers adequately.

Training and workforce development:

Educational attainment and ongoing training for ECCE providers can have a significant effect on the quality of care and education they provide. Quality could be substantially improved—and equalized across providers—through increased training and ongoing professional development of the current and future care workforce. However, many child care providers do not have the resources to

finance advanced educational training on their own. Requiring higher levels of educational attainment on its own is unlikely to improve the quality of care significantly, because most providers will still lack the resources needed for educational and professional development opportunities. Financial assistance, including direct state funding for pre-service training for new professionals and professional development for the current child care workforce, as well as paid time off or some other form of compensation to attend these training programs, will be critical to help improve the quality of services for early care and education. Funding education and professional development for ECCE providers could also help increase the wages of women—including women of color—because women make up a disproportionate percentage (well over 90 percent) of ECCE providers.¹⁰⁰ Collaboration with stakeholders in the care workforce community could help foster creative solutions for these challenges.

Funding education and professional development for ECCE providers could help increase the wages of women—including women of color—because women make up well over 90 percent of ECCE providers.

¹⁰⁰ For a more extensive discussion of policy options to address improving care provider training and promoting workforce development, see the “Policy Recommendations” section of: Nina Dastur, Indivar Dutta-Gupta, Laura Tatum, Peter Edelman, Kali Grant, and Casey Goldvale, “Building the Caring Economy: Workforce Investments to Expand Access to Affordable, High-Quality Early and Long-Term Care,” Creative Commons, 2017, http://www.georgetownpoverty.org/wp-content/uploads/2017/05/Building-the-caring-economy_hi-res.pdf.

Spotlight on Provider Training in Connecticut: All Our Kin

All Our Kin, a nationally recognized nonprofit organization, offers training, support, and other resources to family child care providers in Connecticut. Additionally, it provides an Early Head Start program as a delegate agency for the United Way of Greater New Haven.

Research has shown that All Our Kin training and supports have helped family child care providers enhance their knowledge, skills, and practice as early childhood educators; improve their business practices and earnings; and increase the supply of high-quality, affordable child care options.¹⁰¹

Improving supply of ECCE

A policy that increases demand for early child care and education services will need to consider expansions and improvements in ECCE infrastructure, including both the physical spaces required to provide services, and the accessibility and usefulness of these spaces for families of different backgrounds and circumstances.

Regional distribution: Many families struggle to access ECCE because services are not equally distributed across regions within the same state, or in some cases parts of the same city. Even when resources are available, their quality may vary across regions. Additionally, without public funding, early child care and education providers rely on payments from parents. When parents can't afford the cost of quality, the care available in a neighborhood reflects that. Implementing a universal or expanded early child care and education system will require assessing gaps in access to ECCE resources and identifying strategies for closing those gaps.¹⁰²

Diversity and cultural competence:

The accessibility of ECCE resources is also affected by the needs of children from diverse circumstances—including (but not limited to) diversity in racial, ethnic, socioeconomic, ability status, lingual, and regional backgrounds. One solution is encouraging the recruitment and hiring of a workforce that is itself diverse. Incorporating diversity training into state quality requirements could provide another strategy to help improve cultural competence among providers of different backgrounds and experiences. States should also be mindful of inclusivity when developing strategies for educating families about and enrolling children into the program.

Nonstandard hours: Parents/guardians from all family types and income levels may be engaged in non-standard employment relationships and schedules. Many workers—particularly single and/or low-income mothers—have little control over their work schedules, cannot work from home in order to provide supervision for a young child, and/or do not adhere to a “standard”

¹⁰¹ Further details on the organization may be found at www.allourkin.org.

¹⁰² Rasheed Malik and Katie Hamm, “Mapping America’s Child Care Deserts,” Washington, DC: Center for American Progress, 2018, <https://www.americanprogress.org/issues/early-childhood/reports/2018/12/06/461643/americas-child-care-deserts-2018/>.



9-to-5 workday. Many ECCE programs cover only a fraction of the hours that parents/guardians might be working and require child care services. Programs with “standard” hours that provide educational benefits to children offer valuable services and hold the potential for long-term improvements in child development and outcomes. But young children require round-the-clock supervision and care, and many pre-K and other educational programs fall short of meeting the often-complex scheduling needs of working families. Policy provisions that address the availability of ECCE coverage for nonstandard hours will be a critical consideration for state policymakers, particularly those with a targeted interest in increasing labor force attachment for parents/guardians.¹⁰³

Improving the quality of care and education

In any discussion of the care and education of children, it is crucial to acknowledge the value of helping families gain access not just to any resources, but rather to those with the highest possible standards of quality and safety. Particularly for preschool programs, high-quality early care and education is characterized by not just structural quality—including issues such as child safety and physical well-being—but also process quality—including robust and age-appropriate educational curricula and rich child-educator interactions.¹⁰⁴ If access to ECCE resources is expanded, and especially if a social insurance program funds those services, states will need to

¹⁰³ Angela Rachidi, “Child Care Assistance in the United States and Nonstandard Work Schedules,” Washington, DC: American Enterprise Institute, 2015, <https://www.aei.org/publication/child-care-assistance-in-the-united-states-and-nonstandard-work-schedules/>.

¹⁰⁴ For an extensive discussion of high-quality Pre-K programs, see Chapter 4 of: Ajay Chaudry, Taryn Morrissey, Christina Weiland, and Hirokazu Yoshikawa, *Cradle to Kindergarten: A New Plan to Combat Inequality* (New York: Russell Sage Foundation, 2017).

consider how they will establish and enforce protections for ensuring that providers are qualified and for preventing child abuse and neglect. Different program design options offer opportunities for varying levels of state oversight of child care and education providers, ranging from full regulation in a universal, state-run program to minimal (or even no) regulation in a direct cash benefit program. Policymakers should consider local needs and desires when striking the balance between administrative simplicity and regulating quality and safety standards.

One option for states interested in a relatively high level of oversight would be to align the level of a provider's quality standards with a tiered payment system. In other words, higher-quality providers would receive higher reimbursements, while payments to lower-quality providers would be smaller. Such a system design could be applied only to center-based care or could include home-based providers and FFN caregivers. This approach is complicated, however, and could lead to unintended consequences. On the one hand, the prospect of higher reimbursements could give providers incentives to make investments and improvements in their ECCE services. Tiered reimbursements also demonstrate the state's recognition of the costs of achieving and maintaining higher levels of quality, which arguably would justify higher-quality providers receiving higher reimbursement rates. On the other hand, lower-performing providers might have difficulty reaching

higher quality standards without additional resources to invest in education, training, and infrastructure improvements. Limiting payments to such programs could simply perpetuate the divide between higher- and lower-quality providers, particularly because many ECCE providers are already operating under thin margins. Additionally, there is evidence to suggest that higher Quality Rating and Improvement Scores System (QRIS) scores do not necessarily correlate to substantial improvements in educational outcomes,¹⁰⁵ suggesting a potential need for more careful consideration of how quality standards are being measured.

States should carefully consider working to help providers with improving quality and safety standards. For example, state regulatory agencies might collaborate with public higher education institutions to develop and refine programs to train ECCE specialists. Such programs would likely be more affordable for individuals looking to enter the early child care and education workforce, or to advance their existing ECCE careers. Policymakers could consider adding provisions to help prospective—and current—ECCE professionals pursue advanced degrees. Financial support for education would be particularly important if a new state policy required that ECCE providers meet higher minimum educational standards to be eligible for program funds. Alternatively, states could offer free or affordable state-level training programs to help care providers (especially home-based and FFN providers) improve the quality of their care.

¹⁰⁵ Terri J. Sabol, Sandra L. Soliday Hong, Robert C. Pianta, and Margaret R. Burchinal, "Can Rating Pre-K Programs Predict Children's Learning?," *Science*, vol. 341, <https://science.sciencemag.org/content/341/6148/845>.

Public-Private Partnerships in Oklahoma: Funding Quality Child Care

In 2006, Oklahoma established the Oklahoma Early Childhood Project (OECF), which distributes grants for programs serving at-risk infants and toddlers that wish to expand or enhance their quality. The State of Oklahoma allocates general revenue funds that are then matched by private philanthropic dollars, with private dollars making up a slight majority of funds. The Community Action Project of Tulsa County (CAP) administers the program, providing technical assistance to participating providers. Grant recipients are required to meet minimum standards, including staff educational levels, pay rates, and accreditation benchmarks. Children in OECF programs had higher social-emotional development scores and their classroom environments had higher child-teacher interaction scores, among other differences, than children and classrooms not in OECF programs.¹⁰⁶

Helping families and professional caregivers navigate the ECCE landscape

A state in the process of developing a new ECCE program should consider strengthening its Child Care Resource & Referral agencies to help families and paid caregivers take full advantage of the new and existing programs.

Establishing a state ECCE program—of whatever type—involves additional considerations that are beyond the scope of this report. For example, early and intensive engagement of a diverse array of stakeholders could help secure broad community support. An extended period might be required between passage of a new ECCE program and its effective date in order to allow time to secure adequate funding, expand provider capacity, establish quality standards and contingencies for enforcement, and develop administrative capacity. These considerations are not discussed in depth here but will need to be addressed by policymakers developing any program expanding access to and affordability of ECCE.

¹⁰⁶ Oklahoma Early Childhood Program (OECF), “Oklahoma Early Childhood Program,” 2018, <http://okecp.org/wp-content/uploads/2018/06/oecf-1-page-handout.pdf>.

Section V.

CONCLUSION



High-quality early care and education is an investment in the future of children and our society. To date, however, the United States has not funded programs to meet the developmental needs of children in the earliest years with anything near the same investment as K-12 education. At the same time, the dynamics of work and family life have shifted dramatically over the past several decades, and children are increasingly living in homes where all parents/guardians are working. Policy has been slow to adapt to the changing needs of workers and their families. As a result, many children have been left with insufficient and/or low-quality early child care and education. The policy options

and considerations outlined in this chapter reflect varied potential program scopes and goals. States interested in developing a new or expanded program for financing ECCE will need to weigh these options based on the specific needs of their constituents and their policy objectives. The costs associated with maintaining the status quo, however, should be considered when assessing whether and how much to expand investments in early child care and education. Without an investment in the care and education of our youngest children, family economic security, child development, educational outcomes, labor force attachment, economic output, and societal well-being will continue to suffer.



Designing a State-Based Social Insurance Program for Paid Family and Medical Leave

2019

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Preface

ABOUT THE CHAPTER

This chapter explores policy options for states seeking to develop a paid family and medical leave program. It was developed during a year of deliberations by a Working Group of 13 experts on child and family policy, poverty and inequality, social policy, and tax law, representing a variety of perspectives and fields of expertise. It is part of a larger Study Panel project on Universal Family Care. While addressed primarily to state policymakers, the report may also interest federal policymakers, administrators, and advocacy organizations, as well as workers, families, business owners, and others directly affected by the sometimes competing needs to earn income and care for themselves and/or their families.

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EXECUTIVE SUMMARY

At some point during their lives, virtually all workers will need time away from work to care for a loved one and/or cope with a health problem of their own. While this need for time off is nearly universal, a significant share of workers in the United States currently lacks access to any kind of guaranteed leave to provide or receive care. Thus, many workers are forced to choose between caring for themselves or a loved one and losing wages or even their job. Paid leave benefits are also highly inequitably distributed; workers who earn more, work for large employers, or hold white-collar jobs are much more likely to have access to paid family and/or medical leave.

This chapter describes how, in the absence of a national policy, states have stepped up as critical leaders in advancing paid family and medical leave (PFML) programs. To date, ten jurisdictions have adopted some form of paid leave policy (CA, CT, DC, HI, MA, NJ, NY, PR, RI, WA). The experiences of these states can offer valuable lessons for future programs. In particular, states have learned the importance of providing sufficient wage replacement rates to permit lower-wage workers to actually use the benefits, conducting robust education and outreach campaigns to inform the public about the program, and simplifying the administrative burden of applying for benefits for both applicants and administrators.

Next, the chapter discusses three policy options for states interested in developing a paid family and medical leave program:

1. **Universal, contributory social insurance program, exclusive state fund**—Throughout their careers, all workers contribute to a state social insurance fund—out of which all benefits are paid—in return for an earned benefit should a PFML need arise.
2. **Contributory social insurance program with regulated private options**—Employers are required to offer a certain level and type of coverage and to comply with specified anti-discrimination and other consumer protections. Employers are free to choose between utilizing the state fund, self-insuring, and/ or purchasing a private plan for coverage.
3. **Employer mandate**—Employers are obligated to provide paid leave benefits directly to their workers, either by self-insuring or by purchasing private coverage.

After choosing a model for the program, policymakers must determine other important design features, including eligibility requirements, qualifying events, the definition of family, benefit design, and job protection. There are also factors surrounding program implementation and integration to consider, such as program administration, education and outreach, evaluation, integration with other state policy mechanisms, coordination with existing employee benefit plans, and coverage for self-employed workers. Ultimately, however, absent a robust national program, states can substantially improve quality of life and financial security for workers and their families by implementing well designed paid family and medical leave programs.

Section I.

INTRODUCTION

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At some point during their lives, virtually all workers will need time away from work to care for a loved one and/or cope with a health problem of their own. While this need for time off is nearly universal, a significant share of workers in the United States currently lacks access to any kind of guaranteed leave to provide or receive care, and particularly to the types of financial support—such as wage replacement—that would make such leave possible. As a result, many workers are forced to choose between caring for themselves or a loved one and losing wages or even their job.

The current landscape of family and medical leave policies in the United States leaves substantial gaps in workplace supports for family caregiving and personal medical needs. The Family and Medical Leave Act of 1993 (FMLA) provides many U.S. workers

with access to *unpaid*, job-protected time off to provide or receive care. Under this law, a worker is eligible for 12 weeks of unpaid leave in the event of the birth, adoption, or foster placement of a child; the serious health condition of a close family member; a worker's own serious health condition; or the military deployment of a worker's spouse, child, or parent.¹ Family members of qualified veterans, reservists, and active duty military personnel may also take up to 26 weeks of leave from their jobs to care for the military member or veteran who is injured or ill under the Military Caregiver Leave extension of the FMLA.² This legislation undeniably marked a significant shift in U.S. work-family policy, but the coverage remains insufficient for a substantial portion of the workforce. Due to restrictive eligibility requirements, roughly 40 percent of workers are excluded entirely

¹ Family and Medical Leave Act of 1993, Pub. L. No. 103-3, 107 Stat. 6 (1993), <https://www.law.cornell.edu/uscode/text/29/chapter-28>.

² U.S. Department of Labor, Wage and Hour Division, "Fact Sheet #28M(b): Military Caregiver Leave for a Veteran under the Family and Medical Leave Act," n.d., <https://www.dol.gov/whd/regs/compliance/whdfs28mb.pdf>.

from FMLA coverage, and even those who are covered often cannot afford time away from work without any compensation.³ As many families across the nation struggle with economic insecurity, and as workers increasingly juggle work and caregiving responsibilities, paid family and medical leave is being offered or discussed in a growing number of states and by an increasing number of employers across the country.

The United States is the only industrialized country—and one of only a handful of countries across the world—without a national program offering workers some form of paid caregiving leave. Only 17 percent of civilian workers have paid caregiving leave coverage through an employer-provided benefit.⁴ Similarly, no national policy provides or mandates that workers be paid for time off to address their own health-related issues. Although paid sick leave is more common than paid family leave, coverage remains far from universal:

The U.S. is the only industrialized country with no national program offering workers some form of paid caregiving leave.

among civilian workers, 74 percent have access to paid sick leave,⁵ 39 percent have access to short-term disability insurance benefits, and 34 percent have access to long-term disability insurance.⁶ Access to paid leave benefits is also unequally distributed across the workforce. Only 8 percent of the lowest-earning quartile has access to paid family leave,⁷ and only 19 percent has access to short-term disability insurance;⁸ for workers in the highest-earning quartile, those numbers jump to 28 percent⁹ and 54 percent,¹⁰ respectively. Coverage also varies by employer size: the larger the employer, the more likely its employees are to have access to paid family leave¹¹ and temporary disability insurance.¹²

³ Jacob Alex Klerman, Kelly Daley, and Alyssa Pozniak, “Family and Medical Leave in 2012: Technical Report,” Cambridge, MA: Abt Associates, Revised April 2014, <http://www.dol.gov/asp/evaluation/fmla/FMLA-2012-Technical-Report.pdf>.

⁴ Bureau of Labor Statistics, “Table 32. Leave Benefits: Access, Civilian Workers, March 2018,” U.S. Department of Labor, 2019, <https://www.bls.gov/ncs/ebs/benefits/2018/ownership/civilian/table32a.htm>.

⁵ Ibid.

⁶ Bureau of Labor Statistics, “Table 16. Insurance Benefits: Access, Participation, and Take-Up Rates, Civilian Workers, March 2018,” U.S. Department of Labor, 2019, <https://www.bls.gov/ncs/ebs/benefits/2018/ownership/civilian/table16a.htm>.

⁷ Bureau of Labor Statistics, “Table 32. Leave Benefits: Access, Civilian Workers, March 2018,” U.S. Department of Labor, 2019, <https://www.bls.gov/ncs/ebs/benefits/2018/ownership/civilian/table32a.htm>.

⁸ Bureau of Labor Statistics, “Table 16. Insurance Benefits: Access, Participation, and Take-Up Rates, Civilian Workers, March 2018,” U.S. Department of Labor, 2019, <https://www.bls.gov/ncs/ebs/benefits/2018/ownership/civilian/table16a.htm>.

⁹ Bureau of Labor Statistics, “Table 32. Leave Benefits: Access, Civilian Workers, March 2018,” U.S. Department of Labor, 2019, <https://www.bls.gov/ncs/ebs/benefits/2018/ownership/civilian/table32a.htm>.

¹⁰ Bureau of Labor Statistics, “Table 16. Insurance Benefits: Access, Participation, and Take-Up Rates, Civilian Workers, March 2018,” U.S. Department of Labor, 2019, <https://www.bls.gov/ncs/ebs/benefits/2018/ownership/civilian/table16a.htm>.

¹¹ Bureau of Labor Statistics, “Table 32. Leave Benefits: Access, Civilian Workers, March 2018,” U.S. Department of Labor, 2019, <https://www.bls.gov/ncs/ebs/benefits/2018/ownership/civilian/table32a.htm>.

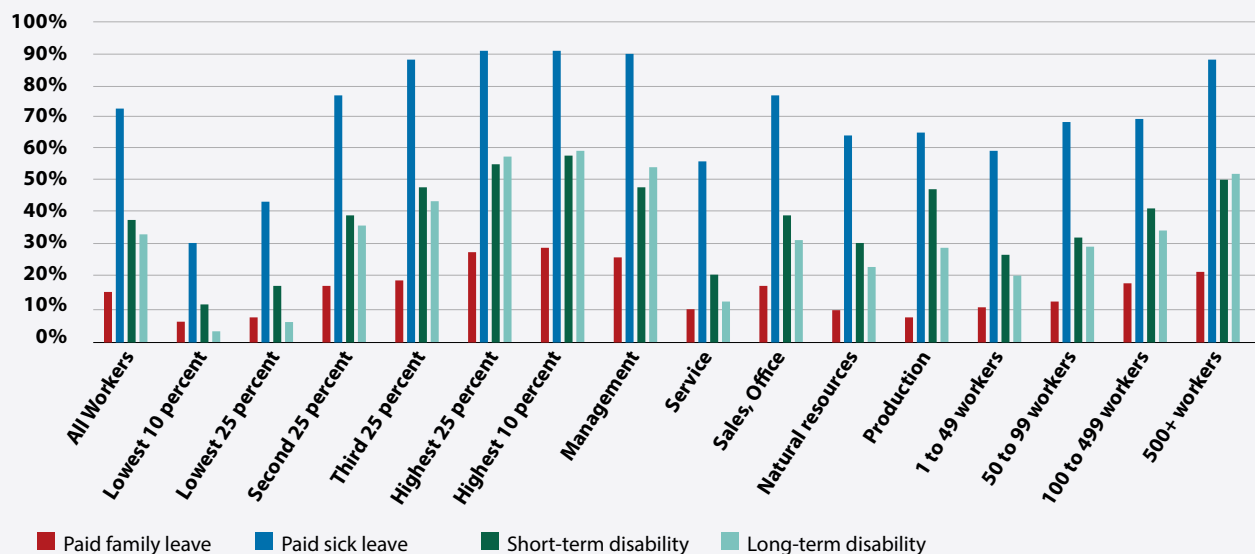
¹² Bureau of Labor Statistics, “Table 16. Insurance Benefits: Access, Participation, and Take-Up Rates, Civilian Workers, March 2018,” U.S. Department of Labor, 2019, <https://www.bls.gov/ncs/ebs/benefits/2018/ownership/civilian/table16a.htm>.

Occupational disparities exist as well. For example, nearly 1 in 3 workers in the fields of finance and management have access to employer-provided paid family leave, while that proportion is closer to 1 in 20 for workers in the construction and hospitality industries (see Figure 1).¹³

Proposals to implement universal paid family and medical leave programs have been gaining traction at both the state and federal level. Paid family and medical leave refers to a program that incorporates both paid medical leave—also known as temporary or short-term disability insurance—and paid family leave—where workers can take time to provide care for a family member

or loved one. (See text box on p. 91: Paid Leave Terminology.) Although this report chapter focuses on options for state-level paid leave policies, many of the issues discussed are also integral to the design of a federal paid leave policy. Several states have already implemented their own paid family and medical leave programs (see Section II of this chapter), and others are starting up or passing new laws that establish such programs. A number of employers are also voluntarily offering paid leave to employees, (see text box on p. 90: Employer-Provided Paid Family and Medical Leave) although low-wage workers frequently receive little or no benefit under these programs. Limiting paid leave to full-time or higher-earning

FIGURE 1: Employer-Provided Paid Leave Benefits: Civilian Workers



Source: Bureau of Labor Statistics, "Table 32. Leave benefits: Access, civilian workers, March 2018," U.S. Department of Labor, 2019, <https://www.bls.gov/ncs/ebs/benefits/2018/ownership/civilian/table32a.htm>; Bureau of Labor Statistics, "Table 16. Insurance benefits: Access, participation, and take-up rates, civilian workers, March 2018," U.S. Department of Labor, 2019, <https://www.bls.gov/ncs/ebs/benefits/2018/ownership/civilian/table16a.htm>.

¹³ Bureau of Labor Statistics, "Table 32. Leave Benefits: Access, Civilian Workers, March 2018," U.S. Department of Labor, 2019, <https://www.bls.gov/ncs/ebs/benefits/2018/ownership/civilian/table32a.htm>.



employees may exclude those who need the benefit the most; workers with the greatest need—such as people with disabilities¹⁴ or mothers with young children¹⁵—are more likely to hold part-time and/or lower-wage positions.

A universal program offers a promising avenue for workers to access these critical benefits regardless of their income, industry, job title, gender, or family composition. But programs must be carefully designed to ensure that policy choices do not unduly or unwittingly exclude many of the workers most in need of protection and coverage.

This chapter describes the variety of design options available to policymakers considering a paid leave policy and discusses the effects of different options on the equity, efficiency, affordability, and adequacy of a new (or updated) paid family and medical leave program.

Several states have implemented paid family and medical leave programs, and others are starting up new programs.

¹⁴ Kali Grant, T.J. Sutcliffe, Indivar Dutta-Gupta, and Casey Goldvale, “Security and Stability: Paid Family and Medical Leave and Its Importance to People with Disabilities and Their Families,” Georgetown Center on Poverty and Inequality and The Arc, Creative Commons, 2017, <http://www.thearc.org/file/public-policy-document/Paid-Leave-Report.pdf>.

¹⁵ Women’s Bureau: U.S. Department of Labor, “Working Mothers Issue Brief,” 2016, https://www.dol.gov/wb/resources/WB_WorkingMothers_508_FinalJune13.pdf.

Paid Leave Terminology

Paid Family Leave provides workers with paid time off to care for a loved one. Qualifying events typically include the birth, adoption, or foster placement of a child; the need to care for a loved one with a serious health condition; and, in some cases, contingencies surrounding the military deployment of a close family member. Some employers voluntarily offer paid family leave to some or all employees and pay the costs of that coverage out of pocket (i.e., self-insure). Several states have developed family leave insurance programs for workers, typically funded through employee payroll contributions.

Paid Medical Leave (or Short-Term or Temporary Disability Insurance) compensates workers for lost wages in the event of a longer-term health condition that is not related to work. Common conditions include pregnancy, long-term illness, or recovery from a surgical procedure. Paid medical leave typically provides partial wage replacement for up to a designated number of weeks, but some employers do offer total wage replacement throughout the leave period. Currently, coverage for paid medical leave, including temporary disability insurance (TDI), may be funded either by a public state-level program or by private coverage purchased by the employer or employee. Eligibility for benefits is typically determined by the state administrative agency or private plan provider, which may limit employer influence on the coverage decision and give workers a right to appeal benefit denials. Benefits often begin after a brief waiting period (e.g., one week) and, in some cases, decrease over the

duration of leave (i.e., workers may receive a high portion of wages for a designated period, followed by lower wage replacement for subsequent days/weeks).

In addition to paid family and medical leave, there are several other ways in which workers can receive wage replacement and medical benefits in case of inability to work for health reasons:

Paid Sick Days provide workers with paid time off to address acute personal health or safety needs. Employers generally fund and manage sick leave programs directly, either voluntarily or as a result of a state- or local-level mandate. Particularly for state or locally mandated programs, employees can typically use paid sick days for short-term, non-work-related illnesses and injuries; medical appointments; and accessing services or care related to domestic violence, sexual assault or abuse, or stalking. Some programs and employer policies permit workers to use paid sick days to attend to a family member with one of these acute needs. Workers typically accrue sick leave based on hours worked, and employers usually impose relatively strict limits on workers' ability to accrue sick days. Some employers, however, permit workers to accrue relatively high numbers of sick days, sometimes allowing leave to be carried over from year to year. These more generous benefits can support longer periods of leave for serious health conditions or events such as childbirth.

Long-Term Disability Insurance provides cash benefits in the event of an illness or injury that is expected to impede a worker's ability to remain

gainfully employed, either permanently or for a substantial period of time (i.e., years). In addition to the coverage available to all eligible workers through the Social Security Disability Insurance program, some employers offer private long-term disability insurance coverage as a benefit, and some workers purchase private coverage directly.

Workers' Compensation helps compensate for lost wages and pays medical expenses associated with an injury or illness that occurs on the job. Coverage is funded by employers, except for three states where

employers and employees contribute towards premium costs. Employers typically decide whether to obtain coverage through a private carrier plan, self-insuring, or a state Workers' Compensation insurance fund. Workers' Compensation coverage is required by law in all states except Texas, where coverage is voluntary. While there is consistency among central features of Workers' Compensation programs, benefits, program administration, eligibility requirements, and other program design features vary tremendously across the country.

The Changing Nature of Work and Family Life

The dynamics of work and family life in the U.S. have changed substantially over the past several decades, and national policy has been slow to adapt to this shifting reality. The vast majority of children are now growing up in households where every parent is working,¹⁶ and nearly one in three children lives in a single-parent household.¹⁷ Women also now make up a substantial proportion of the workforce.¹⁸ Most of today's families need all parents' earnings to make ends meet; 64 percent of mothers bring in at least

The vast majority of children live in households where every parent is working.

one quarter of family earnings, including 41 percent who bring in half or more, and the proportional contributions of low-income mothers and women of color to family earnings are even higher.¹⁹

Since the mid-20th century, the proportion of women in the workforce has increased

¹⁶ Eileen Patten, "How American Parents Balance Work and Family Life When Both Work," Pew Research Center, 2015, <http://www.pewresearch.org/fact-tank/2015/11/04/how-american-parents-balance-work-and-family-life-when-both-work/>.

¹⁷ Authors' calculations based on November 2017 data from the Current Population Survey, available at: U.S. Census Bureau, "Historical Families Tables, 2017, <https://www.census.gov/data/tables/time-series/demo/families/families.html>.

¹⁸ Bureau of Labor Statistics, "Table 5. Employment Status of the Population by Sex, Marital Status, and Presence and Age of Own Children under 18, 2015-2016 Annual Averages," U.S. Department of Labor, 2018, <https://www.bls.gov/news.release/fameet05.htm>.

¹⁹ Sarah Jane Glynn, "Breadwinning Mothers Continue to be the U.S. Norm," Center for American Progress, May 10, 2019, <https://www.americanprogress.org/issues/women/reports/2019/05/10/469739/breadwinning-mothers-continue-u-s-norm/>.



substantially, from roughly 34 percent in 1950 to about 57 percent in 2015.²⁰ At the same time, women still often retain the primary caregiving responsibilities for children, family members with disabilities and/or chronic illnesses, and aging family members.²¹ As a result, working women often suffer stagnated earnings, heightened barriers to professional growth, and employer discrimination. Men are also—and increasingly—confronting the financial consequences of caregiving, as

they become more involved in providing care, desire to spend more time with their children,²² and face stigma in the workplace.²³ As a result of these changing workplace and gender dynamics, most families have no one to provide full-time care for a child and/or family member when needed. Without access to paid leave, family income and financial security suffer regardless of who takes time off to provide or receive care.

²⁰ Mitra Toossi and Teresa L. Morisi, “Women in the Workforce Before, During, and After the Great Recession,” U.S. Department of Labor, Bureau of Labor Statistics, 2017, <https://www.bls.gov/spotlight/2017/women-in-the-workforce-before-during-and-after-the-great-recession/pdf/women-in-the-workforce-before-during-and-after-the-great-recession.pdf>.

²¹ Richard Schulz and Jill Eden (Eds.), *Families Caring for an Aging America*, Committee on Family Caregiving for Older Adults; Board on Health Care Services; Health and Medicine Division; National Academies of Sciences, Engineering, and Medicine (Washington, DC: National Academies Press, 2016), https://www.ncbi.nlm.nih.gov/books/NBK396401/pdf/Bookshelf_NBK396401.pdf.

²² Kim Parker and Wendy Wang, “How Mothers and Fathers Spend Their Time,” Chapter 4 of *Modern Parenthood: Roles of Moms and Dads Converge as They Balance Work and Family* (Washington, DC: Pew Research Center, 2013), http://assets.pewresearch.org/wp-content/uploads/sites/3/2013/03/FINAL_modern_parenthood_03-2013.pdf.

²³ Joseph A. Vandello, Vanessa E. Hettinger, Jennifer K. Bosson, and Jasmine Siddiqi, “When Equal Isn’t Really Equal: The Masculine Dilemma of Seeking Work Flexibility,” *Journal of Social Issues*, vol. 69, no. 2, 2013.

However, the need for caregiving has not disappeared—and will not—simply because the number of stay-at-home caregivers has decreased. In fact, families are coping with a variety of care needs. Many modern families extend well beyond the scope of the “nuclear” household. Workers are providing care for a broad range of family members, from spouses, children, and parents; to extended family members such as grandparents, siblings, aunts, uncles, and cousins; to “chosen family” and others in their extended communities.²⁴ The Baby Boomer generation is also aging at a rapid pace, and the number of caregivers available for each senior is in steady decline.²⁵ As of 2010, there were roughly seven potential caregivers (defined as people aged 45-64) for each person aged 80 or older; that ratio is projected to drop to 4:1 by 2030 and 3:1 by 2050.²⁶ Roughly 1 in 6 working adults is already providing care for a family member over the age of 65. Some adults leave the workforce altogether because they cannot manage the competing demands

Roughly 1 in 6 working adults is providing care for a family member over age 65.

of work and caregiving. Additionally, almost a quarter of these family eldercare providers also have children.²⁷ While family caregiving leave-taking currently comprises a smaller portion of FMLA claims than personal medical leave (which accounts for over half of claims), family caregiving claims do not lag far behind new child bonding claims (18 versus 21 percent of claims in a given 12-month period, respectively),²⁸ demonstrating the importance of covering caregiving beyond new parenthood.

Impact of Paid Leave on Economic Security, Health, and Child Development

Research in the United States²⁹ and across OECD nations³⁰ has found that access to paid

²⁴ Jacqueline L. Angel and Richard A. Settersten, “What Changing American Families Mean for Aging Policies,” *Public Policy & Aging Report*, vol. 25, no. 3, 2015, doi: 10.1093/ppar/prv011.

²⁵ Nina Dastur, Indivar Dutta-Gupta, Laura Tatum, Peter Edelman, Kali Grant, and Casey Goldvale, “Building the Caring Economy: Workforce Investments to Expand Access to Affordable, High-Quality Early and Long-Term Care,” Georgetown Center on Poverty and Inequality, Creative Commons, 2017, http://www.georgetownpoverty.org/wp-content/uploads/2017/05/Building-the-caring-economy_hi-res.pdf.

²⁶ Donald Redfoot, Lynn Feinberg, and Ari Houser, “The Aging of the Baby Boom and the Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers,” AARP Public Policy Institute, Insight on the Issues 85, 2013, http://www.aarp.org/content/dam/aarp/research/public_policy_institute/lrc/2013/baby-boom-and-the-growing-care-gap-insight-AARP-ppi-lrc.pdf.

²⁷ U.S. Department of Labor, *Navigating the Demands of Work and Eldercare*, (Washington, DC, 2016), http://digitalcommons.ilr.cornell.edu/key_workplace/1602.

²⁸ Jacob Alex Klerman, Kelly Daley, and Alyssa Pozniak, “Family and Medical Leave in 2012: Technical Report,” Abt Associates, 2014, <https://www.dol.gov/asp/evaluation/fmla/FMLA-2012-Technical-Report.pdf>.

²⁹ Charles L. Baum and Christopher J. Ruhm, “The Effects of Paid Family Leave in California on Labor Market Outcomes,” *Journal of Policy Analysis and Management*, vol. 35, no. 2, 2016; Nuno Mota, “Parental Leave Assistance and Long-Term Effects on Female Labor Supply,” 2015, https://nabreufa.expressions.syr.edu/wp-content/uploads/2014/09/NM_Paid_Leave_01-26-15.pdf.

³⁰ Becky Pettit and Jennifer Hook, “The Structure of Women’s Employment in Comparative Perspective,” *Social Forces*, vol. 84, no. 2, 2005; Jane Waldfogel, Higuchi Yoshio, and Abe Masahiro, “Family Leave Policies and Women’s Retention after Childbirth: Evidence from the United States, Britain, and Japan,” *Journal of Population Economics*, vol. 12, no. 4, 1999; WORLD Policy Analysis Center, “A Review of the Evidence on the Length of Paid Family and Medical Leave. Policy Brief,” 2018, <https://www.worldpolicycenter.org/sites/default/files/WORLD%20Brief%20-%20Length%20Paid%20Family%20and%20Medical%20Leave.pdf>.

leave increases maternal workforce attachment after giving birth, reduces poverty for households with children,³¹ and may also be associated with increased earnings for mothers.³² Access to paid parental leave for new fathers has been demonstrated to increase women's employment³³ and future earnings.³⁴ Paid medical leave can help workers with disabilities avoid income loss, separation from the workforce, or unwanted reductions in hours.³⁵ Workers who experience a serious medical incident are also more likely to return to work when paid leave is available,³⁶ though further research is needed on the long-term effects of paid medical leave.

Additionally, as the Baby Boomer generation ages, the demand for family caregivers who can provide support to their parents and other aging loved ones will grow. As the challenges of balancing work and caregiving responsibilities mount, many workers—particularly women, people of color, and low-wage workers, who may have more care

responsibilities and less access to paid family leave—risk negative economic outcomes, such as lost earnings, undesired shifts from full- to part-time work, or being pushed out of the workplace altogether. One study found that women over the age of 50 who left the labor force early to care for an elder suffered forgone wages averaging \$142,693 and reductions in lifetime Social Security benefits averaging \$131,351; for men, forgone wages and Social Security benefits averaged \$89,107 and \$144,609, respectively.³⁷

Access to paid leave increases maternal workforce attachment after giving birth and reduces poverty for households with children.

In addition to the financial benefits for workers and their families, access to paid parental leave has been associated with

³¹ Laurie C. Maldonado and Rense Nieuwenhuis, "Family Policies and Single Parent Poverty in 18 OECD Countries, 1978–2008," *Community, Work & Family*, vol. 18, no. 4, 2015.

³² WORLD Policy Analysis Center "Policy Brief: A Review of the Evidence on the Length of Paid Family and Medical Leave," 2018, <https://www.worldpolicycenter.org/sites/default/files/WORLD%20Brief%20-%20Length%20Paid%20Family%20and%20Medical%20Leave.pdf>.

³³ Mohammad Amin, Asif Islam, and Alena Sakhonchik, "Does Paternity Leave Matter for Female Employment in Developing Economies? Evidence from Firm Data," The World Bank Group, Policy Research Working Paper 7588, 2016, <http://documents.worldbank.org/curated/en/124221468196762078/pdf/WPS7588.pdf>.

³⁴ Elly-Ann Johansson, "The Effect of Own and Spousal Parental Leave on Earnings," Institute for Labour Market Policy Evaluation, Working Paper 2010:4, March 2010, <https://www.ifau.se/globalassets/pdf/se/2010/wp10-4-The-effect-of-own-and-spousal-parental-leave-on-earnings.pdf>.

³⁵ Kali Grant, T.J. Sutcliffe, Indivar Dutta-Gupta, and Casey Goldvale, "Security and Stability: Paid Family and Medical Leave and its Importance to People with Disabilities and their Families," Georgetown Center on Poverty and Inequality and The Arc, Creative Commons, 2017, <http://www.thearc.org/file/public-policy-document/Paid-Leave-Report.pdf>.

³⁶ Alison Earle, John Z. Ayanian, and Jody Heymann, "Work Resumption after Newly Diagnosed Coronary Heart Disease: Findings on the Importance of Paid Leave," *Journal of Women's Health*, vol. 15, no. 4, May 2006.

³⁷ MetLife Mature Market Institute, *The MetLife Study of Caregiving Costs to Working Caregivers: Double Jeopardy for Baby Boomers Caring for Their Parents*, (New York: MetLife, 2011), <http://www.caregiving.org/wp-content/uploads/2011/06/mmi-caregiving-costs-working-caregivers.pdf>.

positive health outcomes for both children and parents. Research reveals that paid parental leave is correlated with substantial reductions in mortality for infants and young children; this effect increases as the duration of benefits is extended.³⁸ Infants whose parents have access to paid parental leave are more likely to be breastfed³⁹ and to receive vaccinations according to the medically recommended schedule.⁴⁰ Recent research suggests that access to paid leave may play a role in reducing physical abuse and maltreatment of young children.⁴¹ New mothers also benefit from the time to recover and bond with their infants; women with more generous leave benefits showed decreased depressive symptoms and higher overall health status after childbirth compared to those who took shorter leaves.⁴² Additionally, paid leave is correlated with

higher participation in preventive health screenings and care, both for workers themselves and for their dependent children.⁴³

Access to paid parental leave has been associated with positive health outcomes for both children and parents.

To date, few studies have examined the effects of paid leave on adult loved ones and older children with care needs. The available literature does suggest that health outcomes for sick older children and aging individuals alike are improved with support from family members.⁴⁴ One recent study on paid family leave in California found that the program is correlated with an 11 percent relative decline in nursing home utilization among seniors.⁴⁵

³⁸ Christopher J. Ruhm, "Parental Leave and Child Health," *Journal of Health Economics*, vol. 19, no. 6, 2000, <https://pdfs.semanticscholar.org/4d10/696ad848f316382f65b2f85b43442acf51e3.pdf>; Maya Rossin-Slater, "The Effects of Maternity Leave on Children's Birth and Infant Health Outcomes in the United States," *Journal of Health Economics*, vol. 30, no. 2, 2011.

³⁹ Rui Huang and Muzhe Yang, "Paid Maternity Leave and Breastfeeding Practice Before and After California's Implementation of the Nation's First Paid Family Leave Program," *Economics & Human Biology*, vol. 16, no. 1, 2015; Eileen Appelbaum and Ruth Milkman, *Leaves that Pay: Employer and Worker Experiences with Paid Family Leave in California*, (Washington, DC: Center for Economic and Policy Research, 2011), <http://cepr.net/documents/publications/paid-family-leave-1-2011.pdf>.

⁴⁰ Lawrence Berger, Jennifer Hill, and Jane Waldfogel, "Maternity Leave, Early Maternal Employment and Child Health and Development in the US," *The Economic Journal*, vol. 115, no. 501, 2005.

⁴¹ Joanne Klevens, Feijun Luo, Likang Xu, Cora Peterson, and Natasha E. Latzman, "Paid Family Leave's Effect on Hospital Admissions for Pediatric Abusive Head Trauma," *Injury Prevention*, vol. 22, no. 6, 2016.

⁴² Pinka Chatterji and Sara Markowitz, "Family Leave After Childbirth and the Mental Health of New Mothers," *The Journal of Mental Health Policy and Economics*, vol. 15, 2012; Rada K. Dagher, Patricia M. McGovern, and Bryan E. Dowd, "Maternity Leave Duration and Postpartum Mental and Physical Health: Implications for Leave Policies," *Journal of Health Politics, Policy, and Law*, 2013, Doi: 10.1215/03616878-2416247. <http://jhppl.dukejournals.org/content/early/2013/11/27/03616878-2416247.abstract>.

⁴³ Liz Ben-Ishai, Zoe Ziliak Michel, and Alex Wang, "Paid Leave Necessary for an Ounce of Prevention: Paid Leave and Access to Preventive Care," Center for Law and Social Policy (CLASP), 2017, <https://www.clasp.org/sites/default/files/publications/2017/04/PreventiveHealthPaidLeave.pdf>.

⁴⁴ See literature review in: Jody Heymann, Hye Jin Rho, John Schmitt, and Alison Earle, "Contagion Nation: A Comparison of Paid Sick Day Policies in 22 Countries," Center for Economic Policy Research, 2009, cepr.net/publications/reports/contagion-nation.

⁴⁵ Kanika Arora and Douglas A. Wolf, "Does Paid Family Leave Reduce Nursing Home Use? The California Experience," *Journal of Policy Analysis and Management*, vol. 37, no. 1, 2017, <https://doi.org/10.1002/pam.22038>.



Impact of Paid Leave on Business and the Economy

Paid leave's effects on the economy as a whole represent an important metric by which to gauge the policy's success. To date there is little evidence that paid leave has any negative impact on business or the economy. Research on the existing programs in California,⁴⁶ Rhode Island,⁴⁷ and New Jersey⁴⁸ demonstrates no substantial negative impact on business. To

the contrary: employers report benefits from paid leave including improved employee retention (particularly among women), morale, engagement, and productivity.⁴⁹

Although some have suggested that businesses below a certain number of employees should be exempt from paying contributions into a state-level paid leave program, a national poll of small businesses found that a substantial majority supported

⁴⁶ Ruth Milkman and Eileen Appelbaum, *Unfinished Business: Paid Family Leave in California and the Future of U.S. Work-Family Policy*, (Ithaca, NY: ILR Press, 2013), <http://digitalcommons.ilr.cornell.edu/cgi/viewcontent.cgi?article=1090&context=books>.

⁴⁷ Ann Bartel, Maya Rossin-Slater, Christopher Ruhm, and Jane Waldfogel, "Assessing Rhode Island's Temporary Caregiver Insurance Act: Insights from a Survey of Employers," U.S. Department of Labor, Chief Evaluation Office, 2016, https://www.dol.gov/asp/evaluation/completed-studies/AssessingRhodeIslandTemporaryCaregiverInsuranceAct_InsightsFromSurveyOfEmployers.pdf.

⁴⁸ Miriam Ramirez, "The Impact of Paid Family Leave on New Jersey Businesses," New Jersey Business and Industry Association and Bloustein School of Planning and Public Policy at Rutgers, The State University of New Jersey, MPP AFE Presentation, Fall 2012, <http://bloustein.rutgers.edu/wp-content/uploads/2012/03/Ramirez.pdf>.

⁴⁹ Eileen Appelbaum and Ruth Milkman, "Leaves That Pay: Employer and Worker Experiences with Paid Family Leave in California," Center for Economic and Policy Research, 2011, <http://cepr.net/documents/publications/paid-family-leave-1-2011.pdf>; Trish Stroman, Wendy Woods, Gabrielle Fitzgerald, Shalini Unnikrishnan, and Liz Bird, "Why Paid Family Leave Is Good for Business," The Boston Consulting Group, 2017, <http://media-publications.bcg.com/BCG-Why-Paid-Family-Leave-Is-Good-Business-Feb-2017-Revised.pdf>; Ernst & Young LLP, "Viewpoints on Paid Family and Medical Leave: Findings from a Survey of U.S. Employers and Employees," 2017, [https://www.ey.com/Publication/vwLUAssets/EY-viewpoints-on-paid-family-and-medical-leave/\\$FILE/EY-viewpoints-on-paid-family-and-medical-leave.pdf](https://www.ey.com/Publication/vwLUAssets/EY-viewpoints-on-paid-family-and-medical-leave/$FILE/EY-viewpoints-on-paid-family-and-medical-leave.pdf).



a social insurance model for paid leave, particularly when the program is financed by shared costs between employees and their employers.⁵⁰ This is in part because a universal paid leave program can help to level the playing field between larger companies and small businesses, who often want to provide such benefits to their employees and understand the value of paid leave benefits, but simply cannot afford the financial shock of paying fully out of pocket. A social insurance program that spreads costs widely across all workers and/or employers in a state (or country) can offer a more predictable and affordable option than self-insurance.

Survey research has also found widespread support among small- and medium-sized businesses for state-level paid family leave programs. A representative sample of employers from New Jersey and New York

found that over 60 percent of small- and medium-sized employers—those with 10-19 or 20-49 employees, respectively—supported their states' paid family leave programs. Only about 15 percent of businesses in both states expressed opposition.⁵¹ Additionally, an early analysis of Rhode Island's program found that two-thirds of small business employees reported experiencing no impact from a coworker's leave, while their employers adjusted in ways generally comparable to larger employers.⁵²

It is important to note that research from the United States that assesses the effects of paid leave policies on business practices and outcomes has been limited. Current state paid leave policies offer relatively modest benefits in terms of wage replacement and—for paid family leave—duration (between 4 and 6 weeks, although some newer state programs

⁵⁰ Small Business Majority and Center for American Progress, "Opinion Survey: Small Businesses Support Paid Family Leave Programs," March 2017, <http://www.smallbusinessmajority.org/sites/default/files/research-reports/033017-paid-leave-poll.pdf>.

⁵¹ Ann Bartel, Maya Rossin-Slater, Christopher Ruhm and Jane Waldfogel, "Employer Attitudes to Paid Family Leave," 2017, https://web.stanford.edu/~mrossin/Bartel_et_al_EmployerAttitudesReport_Aug2017.pdf.

⁵² Ann Bartel, Maya Rossin-Slater, Christopher J. Ruhm and Jane Waldfogel, "Assessing Rhode Island's Temporary Caregiver Insurance Act: Insights from a Survey of Employers," U.S. Department of Labor, Chief Evaluation Office, 2016, www.dol.gov/asp/evaluation/completedstudies/AssessingRhodeIslandTemporaryCaregiverInsuranceAct_InsightsFromSurveyOfEmployers.pdf.

Research has found widespread support among small- and medium-sized businesses for state-level paid family leave programs.

will offer leaves up to 12 weeks). Furthermore, they are funded either exclusively by employees or by shared contributions from employers and employees. These factors limit the cost of these programs for employers, as well as their broader impact on the economy. A paid family and medical leave program funded entirely by employers,⁵³ or an employer mandate,⁵⁴ might affect businesses more than current programs. Employers might seek to offset these effects by reducing wages, especially for employees perceived to be the most likely program users.⁵⁵ Successful implementation of new state-level programs should include funding and a plan for program evaluation to shed light on these issues.⁵⁶

⁵³ As of June 2019, Washington, DC has passed—but not yet implemented—an employer-funded social insurance program for paid family and medical leave.

⁵⁴ Hawaii has an employer mandate for paid medical leave (TDI) only. There has been little research evaluating this policy and its effects on businesses, the workforce, or the economy.

⁵⁵ Jonathan Gruber, “The Incidence of Mandated Maternity Benefits,” *The American Economic Review*, vol. 84, no. 3, 1994, <https://www.jstor.org/stable/2118071>.

⁵⁶ Analysis of employer attitudes and outcomes resulting from the recently implemented paid leave program in New York state and the ordinance mandating employers to finance increased paid leave benefits in the city of San Francisco is already underway. [Jane Waldfogel, “Paid Family and Medical Leave: Evidence from Employers. Symposium on Paid Family and Medical Leave,” Federal Reserve Bank of Boston, January 22, 2018.] Studies of programs with different funding mechanisms and/or benefit levels will be particularly revealing; these include programs in the District of Columbia (fully employer-funded) and Washington State (longer duration of leave and jointly funded between employees and employers).

Employer-Provided Paid Family and Medical Leave

Employers have long been aware that a generous employee benefits package can play a significant role in recruiting and retaining talented workers. Many high-road businesses are already offering paid family and medical leave to their employees. Recently, some employers have expanded benefits by increasing the generosity of benefit duration and/or by offering benefits to a broader range of their employees.⁵⁷ The generosity of those benefits varies by employer, but it is worth examining the range of what employers are already offering when considering what could be appropriate versus excessively burdensome on employers when designing a state or federal program.

■ **Leave duration:** The duration of voluntary paid leave benefits varies substantially across employers and type of leave. Most companies that provide paid leave limit its duration to 4 to 20 weeks; birth mothers sometimes may extend their leaves by combining paid medical and parental

leave allowances.⁵⁸ The Bill & Melinda Gates Foundation offers employees unlimited time off for a personal health issue.⁵⁹ Etsy provides 26 weeks of paid parental leave; after the first 8 weeks, leave may be spread over the first two years following the birth or adoption of a child, offering added flexibility to new parents.⁶⁰

■ **Wage replacement:** While not all companies are fully transparent regarding their wage replacement rate policies, a notable and growing number of employers offer paid parental leave, and in some cases also family caregiving leave, at 100 percent wage replacement, just as they would for vacation or sick leave (e.g., Discovery Communications,⁶¹ Ernst & Young LLP,⁶² and Microsoft⁶³). A recent survey of major U.S. employers shows that employers generally offer somewhere in the range of 60-100 percent wage replacement for paid medical leave. Some employers have tiered structures

⁵⁷ National Partnership for Women & Families, "Leading on Leave: Companies with New or Expanded Paid Leave Policies (2015-2018)," April 2018, <http://www.nationalpartnership.org/research-library/work-family/paid-leave/new-and-expanded-employer-paid-family-leave-policies.pdf>.

⁵⁸ Ibid.

⁵⁹ Bill & Melinda Gates Foundation, "Benefits," <https://www.gatesfoundation.org/Careers/Benefits>.

⁶⁰ Juliet Gorman, "Strong Families, Strong Business: A Step Forward in Parental Leave at Etsy," March 15, 2016, <https://blog.etsy.com/news/2016/strong-families-strong-business-a-step-forward-in-parental-leave-at-etsy/>.

⁶¹ Discovery Communications, "Discovery Communications Announces Significant Enhancement of U.S. Employee Paid Leave Policy For New Parents and Caregivers," Silver Spring, MD, September 15, 2016, <https://corporate.discovery.com/discovery-newsroom/discovery-communications-announces-significant-enhancement-of-u-s-employee-paid-leave-policy-for-new-parents-and-caregivers/>.

⁶² Ernst & Young LLP, "EY's Paid Parental Leave Policy in US Increased to 16 Weeks for New Moms and Dads," April 13, 2016, <https://www.prnewswire.com/news-releases/eys-paid-parental-leave-policy-in-us-increased-to-16-weeks-for-new-moms-and-dads-300250716.html>.

⁶³ Kathleen Hogan, "The Employee Experience at Microsoft: Aligning Benefits to Our Culture," August 15, 2015, <https://blogs.microsoft.com/blog/2015/08/05/the-employee-experience-at-microsoft-aligning-benefits-to-our-culture/>.

where workers with longer tenures at the organization receive higher wage replacement rates.⁶⁴

- **Qualifying events:** Qualifying events triggering a paid family leave benefit vary widely across employers. Many firms offer paid leave only for new parents, often with more generous benefits for new mothers than for new fathers.⁶⁵ Other companies provide paid leave for a wider range of family care needs, such as a close family member's serious health condition or bereavement following the death of a loved one. For example, Deloitte now offers 16 weeks of fully paid family caregiving leave.⁶⁶ As of 2019, General Mills provides 2 weeks of paid family caregiving leave and 4 weeks of bereavement leave upon the death of an immediate family member.⁶⁷

- **Inclusiveness across employees:** As with many benefits, employers may offer different paid leave benefits to different groups of workers. For example, at Netflix, salaried employees are offered up to a year of unlimited paid parental leave, but hourly employees are offered just 12 to 16 weeks (depending on their department).⁶⁸ Other companies offer benefits more equitably; for example, eBay provides 24 weeks of paid maternity leave and 12 weeks of paid parental, family caregiving, and medical leave to all employees working over 20 hours a week, regardless of whether they are salaried or hourly workers.⁶⁹

⁶⁴ PL+US, "Paid Family Leave Policies at Top US Employers," <http://paidleave.us/topemployerpolicies/>.

⁶⁵ National Partnership for Women & Families, "Leading on Leave: Companies with New or Expanded Paid Leave Policies (2015-2018)," April 2018, <http://www.nationalpartnership.org/research-library/work-family/paid-leave/new-and-expanded-employer-paid-family-leave-policies.pdf>.

⁶⁶ Deloitte, "Press Release: Deloitte Announces 16 Weeks of Paid Family Leave Time for Caregiving," September 8, 2016, <https://www2.deloitte.com/us/en/pages/about-deloitte/articles/press-releases/deloitte-announces-sixteen-weeks-of-fully-paid-family-leave-time-for-caregiving.html>.

⁶⁷ General Mills, "General Mills Announces Expanded U.S. Benefits Plan to Support Employees at All Life Stages," August 29, 2018, <https://www.generalmills.com/en/News/NewsReleases/Library/2018/July/Expanded-US-benefits-aug29>.

⁶⁸ National Partnership for Women & Families, "Leading on Leave: Companies with New or Expanded Paid Leave Policies (2015-2018)," April 2018, <http://www.nationalpartnership.org/research-library/work-family/paid-leave/new-and-expanded-employer-paid-family-leave-policies.pdf>.

⁶⁹ Kathryn Vasel, "eBay to Give New Moms 6 Months of Paid Leave," *CNN Money*, December 4, 2015, <http://money.cnn.com/2015/12/04/pf/jobs/ebay-increased-parental-benefits/index.html>.

Section II.

**THE LANDSCAPE OF
PAID FAMILY AND
MEDICAL LEAVE
POLICIES IN THE
UNITED STATES**

NATIONAL
ACADEMY
OF SOCIAL
INSURANCE



The United States lacks many family-friendly employment policies that characterize peer nations, including national paid leave. Several bills have been introduced in Congress that offer varying approaches to a national paid family and medical leave program, and Congressional support for such a program at the federal level has been steadily growing,⁷⁰ but none has yet passed either chamber of Congress.⁷¹

In the current absence of any large-scale national policy, states have stepped up as critical leaders in advancing paid family and medical leave programs. These programs are summarized in Table 1. A timeline of state-level PML and/or PFL programs is presented in Figure 2. The maximum duration of leave benefits varies considerably across states, as illustrated in Figures 3 and 4.

⁷⁰ The Family and Medical Insurance Leave (FAMILY) Act (S. 337/H.R. 947) would create a national paid family and medical leave social insurance program offering up to 12 weeks of leave for any event covered under the FMLA. As of June 2019, the bill has 34 cosponsors in the Senate and 189 cosponsors in the House. [For more information, see: National Partnership for Women and Families, “The Family And Medical Insurance Leave (FAMILY) Act: Fact Sheet,” 2019, <http://www.nationalpartnership.org/research-library/work-family/paid-leave/family-act-fact-sheet.pdf>.]

The New Parents Act of 2019 (S. 920) would offer parents of a new child the option to pull forward a portion of their Social Security benefits to use for paid parental leave after the birth or adoption of a child. Parents may elect to take up to three months (benefit selections must be in monthly increments) of parental leave upon the birth or adoption of a child against their future retirement benefits. [116th Congress, 1st Sess., S.920 - New Parents Act of 2019, <https://www.congress.gov/bill/116th-congress/senate-bill/920/text>.]

⁷¹ The Tax Cuts and Jobs Act of 2017 includes a business tax credit for employers who voluntarily offer paid family and medical leave to all qualifying full-time employees; part-time employees can be offered benefits on a pro-rated basis. This credit gives employers an incentive to offer paid leave voluntarily to their employees earning under \$72,000 per year. It does not provide universal paid family and medical leave.

TABLE 1: Key Features of Existing Paid Family and Medical Leave Programs

Jurisdiction	Architecture and Funding		Administrative Agency	Contributions		Length of Leave Available		Wage Replacement	Eligibility Requirements
	Paid Medical Leave (PML)	Paid Family Leave (PFL)		PML	PFL	PML	PFL		
California	Social insurance with limited employer opt outs; Funded through employee payroll tax		California Employment Development Department	Employee: 1.0% of the first \$118,371 in earnings	Up to 6 weeks	Up to 52 weeks	Up to 6 weeks	70% of worker's average weekly wage (AWW) for workers earning at least \$929 but < 1/3 of state average quarterly wage (AQW); 60% of the worker's AWW OR 23.3% of state AWW—which ever is greater—for all earnings > 1/3 of state AQW, up to weekly max of \$1,252	Earned at least \$300 in 12-month base period* Self-employed workers may opt in to the program Some public sector employees are covered
New Jersey	Social insurance with regulated employer opt outs; Funded through employee / employer payroll tax; Employers may request approval to opt out of state plan to self-insure or provide insurance through private carrier	Social insurance with limited employer opt outs; Funded through employee payroll tax; Employers may request approval to opt out of state plan to self-insure or provide insurance through private carrier	New Jersey Department of Labor and Workforce Development	Employee: 0.17% on the first \$34,400 in earnings; New employers: 0.5%; All other employers: experience rated, maximum wage base = \$34,400	Up to 26 weeks	Up to 6 weeks in 2019; up to 12 weeks in 2020	Up to 6 weeks in 2019; up to 12 weeks in 2020	67%, weekly max of \$650, in 2019; 85%, maximum benefit of 70% of the statewide AWW, in 2020	Earned at least \$8,600 in base year** OR Earned at least \$172 per week for a minimum of 20 weeks Private and public sector employees are covered, with some exceptions for government employers
Rhode Island	Social insurance with exclusive state fund; Funded through employee payroll tax		Rhode Island Department of Labor and Workforce Development	Employee: 1.1% of the first \$71,000 in earnings	Up to 30 weeks	Up to 4 weeks		60%, with a weekly maximum of \$852 plus dependent benefits	Earned at least \$12,600 in base or alternate base period*** OR Earned at least \$4,200 in base period & at least \$2,100 in one quarter & have total base period earnings of at least 150% of highest quarter's earnings Some public sector employees are covered

Jurisdiction	Architecture and Funding		Administrative Agency	Contributions		Length of Leave Available		Wage Replacement	Eligibility Requirements
	Paid Medical Leave (PML)	Paid Family Leave (PFL)		PML	PFL	PML	PFL		
New York	Hybrid social insurance program with regulated private options; Funded through employee / employer payroll tax;	SHybrid social insurance program with regulated private options; Funded through employee payroll tax; Employers may opt to cover full cost of PFL for employees;	New York State Workers' Compensation Board	Employee: 0.5% of wages paid, up to \$0.60 per week Employer: all additional costs	Employee: 0.126% of employee's weekly wage up to the state AWW	Up to 26 weeks	Up to 10 weeks in 2019; up to 12 weeks in 2021	PML: 50%, with a weekly maximum of \$170; PFL: 55% up to cap of 55% of state AWW in 2019; 60% up to cap of 60% of state AWW in 2020; 67% up to a cap of 67% of state AWW in 2021	For medical leave: Worked at least four weeks for a covered employer OR Work for an employer who provides voluntary coverage OR Work at least 40 hours per week for one employer as a domestic or personal employee for a minimum of 30 days in a calendar year For family leave: Currently employed by a covered employer & worked at least 26 consecutive weeks for a covered employer OR Worked at least 175 days for a covered employer if part-time Self-employed workers may opt in to the program Certain public employers can opt in to both PML and PFL; state government, some public employers, and workers represented by an employee organization can opt in to PFL only
	Employers must provide coverage either through private insurance or the state plan, or request approval to self-insure; Employers may waive the employee contribution to fully fund coverage	Employers must provide coverage either through private insurance or the state plan, or request approval to self-insure; approval to self-insure							

Jurisdiction	Architecture and Funding		Administrative Agency	Contributions		Length of Leave Available		Wage Replacement	Eligibility Requirements
	Paid Medical Leave (PML)	Paid Family Leave (PFL)		PML	PFL	PML	PFL		
Hawaii	Employer mandate	n/a	Hawaii Department of Labor and Industrial Relations	Employee: up to 0.5% of weekly wages, up to \$5.44 Employer: all additional costs		Up to 26 weeks	n/a	58%, with a weekly maximum of \$632	Worked at least 20 hours per week for at least 14 weeks AND Earned at least \$400 in the 52 weeks prior to the claim date AND Be in current employment
District of Columbia (Enacted July 2019, effective July 2020 (premiums) / July 2020 (benefits))	Social insurance with exclusive state fund; Funded through employer payroll tax		District of Columbia Department of Employment Services	Employer: 0.62% of the annual salary of each covered employee		Up to 2 weeks	Up to 8 weeks of parental leave & up to 6 weeks of family care-giving leave; No more than 8 weeks of total leave in a 52-week period	For workers with weekly earnings <150% of D.C. min wage (\$795 in 2019), 90% of AWW; For workers with weekly earnings >150% of D.C. min wage, 90% of earnings up to 150% of D.C. min wage, plus 50% of earnings above this threshold, with weekly max of \$1,000	Worked more than 50% of the time for a covered employer in DC AND Worked for a covered employer for at least some time in last 52 weeks, OR Self-employed with self-employment income for work performed more than 50% of the time in DC AND Opted into paid leave program & paid appropriate taxes into system Employees of the District and federal governments are not covered, nor are employees of any other entity that the District cannot tax

Jurisdiction	Architecture and Funding		Administrative Agency	Contributions		Length of Leave Available		Wage Replacement	Eligibility Requirements
	Paid Medical Leave (PML)	Paid Family Leave (PFL)		PML	PFL	PML	PFL		
Washington State (Enacted 2017, effective 2019 (premiums) / January 2020 (benefits))	Social insurance with limited employer opt outs; Funded through an employee / employer payroll tax		Washington State Employment Security Department	0.4% of wages, with a minimum of 37.5% paid for by employers and the remaining amount, up to 62.5%, by employees Employers with fewer than 50 workers are not required to pay the employer portion, but receive special incentives and offsets if they do		Up to 12 weeks, OR up to 14 weeks for serious pregnancy-related complications resulting in incapacity	Up to 12 weeks; Combined family/medical leave may not exceed 16 weeks, or 18 weeks in case of serious pregnancy-related complication	For workers with earnings <50% of statewide AWW, 90% of worker's AWW; For workers earning over 50% of statewide AWW, 90% AWW up to 50% of state-wide AWW, plus 50% of employee's AWW for all earnings above 50% of statewide AWW, with weekly max of \$1,000, to be adjusted annually to equal 90% of state AWW	Worked at least four out of five completed quarters prior to application AND Must have worked for at least 820 hours in the qualifying period Self-employed workers may opt in to the program if they have worked at least 820 hours in the qualifying period

Jurisdiction	Architecture and Funding		Administrative Agency	Contributions		Length of Leave Available		Wage Replacement	Eligibility Requirements
	Paid Medical Leave (PML)	Paid Family Leave (PFL)		PML	PFL	PML	PFL		
Massachusetts (Enacted 2018, effective July 2019 (premiums) / 2021 (benefits))	Social insurance with limited employer opt outs; Funded through an employee / employer payroll tax		Massachusetts Executive Office of Labor and Workforce Development	0.63% of wages			Up to 12 weeks for family leave; Up to 26 weeks to care for a covered service member; Combined family/medical leave may not exceed 26 weeks, with 2 extra weeks in the case of serious pregnancy complications	For workers with earnings < 50% of statewide average weekly wage (AWW), 80% of worker's AWW; For workers earning > 50% of statewide AWW, 80% of the employee's AWW up to 50% of the statewide AWW, plus 50% of the employee's AWW over 50% of state AWW; Weekly maximum benefit: \$850, to be adjusted annually to equal 64% of state AWW	Employee must be financially eligible for state unemployment insurance coverage: As of 2018, \$4,700 in the last 4 completed calendar quarters and at least 30 times the weekly unemployment benefit amount that the employee would be eligible to collect Private sector and state government employees are covered Self-employed workers and local governments may opt in to the program
				Employees: 100% of the PFL premium and up to 40% of the PML premium from employee wages Employers: at least 60% of the PML premium; Employers may opt to pay for some or all of the remaining cost of PML and/or PFL coverage if desired Employers with fewer than 25 workers are not required to pay the employer portion	Up to 20 weeks; Combined family/medical leave may not exceed 26 weeks				
Connecticut (Enacted 2019, effective 2021 (premiums) / 2022 (benefits))	Social insurance with limited employer opt outs; Funded through an employee payroll tax		Paid Family and Medical Leave Insurance Authority; Department of Revenue Services; Department of Labor	0.5% of wages up to Social Security cap	Up to 12 weeks	Up to 12 weeks; Combined family/medical may not exceed 12 weeks (14 for serious pregnancy complications); Compensation will be capped at 60 times the hourly minimum wage.	95% of weekly earnings up to 40 hours of minimum wage earnings; plus 60% of earnings above minimum wage up to 40 hours/week. The total weekly compensation will be capped at 60 times the hourly minimum wage.	Employee must earn at least \$2325 in the highest earning quarter within the base period (four of the five most recently completed quarters). Self-employed workers may opt in to the program for an initial period of three years.	

*In California, the base period covers 12 months and is divided into four consecutive quarters. The base period includes wages subject to state disability insurance (SDI) taxes that were paid approximately 5 to 18 months before the claim began. The base period does not include wages paid at the time the claim begins. If a claim begins on or after January 1, 2018:

- January, February, or March, the base period is the 12 months ending last September 30.
- April, May, or June, the base period is the 12 months ending last December 31.
- July, August, or September, the base period is the 12 months ending last March 31.
- October, November, or December, the base period is the 12 months ending last June 30.

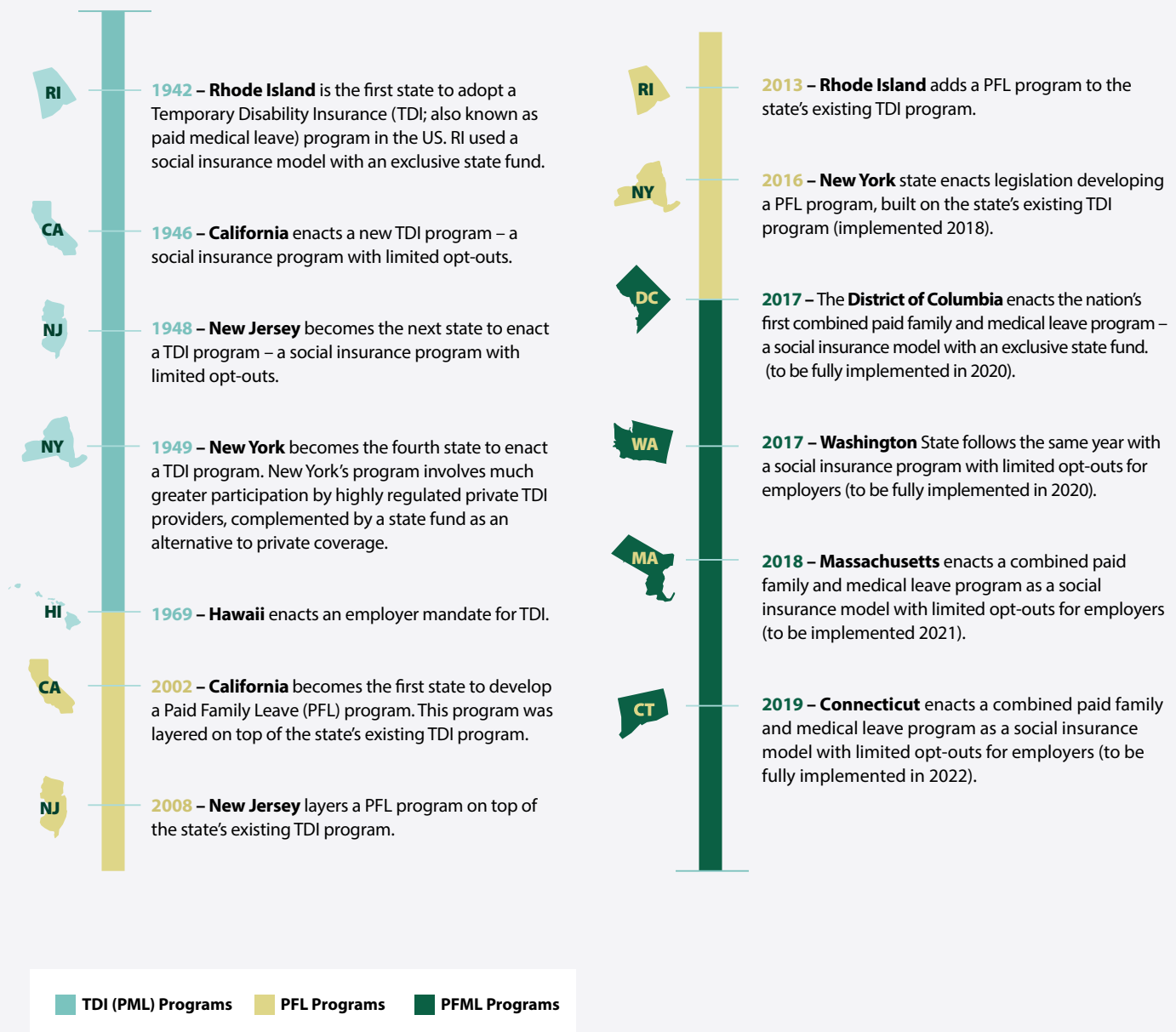
** In New Jersey, the base year is defined as the first four of the last five completed calendar quarters before the worker files a claim.

*** In Rhode Island, the base period is defined as the first four of the last five completed calendar quarters before the starting date of a new claim. If an individual is not eligible due to insufficient earnings using the base period, the state will recalculate earnings from an alternate base period consisting of the last four completed calendar quarters before the starting date of a claim. While the same earnings requirements must be met to qualify for this alternate base period, it allows for wage replacement to be set based on more recent earnings when the employee might have been earning higher wages that would permit them to qualify for benefits.

Sources:

The Commonwealth of Massachusetts, House Bill No. 4640, 2018, <https://www.jacksonlewis.com/sites/default/files/docs/H4640.pdf>; District of Columbia, "Universal Paid Leave Amendment Act of 2016," D.C. Act 21-264, 2016, <https://code.dccouncil.us/dc/council/laws/21-264.html>; New York State Paid Family Leave, New York State Paid Family Leave: Employer Facts, 2017, https://www.ny.gov/sites/ny.gov/files/atoms/files/PaidFamilyLeave_BusinessOwnerFactSheet.pdf; New York State Workers' Compensation Board, "Disability Benefits: (Off-the-Job Injury or Illness)," 2019, <http://www.wcb.ny.gov/content/main/DisabilityBenefits/Employer/introToLaw.jsp>; State of California, "2019 UI, ETT, and SDI Rates," Sacramento, CA: State of California Employment Development Department, 2019, https://www.edd.ca.gov/Payroll_Taxes/Rates_and_Withholding.htm#Rates; State of California, "FAQs – Paid Family Leave (PFL) Benefits," Sacramento, CA: State of California Employment Development Department, 2018, https://www.edd.ca.gov/Disability/FAQ_PFL_Benefits.htm; State of California, "Calculating Benefit Payment Amounts," Sacramento, CA: State of California Employment Development Department, 2019, https://www.edd.ca.gov/disability/Calculating_DL_Benefit_Payment_Amounts.htm; State of Connecticut, Senate Bill 0001, "An Act Concerning Paid Family and Medical Leave," 2019, https://www.cga.ct.gov/asp/cgabillstatus/cgabillstatus.asp?selBillType=Bill&bill_num=SB-0001; State of Hawaii, "2019 Maximum Weekly Wage Base and Maximum Weekly Benefit Amount," Honolulu, HI: State of Hawaii Disability Compensation Division, 2018, <http://labor.hawaii.gov/dcd/files/2018/11/2019wagebase.pdf>; State of Hawaii, "About Temporary Disability Insurance," Honolulu, HI: State of Hawaii Disability Compensation Division, 2019, <http://labor.hawaii.gov/dcd/home/about-tdi/>; State of New Jersey, "FAQ: Temporary Disability Insurance," Trenton, NJ: Division of Temporary Disability and Family Leave Insurance, State of New Jersey Department of Labor and Workforce Development, 2019, <https://myleavebenefits.nj.gov/labor/myleavebenefits/help/faq/tdi.shtml>; State of New Jersey, "Division of Employer Accounts 2019 Rates," Trenton, NJ: Division of Temporary Disability and Family Leave Insurance, State of New Jersey Department of Labor and Workforce Development, 2019, <https://www.nj.gov/labor/ea/rates/ea2019.html>; State of Rhode Island, "Temporary Disability Insurance/Temporary Caregiver Insurance," Providence, RI: Rhode Island Department of Labor and Training, 2019, <http://www.dlt.ri.gov/tdi/tdifaqs.htm>; State of Washington, S.B. 5975, 65th Leg., 3rd Special Session, 2017, <http://lawfilesexternal.wa.gov/biennium/2017-18/Pdf/Bills/Senate%20Passed%20Legislature/5975-S.PL.pdf>.

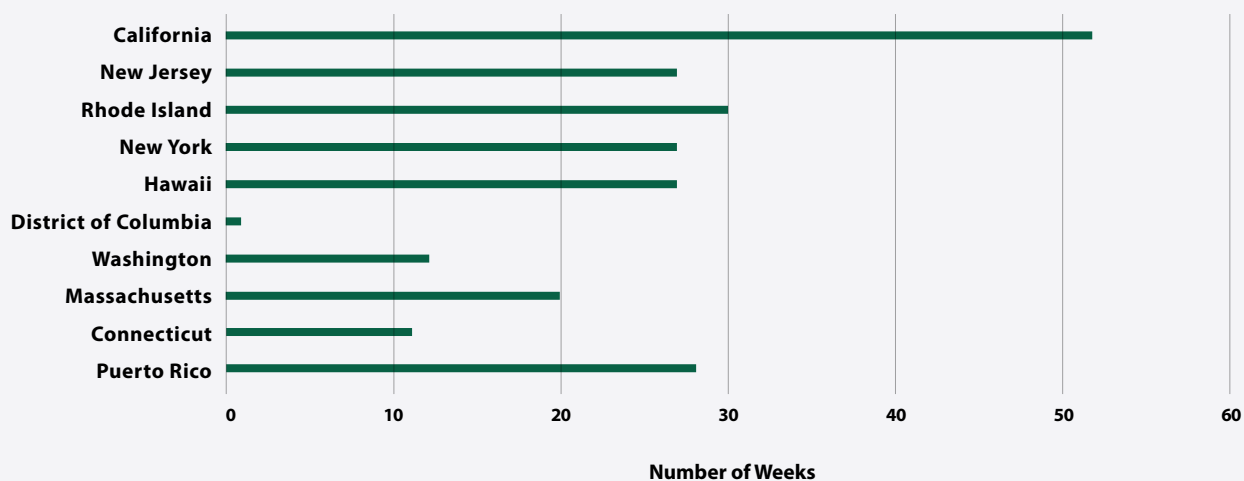
FIGURE 2: A Timeline of State Paid Family and Medical Leave Programs



Sources: Sarah Jane Glynn, Alexandra L. Bradley, and Benjamin W. Veghte, "Paid Family and Medical Leave Programs: State Pathways and Design Options," Washington, DC: National Academy of Social Insurance, 2017, <https://www.nasi.org/research/2017/paid-family-medical-leave-programs-state-pathways-design>; The Commonwealth of Massachusetts, House Bill No. 4640, 2018, <https://www.jacksonlewis.com/sites/default/files/docs/H4640.pdf>; State of Connecticut, Senate Bill 0001, "An Act Concerning Paid Family and Medical Leave," 2019, <https://www.cga.ct.gov/2019/amd/S/pdf/2019SB-00001-R00SA-AMD.pdf>.



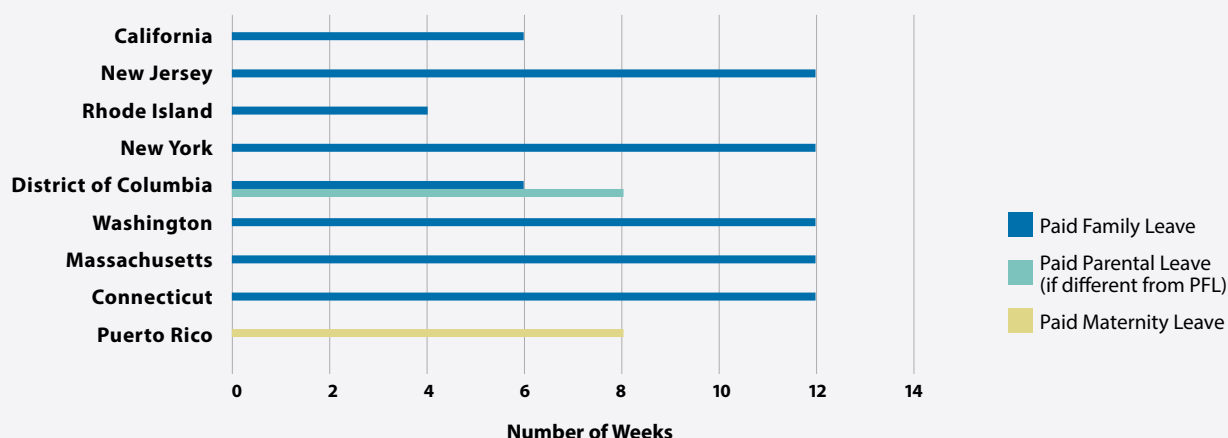
FIGURE 3: Maximum Duration (in weeks) of Paid Medical Leave, by State



Sources: The Commonwealth of Massachusetts, House Bill No. 4640, 2018, <https://www.jacksonlewis.com/sites/default/files/docs/H4640.pdf>; District of Columbia, “Universal Paid Leave Amendment Act of 2016,” D.C. Act 21-264, 2016, <https://code.dccouncil.us/dc/council/laws/21-264.html>; New York State Workers’ Compensation Board, “Disability Benefits: (Off-the-Job Injury or Illness),” 2019, <http://www.wcb.ny.gov/content/main/DisabilityBenefits/Employer/introToLaw.jsp>; State of California, “FAQs – Disability Insurance (DI) Benefits,” Sacramento, CA: State of California Employment Development Department, 2018, https://www.edd.ca.gov/Disability/FAQ_DI_Benefits.htm; State of Hawaii, “About Temporary Disability Insurance,” Honolulu, HI: State of Hawaii Disability Compensation Division, 2019, <http://labor.hawaii.gov/dcd/home/about-tdi/>; State of New Jersey, “FAQ: Temporary Disability Insurance,” Trenton, NJ: Division of Temporary Disability and Family Leave Insurance, State of New Jersey Department of Labor and Workforce Development, 2019, <https://myleavebenefits.nj.gov/labor/myleavebenefits/help/faq/tdi.shtml>; State of Rhode Island, “Temporary Disability Insurance/Temporary Caregiver Insurance,” Providence, RI: Rhode Island Department of Labor and Training, 2019, <http://www.dlt.ri.gov/tdi/tdifaqs.htm>; State of Washington, S.B. 5975, 65th Leg., 3rd Special Session, 2017, <http://lawfilesex.leg.wa.gov/biennium/2017-18/Pdf/Bills/Senate%20Passed%20Legislature/5975-S.PL.pdf>; State of Connecticut, Senate Bill 0001, “An Act Concerning Paid Family and Medical Leave,” 2019, <https://www.cga.ct.gov/2019/amd/S/pdf/2019SB-00001-R00SA-AMD.pdf>; Society for Human Resource Management, “An Overview of Puerto Rico Employment Law,” 2018, <https://www.shrm.org/resourcesandtools/legal-and-compliance/state-and-local-updates/pages/overview-puerto-rico-law.aspx>.

Note: In Washington and Connecticut, workers may be eligible for up to 14 weeks of paid medical leave in the event of serious pregnancy complications.

FIGURE 4: Maximum Duration (in weeks) of Paid Family Leave, by State



Sources: The Commonwealth of Massachusetts, House Bill No. 4640, 2018, <https://www.jacksonlewis.com/sites/default/files/docs/H4640.pdf>; District of Columbia, Universal Paid Leave Amendment Act of 2016, D.C. Act 21-264, 2016, <https://code.dccouncil.us/dc/council/laws/21-264.html>; New York State Paid Family Leave, "New York State Paid Family Leave: Employer Facts," 2017, https://www.ny.gov/sites/ny.gov/files/atoms/files/PaidFamilyLeave_BusinessOwnerFactSheet.pdf; State of California, "FAQs – Paid Family Leave (PFL) Benefits," Sacramento, CA: State of California Employment Development Department, 2018, https://www.edd.ca.gov/Disability/FAQ_PFL_Benefits.htm; State of New Jersey, "FAQ: Temporary Disability Insurance," Trenton, NJ: Division of Temporary Disability and Family Leave Insurance, State of New Jersey Department of Labor and Workforce Development, 2019, <https://myleavebenefits.nj.gov/labor/myleavebenefits/help/faq/tdi.shtml>; State of Rhode Island, "Temporary Disability Insurance/Temporary Caregiver Insurance," Providence, RI: Rhode Island Department of Labor and Training, 2019, <http://www.dlt.ri.gov/tdi/tdifaqs.htm>; State of Washington, S.B. 5975, 65th Leg., 3rd Special Session, 2017, <http://lawfilesexternal.wa.gov/biennium/2017-18/Pdf/Bills/Senate%20Passed%20Legislature/5975-S.PL.pdf>; State of Connecticut, Senate Bill 0001, "An Act Concerning Paid Family and Medical Leave," 2019, <https://www.cga.ct.gov/2019/amd/S/pdf/2019SB-00001-R00SA-AMD.pdf>; Society for Human Resource Management, "An Overview of Puerto Rico Employment Law," 2018, <https://www.shrm.org/resourcesandtools/legal-and-compliance/state-and-local-updates/pages/overview-puerto-rico-law.aspx>.

Note: The maximum duration of leave in New Jersey is 6 weeks in 2019 but will increase to 12 weeks in 2020. The maximum duration of leave in New York is 10 weeks as of 2019, but that period will increase annually until reaching a maximum of 12 weeks by 2021. The District of Columbia offers longer leave for new parents (8 weeks) than for other family caregiving needs (6 weeks). In Massachusetts, workers may be eligible for up to 26 weeks of paid family leave in the event of an illness or injury that arises from a close family member's military service. The social insurance program in Puerto Rico is available only to women after the birth or adoption of a child; it does not provide any other type of parental or family leave. The state of Hawaii is not included in this figure because it does not offer paid family leave.

Five states and Puerto Rico have longstanding temporary disability insurance (TDI) programs that cover paid medical leave. Four of these have added paid family leave coverage over the past two decades, and Puerto Rico has required 8 weeks of paid leave for mothers following the birth or adoption of a child since 1942. As of June 2019, another four jurisdictions are in the process of implementing new paid family and medical leave programs. A brief overview of these existing paid leave programs in the United States is provided below. For full descriptions

of the broader range of structural design and financing options that a state could utilize in developing a paid family and medical leave program, see Section IV: Overview of Key Design Elements and Considerations.

California was the first state to add paid family leave to its longstanding TDI program (also known as paid medical leave) in 2002. This social insurance program is funded by a payroll tax on employees, though limited options for employer self-insurance are permitted under certain strict conditions.

The program allows workers to take up to 52 weeks of paid medical leave⁷² and up to 6 weeks of paid family leave in a 12-month period.⁷³

New Jersey added paid family leave to its longstanding TDI program in 2008. As in California, this is principally a social insurance program, though employers may self-insure or provide coverage through a private carrier. The TDI program affords workers up to 26 weeks of paid medical leave in a 12-month period, funded by a shared employee-employer payroll tax. The paid family leave policy, which is funded entirely by a payroll tax levied on employees, currently offers up to 6 weeks of leave in a 12-month period, though the maximum leave period benefit will expand to 12 weeks as of July 1, 2020.⁷⁴

Rhode Island extended its existing TDI program to offer paid family leave in 2013. This social insurance model is financed entirely by an employee payroll tax. Rhode Island uses a social insurance model with an exclusive state fund—that is, a public, pooled fund that covers every eligible worker in the state. Employers have no option to self-insure or obtain other private coverage. The program allows workers to take up to 30 weeks of paid medical leave and up to 4 weeks of paid family leave

(limited to 30 weeks total of paid family and/or medical leave per year) within a 52-week period.⁷⁵

New York extended its TDI program to include paid family leave in 2018. Its paid family and medical leave program is similar to a traditional social insurance program, but it allows employers a substantial amount of choice in how benefits are delivered. Employers can choose to purchase a competitive state fund insurance plan, buy a highly regulated private market policy, or self-insure. Paid medical leave is funded through shared employee-employer payroll contributions, where employers are permitted to charge workers for a portion of their premiums for coverage and then are required to cover the remaining share. Workers pay the full premium amount for paid family leave, and these payroll contributions are community rated. Workers are currently entitled to up to 26 weeks of paid medical leave and up to 10 weeks of family leave, which will increase to 12 weeks by 2021 (limited to a total of 26 weeks of paid family and/or medical leave in a 52-week period).⁷⁶

Hawaii has an employer mandate that entitles workers to up to 26 weeks of paid medical leave. Employers are permitted

⁷² State of California, “About Disability Insurance (DI),” Sacramento, CA: State of California Employment Development Department, 2019, https://www.edd.ca.gov/Disability/About_DI.htm.

⁷³ Ibid.

⁷⁴ State of New Jersey, “Temporary Disability Insurance,” 2019, <https://nj.gov/labor/tdi/tdihome.html>; State of New Jersey, “Family Leave Insurance,” 2019, <https://myleavebenefits.nj.gov/labor/myleavebenefits/worker/fli/index.shtml>.

⁷⁵ State of Rhode Island, “Temporary Disability Insurance/Temporary Caregiver Insurance,” Rhode Island Department of Labor and Training, 2019, <http://www.dlt.ri.gov/tdi/tdifaqs.htm>.

⁷⁶ State of New York, S. 6406C, Part SS, 239th Legislature, Reg. Sess., 2016.



to charge workers for a portion of their premiums for coverage.⁷⁷ Employers can choose a private insurance company to provide the benefits or can self-insure. The state has no provision for paid family leave.⁷⁸

Puerto Rico's longstanding TDI program, which follows a social insurance model, offers up to 26 weeks of paid medical leave. Employers and employees share the cost of the payroll tax, but, with state Department of Labor approval, employers can purchase private short-term disability insurance in lieu of participating in

the state program. Under a 1942 law, employers in Puerto Rico are required to provide up to 8 weeks of leave at full pay to mothers after the birth or adoption of a child.⁷⁹

The **District of Columbia** enacted a paid family and medical leave social insurance program as one integrated program in 2017, to become fully effective in July 2020. The system will be funded through an employer payroll tax and is designed as an exclusive state fund. Workers are eligible for up to 2 weeks of paid medical leave, 8 weeks of paid parental leave, and 6 weeks of

⁷⁷ State of Hawaii: Disability Compensation Division, "About Temporary Disability Insurance," 2019, <http://labor.hawaii.gov/dcd/home/about-tdi/>.

⁷⁸ In 2017, Hawaii adopted the "Kūpuna Caregivers Program," which helps workers remain in the workforce while they care for an aging family member. Caregivers can receive financial assistance to cover some of the costs, up to a daily maximum, of professional services and supports required by the care recipient (e.g., adult day care, transportation, respite care, etc.). This program will be discussed further in Chapter 3: Long-Term Services and Supports. While the Kūpuna Caregivers Program provides financial assistance and relief to workers caring for an aging family member, it is not a paid family leave program, because benefits may be remitted only to a qualified service provider—not directly to working family caregivers.[For more information, see: <http://www.care4kupuna.com/>.]

⁷⁹ Society for Human Resource Management, "An Overview of Puerto Rico Employment Law," 2018, <https://www.shrm.org/resourcesandtools/legal-and-compliance/state-and-local-updates/pages/overview-puerto-rico-law.aspx>.

paid family caregiving leave (limited to 8 weeks of paid family and/or medical leave total in any 52-week period).⁸⁰

Washington State adopted a combined paid family and medical leave program in 2017. This social insurance program, funded by a payroll tax on employers and employees, will take full effect in 2020. Employers have limited opportunities to choose private coverage. Workers are eligible for up to 12 weeks of paid medical leave (14 weeks in the case of serious pregnancy-related complications) and up to 12 weeks of paid family leave (limited to 16 weeks of paid family and/or medical leave total in any given year, or 18 weeks in the case of serious pregnancy complications).⁸¹

Massachusetts chose a social insurance model for its combined paid family and medical leave program, though employers may self-insure or provide coverage through a private carrier if they meet or exceed the benefits provided under the state program. Enacted in 2018, and scheduled to become fully effective in 2021, the program will be funded through a payroll tax on employees. Employers are permitted to deduct from wages up to 100 percent of paid family leave contributions and up to 40 percent of paid medical leave contributions. Workers can take as many as 12 weeks of paid family leave, 20 weeks of paid medical leave, and 26 weeks of leave to provide care for a family member experiencing a serious injury or illness arising from service in the military (limited to 26 weeks total leave per year).⁸²

Connecticut adopted a combined paid family and medical leave program in 2019. The social insurance program, funded by a payroll tax on employees, will take full effect in 2022. Employers may apply to self-insure if they exceed the state program's generosity and meet strict requirements surrounding employee rights and protections. Workers are eligible for up to 12 weeks of paid medical leave (14 weeks in the event of serious pregnancy complications) and up to 12 weeks of paid family leave (limited to 12 weeks total, or 14 weeks for serious pregnancy complications, in a 12-month period).⁸³

The city of **San Francisco** adopted a Paid Parental Leave Ordinance (PPLO) in 2016, which since 2018 has required employers with 20 or more employees to provide supplemental compensation to workers who are receiving benefits for bonding with a new child via California's Paid Family Leave (PFL) program.⁸⁴ Under the ordinance, many workers in San Francisco receive 100 percent of their usual wages; the ordinance requires employers to pay the difference between the California PFL benefit amount (currently between 60 percent and 70 percent of a worker's usual wages, up to a cap of \$1252/week in 2019) and the employee's typical full weekly wages (capped at the ordinance's weekly maximum benefit level, which is \$2087/week in 2019), for up to the full 6 weeks of leave to which new parents are entitled in the state.⁸⁵

⁸⁰ District of Columbia, D.C. Law 21-264, "Universal Paid Leave Amendment Act of 2016."

⁸¹ State of Washington, Senate Bill 5975, 65th Leg., 3rd Special Sess., 2017.

⁸² Commonwealth of Massachusetts, House 4640 §29, 190th Gen. Court, Reg. Sess., 2018.

⁸³ State of Connecticut, Senate Bill 0001, "An Act Concerning Paid Family and Medical Leave," 2019, <https://www.cga.ct.gov/2019/amd/S/pdf/2019SB-00001-R00SA-AMD.pdf>.

⁸⁴ San Francisco Paid Sick Leave Ordinance, Administrative Code Chapter 12W.8(a), 2018, <https://sfgov.org/olse/paid-parental-leave-ordinance>

⁸⁵ Office of Labor Standards Enforcement, City and County of San Francisco, "Paid Parental Leave Ordinance," 2018, <https://sfgov.org/olse/paid-parental-leave-ordinance>.

Early Lessons from State Paid Family and Medical Leave Programs

Because jurisdictions have adopted a range of different design elements in their paid leave programs, they serve as laboratories for others considering the adoption of paid leave. New programs can benefit from some of the lessons learned in existing programs—namely, that to make take-up feasible for all workers, particularly those from low-income and disadvantaged backgrounds, programs need to offer higher and more progressive wage replacement and make significant investments in education and outreach.

California: At the program's original wage replacement rate of 55 percent, many workers could not afford to take leave. In 2013, fewer than 4 percent of PFL claimants earned less than \$12,000 per year, while nearly 21 percent of claimants earned over \$84,000 per year.⁸⁶ In response to concerns about benefit inadequacy, the state raised its wage replacement rate in 2016 to between 60 and 70 percent of earnings, with lower-earning employees receiving a higher percentage of their typical wages.⁸⁷

New Jersey: Early research on New Jersey's PFL program suggested that the state has struggled with education and public promotion, at least in part due to a lack of funding for and investment in outreach about the program, which has led to disparities in knowledge of the PFL program's existence. After three years of implementation, over 60 percent of surveyed individuals said they had never heard of the program. Knowledge of the program was particularly low among residents who are young (aged 18-29), Black, and lower-income.⁸⁸ In 2017, the state rolled out new computer systems and outreach information for employees and employers. In 2019, the state enacted updates to its program to enhance accessibility for lower-wage workers and better meet the needs of all workers: namely, the wage replacement rate for lower-income workers will increase to 85 percent, job protection will be expanded to workers in smaller businesses, and the duration of family leave will increase to 12 weeks. The law also allocated \$1.2 million for an education and outreach campaign, at least half of which must go to community-based organizations.⁸⁹

⁸⁶ Brie Lindsey and Daphne Hunt, "California's Paid Family Leave Program. Ten Years After the Program's Implementation, Who Has Benefited and What Has Been Learned?," The California Senate Office of Research, 2014, <https://sor.senate.ca.gov/sites/sor.senate.ca.gov/files/Californias%20Paid%20Family%20Leave%20Program.pdf>.

⁸⁷ California Assembly Bill 908, 2016. For more information, see: <https://www.sequoia.com/2017/09/california-state-disability-paid-family-leave-program-benefits-increase-2018/>.

⁸⁸ Linda Houser and Karen White, "Awareness of New Jersey's Family Leave Insurance Program Is Low, Even as Public Support Remains High and Need Persists," Rutgers Center for Women and Work: Issue Brief, 2012, http://njtimetocare.com/sites/default/files/03_New%20Jersey%20Family%20Leave%20Insurance-%20A%20CWW%20Issue%20Brief.pdf.

⁸⁹ State of New Jersey, Senate No. 2528, 218th Legislature, 2019, <https://legiscan.com/NJ/text/S2528/id/1794451>.



Rhode Island: Rhode Island made a concerted effort to streamline its application process. In a survey of beneficiaries, over two-thirds of applicants reported being satisfied or very satisfied with the application process, and over half received their first benefit check

within two weeks of applying.⁹⁰ Much like in New Jersey, Rhode Island reported that knowledge of the program was much lower among those with lower income and education and non-White populations, as well as among older workers and those who work for smaller employers.⁹¹

⁹⁰ Barbara E Silver, Helen Mederer, and Emilija Djurdjevic, “Launching the Rhode Island Temporary Caregiver Insurance Program (TCI): Employee Experiences One Year Later,” University of Rhode Island, 2016, https://www.dol.gov/wb/media/RI_paid_leave_report.pdf.

⁹¹ Ibid.

Section III.

**POLICY OPTIONS
FOR STATE PAID
FAMILY AND
MEDICAL LEAVE
PROGRAMS**



States seeking to establish a program for paid family and medical leave may choose from three principal design options: a universal, contributory social insurance program; a hybrid social insurance program with regulated private options; and an employer mandate. What follows is a description of each design, noting which states have adopted it and why, and summarizing their experiences to date. Funding options and their suitability for each design choice are explained thereafter. The discussion of each design option concludes with an analysis of its implications for fiscal sustainability, program stability, political feasibility, administrative simplicity, and effects on workers and employers.

Option 1. Universal, contributory social insurance program, exclusive state fund

A universal, contributory model is a classic social insurance program design. Other programs at the national level (e.g., Social Security) that have used this model for decades offer valuable experience. It is also the prevailing design choice among the vast majority of paid leave programs in industrialized nations across the world.⁹² With this policy option, workers contribute to an exclusive state social insurance fund throughout their careers in return for an earned benefit should the need arise. Social Security and Unemployment Insurance operate in similar fashion, and Rhode Island and the District of Columbia (effective 2020) use an exclusive state fund approach for their PFML programs.

Universal, contributory social insurance is the prevailing design choice for paid leave programs across the world.

Financing: Social insurance programs are traditionally financed through payroll contributions paid by workers and/or their employers. However, payroll contributions could be supplemented with general revenues or an earmarked tax, particularly for expenses such as administrative costs; infrastructure and technological startup, maintenance, and improvement; and program evaluation.

⁹² Laura Addati, Naomi Cassirer, and Katherine Gilchrist, *Maternity and Paternity at Work: Law and Practice Across the World*, (Geneva, Switzerland: International Labour Organization, 2014), http://www.ilo.org/global/publications/ilo-bookstore/order-online/books/WCMS_242615/lang--en/index.htm.

Policy Assessment: Option 1. Universal, contributory social insurance program, exclusive state fund

Fiscal sustainability: Using dedicated payroll taxes to fund a program makes it highly sustainable from a fiscal standpoint, as the funding stream is likely to be relatively consistent from year to year. As benefit amounts fluctuate over time, due to inflation or other causes, states may need periodically to adjust their tax rates and/or the wage base subject to taxation. Social Security has made such adjustments many times during its eight-decade history.

Program stability: Like all insurance plans, a universal social insurance program is designed to provide stability by sharing costs and benefits as broadly as possible. A state's entire workforce comprises a large pool of funders and beneficiaries, thus reducing the likelihood of dramatic swings from year to year.

Political feasibility: The vast majority of states with programs in place have adopted a universal contributory social insurance model, as have the majority of parental leave programs in other countries with advanced economies.⁹³ This experience suggests that this model is very politically feasible.

Administrative simplicity: State and federal governments have decades of experience administering social insurance programs, including Social Security, Unemployment Insurance, and Medicare, among others. A new state paid leave program could readily draw upon the administrative processes and structures developed in those well-established programs, making program

management relatively straightforward. From an administrative standpoint, the simplest option would be an exclusive state fund. Allowing employers to opt out of the state fund by self-insuring or purchasing private coverage would increase complexity for state administrators, who then would be required to both manage the state fund and monitor compliance by employers who chose alternate coverage options. States may consider putting a surcharge on employers who opt for private coverage or self-insurance to compensate for the costs of the additional administrative burden associated with monitoring these programs.

Effect on workers: Although universal contributory paid leave social insurance programs reduce workers' take-home pay, these reductions are typically quite low. Additionally, workers who obtain paid leave from a state program (as opposed to a self-insured employer program) are typically spared the need to reveal highly personal details of their family or personal health circumstances to their employers.

Effect on employers: Most existing state paid leave programs are financed entirely by employee payroll taxes. In those states where employers share in the contributions, they typically pay very modest costs. State-managed programs may also save employers the time and money required to administer paid leave benefits themselves, which is particularly challenging for small businesses and the self-employed.

⁹³ Laura Addati, Naomi Cassirer, and Katherine Gilchrist, *Maternity and Paternity at Work: Law and Practice Across the World*, (Geneva, Switzerland: International Labour Organization, 2014), http://www.ilo.org/global/publications/ilo-bookstore/order-online/books/WCMS_242615/lang--en/index.htm.

Option 2. Contributory social insurance program with regulated private options

A contributory social insurance program with regulated private options requires employers to offer a certain level and type of coverage, and to comply with specified anti-discrimination and other consumer and employment law protections. In this model, state law would set a minimum required benefit level and a maximum permissible employee contribution, and would regulate both benefit provision and enforcement to ensure employees are receiving the insurance and employment protections the law requires. As long as the program meets these requirements, employers are free to choose how to provide coverage. They can purchase private insurance coverage, participate in the state social insurance fund, or self-insure. State Workers' Compensation programs frequently offer flexibility of this sort.⁹⁴

Two variants of this approach exist in the United States:

■ **State fund with limited private options:** **California, New Jersey, Washington** State (effective 2020), **Massachusetts** (effective 2021), and **Connecticut** (effective 2022) have adopted a *state fund with limited private options*. The vast majority of employers participate in the state fund. If employers meet certain regulatory

requirements, they are permitted to use self-insurance and/or a private plan to provide equal or greater benefits.

■ **Hybrid social insurance program with regulated private options:** The state of **New York** has adopted a *hybrid social insurance* model for its paid leave program.⁹⁵ Employers can choose between purchasing private insurance coverage, participating in the state social insurance fund, or self-insuring, as long as they offer the statutorily prescribed level and type of coverage and comply with anti-discrimination and other consumer protections.

Financing: As with a an exclusive state fund social insurance program, a contributory paid leave program with regulated private options could be funded in whole or in part by employee payroll contributions. Depending on the model selected by the employer, these funds would be channeled to the private plan provider, the state fund, or an employer-managed self-insurance pool. Employers could make their program more generous to workers by waiving some or all of the required employee contributions and/or offering benefits above and beyond the state-mandated levels.

⁹⁴ Christopher McLaren and David Maddy, "Workers' Compensation: Benefits, Coverage, and Costs: Sources, Methods, and State Summaries," Washington, DC: National Academy of Social Insurance, 2017, <https://www.nasi.org/research/2017/sources-methods-workers-compensation-2015-data>.

⁹⁵ Sarah Jane Glynn, Alexandra L. Bradley, and Benjamin W. Veghte, "Paid Family and Medical Leave Programs: State Pathways and Design Options," Washington, DC: National Academy of Social Insurance, 2017, <https://www.nasi.org/research/2017/paid-family-medical-leave-programs-state-pathways-design>.

Policy Assessment: Option 2. Contributory social insurance program with regulated private options

Fiscal sustainability: Like other programs that rely on payroll taxes for funding, this design option is likely to be quite sustainable from a fiscal standpoint. However, the flexibility inherent in this model presents more fiscal risk than the exclusive state fund model. For states with limited options for private coverage (versus the robust, highly regulated, competitive market in New York state), employers whose employees were disproportionately women of childbearing age and/or older workers—that is, who might be expected to avail themselves of paid leave benefits more than those from other demographics—might opt into the state fund for administrative or cost reasons. This in turn might require increasing the funding required for the state program relative to other program models, though such a model might decrease funding needs in other areas (e.g., claims processing and determination, since this is conducted to some degree by private carriers).

Program stability: For decades, many state Workers' Compensation programs have used a hybrid social insurance model. New York's long-standing TDI program and more recent PFL program likewise employ this design. These experiences suggest that a hybrid paid leave model might be similarly stable over time. Employers' ability to choose among different providers in states with more limited and less robustly regulated private options might lead to concentrations of certain employee groups in one program type, however, with the potential of destabilizing the overall program framework.

Political feasibility: State Workers' Compensation programs throughout the U.S. have used a hybrid design for many decades. As recently as 2018, New York adopted this model for its paid family leave program.

Increasing employer options while simultaneously ensuring workers' access to state-protected benefits would likely prove popular selling points and render the enactment of such a model politically feasible.

Administrative simplicity: Administering a contributory paid leave program with regulated private options would be complex for the state administrative agency and employers. A state agency would be required both to administer the state fund and to monitor compliance among the private plans and self-insured employers. Employers would be responsible for choosing among a plethora of available options, as they do currently with health insurance and other benefits.

Effect on workers: A contributory system with private options could very closely resemble an exclusive state fund program for workers, since contributions would be deducted from their pay as with any other standard employment benefit. Absent appropriate state regulation, workers might face discrimination based on their perceived level of "risk" to employers. To mitigate this hazard, states could require private plans to use community rating, where everyone contributes at the same rate or level, rather than experience rating, where rates are set based on the actual or perceived risk of an individual or group.

Effect on employers: Giving employers choice in how to provide paid leave for employees increases employers' flexibility, but also requires them to spend time and effort determining which type of plan best meets their needs. Small businesses in particular might find it challenging to research fully the available options.



Option 3. Employer mandate

An employer mandate model would simply impose a state-mandated requirement for employers to provide a meaningful number of weeks or months of paid leave coverage and benefits directly to their workers. Hawaii is the only state to adopt this option for its paid medical leave program; to date no state has enacted an employer mandate for paid family leave. Outside the United States, an employer mandate has been adopted principally by less affluent, emerging economies, often with limited enforcement.⁹⁶ As with the hybrid social insurance model, employers could elect to exceed the required coverage.

Funding: In this model, the employer typically funds benefits either by self-insuring or by purchasing a paid leave insurance policy. Depending on the language of the legal mandate, employees may be required to contribute as well. Any monitoring or enforcement of the mandate would require funding from general revenues or an earmarked tax on employers, employees, and/or some other broad-based source, such as a sales tax.

Hawaii requires employers to provide paid medical leave, but no state has an employer mandate for paid family leave.

⁹⁶ Laura Addati, Naomi Cassirer, and Katherine Gilchrist, *Maternity and Paternity at Work: Law and Practice Across the World*, (Geneva, Switzerland: International Labour Organization, 2014), http://www.ilo.org/global/publications/ilo-bookstore/order-online/books/WCMS_242615/lang--en/index.htm.

Policy Assessment: Option 3. Employer mandate

Fiscal sustainability: Predicting the employer mandate's fiscal sustainability is difficult. Any governmental monitoring and enforcement of the mandate would require funding from general revenues or an earmarked tax. Regardless of whether the employer chooses to self-insure or to purchase private insurance coverage, the availability of paid leave benefits depends heavily on each employer's long-term solvency. Because private insurance coverage would reduce administrative requirements for employers, and perhaps cost less as well, the sustainability of an employer mandate would depend on a strong private market for such coverage. An employer mandate may also impose disproportionate burdens on small businesses and employers whose labor force is heavily dependent on workers who are statistically more likely to use paid family and/or medical leave.

Program stability: It is difficult to assess the stability of an employer mandate model for paid leave. Any state that enacted such a policy would need to monitor employer compliance with the policy as well as whether or not the appropriate receipt of benefits was achieved in order to determine whether or not the program was stable.

Political feasibility: Because no state has adopted an employer mandate for paid family and medical leave, the political feasibility of enacting such a model is uncertain.

Presumably, some employers would prefer to control every aspect of the paid leave policy applicable to their employees. Other businesses might wish to outsource all or part of the administrative burden to a governmental or private agency. Concentrating full control of paid leave in the employer's hands might deter some workers from using the benefits out of concern for privacy and/or discrimination.

Administrative simplicity: An employer mandate standing alone would require little or no governmental administration. But absent some monitoring mechanism, employers could simply ignore the mandate. In order to ensure that employees have access to the leave the mandate requires, some government administrative effort would be necessary. In addition, employers would bear significant administrative responsibility for making eligibility determinations, maintaining records, and demonstrating compliance with the law.

Effect on workers: Requiring employers to shoulder the costs of providing paid family and medical leave brings unique policy challenges for workers and, in some cases, unintended consequences. International research has suggested that employer mandates for paid parental leave may lead to employment discrimination against women, though employee contributions to financing coverage may temper that effect.⁹⁷ If employers are funding the entirety of paid

⁹⁷ Laura Addati, Naomi Cassirer, and Katherine Gilchrist, *Maternity and Paternity at Work: Law and Practice Across the World*, (Geneva, Switzerland: International Labour Organization, 2014), http://www.ilo.org/global/publications/ilo-bookstore/orderonline/books/WCMS_242615/lang--en/index.htm.

leave for their workers, it may be appropriate that workers serve longer in their jobs before becoming eligible for benefits. Such requirements might force employees who anticipate a need to use paid leave to remain in jobs longer than is optimal. Conversely, workers perceived as “high risk” for requiring paid leave (e.g., women of childbearing age, individuals with disabilities, older workers) might confront discrimination in hiring, wages, or working conditions from employers seeking to minimize their paid leave costs. An employer mandate model would also make it all but impossible for self-employed workers to participate in the program, leaving out a substantial portion of the workforce, and would raise questions regarding whether

and how other nonstandard workers (e.g., temporary workers) would be covered.

Effect on employers: An employer mandate imposes higher and less predictable costs on employers than does a social insurance. Accordingly, employers might choose to avoid opening or expanding operations in a state with such a mandate. These considerations might be particularly salient for small businesses and/or for firms in industries that rely heavily on workers who are or are perceived to be more likely to use paid leave. To the extent that such perceptions are accurate, the impact of an employer mandate might be to deny benefits to the very workers who need them most.



Section IV.

KEY POLICY DESIGN ELEMENTS AND CONSIDERATIONS

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Choosing a paid leave model is only the first step for states seeking to adopt such a policy. Thereafter, policymakers must determine other important features, including eligibility requirements, qualifying events (circumstances that trigger worker eligibility for paid leave), the definition of family, benefit design, and job protection.

Eligibility Requirements

What work history and/or earnings levels are prerequisites for worker eligibility?

Requiring lengthy job tenure and/or high wage levels reduces access to paid leave, particularly for younger and lower-income workers, who often have shorter and more

Requiring lengthy job tenure and/or high wage levels reduces access to paid leave for younger and lower-income workers.

fragmented work histories. For example, under the FMLA, only employees who have worked for their current employer for at least 1,250 hours in the last 12 months are eligible for leave. As a result, the policy covers only about 60 percent of U.S. workers.⁹⁸ By contrast, in California, where workers are eligible for coverage if they earned at least

⁹⁸ Jacob Alex Klerman, Kelly Daley, and Alyssa Pozniak, "Family and Medical Leave in 2012: Technical Report," Cambridge, MA: Abt Associates, 2012, <http://www.dol.gov/asp/evaluation/fmla/FMLA-2012-Technical-Report.pdf>.

\$300 during the base period, nearly all private sector workers are covered.⁹⁹

To determine eligibility, states typically designate a base period of employment, and then require workers to demonstrate a certain number of hours worked and/or wages earned during that period. Predicating eligibility on continuous tenure with a single employer may lead workers to remain in suboptimal jobs solely in order to ensure access to paid leave. This so-called “job lock” may result in workers clinging to lower-wage positions, perhaps with poor or even hazardous working conditions, that may not draw upon all their skills—with predictable negative consequences for individuals, employers, and the economy as a whole. By contrast, basing eligibility on a minimum earnings level could extend benefits to workers with sporadic employment histories—including self-employed, part-time, temporary, seasonal, and “gig economy” workers—as long as the earnings threshold is not set at too high a dollar amount. The vast majority of existing state policies have made their paid leave benefits portable by allowing workers to combine earnings and/or job tenure periods across multiple places of employment in order to meet the eligibility criteria.¹⁰⁰ Linking eligibility to earnings may also be easier to administer, as states typically already have mechanisms in place to track earnings but not hours worked.

Is eligibility based on where you work or where you live? To date, state paid leave laws have tied eligibility to the location of the individual’s job, rather than residence. The reasons for this choice include:

- Making paid leave consistent with other employment-related social insurance programs, such as Workers’ Compensation, and preventing conflicting eligibility issues across state lines
- Ensuring that, even if they live in different states, employees who work for the same employer have access to the same benefits
- In employer contribution models, reducing employers’ reporting and payroll deduction complexities, as well as avoiding the need for state administrators to locate and collect contributions from out-of-state employers that employ state residents
- Potentially helping to attract new talent to in-state employers

Alternatively, basing eligibility on a worker’s state of residence might advance other policy priorities, including:

- Facilitating access to benefits for self-employed workers, who may have no formal workplace
- Potentially attracting new residents to the state

⁹⁹ Authors’ calculations based on 2016 data estimating 17.9 million workers covered under the California State Disability Insurance law and total employment in that year of 18.1 million workers. [See: Employment Development Department, State of California, “State Disability Insurance Program: Fact Sheet,” 2016, http://www.edd.ca.gov/pdf_pub_ctr/de8714c.pdf; Employment Development Department, State of California, “Labor Market Information: Historical Labor Force Data: Employment – 2016,” accessed June 13, 2018, <http://www.labormarketinfo.edd.ca.gov/cgi/dataanalysis/areaselection.asp?tablename=labforce>.]

¹⁰⁰ For a more comprehensive discussion of this topic, see: Molly Weston Williams, Sherry Leiwant, and Julie Kashen, “Paid Family and Medical Leave & Nonstandard Employees,” *Constructing 21st Century Rights for a Changing Workforce: A Policy Brief Series: Brief 2*, New York: A Better Balance, 2019, <https://www.abetterbalance.org/resources/report-constructing-21st-century-rights-for-a-changing-workforce-a-policy-brief-series-brief-2/>.



Qualifying Events

When may a worker take paid leave? Most paid leave programs in the United States permit workers to use leave for some or all of the following:

- The birth, adoption, or foster placement of a child
- Providing care for a family member or loved one in the event of a serious health-related need, including one related to a physical or mental illness, injury, disability, or medical condition, or a safety concern such as domestic violence, sexual assault or abuse, and/or stalking
- Receiving care for an employee's own serious health-related needs—including

those related to a physical or mental illness, injury, disability, or medical condition—or to access services and supports related to domestic violence, sexual assault or abuse, and/or stalking

- Deployment or notification of impending deployment of a close family member on active military service

Definition of Family

Who is considered a qualifying family member for the purpose of taking leave? States define the term “family member” differently under their paid family leave policies. To date, these definitions typically include some or all of the following relationships: spouse, child, parent, domestic

partner, grandparent, grandchild, or sibling.¹⁰¹ A state might define the term more broadly to include any person, regardless of biological or legal ties, with whom the employee had a significant personal bond akin to that traditionally associated with a family relationship, as is the case in New Jersey's recent amendment to its PFL law and Connecticut's recently passed PFML law.¹⁰² This expanded definition would benefit workers whose primary relationships are with "chosen family," which is especially common among people with disabilities and the LGBTQ+ community.¹⁰³ As household composition in the United States becomes more diverse, broadening the definition of family member could help ensure access to paid leave benefits for those who need it most.

Expanding the definition of family would benefit people with disabilities and the LGBTQ+ community.

Benefit Design

Duration: How much time can a worker take off to provide or receive care? Different jurisdictions have adopted a wide range of leave duration periods. At the national level,

the FMLA offers workers up to 12 weeks of unpaid leave for all purposes that qualify under the statute. By contrast, many states provide different periods of leave for each qualifying event. The duration of paid medical leave ranges from 2 weeks in the District of Columbia (effective in 2020) to 52 weeks in California. For paid family leave, workers may take 4 weeks in Rhode Island but 12 weeks in New York (as of 2021), Washington (as of 2020), Massachusetts (as of 2021), and Connecticut (effective 2022) (see Figures 3 and 4).¹⁰⁴ International policies typically offer longer leave periods, particularly for new parents: many countries provide 6, 12, or even 18 months of paid leave to workers upon the birth or adoption of a child.¹⁰⁵

To date, every state paid family leave program permits workers to take leave intermittently, as the need arises. Some states require workers to take leave in 8-hour increments, while others do not specify any minimum leave duration. This flexibility is not necessarily applicable, however, to the paid medical leave programs in those same states, which often are subject to much more restrictive criteria, including waiting periods in some cases.

Policymakers face many—sometimes competing—considerations when determining the duration of paid leave benefits. Research

¹⁰¹ National Partnership for Women and Families, "State Paid Family and Medical Leave Insurance Laws: February 2018," 2018, <http://www.nationalpartnership.org/research-library/work-family/paid-leave/state-paid-family-leave-laws.pdf>

¹⁰² A Better Balance, "Overview of Paid Family & Medical Leave Laws in the United States," 2019, <https://www.abetterbalance.org/resources/paid-family-leave-laws-chart/>.

¹⁰³ Katherine Gallagher Robbins, Laura E. Durso, Frank J. Bewkes, and Eliza Schultz, "People Need Paid Leave Policies That Cover Chosen Family," Center for American Progress, 2017, <https://cdn.americanprogress.org/content/uploads/2017/10/26135206/UnmetCaregivingNeed-brief.pdf>.

¹⁰⁴ Sarah Jane Glynn, Alexandra L. Bradley, and Benjamin W. Veghte, "Paid Family and Medical Leave Programs: State Pathways and Design Options," Washington, DC: National Academy of Social Insurance, 2017, <https://www.nasi.org/research/2017/paid-family-medical-leave-programs-state-pathways-design>.

¹⁰⁵ Gretchen Livingston, "Among 41 Nations, U.S. Is the Outlier When It Comes to Paid Parental Leave," Pew Research Center, 2016, <http://www.pewresearch.org/fact-tank/2016/09/26/u-s-lacks-mandated-paid-parental-leave/>.

offers some guidance regarding the health and employment effects of varying leave durations, especially for maternity leave. Medical evidence suggests that at least 4 to 6 weeks to recover physically from vaginal childbirth, and up to 8 weeks is required for cesarean deliveries.¹⁰⁶ Other studies reveal that new mothers experience an increase in depressive symptoms and lower overall health status when they take fewer than 8 weeks of leave.¹⁰⁷ Some studies have concluded that maternal return to work before 12 weeks after giving birth has a negative effect on breastfeeding, timely

immunizations, child behavioral outcomes,¹⁰⁸ and infant mortality.¹⁰⁹ Additionally, the American Academy of Pediatrics,¹¹⁰ the World Health Organization,¹¹¹ and other public health organizations recommend that infants be breastfed exclusively for the first six months of life. Achieving that goal can be challenging when mothers are back at work. Women's wages may also be affected by maternity leave. While moderate leave periods have a neutral or positive effect on women's earnings, maternity leave in excess of six months seems to have a negative impact on maternal wages.¹¹²

¹⁰⁶ Amy Raub et al., "Paid Parental Leave: A Detailed Look at Approaches Across OECD Countries," WORLD Policy Analysis Center, 2018, https://www.worldpolicycenter.org/sites/default/files/WORLD%20Report%20-%20Parental%20Leave%20OECD%20Country%20Approaches_0.pdf.

¹⁰⁷ P. Chatterji and S. Markowitz, "Family Leave After Childbirth and the Mental Health of New Mothers," *The Journal of Mental Health Policy and Economics*, vol. 15, 2012, <https://www.ncbi.nlm.nih.gov/pubmed/22813939>.

¹⁰⁸ Lawrence M. Berger, Jennifer Hill, and Jane Waldfogel, "Maternity Leave, Early Maternal Employment and Child Health and Development in the US," *The Economic Journal*, vol. 115, no. 501, 2005, <https://www.jstor.org/stable/3590462>.

¹⁰⁹ Maya Rossin, "The Effects of Maternity Leave on Children's Birth and Infant Health Outcomes in the United States," *Journal of Health Economics*, vol. 30, no. 2, 2011, <https://www.ncbi.nlm.nih.gov/pubmed/21300415>.

¹¹⁰ American Academy of Pediatrics, "AAP Reaffirms Breastfeeding Guidelines," 2012, <https://www.aap.org/en-us/about-the-aap/aap-press-room/pages/aap-reaffirms-breastfeeding-guidelines.aspx>.

¹¹¹ World Health Organization, "Exclusive Breastfeeding for Six Months Best for Babies Everywhere," 2011, http://www.who.int/mediacentre/news/statements/2011/breastfeeding_20110115/en/.

¹¹² Christopher J. Ruhm, "The Economic Consequences of Parental Leave Mandates: Lessons from Europe," *The Quarterly Journal of Economics*, vol. 113, no. 1, 1998.



Wage Replacement Rate: The wage replacement rate is the percentage of a worker's wages paid out as benefits. Some countries' programs provide workers their full standard pay for the entirety of their leave. State programs in the U.S. require only that workers receive part of their typical wages while on leave.

The appropriate duration of medical leave is often more variable and less robustly researched, regardless of whether the health condition needing treatment is the worker's own or a family member's. Medical events such as a heart attack can often require a minimum of four weeks of recovery time, while severe illnesses such as cancer can require up to six months of treatment, depending on the severity of the individual case and the physical demands of the employee's job.¹¹³ Additionally, regardless of the amount of leave permitted by law, medical providers typically determine what is considered the "medically appropriate" duration of leave for a worker's or family member's medical needs, which can mean that workers will experience limits on the duration of leave for which they are eligible depending on their relevant medical condition. An employee may or may not be capable of returning to work, performing so-called "light duty" tasks, and/or working part-time while receiving treatment for a severe medical condition. States might address this complex set of considerations by offering a range of leave periods for different circumstances.

Wage replacement: How much compensation will workers receive while on leave? When deciding how much to pay workers while they

are on leave, states typically consider two important factors. First, states choose whether to set a single wage replacement rate for all workers regardless of income, or to replace a higher share of wages for lower earners. Second, states determine the level at which to cap weekly benefits. A state might choose to support longer leaves for certain qualifying events (e.g., a serious personal medical need) by varying the wage replacement rate over time. For example, a worker might receive a high wage replacement rate in the early weeks of leave, followed by a lower rate after a certain point. Some private insurance plans follow this "stepwise" model. A new paid leave program should also specify whether paid leave benefits constitute taxable income under state law, as well as whether benefits are counted when determining eligibility for means-tested benefits (e.g., WIC, SNAP).

Setting an appropriate wage replacement rate is essential to ensure that workers at all income levels can afford to take paid leave. The first state paid leave programs established flat wage replacement rates, ranging from 55 to 67 percent of earnings (CA, NJ, RI). In practice, these programs showed that many low-wage workers could not afford the income reduction and thus did not use paid leave (see text box on

¹¹³ WORLD Policy Analysis Center, "A Review of the Evidence on the Length of Paid Family and Medical Leave. Policy Brief," 2018, <https://www.worldpolicycenter.org/sites/default/files/WORLD%20Brief%20-%20Length%20Paid%20Family%20and%20Medical%20Leave.pdf>.



p.106, *Early Lessons from State Paid Family and Medical Leave Programs*).

In spite of concerns that higher benefit levels might disincentivize return to work, particularly for new mothers, a recent study of California's administrative data found that there was no adverse effect of higher benefits on women's labor market outcomes. In fact, research has shown that there was a small positive effect on the labor force attachment of new mothers over the two years immediately following the period of paid leave.¹¹⁴

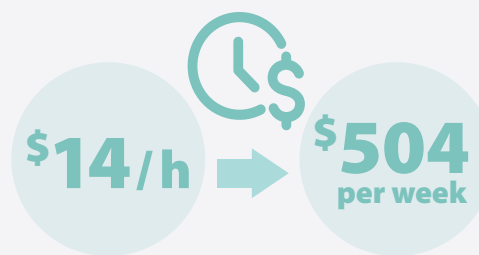
More recent paid leave programs (DC, WA, MA, CT) have adopted a graduated wage replacement approach. These four states will provide a

higher wage replacement rate up to a certain percentage of the state's average weekly wage (AWW) or the minimum wage, and a lower rate of wage replacement for all earnings above that amount, up to a weekly benefit cap. For example, workers in the District of Columbia with weekly earnings below 150 percent of the minimum wage will receive 90 percent of their AWW. Any earnings above 150 percent of the District's minimum wage will be replaced at a rate of 50 percent of the worker's AWW, with a weekly benefit cap of \$1,000.¹¹⁵ As of 2018, California adopted a graduated wage replacement rate: the lowest-income workers receive a higher proportion of their income (70 percent) than the highest earners (60 percent).

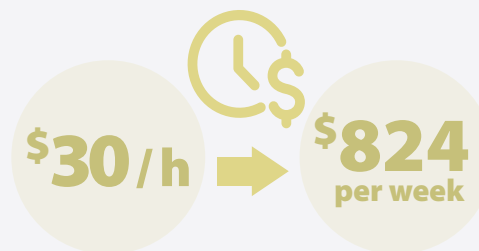
¹¹⁴ Sarah Bana, Kelly Bedard, and Maya Rossin-Slater, "The Impacts of Paid Family Leave Benefits: Regression Kink Evidence from California Administrative Data," IZA Discussion Paper No. 11381, IZA Institute of Labor Economics, 2018.

¹¹⁵ Sarah Jane Glynn, Alexandra L. Bradley, and Benjamin W. Veghte, "Paid Family and Medical Leave Programs: State Pathways and Design Options," Washington, DC: National Academy of Social Insurance, 2017, <https://www.nasi.org/research/2017/paid-family-medical-leave-programs-state-pathways-design>.

For a full-time worker earning **\$14/hour** in the District of Columbia, average weekly wages are \$560. During a PFML claim period, **that worker would earn \$504 per week in benefits.**



For a full-time worker earning **\$30/hour** in the District of Columbia, average weekly wages are \$1,200. During a PFML claim period, **that worker would earn \$824 per week in benefits.**¹¹⁶



Workers employed at companies that voluntarily offer paid family and/or medical leave benefits can often receive full (100 percent) wage replacement for the duration of their leave. However, access to voluntary employer-provided benefits is highly concentrated among workers near the top of the income spectrum. A state might consider adopting full wage replacement for all workers, but the cost of any such program, along with concerns about misuse or fraud, might render that option politically unfeasible.

States could consider making paid leave more widely accessible by providing some form of monetary bonus to families with particularly high levels of need. A dependency allowance, for example, could boost the compensation of

workers who need to take time off due to illness but also have dependents in the home.¹¹⁷

Some countries pay all workers, regardless of income, a flat rate for paid leave. To date no state has adopted this approach. In order to enact such a program, policymakers would need carefully to calibrate the benefit amount to ensure it could support workers and their families during difficult circumstances. Periodic cost-of-living adjustments would likely be required.

Job Protection

Is the worker's job guaranteed after they return from paid leave? Job protection is a key issue for policymakers considering any type of paid

¹¹⁶ Authors' calculations. The DC minimum wage will increase to \$14/hour effective July 1, 2019. The calculations for this example are determined based on this imminent minimum wage adjustment.

¹¹⁷ For example, Rhode Island's dependency allowance for temporary disability leave offers the greater of either \$10 per week or an additional 7 percent of weekly benefits for up to five dependents, who are defined as children under the age of 18 or adult children with disabilities who are incapable of independently earning wages. [Rhode Island Department of Labor and Training, "Common TDI References and Terms," <http://www.dlt.ri.gov/tdi/commonref.htm#7>.]



leave program. Guaranteeing workers the right to return to their positions after taking leave is particularly important for low-income families, who often may not have the financial reserves to adequately weather a family member's job loss. By definition, paid leave is designed to fill a temporary gap in employment, not compensate for a permanent job loss. The federal FMLA provides job-protected leave, but, as discussed earlier, roughly 40 percent of the workforce is ineligible for FMLA benefits. Several states have passed laws designed to expand access to job protection coverage for workers taking family or medical leave.¹¹⁸ Some states have separate laws that expand job protection beyond FMLA qualifications (e.g., NJ, DC), while others have incorporated job protection into their paid leave laws (NY and RI for PFL only, MA and CT for both

PFML and PFL). Tying job protection to a state's paid leave law can help to prevent gaps in coverage between who is covered for paid leave benefits and who is eligible for job protection. Policymakers in states without this expanded FMLA coverage should consider including job protection directly in any new paid leave program.

Providing job-protected leave is particularly important for low-income families.

¹¹⁸ National Partnership for Women and Families, "State Paid Family and Medical Leave Insurance Laws: February 2019," 2019, <http://www.nationalpartnership.org/research-library/work-family/paid-leave/state-paid-family-leave-laws.pdf>.

Section V.

INTEGRATION AND IMPLEMENTATION CONSIDERATIONS

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Once a state has selected and refined the design of a new paid leave program, policymakers will face a number of issues surrounding the program's execution. These include matters of program administration, education and outreach, evaluation, integration with other state policy mechanisms, and coordination with existing employee benefit plans, among others.

Program Administration

Like every state program, a new paid leave plan will require management. An effective paid leave administration must perform at least three key functions: (1) determining eligibility, which requires finding that the worker or the worker's covered family member or loved one has experienced a qualifying event, and ensuring that the worker meets any work history and/or earnings requirements; (2) calculating the duration of leave and amount of compensation to which the

employee is entitled; and (3) giving the worker an opportunity to appeal the denial of a claim or the amount of weekly benefits. If a state permits employers to self-insure and/or purchase private market coverage, administering the program must also include monitoring and enforcing compliance with regulations governing those options. States will need to guard against hiring discrimination and/or wrongful claim denial, particularly when an employer self-insures, against workers who may be perceived as more likely to use paid leave and thus be burdensome and costly (e.g., younger women, people with disabilities, older adults).

State PFML programs should guard against hiring discrimination and/or wrongful claim denial.

Program funding must cover the costs of program start-up, maintenance, and development. While it will always be necessary (and important) to build up sufficient staff and infrastructural capacity to address the various responsibilities that come with managing a new program, it can be especially efficient and cost-effective to build upon existing processes, procedures, and resources, rather than to start from scratch. States with existing paid leave policies have located their program administration either in the state's employment/labor agency—where the state's Unemployment Insurance program is housed—or in the state's Workers' Compensation administration. The former would be better suited to administer an exclusive state fund social insurance program, while the latter might work more effectively for a model with regulated private options, as these agencies frequently already monitor private carriers and/or self-insuring employers.

At present, the four states that have implemented paid family leave (California, New Jersey, Rhode Island, and New York) added those benefits to existing temporary disability insurance (TDI) programs; both sets of benefits are managed by the same government agency.¹¹⁹ Future states will have no existing TDI infrastructure upon which to build, and may elect to create an entirely new agency to administer paid leave. The four newest jurisdictions (DC, WA, MA, and CT) have all developed new administrative agencies to implement their programs. Regardless of the option chosen, however, states should capitalize on existing infrastructure, particularly when state agencies already collect a substantial portion of the data needed to manage a paid family and medical leave program. Wherever a state paid leave program is housed, collaboration will doubtless be required with the state's tax collection authority, among others.

¹¹⁹ Sarah Jane Glynn, Alexandra L. Bradley, and Benjamin W. Veghte, "Paid Family and Medical Leave Programs: State Pathways and Design Options," Washington, DC: National Academy of Social Insurance, 2017, <https://www.nasi.org/research/2017/paid-family-medical-leave-programs-state-pathways-design>.



Education and outreach

An effective paid leave policy requires significant education and outreach to workers and employers. Policymakers should include adequate funding for this function in the program's budget from the beginning. Absent a comprehensive effort, a state program could mirror the early experience of states such as California, where many employees—especially low-wage workers—were not aware that a paid leave program existed. Employers, too, must be educated about the program's existence, scope, and funding mechanisms, as well as any new reporting or administrative obligations.

To ensure that all affected parties are aware of the new program, a state might consider dedicating staff members or recruiting community volunteers to conduct outreach efforts, particularly in the months leading up to the program's full implementation. The state administrative agency could engage stakeholder groups and local government officials to determine the best avenues for widespread communication and education. In addition, the state should coordinate education on the paid leave program with enrollment in and access points to other social services and benefits (including federally qualifying health centers, Medicaid, WIC, SNAP, and TANF, among others) and state lawmakers should consider including

legislative language to ensure sufficient cooperation and coordination. Employers might also be encouraged to share educational materials directly with their employees through posters, digital messages, and other channels of communication.

Program evaluation

Ongoing assessment of the paid leave program is critical to its long-term success. Researchers from academic and other external institutions can often be a resource for this process, but the program's administration should provide data and other assistance as needed. Ideally, data should be collected before the program takes effect, in order to establish a baseline for comparison. Among other metrics, evaluators should assess labor force attachment, employee retention, child health and development outcomes, productivity and morale, impact on businesses, knowledge of the availability of the program, and patterns of leave-taking among different demographic groups (for example, by gender, race, socio-economic status, and type of job).¹²⁰

Interaction with employer plans

Although most workers in the United States have no access to paid leave of any type, certain employers do provide paid family leave and/or temporary disability benefits.

¹²⁰ For examples of state paid leave program evaluations, see: Charles L. Baum and Christopher J. Ruhm, "The Effects of Paid Family Leave in California on Labor Market Outcomes," *Journal of Policy Analysis and Management*, vol. 35, no. 2, 2016; Ruth Milkman and Eileen Appelbaum, *Unfinished Business: Paid Family Leave in California and the Future of U.S. Work-Family Policy*, (Ithaca, NY: ILR Press, 2013), <http://digitalcommons.ilr.cornell.edu/cgi/viewcontent.cgi?article=1090&context=books>; Ann Bartel, Maya Rossin-Slater, Christopher Ruhm, and Jane Waldfogel, "Assessing Rhode Island's Temporary Caregiver Insurance Act: Insights from a Survey of Employers," 2016, https://www.dol.gov/asp/evaluation/completed-studies/AssessingRhodeIslandTemporaryCaregiverInsuranceAct_InsightsFromSurveyOfEmployers.pdf; Nuno Mota, "Parental Leave Assistance and Long-Term Effects on Female Labor Supply," 2015, https://nabreufa.expressions.syr.edu/wp-content/uploads/2014/09/NM_Paid_Leave_01-26-15.pdf.

In these circumstances, the state program will need to coordinate carefully with the existing employer plans. In the case of a social insurance fund or state-run program, employers could be permitted to require their employees to exhaust leave provided under the state program before tapping into employer-provided benefits. State program administrators should ensure that employers retain the ability to provide benefits that are more generous than those available under the state plan if they so desire.

A state PFML program will need to coordinate carefully with existing employer plans.

Some states that elect to design their program as a social insurance or state-funded program may also consider permitting employers to opt out of the state-run program and instead choose to either self-insure or provide coverage available through the private market. There are a few factors to consider when determining whether or not to allow employers to opt out of the state program. First, in order to maintain equity in access to paid leave coverage, any law permitting private options should stipulate that employers must provide coverage equal to or greater than what is available through the state plan. Second, it is important that the law protects equal access to the program by stipulating that all employees eligible under

the state program would receive benefits under the employer-provided coverage. Many private employers do currently offer paid leave to some of their workers, but that coverage is often not equally available to all employees. While 28 percent of workers in the highest earnings quartile have access to paid family leave and 54 percent have access to temporary disability coverage, those numbers drop to 8 percent and 18 percent, respectively, for workers in the lowest earnings quartile.¹²¹ Finally, it is important that states that choose to allow employers to provide private coverage and/or to self-insure also provide coverage immediately for workers who change jobs, regardless of which method of coverage their new employer has chosen. States should also consider the increased administrative capacity that would be required to monitor and enforce compliance among employers who opt out of state coverage, in addition to the staff already necessary to run the state plan.

Coverage of self-employed workers

State paid leave programs may address self-employed workers in one of three ways: provide full, automatic coverage; permit workers to opt into the program; or exclude them from the program entirely. Several states (CA, NY, DC, WA, MA, CT) allow self-employed workers to opt into the program. While this policy decision advances individuals' freedom of choice, it also poses certain risks. First is the likelihood of selection bias. Because workers are more likely to opt into a program whose benefits they anticipate

¹²¹ Bureau of Labor Statistics, "Table 32. Leave Benefits: Access, Civilian Workers, March 2018," U.S. Department of Labor, 2019, <https://www.bls.gov/ncs/ebs/benefits/2018/ownership/civilian/table32a.htm>; Bureau of Labor Statistics, "Table 16. Insurance Benefits: Access, Participation, and Take-Up Rates, Civilian Workers, March 2018," U.S. Department of Labor, 2019, <https://www.bls.gov/ncs/ebs/benefits/2018/ownership/civilian/table16a.htm>.



needing—soon—the stability of the program’s funding may be jeopardized. Further, education and outreach efforts may be complicated by the need to ensure that self-employed workers understand the costs, benefits, and mechanisms to access paid leave benefits. A state might categorically exclude self-employed workers, which would reduce administrative complexity but also raise concerns about inequitable treatment of workers in similar situations.

To avoid these problems, a state could automatically cover all self-employed workers in the program. This policy choice would both reduce administrative complexity and increase equity across types of workers. For programs funded in part or

in whole by employer contributions, states would need to determine how to collect the employer-equivalent share of contributions for self-employed workers. In that case, states could potentially supplement the employer portion through general revenues or require employers to contribute a percentage of all payments made to independent contractors to the paid leave fund.¹²² Alternatively, self-employed workers could be required to pay both the employer and employee share of contributions, as is currently the case for Social Security. However, this model places a significant (and, for lower-income workers, unmanageable) financial burden on the self-employed and independent contractors.

¹²² Massachusetts’ program will require such payments, for example, but only for businesses where self-employed workers make up more than half of the workforce. Workers in these businesses will be covered automatically and be required to pay the employee contribution. [Molly Weston Williamson, Sherry Leiwant, and Julie Kashen, “Constructing 21st Century Rights for a Changing Workforce: A Policy Brief Series; Brief 1: Paid Family and Medical Leave & Self-Employment,” 2019, <https://www.abetterbalance.org/resources/report-constructing-21st-century-rights-for-a-changingworkforce-a-policy-brief-series/>.]

Section VI.

CONCLUSION



As human beings, workers inevitably will get sick and need time to recover. As family members, workers will have loved ones who need care. At some point, then, virtually every worker will need time away from work to provide or receive care. However, the United States stands virtually alone among nations across the world in failing to give workers the tools required to address these universal human needs. The Family and Medical Leave Act offers only unpaid leave and leaves roughly 40 percent of the workforce without access even to this inadequate benefit. In the absence of a federal program, states have begun to implement their own paid family and medical leave policies. To date, eight states plus the District of Columbia and Puerto Rico have adopted some form of paid family and/or medical leave legislation. Universal, contributory social insurance is

the prevailing design choice for state paid leave programs. Policymakers and advocates interested in developing new paid leave policies will benefit from the growing body of research into the experiences of these existing state-level—and international—programs.

This chapter examines several options for designing a paid leave program, and considers each model from the perspective of fiscal, administrative, and political sustainability, among other concerns. Policymakers seeking to provide paid leave benefits for their constituents will need to weigh all these considerations—and more. In the interim, however, the country continues to bear the burden of the cost of doing nothing. Workers, families, and employers—large and small—all are waiting for action.



Designing a State-Based Social Insurance Program for Long-Term Services and Supports

2019

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Preface

ABOUT THE CHAPTER

This chapter explores social insurance solutions to the growing challenge states face in meeting the long-term services and supports (LTSS) needs of their residents. There are other complementary or alternative approaches to enhancing access to LTSS, such as expanding Medicaid or improving the private insurance market, but this report focuses on social insurance strategies. It does not offer specific recommendations but instead identifies key design questions for states to consider in crafting a program, outlines a range of vetted approaches states could adopt, and describes the building blocks and tradeoffs associated with a wide variety of options. This analysis was developed during a year of deliberations by a Working Group of 16 experts in LTSS with a variety of perspectives. It is part of a larger Study Panel project on Universal Family Care. While addressed primarily to state policymakers, this report may also be of interest to providers, advocacy organizations, insurers, and administrators, as well as to any person interested in these issues.

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EXECUTIVE SUMMARY

Long-term services and supports (LTSS) needs are growing and for a variety of reasons families are becoming less able to meet them. One in two of those turning 65 today will need LTSS. Around 40 percent of those needing LTSS today are under 65; many will require lifelong services and supports. LTSS can be costly both for those needing care and for family caregivers. These costs often come at a time when individuals and their families are most vulnerable and in a context where they have had little opportunity to prefund or insure against such risks. Thus, the fundamental LTSS financing problem today is the absence of an effective insurance mechanism to protect people against these costs.

The majority of LTSS today is provided by family and friends, often to the detriment of their health and financial security. In the coming decades, most professional care will be paid for by families out of pocket. Most of the remainder of paid care will be covered by Medicaid, the primary public payer of LTSS. To qualify for Medicaid, however, a person must have low income and may not have assets above a certain level. Many middle-income people “spend down”—they use their assets to pay for care until they have very little left and qualify for Medicaid. Those who qualify for Medicaid (whether low- or middle-income) must contribute most of their income to their care costs, losing financial independence, and may be forced to enter a nursing home because they cannot access sufficient home- and community-based services or afford to remain at home.

States are grappling with the growing demand for LTSS as their Baby Boomers age. They already struggle to keep up with the growing need

in the context of budget constraints. Social insurance could provide universal, affordable LTSS coverage. Indeed, Washington State enacted an LTSS social insurance program in 2019. As other states consider similar measures, policymakers need to be mindful of key design issues, including:

- **Program structure.** Who will be eligible for the program’s benefits? How will generational transition issues be addressed? Will front-end, back-end (catastrophic), or temporally unlimited coverage be offered?
- **Financing approach.** How will the program be financed? Will it be funded through a payroll tax, an income tax, or some other dedicated revenue source? And will it be financed on a pay-as-you-go or prefunded basis?
- **Program integration.** How will the new program interface with Medicaid LTSS and private long-term care insurance?
- **Program implementation strategy.** How will the program be administered, revenues collected and managed, eligibility determined, and program integrity ensured?

The chapter discusses tradeoffs among alternative approaches to these core design choices and compares the cost of different structural approaches by financing source. Also illustrated is how proactive policies could lessen the financial pressure on state Medicaid budgets, reduce care burdens on families, and also support significant job creation in one of the fastest-growing sectors of the economy—personal care and home health care.

Section I.

INTRODUCTION

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Long-term services and supports can be costly both for those needing care and for family caregivers. Moreover, these costs often come at a time when individuals and their families are most vulnerable and in a context where they have had little opportunity to prefund or insure against such risks. The fundamental LTSS financing problem today is the absence of an effective insurance mechanism to protect people against these costs.

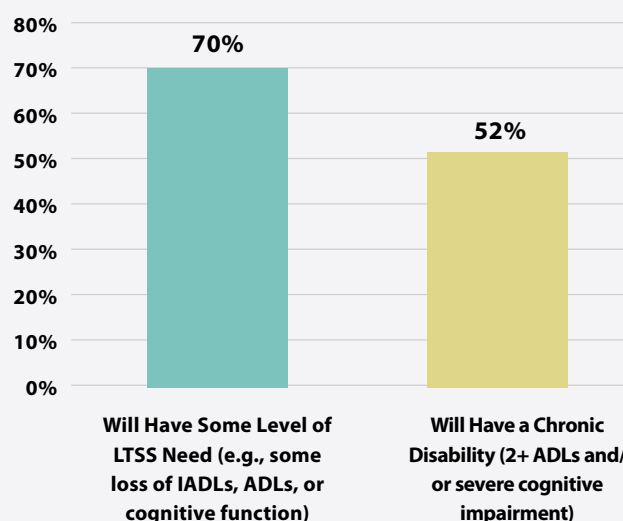
State policymakers could avail themselves of a number of viable social insurance policy options to make LTSS more affordable and accessible for their residents. Such options could enable those in need of care to remain at home longer and retain their autonomy. They would also give people the peace of mind of knowing that they will have access to the care they need as they age, without burdening their spouse or children. Proactive policies would also lessen the financial pressure on state Medicaid budgets and support significant job creation in one of the fastest-growing sectors of the economy—personal care and home health care.

Today's Long-Term Care System Ill-Equipped to Cope with Growing Demand

Seventy percent of those turning 65 today are expected to need help with at least one *activity of daily living* (ADL) (bathing,

dressing, toileting, continence, transferring, and eating) at some point in their remaining lifetime (Figure 1).¹ More than half (52 percent) of those turning 65 today are expected to meet the commonly used threshold for requiring paid long-term services and supports, and, on average, they will need LTSS for nearly four years.²

FIGURE 1: Majority Turning 65 Today Will Need LTSS
Among those turning 65 in 2015-19



Source: Favreault, 2015; Favreault and Dey, 2016.

Note: ADLs = Activities of Daily Living: eating, bathing, dressing, transferring, toileting, and continence; IADLS = Instrumental Activities of Daily Living: e.g., shopping, housework, and meal preparation, which allow an individual to live independently in the community.

¹ Melissa Favreault, "The Risk of Needing LTSS: DYNASIM Projections," Briefing for ASPE Long-Term Care Colloquium, Washington, DC, July 30, 2015, <https://aspe.hhs.gov/report/risk-needing-ltss-dynasim-projections>.

² Estimates of the share of people who survive to retirement age who ever develop LTSS needs are quite sensitive to measurement and definition. Recent studies report that between fifty and seventy percent of adults who survive to age 65 can expect to have LTSS needs. (Melissa Favreault and Judith Dey, "Long-Term Services and Supports for Older Americans: Risks and Financing Research Brief," Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, February 2016, <https://aspe.hhs.gov/basic-report/long-term-services-and-supports-older-americans-risks-and-financing-research-brief>; Richard W. Johnson, "What is the Lifetime Risk of Needing and Receiving Long-Term Services and Supports?" Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, April 2019, <https://aspe.hhs.gov/basic-report/what-lifetime-risk-needing-and-receiving-long-term-services-and-supports#table4>.)

While about half of seniors will need LTSS, there is considerable variation in the nature of the risk. Some will need extensive LTSS at considerable cost. Many will need LTSS for less than a year, and roughly half will require none at all. This heterogeneity of the LTSS risk makes it well-suited to pooling through insurance. Since not everyone can afford or qualify for private long-term care insurance, there is a strong case for a social insurance approach to LTSS.³ (These issues will be discussed in more depth in Section III of this chapter.)

The disability threshold identified in the second column above, set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), is defined as being unable to perform (without substantial assistance from another person) at least two ADLs for a period expected to last at least 90 days, or requiring substantial supervision to protect against threats to the individual's health and safety, due to severe cognitive impairment.⁴ Since paid LTSS is most common among those who meet these HIPAA criteria,⁵ and since this report is concerned with policy options for financing paid LTSS, henceforth when we refer to people "needing LTSS" we mean those meeting this threshold.

In addition to older adults, millions of people with disabilities require LTSS. They may have an intellectual or developmental disability (IDD), a mental health disability, or a physical disability, and some have a lifelong need for LTSS. While reliable data on this heterogeneous population is scarce,⁶ it is estimated that today about 40 percent of those requiring LTSS are under age 65.⁷ It is important to understand the role that LTSS plays in the lives of those with disabilities. It enables them to have a meaningful life as part of a community, allows them to achieve or regain a certain degree of independence, and positions them to pursue greater economic self-sufficiency and give back to their community.

The aging population will increase the number of people needing LTSS so that, in the coming decades, the growth in LTSS needs will be particularly strong among older Americans. By 2050, the population 85 or older will more than triple (growing by 208 percent), while the population younger than 65 will increase by only 12 percent.⁸ The number of seniors needing LTSS is expected to rise from 6.3 million in 2015 to an estimated 15 million by 2050.

³ Michael J. Graetz and Jerry L. Mashaw, *True Security: Rethinking American Social Insurance* (New Haven: Yale University Press, 1999).

⁴ Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936 (1996), <https://www.gpo.gov/fdsys/pkg/PLAW-104publ191/pdf/PLAW-104publ191.pdf>.

⁵ Melissa Favreault and Judith Dey, "Long-Term Services and Supports for Older Americans: Risks and Financing Research Brief," Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, February 2016, <https://aspe.hhs.gov/basic-report/long-term-services-and-supports-older-americans-risks-and-financing-research-brief>.

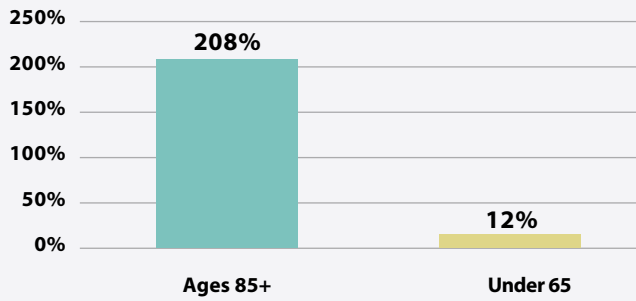
⁶ Long Term Care Quality Alliance, "Data Resources to Determine the LTSS Needs of Working-Age Adults with Disabilities: Gaps and Recommendations," July 30, 2018, <http://www.ltqa.org/wp-content/themes/LtqaMain/custom/images/LTQA-Disability-Data-White-Paper-%E2%80%93-7-30-18.pdf>.

⁷ Vivian Nguyen, "Long-Term Support and Services," AARP Public Policy Institute Fact Sheet, March 2017, <https://www.aarp.org/content/dam/aarp/ppi/2017-01/Fact%20Sheet%20Long-Term%20Support%20and%20Services.pdf>.

⁸ Ari Houser, Wendy Fox-Grage, and Kathleen Ujvari, "Across the States: Profiles of Long-Term Services and Supports," AARP Public Policy Institute, August 2018, <https://www.aarp.org/content/dam/aarp/ppi/2018/08/across-the-states-profiles-of-long-term-services-and-supports-full-report.pdf>.

FIGURE 2: Aging of the Population Increasing Need for LTSS

Projected Population Growth by Age Group, 2015-2050



Source: Houser et al., 2018.

The increase in the demand for LTSS will strain the existing care infrastructure, which is already overburdened.⁹ Current trends suggest that the nation is headed toward a shortage of caregivers—paid and unpaid.

By 2050, the population 85 or older will more than triple, while the population younger than 65 will increase by only 12 percent.

Today, for every person 80 or older there are about seven people age 45 to 64 (the peak caregiving age). By 2050, for every person 80 or older, there will be only three people of peak caregiving age.¹⁰ Already in the coming decade, this caregiver gap will begin to manifest itself. In a little over a decade—by 2030—there is projected to be a national shortage of 3.8 million unpaid family caregivers and 151,000 paid care workers. By 2040, the shortfall is expected to grow to 11 million family caregivers and 355,000 paid workers.¹¹

⁹ National Academies of Sciences, Engineering, and Medicine, *Families Caring for an Aging America*, (Washington, D.C.: The National Academies Press, 2016).

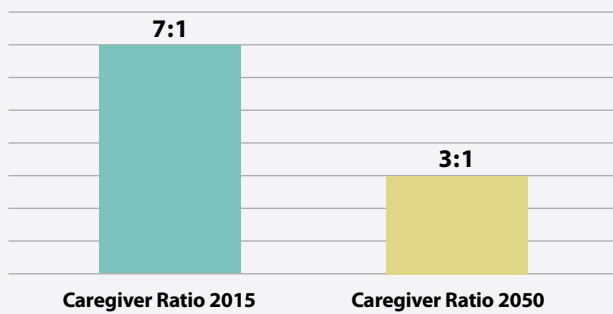
¹⁰ Ari Houser, Wendy Fox-Grage, and Kathleen Ujvari, “Across the States: Profiles of Long-Term Services and Supports,” AARP Public Policy Institute, August 2018, <https://www.aarp.org/content/dam/aarp/ppi/2018/08/across-the-states-profiles-of-long-term-services-and-supports-full-report.pdf>.

¹¹ Paul Osterman, *Who Will Care for Us?* (New York: Russell Sage Foundation, 2017).



FIGURE 3: Caregiver Gap Widening

Ratio of Population 45-64 to Population 80+



Source: Houser et al., 2018.

With the need for LTSS projected to rise and the availability of family caregivers projected to decline, there will be a growing need for paid long-term services and supports. Because of state budget constraints and other financial demands, state Medicaid programs—the primary public payers of LTSS—will face challenges paying for enough LTSS to meet the growing need. In light of all these trends, in this report we outline one possible solution to the LTSS financing challenge: the introduction of new state-based LTSS social insurance programs.

Because of state budget constraints, state Medicaid programs—the primary public payers of LTSS—will face challenges paying for enough LTSS to meet the growing need. In light of all these trends, in this report we outline one possible solution to the LTSS financing challenge: the introduction of new state-based LTSS social insurance programs.

Why Social Insurance?

This report discusses considerations for the development of state long-term care programs that provide universal, affordable coverage and have dedicated financing. Broadly speaking, this means social insurance. Social insurance programs are universal, public insurance programs such as Social Security, Medicare Part A (Hospital Insurance), and Unemployment Insurance. They share the following characteristics:¹²

- Social insurance programs are “social” in the sense that risk is pooled broadly across a population, often society as a whole. Virtually everyone contributes to a state or national insurance plan (typically a fixed percentage of their earnings), and everyone who contributes is eligible for benefits.
- Social insurance is distinct from social assistance or *welfare programs* (such as Medicaid, food stamps, or housing vouchers) in that benefits are paid only to those who have contributed to the program’s financing. Benefits from social insurance programs are therefore typically considered earned benefits. By contrast, in social assistance programs, benefit eligibility is based not on having contributed but simply on having a need (meeting certain financial, functional, and/or clinical criteria).
- Social insurance differs from social assistance programs further in that, for those who have contributed, benefits are universally available to all for whom the insured risk (e.g., the

¹² For an in-depth examination of the conceptual foundations of social insurance, see Theodore R. Marmor, “Beneath the Surface. Social Insurance and American Health Care: Principles and Paradoxes,” *Journal of Health Politics, Policy and Law*, Vol. 43, No. 6, December 2018, DOI 10.1215/03616878-7104419.



need for long-term care) transpires. In social assistance programs, access to benefits is subject to a means test.

- Traditional social insurance programs are typically self-funded by contributions from participants and/or their employers; their finances are distinct and separate from those of the rest of the government. Assistance programs are typically funded out of general revenues.
- Traditional social insurance differs from private insurance in that there is no individual underwriting—no one can be excluded from the program because they have a high risk of needing the benefits provided. And social insurance is community rated: Everyone contributes at the same rate or level.

Some programs are hybrids, combining features of the traditional social insurance model and of either social assistance or private insurance. Medicare Parts B and D are funded by a combination of premiums (25 percent of program cost) and general revenues (75 percent). These parts of Medicare also charge higher premiums to those with higher incomes, so that contributions are progressive. Some social insurance programs have a role for private companies (within well-defined statutory requirements), which provide the insurance and/or administer the benefits, as in many Workers' Compensation programs and all Medicare Advantage plans.

Social insurance represents a promising approach to meeting the challenges states face in ensuring broad access to LTSS.

A universal and affordable program is necessary to achieve broad coverage, which is particularly important given the nature of the LTSS risk. Many people will not have any need for LTSS, others will need it for a moderate duration, and a small number will face catastrophic expenses. As a result, the need for LTSS is difficult to plan for, threatens retirement security, and is well-suited to risk pooling. A social insurance program is an efficient way to mitigate the financial risk associated with LTSS. In addition, dedicated financing is an important feature at the state level, since many states have balanced budget requirements, which make funding a large new program out of general revenues challenging. States can choose from a variety of options in structuring a new social insurance program for long-term care. Those options will be discussed in detail in this report.

Many people will not have any need for LTSS, others will need it for a moderate duration, and a small number will face catastrophic expenses. As a result, the need for LTSS is difficult to plan for, threatens retirement security, and is well-suited to risk pooling. A social insurance program is an efficient way to mitigate the financial risk associated with LTSS.

Decision Points on the Path to Social Insurance Solutions to the LTSS Challenge

States that decide to take action to help meet their residents' long-term care needs ultimately must address a range of considerations. To begin with, there are two critical first-order questions:

- Who is the program seeking to help—only the disabled elderly, or also children and working-age people with disabilities? Only those who start paying into the program now, or current retirees as well?
- How will the program be financed? Will it be funded through a payroll tax, an income tax, or some other dedicated revenue source?

Additional considerations follow from these two overarching questions; these include details about program structure, such as benefit amounts, benefit duration, and when benefits start and stop. Once the broad parameters of program eligibility, finance, and structure are determined, other issues can be considered, such as integration of the program with the current care delivery system, workforce and provider credentialing, and program implementation and sustainability.

The issues involved in LTSS financing are complex and require thoughtful deliberations involving a range of stakeholders. Therefore, while we are confident that the information in this report will be very helpful, we also believe

policymakers would benefit from consulting long-term care experts and stakeholders in their states to determine the choices that best fit their needs and preferences. To make these choices easier to grasp, in the remainder of this report we discuss various alternative design features and highlight the considerations and implications related to them.

If a state implements an LTSS social insurance program, the success of that program should be measured against the objectives for which it is established. Some of the high-level criteria a state might use to assess program effectiveness include the following:

- **Improving access to LTSS.** To what extent does the additional money brought into the LTSS system by the new program allow the purchase of additional services?
- **Improving key outcomes for people with disabilities.** To what extent does greater access to paid LTSS improve the health and well-being of people with disabilities?
- **Reducing family out-of-pocket spending.** To what extent does the program relieve financial burdens on families?
- **Improving key outcomes for family caregivers.** To what extent does access to paid LTSS services make it possible for family caregivers who want to increase their labor force participation and income over the short and medium term to do so, and does the program support their improved well-being?
- **Reducing Medicaid spending.** To what extent does the program reduce budgetary pressure on Medicaid?



- **Financial sustainability/stability.** Is the program sustainable? Can it be paid for over the long term in a stable manner?
- **Political support and sustainability.** Is the program structured in a manner that will garner broad public support that is likely to persist over time?



Section II.

THE RATIONALE FOR STATE ACTION ON LTSS

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Creating a new social insurance program with dedicated financing to address a state's LTSS needs could provide relief on a number of fronts:

■ **Enabling older adults to age in place, families to keep their loved ones at home, and younger people with disabilities to live in the community.**

There are significant gaps in Medicaid's coverage of LTSS today, for both older adults and younger people with disabilities. This is particularly true for *home and community-based services (HCBS)*, which include adult day programs, home health aide services, personal care services, transportation, and rehabilitation services.¹³ For instance, under current arrangements, nearly 70 percent of the cost of HCBS for those turning 65 today will be paid out of pocket by families.¹⁴ A new LTSS social insurance program would make it much easier for those needing LTSS to access HCBS, enabling them to stay at home and avoid or delay institutionalization.

■ **Relieving pressure on the state's Medicaid budget.** As LTSS needs grow with the aging of the population, the increased demand for state Medicaid dollars could crowd out spending on other Medicaid benefits or reduce the state's ability to meet LTSS needs, thus increasing unmet needs and putting greater burdens

on families. Currently, the willingness to fund Medicaid spending growth appears limited, on both the state and the federal levels, as evidenced by recent attempts in Congress to permanently cap the federal contribution.¹⁵ Introducing benefits from a social insurance program, walled off from the existing state budget through new, dedicated financing, would inject hundreds of millions—or, in larger states, billions—of dollars into LTSS provision each year. If combined with a Medicaid waiver allowing the state to retain projected federal matching dollars (as discussed in Section VII of this chapter), a new social insurance program could reduce pressure on state Medicaid spending as social insurance dollars come to replace Medicaid dollars for the large and growing number of individuals who need LTSS. Additional state Medicaid savings could come from lower than projected Medicaid health spending, as a result of fewer individuals needing to spend down into poverty to become eligible for Medicaid.

■ **Supporting the development and enhancing the quality of the state's LTSS providers.** Today, care providers often struggle to generate sufficient revenue to make necessary capital investments or pay their workers adequately, leading to service gaps and uneven quality of care,

¹³ Erica L. Reaves and MaryBeth Musumeci, "Medicaid and Long-Term Services and Supports: A Primer," Kaiser Family Foundation, December 15, 2015, <https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/>.

¹⁴ Melissa Favreault and Judith Dey, "Long-Term Services and Supports for Older Americans: Risks and Financing Research Brief," Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, February 2016, <https://aspe.hhs.gov/basic-report/long-term-services-and-supports-older-americans-risks-and-financing-research-brief>.

¹⁵ Benjamin W. Veghte and Alexandra L. Bradley, "Medicaid and Federal Funding Caps: Implications for Access to Health Care and Long-Term Services and Supports among Vulnerable Americans," National Academy of Social Insurance, June 2017, <https://www.nasi.org/research/2017/medicaid-federal-funding-caps-implications-access-health>.

particularly in rural areas. An infusion of new funding into a state's system of LTSS provision could improve quality by facilitating capital investments, training, certification, and adequate compensation of workers.

- **Stimulating economic growth by increasing labor force participation and creating quality jobs.** The new program, by providing families with funds to hire paid LTSS workers, would both create LTSS jobs and make it easier for family members to remain in the labor force instead of staying home to care for loved ones. And if a state took steps to ensure the quality of new LTSS jobs, the positive economic impact would be magnified. In addition, since (unlike Medicaid) the new program would pay benefits to people with disabilities even if they earn significant wages, more such people are likely to work.

- **Providing state residents with peace of mind.** One of the greatest benefits of social insurance—like all insurance—is the knowledge that one is protected against a risk. Families worry about whether they and their loved ones will be taken care of if they need long-term services and supports. With the new program, they have the assurance that, if care is needed, benefits will be available to help pay for it. They will not have to impoverish themselves or spend down their assets to qualify for Medicaid, and they can receive quality care in the setting of their choice. Even when insurance is not used for many years, or never, a family benefits from having this peace of mind.

One of the greatest benefits of social insurance—like all insurance—is the knowledge that one is protected against a risk. Families worry about whether they and their loved ones will be taken care of if they need long-term services and supports. With the new program, they have the assurance that, if care is needed, benefits will be available to help pay for it.

As for why such programs could be established by the states, it is worth noting that the states have tremendous breadth of experience administering comprehensive LTSS. States have operated Medicaid LTSS programs for over 50 years and already perform functions such as defining and assessing benefit eligibility, certifying qualified providers, reimbursing providers, and managing a cash and counseling benefit. They also have an understanding of and familiarity with the local LTSS service delivery system. In short, states have a wealth of knowledge and experience that can be built on as a new LTSS program is designed and implemented.

States also have a solid track record in launching and running social insurance programs. For well over half a century, states have administered Workers' Compensation and (jointly with the federal government) Unemployment Insurance. Four states—California, New Jersey, New York, and Rhode Island—also operate Paid Family and Medical Leave (PFML) social insurance programs,



and four more jurisdictions—Connecticut, the District of Columbia, Washington, and Massachusetts—have recently enacted PFML programs that are currently awaiting implementation.¹⁶

In LTSS, there has been a wave of state interest in adopting new programs in recent years:

States have a solid track record in launching and running social insurance programs.

■ **Washington State** enacted the Long-Term Care Trust Act in 2019. It creates a public long-term care program that provides front-end coverage based on contributory

social insurance. Front-end coverage pays benefits soon after a beneficiary is assessed as needing functional supports, but it pays only up to a fixed maximum amount—in the case of Washington State, no more than \$36,500 over a beneficiary's lifetime. The program will reimburse beneficiaries for the cost of LTSS services received at home, in the community, or in a facility, up to \$100 per day. The program is funded by an employee contribution of 0.58 percent of wages (without a cap). Independent contractors can opt into the program by paying the same contribution rate on their earnings. Workers become eligible for benefits after a vesting period of a total of 10 years (without any interruption lasting five or more consecutive years) or three of the past six years. Contributions begin January 1, 2022, and benefits will be payable to eligible persons starting January 1, 2025.¹⁷

¹⁶ For in-depth descriptions of these programs, see Chapter 2 of this report.

¹⁷ State of Washington Legislature, H-1732.1, 2019, <http://lawfilesexternal.wa.gov/biennium/2019-20/Pdf/Bills/House%20Bills/1087-S2.pdf>.

■ **Maine** residents considered a ballot initiative to create a new LTSS program in 2018. While not a traditional social insurance program, it was designed to provide a universal benefit to help people needing LTSS receive home care and remain living in their homes for as long as possible. The ballot initiative did not pass.

■ **Hawaii** enacted the **Kūpuna (Elders) Caregivers Program** in 2017 to help family caregivers stay in the workforce. For family caregivers who work at least 30 hours a week, the program pays up to \$210 per week for LTSS services for a loved one living at home (60 or older and not covered by Medicaid or private long-term care insurance). It is not a social insurance program and is funded by general revenues; availability of benefits is subject to funding.¹⁸ In 2018 and 2019, the number of eligible applicants exceeded funding capacity and some applicants were put on a waitlist.¹⁹

■ **Hawaii** enacted the **Kūpuna Care Program** in 2008. It makes limited LTSS available to non-Medicaid-eligible residents 60 or older, supporting them to continue living at home or in the community. Covered services include adult day care, personal care, and transportation. This is not a

social insurance program, because benefit eligibility is not conditioned on having contributed and funding comes from an excise tax on businesses.²⁰ In addition to Hawaii, a number of other states have programs, mostly several decades old, designed to target LTSS benefits to the near-Medicaid-eligible population.

Establishing a state-based program does present some unique challenges that will need to be addressed. Among the most prominent are defining program obligations in the context of interstate mobility among residents, having sufficient vesting requirements to assure that states are not selected against by attracting people more likely to need benefits, and integration and transition issues that could arise should the federal government implement a new program.

Washington State enacted the Long-Term Care Trust Act in 2019.

It creates a public long-term care program that provides front-end coverage based on contributory social insurance.

¹⁸ State of Hawaii Legislature, SB 1025, 2019, https://www.capitol.hawaii.gov/session2019/bills/SB1025_HD2_.htm.

¹⁹ Aging and Disability Resource Center Hawaii, "Kūpuna Caregiver Program Information," <https://www.elderlyaffairs.com/>.

²⁰ 2018 Hawaii Revised Statutes, Title 20, 349-17 Kūpuna Care Program, HI Rev Stat § 349-17 (2018).

Section III.

**THE CURRENT STATE
OF LTSS FINANCING:
HOW CAN SOCIAL
INSURANCE
ADDRESS THE NEED?**

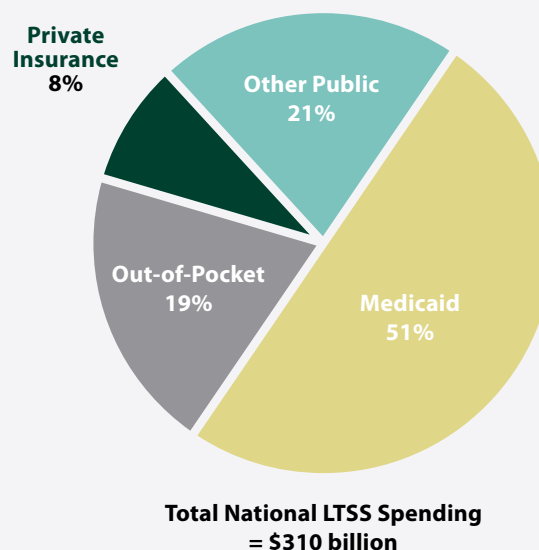


In this section we examine the existing financing sources for LTSS and illustrate how social insurance can help address current and future unmet needs.

The majority of the nation's LTSS is provided by family and friends.²¹ The economic value of such unpaid care has been estimated at nearly \$470 billion in 2013.

With regard to paid care, today about half is financed by Medicaid (51 percent of aggregate costs), while the rest comes out of the pockets of families (household savings or income) (19 percent), private long-term care insurance (8 percent), and a range of other public programs (21 percent).^{22,23} (See Figure 4)

FIGURE 4: Medicaid is the Primary Payer for LTSS Today



Source: Erica L. Reaves and MaryBeth Musumeci, "Medicaid and Long-Term Services and Supports: A Primer," KFF, December 15, 2015, using Kaiser Commission on Medicaid and the Uninsured estimates based on Centers for Medicare and Medicaid Services National Health Expenditure Accounts data for 2013.

Note: Total LTSS expenditures include spending on residential care facilities, nursing homes, home health services, and home and community-based waiver services. Expenditures also include spending on ambulance providers and some post-acute care. This chart does not include Medicare spending on post-acute care (\$74.1 billion in 2013). All home- and community-based waiver services are attributed to Medicaid.

²¹ In some cases family and friends can be compensated for care they provide. (Medicaid.gov, "Self-Directed Services," <https://www.medicaid.gov/medicaid/ltss/self-directed/index.html>.)

²² These National Health Expenditure data are likely to underreport out-of-pocket expenditures vis-à-vis other payers of LTSS due to difficulties documenting such expenditures.

²³ Erica L. Reaves and MaryBeth Musumeci, "Medicaid and Long-Term Services and Supports: A Primer," Kaiser Family Foundation, December 15, 2015, <https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/view/footnotes/#footnote-172646-11>.

As the Baby Boomer population ages, demand for LTSS will increase sharply, and states will struggle to keep up with the growing need in the context of budget constraints. Consequently, in the coming decades families will be left paying a much larger share of costs. For those turning 65 today, the out-of-pocket share of aggregate LTSS costs is projected to amount to 52 percent, with Medicaid picking up only a third (34.3 percent) and private insurance only 3 percent. Medicare is projected to pay only 10 percent (primarily when LTSS overlaps with medical care).^{24,25} Moreover, as important as Medicaid and (to a far lesser extent) private long-term care insurance are in providing access to LTSS for millions of Americans, they leave the broad middle class largely exposed to the risk of not being able to afford the care they need and/or maintain their family's living standards when they do need care. They also have other limitations, as we will see in this section.

As important as Medicaid and (to a far lesser extent) private long-term care insurance are in providing access to LTSS for millions of Americans, they leave the broad middle class largely exposed to the risk of not being able to afford the care they need.

Medicaid

Medicaid pays for health care and LTSS for eligible low-income people. Medicaid is administered by the states, according to federal requirements. It is funded jointly by the states and the federal government.²⁶ To qualify for Medicaid, individuals must meet certain categorical, financial, and functional or clinical requirements.

²⁴ Several important recent developments have paved the way for Medicare to provide non-medical benefits and to better integrate and coordinate medical care and LTSS. First, in 2015 Medicare began covering chronic care management (CCM) services for beneficiaries who have two or more serious chronic conditions expected to last at least one year or until death. These services are limited to the management and coordination of clinical care and do not include the provision of LTSS. (Centers for Medicare and Medicaid Services, "Chronic Care Management Services," December 2016, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf>.) Second, in February 2018 Congress passed the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act, which seeks to facilitate integrated, person-centered care for adults with complex care and support needs. The Act gives Medicare Advantage (MA) plans greater flexibility to provide—at no extra cost—non-medical benefits for identified high-need/high-risk members. These benefits can pay for such items as bathroom grab bars, wheelchair ramps, transportation, or home meals. (Anne Tumlinson, Megan Burke, and Gretchen Alkema, "The CHRONIC Care Act of 2018: Advancing Care for Adults with Complex Needs," The SCAN Foundation, March 7, 2018, <https://www.thescanfoundation.org/chronic-care-act-2018-advancing-care-adults-complex-needs>.) Third, the Department of Health and Human Services has adopted regulations that allow MA plans to provide certain non-medical benefits, including payment for supportive services such as in-home assistance with activities like dressing, bathing, and managing medications. It is too soon to determine the degree to which MA plans will offer LTSS benefits in the coming years and whether the amount of the benefits (such as the number of hours of in-home assistance covered) will be sufficient to address LTSS needs in a significant way. (Howard Gleckman, "What a Medicare Advantage Personal Care Benefit Looks Like," *Forbes*, October 5, 2018, <https://www.forbes.com/sites/howardgleckman/2018/10/05/what-a-medicare-advantage-personal-services-benefit-looks-like/#5c302c2d6066>.)

²⁵ Melissa Favreault and Judith Dey, "Long-Term Services and Supports for Older Americans: Risks and Financing Research Brief," Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, February 2016, <https://aspe.hhs.gov/basic-report/long-term-services-and-supports-older-americans-risks-and-financing-research-brief>.

²⁶ Medicaid.gov, "Medicaid," <https://www.medicaid.gov/medicaid/index.html>.

■ **Categorical eligibility criteria.** Being categorically eligible for Medicaid means belonging to a covered population group (such as children, pregnant women, elderly adults, and people with disabilities). To be categorically eligible based on being elderly or disabled (the majority of LTSS users), individuals must be over the age of 65, have a disability, or have one of several specified medical diagnoses.²⁷ Other categorical eligibility criteria include U.S. citizenship or legal immigration status and state residency.

■ **Financial eligibility criteria.** Medicaid is means-tested—to qualify, a person must have low income. In addition, those qualifying on the basis of disability or age may not have assets (resources) above a certain level. Many middle-income people “spend down”—they spend their assets on care until they have very little left, qualify for Medicaid, and then, while on Medicaid, must spend most of their income on care.²⁸ This of course means that financial independence is lost. (Financial eligibility rules vary somewhat by state, within federal guidelines. For a more detailed discussion, see Appendix II.)

■ **Functional/clinical eligibility criteria.** Functional eligibility criteria can include an individual’s inability to perform

Activities of Daily Living (ADLs: eating, bathing, dressing, transferring, toileting, and continence) or certain Instrumental Activities of Daily Living (IADLs, such as shopping, housework, and meal preparation) that allow an individual to live independently in the community. Some states may use clinical, level-of-care criteria (diagnosis of an illness, injury, disability, or other medical condition, treatment and medications, and cognitive status). Most states use a combination of functional and clinical criteria in defining the need for LTSS.²⁹ For certain programs within Medicaid (including the most important vehicles for the delivery of LTSS, 1915(c) waivers), the clinical criteria that individuals must meet are the same as for an institutional level of care.

The difficulty in accessing HCBS coverage

While federal law stipulates that states must cover nursing home care and home health services, HCBS and personal care benefits are optional for states. The majority of states offer personal care and similar services through their state plans, but the criteria used for access to these services (as well as the amount, duration, and scope of these services) vary widely. In addition, all states offer HCBS through a Medicaid authority called a waiver.³⁰ Waivers are often targeted toward specific populations, and there is wide variation in the

²⁷ Categorical eligibility for Medicaid coverage due to disability can be based on physical conditions (e.g., quadriplegia), intellectual and developmental disabilities (e.g., Down syndrome), and/or severe behavioral or mental illnesses (e.g., schizophrenia). (Medicaid and CHIP Payment and Access Commission, “Medicaid and Persons with Disabilities,” Report to the Congress on Medicaid and CHIP, March 2012, https://www.macpac.gov/wp-content/uploads/2015/01/Medicaid_and_Persons_with_Disabilities.pdf.)

²⁸ Some individuals transfer their assets to family members in order to qualify for Medicaid, although the magnitude of this activity is subject to debate and is generally thought to be relatively modest.

²⁹ Kirstin J. Colello, “Medicaid Financial Eligibility for Long-Term Services and Supports,” Congressional Research Service, 2017, <https://fas.org/sgp/crs/misc/R43506.pdf>.

³⁰ Most states use 1915(c) HCBS waivers, although an increasing number are including HCBS as a part of 1115 demonstration programs. See “State Waivers List,” Medicaid.gov, <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html>.

types of benefits offered. What this means for state residents is that even those who meet all the normal eligibility criteria for Medicaid LTSS may not have access to HCBS coverage. States can seek to contain costs by utilizing additional restrictive financial and functional eligibility standards, enrollment caps, service unit limits, or waiting lists. Figure 5 presents a stylized schematic of the hurdles a disabled individual must clear in order to get access to HCBS through the Medicaid program.

In 2016 there were 656,195 individuals in 39 states on a Section 1915(c) waiver waiting list.³¹ It also is important to note that there is tremendous heterogeneity both in the HCBS waiting list population and in state HCBS waiting list policies.³² And states vary greatly in terms of their level of investment in HCBS, as shown in Figure 6.

³¹ This compares to 1.6 million individuals receiving services through Section 1915(c) programs in 2014 (the latest data available). (Kaiser Family Foundation, “Waiting List Enrollment for Medicaid Section 1915(c) Home and Community-Based Services Waivers, 2016,” State Health Facts, <https://www.kff.org/health-reform/state-indicator/waiting-lists-for-hcbs-waivers/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.)

³² Four states—Texas, Louisiana, Florida, and Ohio—account for two-thirds of the waiting list population nationally. The waiting list population includes different types of disability: nearly two-thirds are people with intellectual/developmental disabilities, 28 percent are seniors or adults with physical disabilities, and 8 percent are other populations (such as children who are medically fragile or technology-dependent, people with HIV/AIDS, people with mental health needs, or people with traumatic brain or spinal cord injuries). About half of state HCBS waiver programs do not screen individuals for HCBS eligibility until they have cleared the waiting list. People on HCBS waiting lists may be receiving other Medicaid LTSS services if such services are included in the state’s Medicaid plan. (Ibid.)



FIGURE 5: Barriers to Access to Home and Community-Based Services (HCBS) under Medicaid

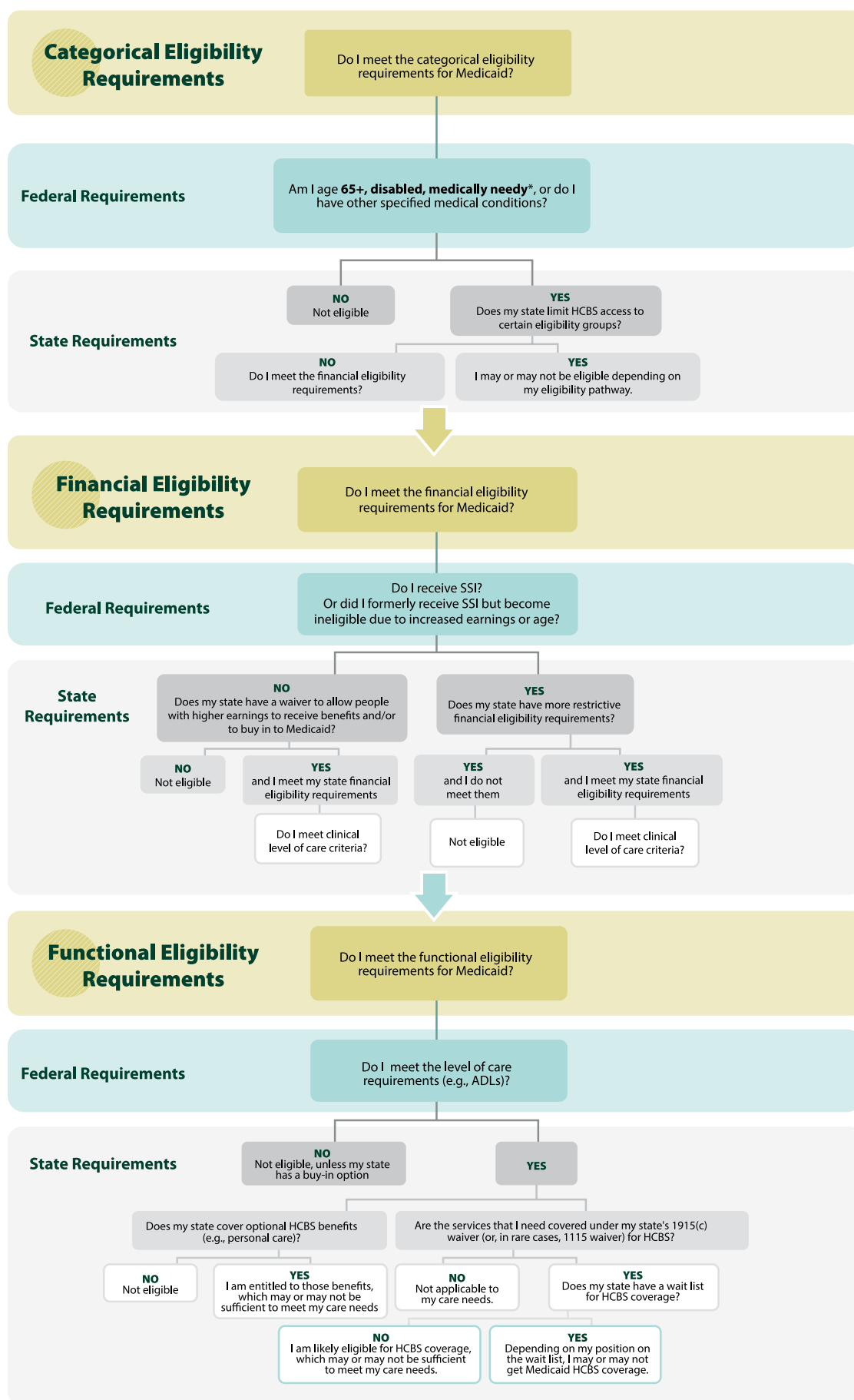
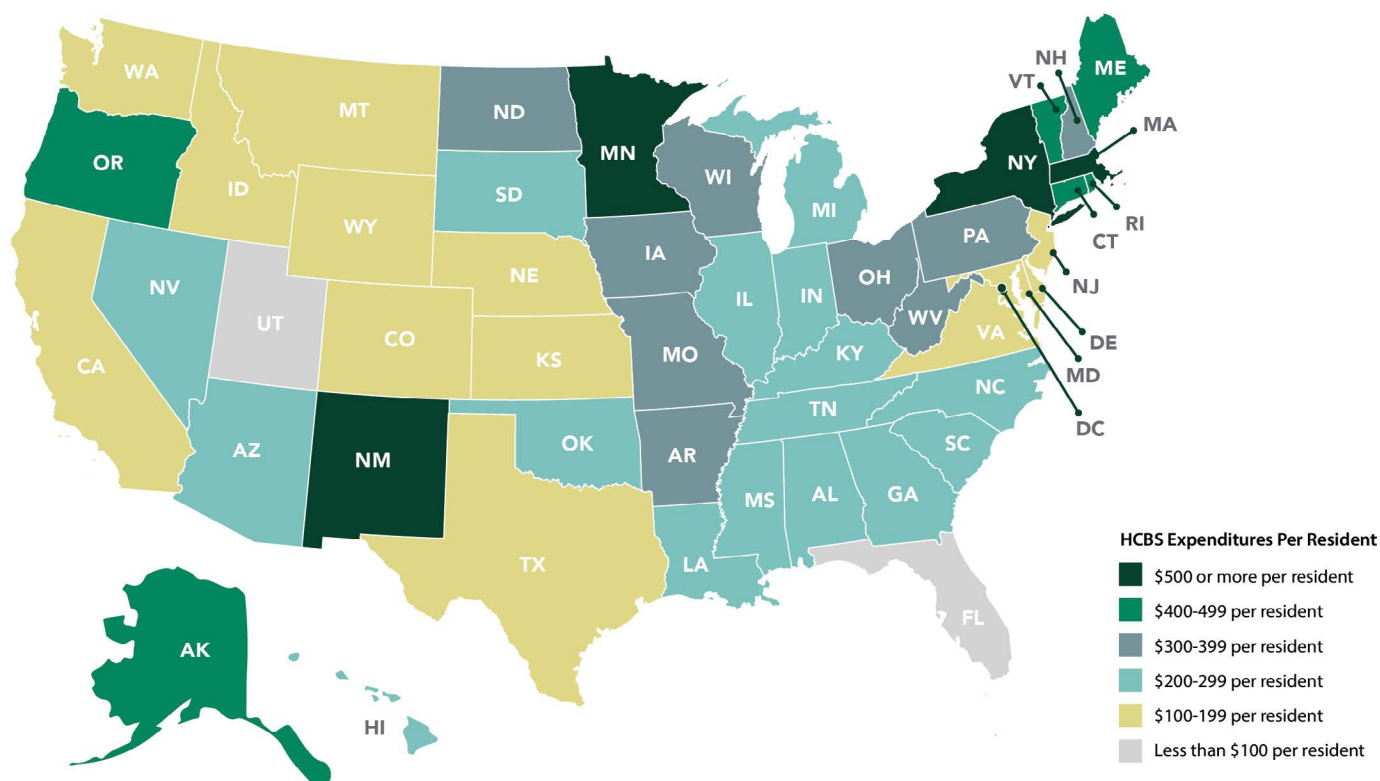


FIGURE 6: HCBS Expenditures per Resident



Source: Truven Health Analytics, “Total Home and Community-Based Services: FY 2015 Expenditures Per Resident,” in “Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015,” April 14, 2017.

State Medicaid coverage and funding can also change over time. Therefore, it is very risky for someone to rely on receiving Medicaid LTSS in a home-and community-based setting, or to make that a cornerstone of their LTSS planning. Most people realize this and do not see reliance on Medicaid as a desirable strategy for coping with their long-term care needs. In a Society of Actuaries survey of adults ages 35 to 55, nearly two-thirds agreed that “someone on Medicaid has less choice about care options.”³³ And in a survey of California adults ages 40 to 69, 73

percent said that they “never want to have to rely on Medi-Cal [California Medicaid] to pay for their long-term care needs.”³⁴

State Medicaid coverage and funding can also change over time. Therefore, it is very risky for someone to rely on receiving Medicaid LTSS in a home-and community-based setting, or to make that a cornerstone of their LTSS planning.

³³ Cindy Malone, “Long-Term Care and the Middle Market,” Society of Actuaries, 2018, http://www.ltcdiscussiongroup.org/archives_160_3663455040.pdf.

³⁴ Eileen J. Tell, “LTSS Financing Solutions: Important Roles for States,” presented at The SCAN Foundation’s *California Summit on Long-Term Care Services & Supports: Strengthening Voices, Driving Change*, Sacramento, California, September 27, 2018.

Individual Savings

Individuals with savings that significantly exceed their retirement income needs may, depending on the duration of their care, be able to pay for their LTSS out of their savings. However, this is not possible for the majority of the population. Half of today's working-age households are projected to be unable to save enough to maintain their pre-retirement standard of living, much less finance their health and long-term care expenses in retirement. This is true even if at age 65 they were to take out a reverse mortgage on their home and annuitize all their assets.³⁵ The typical household approaching retirement (age 55-64) has about \$10,000 in retirement (401(k)/IRA) savings. If one considers only the 58 percent of households with some retirement savings, the median amount of their holdings is \$108,000.³⁶ Among the roughly half of Americans 65 and over who will have significant LTC needs, the average cost for their care will be \$266,000 in today's dollars, and a little more than half of that will need to be paid out of pocket.³⁷

Relying on savings is also an inefficient approach to financing long-term care needs, given the nature and distribution of the risk. Roughly half of individuals turning 65 today are expected to die without incurring a substantial LTSS expense, while a small percentage (15 percent) are expected to incur several hundred thousands of dollars in

costs.³⁸ The distribution of the need and the potentially high cost make saving individually for LTSS needs imprudent for most people. It makes as much sense as saving for the possibility your home might burn down or you might need major surgery. It makes more sense to rely instead on risk-pooling through insurance—but not everyone can afford or qualify for private LTC insurance.

Half of today's working-age households are projected to be unable to save enough to maintain their pre-retirement standard of living, much less finance their health and long-term care expenses in retirement.

Private Insurance

While private long-term care insurance (LTCI) policies have served well those who have had them over the years, these products do not hold the potential to be a broad-based solution to the country's LTSS needs, for several reasons. Just as most families lack the assets to pay for their potential LTSS needs out of pocket, many also lack the disposable income to purchase LTCI. Even those who might be able to afford LTCI prioritize more immediate expenses (e.g., student loan debt, mortgage, child care, or college expenses) over protecting against an

³⁵ Alicia H. Munnell, Wenliang Hou, and Geoffrey T. Sanzenbacher, "National Retirement Risk Index Shows Modest Improvement in 2016," Center for Retirement Research at Boston College, January 2018, http://crr.bc.edu/wp-content/uploads/2017/12/IB_18-1.pdf.

³⁶ Center for Retirement Research at Boston College's calculations based on the U.S. Board of Governors of the Federal Reserve System, *Survey of Consumer Finances* (2016).

³⁷ Melissa Favreault and Judith Dey, "Long-Term Services and Supports for Older Americans: Risks and Financing Research Brief," Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, February 2016, <https://aspe.hhs.gov/basic-report/long-term-services-and-supports-older-americans-risks-and-financing-research-brief>.

³⁸ Ibid.



uncertain and very distant potential liability.³⁹ Only about seven percent of adults age 50 or older have private LTCI today.^{40,41}

Another reason why LTCI has not grown to cover a significant share of the population is that it is voluntary, and many families who could afford to buy it choose not to do so. They are unclear about their future risk and tend to underestimate it, believe they may be covered by other programs, or find LTCI products complex and hard to understand.

Another obstacle is that many people do not qualify for LTCI. Various estimates suggest that upwards of 30 percent of the public age 50 and over would not meet insurers' underwriting criteria.⁴²

In addition to limited consumer demand for LTCI, there are a variety of issues related to the supply of these products that have caused the LTCI market to contract significantly over the last 15 years. First, private insurers are no longer willing to

³⁹ Richard G. Frank, Marc Cohen, and Neale Mahoney, "Making Progress: Expanding Risk Protection for Long-Term Services and Supports through Private Long-Term Care Insurance," The SCAN Foundation, March 2013, http://www.thescanfoundation.org/sites/thescanfoundation.org/files/tsf_ltc-financing_private-options_frank_3-20-13.pdf.

⁴⁰ A growing number of consumers are buying products that combine life insurance or an annuity with long-term care benefits; these are considerably more expensive than traditional LTCI and thus are available only to a more limited upper-income market segment.

⁴¹ Life Insurance and Market Research Association (LIMRA), "Combination Products Giving Life Back to Long-term Care Market," November 9, 2017, https://www.limra.com/Posts/PR/Industry_Trends_Blog/Combination_Products_Giving_Life_Back_to_Long-term_Care_Market.aspx.

⁴² Portia Cornell, David Grabowski, Marc Cohen, Xiaomei Shi, and David Stevenson, "Medical Underwriting in Long-Term Care Insurance: Market Conditions Limit Options for Higher-Risk Consumers," *Health Affairs*, Vol. 35, No. 8, August 2016.

provide policies that pay benefits indefinitely, potentially covering many years of LTC need.⁴³ Second, most companies have been unable to generate a profit because of certain macro-economic events that have been outside of their control but affect the entire industry. These include operating in a very low interest rate environment, changes in both mortality and morbidity trends across the population, and high marketing costs to overcome demand issues.⁴⁴ Consequently, while there were more than 100 companies selling LTCI at the turn of the 21st century, today fewer than a dozen sell a meaningful number of policies. All of these factors have led to higher prices and have made premiums less affordable to middle-income Americans.

Only about seven percent of adults age 50 or older have private long-term care insurance today.

Social Insurance Can Address Many Shortcomings in the Current System

Under the current system, those with high incomes can pay for LTSS out of their savings or with private insurance benefits. But those in the broad middle class either forgo paid

care (relying on family members) or pay for it out of limited income and savings until they deplete their assets and qualify for Medicaid. And those who qualify for Medicaid (whether low- or middle-income) must contribute most of their income to their care costs and may be forced to enter a nursing home because they cannot access sufficient home- and community-based services or afford to remain at home.

A social insurance approach to financing LTSS could go far in efficiently and affordably addressing these coverage gaps. Social insurance contributions are generally more affordable than private insurance premiums, for a number of reasons. Social insurance pools risk across the entire workforce. Contributions are generally paid into a social insurance program for much longer than premiums are paid to an insurance company—they can be collected as payroll deductions for a person’s entire working life. Also, a significant part of the private insurance premium goes to cover marketing and sales expenses (including agent commissions), which is largely unnecessary in a traditional social insurance program. Existing social insurance programs (such as Social Security and Medicare) have had much lower administrative costs than their private-sector counterparts, accounting for only

⁴³ Richard G. Frank, Marc Cohen, and Neale Mahoney, “Making Progress: Expanding Risk Protection for Long-Term Services and Supports through Private Long-Term Care Insurance,” The SCAN Foundation, March 2013, http://www.thescanfoundation.org/sites/thescanfoundation.org/files/tsf_ltc-financing_private-options_frank_3-20-13.pdf.

⁴⁴ Marc Cohen, Ramandeep Kaur, and Bob Darnell, “Exiting the Market: Understanding the Factors behind Carriers’ Decision to Leave the Long-Term Care Insurance Market,” Report to the Office of the Assistant Secretary for Planning and Evaluation, Aging, Disability and Long-Term Care Policy, Department of Health and Human Services, February 2013, <https://aspe.hhs.gov/system/files/pdf/177866/MrktExit.pdf>.



about one percent of expenditures.⁴⁵ Finally, with social insurance the considerable cost of underwriting is eliminated; there is no need to assess and filter out high-risk applicants, since coverage is typically mandatory and extended to large populations with diverse risks (like the entire workforce). For these reasons, overall costs and hence contributions can be lower and more predictable.

State adoption of a social insurance program for LTSS could also spur growth in the private insurance market, since it is unlikely that such a program would pay for all LTSS costs for all people. The program would likely cap benefits at a certain daily or monthly dollar amount, and this potential gap in coverage

would create a market for a supplemental private benefit similar to Medigap insurance. Moreover, if a social insurance program offered only front-end or back-end coverage, this would limit the risk against which a private insurance product could protect beneficiaries. In other words, introducing a social insurance program for LTSS in a state could actually spur growth in the private market, both because of gap-filling opportunities and because tastes for and awareness of the need for insurance would likely change. Clear definitions about public and private responsibilities would eliminate current confusion about what is and is not covered and clarify for people the need for private insurance to cover the portion of

⁴⁵ Elliot Schreur and Benjamin W. Veghte, "Social Security Finances: Findings of the 2018 Trustees Report," National Academy of Social Insurance, June 2018, <https://www.nasi.org/research/2018/social-security-finances-findings-2018-trustees-report>; Board of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2018 Annual Report of the Medicare Trustees, Table II.B1., <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2018.pdf>.

the risk that a social insurance program left unaddressed. In short, given that neither individual savings nor private insurance offers broad-based solutions to the LTSS needs of the population, social insurance is worthy of consideration by policymakers.

State adoption of a social insurance program for LTSS could spur growth in the private insurance market, since it is unlikely that such a program would pay for all LTSS costs for all people.

When introducing a social insurance program to address the LTSS needs of residents, state policymakers need to be mindful of four core design issues:

- **Program structure.** This refers to who will be eligible for the program's benefits, how generational transition issues will be dealt with, and the timing and duration of coverage.
- **Financing approach.** This encompasses two broad and critical issues. One has to do with the source or sources of funding for the program (e.g., payroll tax, income tax, or other options). The other question is whether the program is financed on a pay-as-you-go or prefunded basis.
- **Program integration.** This refers to how the new program interfaces with the existing LTSS financing and service delivery systems. Integration is particularly important for ensuring that

benefits are paid appropriately, consumers do not face discontinuities in coverage, and program accounting and financial forecasting can be completed accurately.

- **Program implementation strategy.** This addresses the strategies and tactics for program administration, collection of revenues, eligibility determination, ongoing program management, program integrity, and evaluation.

These issues are discussed in the following sections.

Section IV.

**PROGRAM
STRUCTURE:
NEW COVERAGE
OPTIONS AND
BENEFIT DESIGN**

While there are many components to be determined in designing a program, this section focuses on the three most critical: **eligible population, generational transition issues, and coverage durations and start times.** Additional considerations—such as the criteria for becoming eligible for benefits (benefit triggers), the amount of the benefit payment, and whether benefits are paid in the form of cash or as a reimbursement for services received—are discussed in Appendix I.

Eligible Population

People needing LTSS include elderly and non-elderly people with intellectual and developmental disabilities, physical disabilities, behavioral health diagnoses (such as dementia), spinal cord or traumatic brain injuries, and/or disabling chronic conditions. A person's age, gender, socioeconomic status, living arrangement, and access to information about care options, in addition to their health and disability status, can influence the types and amounts of LTSS utilized and the duration of care.⁴⁶ People with disabilities may need LTSS at a relatively young age as a result of illness or injury, and in some cases throughout their entire lives. LTSS can facilitate a meaningful life as part of a community and provide modest support to a family to support the individual in need.

How or whether to include people with disabilities in a social insurance program can have a major impact on program costs, the feasibility and suitability of specific program designs, and options for how the program

is to be financed. The decision also has important implications for public support for the program as a broader constituency of individuals with LTSS need would benefit from the program. For the most part, inclusion of those under 65 with LTSS need would result in higher costs compared to a program designed exclusively as a retirement benefit; this is because, everything else held constant, there is less time to prefund (collect and invest contributions to pay for future benefits). Furthermore, if there is no vesting requirement, the funds needed to pay claims will be higher, given that there will be an immediate need on the day the program becomes operational. Finally, the lifetime service costs for people with lifelong LTSS need tend to be higher than for those who become disabled after 65.⁴⁷

On the other hand, including this population ensures that the program is completely universal and focused on the *need* for LTSS rather than the *cause* of the need. It would ensure that individuals with similar needs would receive the same coverage, regardless of age.

Generational Transition Issues

When instituting a new LTSS social insurance program, policymakers must make a choice. The program could cover only those who start paying in now, and only some years from now, after they have vested in the program (paid in long enough to earn benefit eligibility). In such a *prefunded* system, current contributions are invested

⁴⁶ "Who Needs Care?," U.S. Department of Health and Human Services, 2015, <http://longtermcare.gov/the-basics/who-needs-care/>.

⁴⁷ It should also be noted that, through the ABLE Act of 2014, 39 states now have programs to assist families caring for individuals whose disabilities emerged before age 26 by enhancing their ability to save and pay for LTSS on a tax-advantaged basis. (For more on ABLE accounts see the ABLE National Resource Center, <http://ablenrc.org>.)

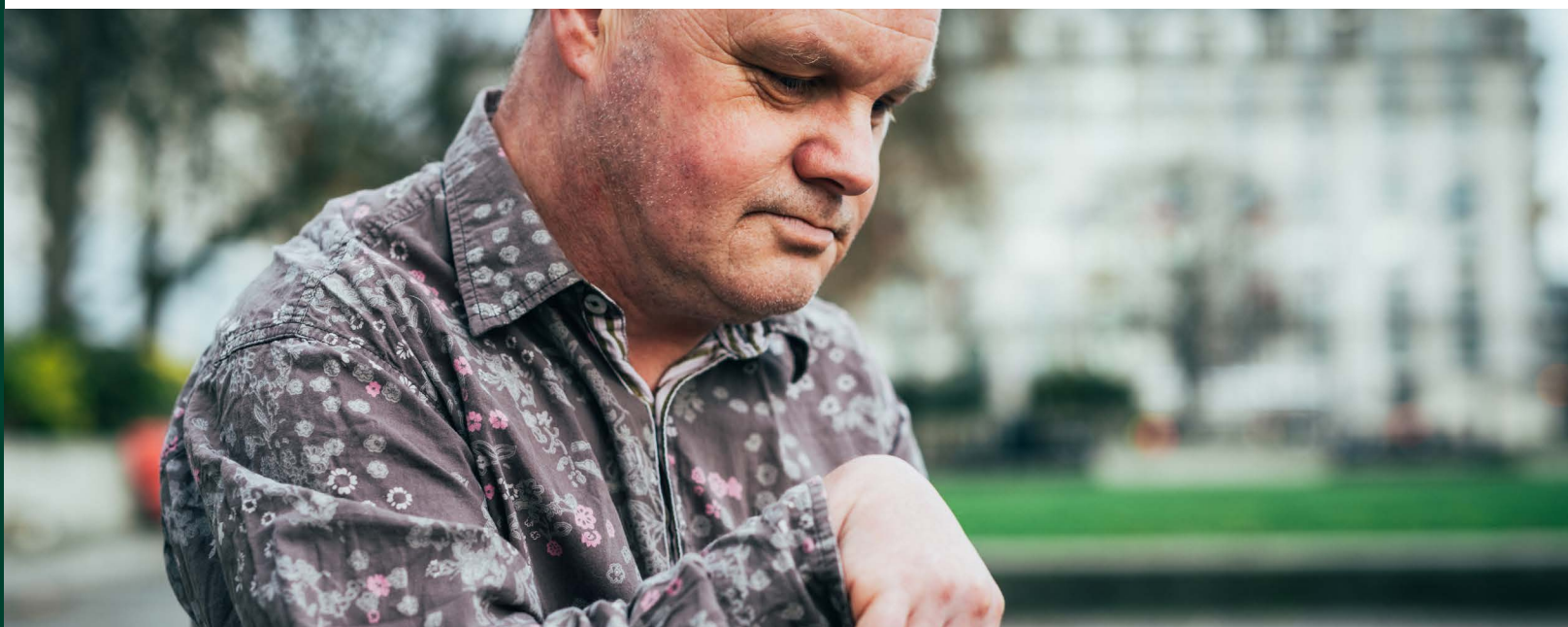
to pay for future needs. Alternatively, the program could cover everyone essentially from the start, including those who are already retired or disabled. In such a *pay-as-you-go* (PAYGO) system, current contributions pay for the benefits of those who need them now. The financial implications of this choice will be examined in the next section of this chapter, which is devoted to financing issues; here we will discuss more general issues.

While prefunded systems require vesting and so would exclude Baby Boomers and most people with lifelong disabilities, PAYGO systems can cover everyone immediately, typically making them a politically more viable approach (particularly given that seniors are more likely to vote than other age groups). For this reason, the vast majority of public long-term care systems around the world operate on a PAYGO basis.

One approach is to adopt a prefunded social insurance program to provide for future LTSS needs while relying on a separate system funded by general revenues to

The vast majority of public long-term care systems around the world operate on a PAYGO basis.

cover those already disabled today as well as the transition cohorts (those too old to become vested under the prefunded system). The second of these components already exists in the form of Medicaid LTSS, so policymakers could choose to introduce a prefunded system and rely on Medicaid to serve transition cohorts. The downsides of this approach are, as we have seen, that under Medicaid LTSS in its current form, individuals must deplete their assets and access to HCBS can be limited. However, a state adopting a prefunded social insurance program for future LTSS needs might be able to obtain a waiver to enhance its Medicaid LTSS program during the transition period. This could provide broader coverage to people who have already retired and so are unable to earn vesting in the new program. Hybrid approaches between a prefunded and PAYGO system are possible as well. One such approach is to collect contributions



for several years before benefit payouts begin, allowing the system to accumulate some level of assets. Another is to cover everyone from the start, but set aside part of the payroll contributions in a “buffer fund” to pay for future cohorts. Germany’s 2015 reform package, for example, increased the contribution rate for its social insurance program and stipulated that part of the money would go to a trust fund that could only be used to pay benefits from 2035 onward.⁴⁸ This approach helps equalize the burden of funding the cost of demographic transition across generational cohorts, and also stabilizes the rate of payroll contributions needed to fund benefits over the long term.

Universal LTSS programs—whether prefunded or PAYGO—require young people to pay into a system that does not usually pay benefits until far into the future (unless a beneficiary is or becomes disabled before retirement age). This can be politically problematic, particularly as many young people may have difficulty imagining that they will ever need long-term care. One way to address this—as Japan has done—is to require participation and contributions only from people 40 and older, who are likely to be more aware of their own long-term care risks and of those of their aging parents. However, restricting the program’s tax base in this way requires an increase in contribution levels, a reduction in benefits, or restrictions on beneficiaries. (For instance,

Japan’s system pays benefits only to those with aging-related disabilities.⁴⁹)

Coverage Durations and Start Times

Policymakers have to choose among three basic structures:

- **Front-end coverage.** Benefits begin to be paid as soon as someone becomes disabled (or after a brief waiting period of, for example, 30 or 90 days), but they last only for a limited time (such as a year or two) or only up to a total dollar amount.
- **Back-end (catastrophic) coverage.** Benefits begin only after someone has been disabled for an extended period (such as two or three years).
- **Comprehensive coverage.** Benefits are paid during the entire period of need.

Once the basic structure is set, there are other choices. For front-end coverage, one must decide how long benefits will last or what the maximum dollar amount will be. For back-end coverage, one must decide how long a person must be disabled before benefits begin, and whether benefits will last as long as care is needed or be subject to a time or dollar limit. In the front-end approach, everyone who becomes disabled receives some benefits, but those who need care for a long time must pay their own expenses if care needs extend beyond the coverage duration. The back-end approach ensures that participants

⁴⁸ Deutscher Bundesrat, “Erstes Gesetz zur Stärkung der pflegerischen Versorgung und zur Änderung weiterer Vorschriften (Erstes Pflegestärkungsgesetz - PSG I),” Drucksache 466/14, October 17, 2014, https://www.bundesrat.de/SharedDocs/drucksachen/2014/0401-0500/466-14.pdf?__blob=publicationFile&v=1.

⁴⁹ Laurie Joshua, “Aging and Long Term Care Systems: A Review of Finance and Governance Arrangements in Europe, North America and Asia-Pacific,” Social Protection and Labor Discussion Paper Nr. 1705, World Bank Group, November 2017, <http://documents.worldbank.org/curated/en/761221511952743424/Aging-and-long-term-care-systems-a-review-of-finance-and-governance-arrangements-in-Europe-North-America-and-Asia-Pacific>.



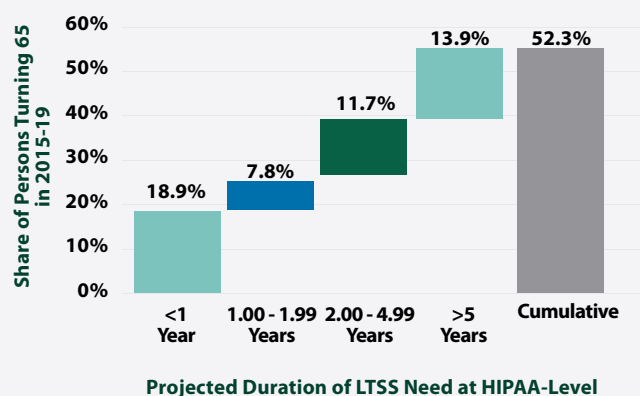
are protected against catastrophic costs, but everyone must cover their own expenses for an initial period. Back-end coverage has the advantage of meeting a need not addressed by currently available private insurance products (which do not cover catastrophic costs). On the other hand, having to pay expenses for an initial period may be a hardship for low-income people, although presumably many would qualify for Medicaid LTSS. For most people, family members would likely provide most needed care until a back-end benefit kicked in. In a back-end system, those who need LTSS for only a limited time will receive no financial benefits at all.

A front-end program typically serves more people but pays them less, while a back-end program serves fewer people but pays them more. If overall program cost is held constant, beneficiaries in a back-end system receive more on average than those in a front-end system. This is because the care needs of those who have required LTSS for a long time are typically greater than those who have recently developed an impairment, and the length of time they receive benefits is open-ended.

Closer examination of the impact of program structures on the older adults reveal some of the differences. Figure 7 shows that a little more than half (52.3 percent) of those turning 65 today will, at some point in their lifetime,

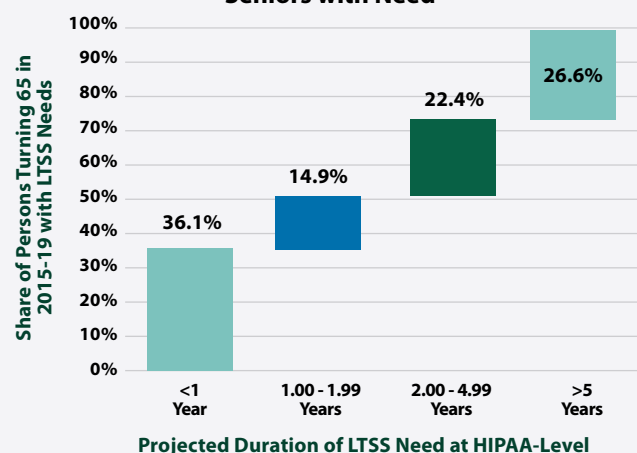
require significant LTSS (because of the inability to perform at least two ADLs and/or a severe cognitive impairment). The other half of seniors would receive no benefits from any type of LTSS program, since they will have no need. Figure 8 focuses on those who will have a need, showing how many need LTSS for different durations; this enables us to see who will benefit from different program structures. A front-end program that provides coverage for the first two years of LTSS need would cover the entire duration of care of the 51 percent of seniors who will need care for less than two years. For the other 49 percent, it would cover the first two years, after which they would be on their own. Thus, 100 percent of those in need would receive some benefit from this front-end program, and about half would receive benefits for the whole time they needed LTSS. In contrast, a back-end program beginning with the third year of LTSS need would cover 49 percent of seniors with LTSS needs; the other 51 percent would receive no benefits. A comprehensive program would cover the entire period of need for everyone with significant LTSS needs regardless of how long that need persisted.

A front-end program typically serves more people but pays them less, while a back-end program serves fewer people but pays them more.

FIGURE 7: Share of Seniors with LTSS Need by Duration

Source: Favreault and Dey, 2016.

For either a front-end or a back-end program, a decision must be made about the maximum duration of benefits or the maximum dollar amount of benefits. This will be a key factor in both the generosity of coverage and the program cost. A front-end program might pay benefits for one or two years, or it might set a dollar maximum based on one or two years. (For instance, the maximum might be based on a daily benefit of \$100 for two years—that is, \$73,000, the product of \$100 x 365 x 2). A pure back-end program would have no limit on duration or total amount of benefits, but a back-end program could be designed with

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

Source: Favreault and Dey, 2016.

such limits. In a comprehensive program, policymakers could consider paying a lower benefit in the early years of LTSS need and a higher benefit after a certain number of years. This could be cost-neutral, but it would address the fact that a person's care costs often go up the longer they need care (as impairments become more severe and unpaid caregivers become less available), and their ability to pay declines as savings are depleted.

Any new public program would likely leave a role for personal savings and supplemental private insurance, which would fill gaps and



meet certain consumer needs and wants. Whether and how the private market could be expected to offer products to supplement a social insurance program is one of many considerations states face. Private insurers are no longer willing to cover LTSS needs for an indefinite period (the back-end, catastrophic risk), but they are interested in covering the front-end risk. A back-end public program thus seems more likely to attract private insurers offering wrap-around or supplemental policies. A back-end public program also provides a clear delineation between when private coverage ends and public coverage begins. With a front-end program, private insurers might be willing to offer additional

coverage, but with a limit on duration. With a comprehensive public program, which is likely to have a lower daily benefit in order to contain costs, private coverage might “top up” the benefit amount for those who are willing and able to afford more coverage. Table 1 summarizes some of the key differences among program structures.

Any new public program would likely leave a role for personal savings and supplemental private insurance, which would fill gaps and meet certain consumer needs and wants.

TABLE 1: Comparison of Front-end, Back-end, and Comprehensive LTSS Coverage

	Front-end	Back-end (Catastrophic)	Comprehensive
Who is covered?	Everyone with an LTSS need receives some benefits.	Targets funding to those with the greatest LTSS needs (longest duration).	Everyone with an LTSS need receives benefits.
Program costs	More predictable program costs and more affordable premiums, all else equal.	Costs may be more unpredictable, as life span increases over time or as duration of morbidity increases.	Most expensive (all else being equal) because both front- and back-end needs are covered and duration of needs is unpredictable. Costs also may be unpredictable as life span increases or as duration of morbidity increases.
Impact on family caregivers	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).	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.	Reduces family care burden throughout duration of need.
Private market gap-filling	More difficult for private market to supplement because private market unlikely to cover catastrophic, back-end risk.	Easier for private market to gap-fill with affordable front-end coverage for those who want it.	Private market might gap-fill with a benefit that adds to the daily benefit amount.

Section V.

SOCIAL INSURANCE FINANCING OPTIONS

NATIONAL
ACADEMY
OF SOCIAL
INSURANCE

Nearly all states are required to balance their budgets, either by constitution or by statute. Hence a new LTSS program will need to be fully paid for. This section identifies the conventional approaches used to finance social insurance programs and also puts forward other potential funding sources. The panel recognizes that each state's tax system and culture are unique. For example, not all states have an income, sales, or estate tax. Moreover, some states will prefer a program with higher benefits and funding levels, while others will prefer a more modest program.

Before discussing revenue sources, it should be noted that our LTSS system today is already asking people with disabilities and their families to pay for LTSS, but in an inefficient manner. The primary source of all LTSS today—if one considers both compensated and uncompensated care—is out-of-pocket costs paid by individuals needing care and the support-related costs of their family caregivers. These costs include cash payments to those providing paid LTSS as well as income lost by family caregivers having to work less.⁵⁰ These costs occur with no risk pooling or prefunding and often come at a time when individuals and their families are most vulnerable. The fundamental LTSS

Before discussing revenue sources, it should be noted that our LTSS system today is already asking people with disabilities and their families to pay for LTSS, but in an inefficient manner.

financing problem today is the absence of an effective insurance mechanism to protect people against these costs.⁵¹

A new LTSS social insurance program could be financed through dedicated payroll taxes (as for Social Security or Medicare), income or sales surtaxes, estate or property taxes, other earmarked taxes, provider fees, a combination of these, or general revenues. Beneficiaries could also be charged premiums, as for Medicare Parts B and D. For a tax-based approach, one needs to consider the base over which the tax is applied (e.g., wages, total income, adjusted gross income), the distribution of the tax burden across different income and age groups, the period over which the tax is collected, and how the tax base is likely to change over time. The financial adequacy and political feasibility of funding sources vary, and in making choices states will need to both ensure fiscal sustainability and garner political support.

Financing Sources for Federal Social Insurance Programs

Existing large-scale social insurance programs in the United States include Social Security, Medicare, Workers' Compensation, Unemployment Insurance, and Paid Family and Medical leave. How are federal social insurance programs funded?

- **Social Security** levies a payroll tax on all earned income, up to an annual cap (\$132,900 in 2019, indexed to wage inflation). This is paid by both workers and

⁵⁰ Vivian Nguyen, "Long-Term Support and Services," AARP Public Policy Institute Fact Sheet, March 2017, <https://www.aarp.org/content/dam/aarp/ppi/2017-01/Fact%20Sheet%20Long-Term%20Support%20and%20Services.pdf>.

⁵¹ Marc Cohen, Judy Feder, and Melissa Favreault, "A New Public-Private Partnership: Catastrophic Public and Front-End Private LTC Insurance," unpublished manuscript, January 2018.

employers, but an LTSS tax could be paid by workers alone. There are many ways a new LTSS program could adapt the Social Security approach. Possibilities include: (1) levy a tax on the Social Security tax base (earned income up to the Social Security tax cap); (2) levy a tax on earned income without a cap; or (3) levy a tax only on earned income above the cap.

■ **Medicare Part A** also levies a payroll tax on earnings, paid by workers and employers, but without an annual cap. Also, an Additional Medicare Tax is levied on earnings above certain thresholds (\$200,000 for an individual, \$250,000 for a couple).⁵²

■ **Medicare Parts B and D.** Roughly three-quarters of funding comes from general revenues, and most of the rest comes from premiums paid by beneficiaries. Higher-income enrollees (those earning more than \$85,000 for individuals and \$170,000 for couples) pay premiums that are 40 to 240 percent higher.⁵³

■ **Medicare Net Investment Income Tax.** This is a tax on unearned (investment) income levied on households with modified adjusted gross income above \$200,000 for individuals or \$250,000 for couples (thresholds not indexed for inflation). The funds raised do not go into the Medicare trust fund but rather to general revenues.

If a new LTSS program is financed by a payroll contribution (i.e., a tax on wages), it must address the issue of whether and/or how people who are not in the labor force would be eligible to participate, and current Social Security regulations may offer a guideline in this regard.

Financing Sources for State Social Insurance Programs

State governments also administer social insurance programs, and these employ additional financing approaches that would be possible for an LTSS program:

■ **Workers' Compensation.** Employers pay premiums for their workers; employers may also (where it is permitted and provided that they meet certain financial requirements) self-insure the risk (pay claims out of their own resources). Premiums are paid either to a state-run insurance program or to a private insurance company. Premiums vary based on a variety of factors, including expected risk and an employer's past record of on-the-job illness and injury (experience rating).⁵⁴

■ **Unemployment Insurance** is funded by a federal tax paid by employers and by employers' state contributions. As with Workers' Compensation, contribution rates vary based on several factors, including an employer's past experience with layoffs.⁵⁵

⁵² Benjamin W. Veghte, Elliot Schreur, and Alexandra L. Bradley (eds.), *Report to the New Leadership and the American People on Social Insurance and Inequality* (Washington, DC: National Academy of Social Insurance, 2017), https://www.nasi.org/sites/default/files/research/Report_to_New_Leadership_and_American_People_web.pdf.

⁵³ Juliette Cubanski and Tricia Neuman, "Medicare's Income-Related Premiums under Current Law and Changes for 2019," Kaiser Family Foundation, <http://files.kff.org/attachment/Issue-Brief-Medicare's-Income-Related-Premiums-Under-Current-Law-and-Changes-for-2019>.

⁵⁴ Ibid.

⁵⁵ Ibid.



■ **Paid Family and Medical Leave.** There are four states with paid family and medical leave programs, one state with a paid medical leave program, and three states and the District of Columbia in the process of implementing recently enacted PFML. Most of these programs are funded through payroll contributions by workers and/or employers, although in some cases employers pay premiums to private insurance companies.⁵⁶

Having administered these programs in some cases for three-quarters of a century or more, states have a proven track record of collecting payroll taxes and/or premiums from employees and/or employers, and in administering the payment of benefits. That said, there may be greater complexities in administering an LTSS program, particularly in long-term actuarial planning and—if a prefunded program is adopted—asset accumulation. This is because Workers' Compensation, Unemployment Insurance, and Paid Family and Medical leave claims

are typically not of long duration, whereas LTSS claims typically are. Furthermore, LTSS program costs and the timing of those costs are heavily influenced by demographic trends.

States have a proven track record in collecting payroll taxes and/or premiums from employees and/or employers, and in administering the payment of benefits.

Additional Potential Funding Sources

■ **Income surtax.** States could levy a surtax on their income tax base and dedicate this to the new LTSS program. State income tax bases differ by state, while seven states—Alaska, Florida, Nevada, South Dakota, Texas, Washington, and Wyoming—have no income tax whatsoever. Residents of New Hampshire and Tennessee pay taxes only on dividends and other income from investments.

⁵⁶ Sarah Jane Glynn, Alexandra L. Bradley, and Benjamin W. Veghte, "Paid Family and Medical Leave Programs: State Pathways and Design Options," National Academy of Social Insurance, September 2017, <https://www.nasi.org/sites/default/files/research/NASI%20PFML%20brief%202017-%20Final.pdf>.

■ **Sales surtax.** A sales tax is a tax on the sale of goods and services. Forty-five states and the District of Columbia have a sales tax, and five—Alaska, Delaware, Montana, New Hampshire, and Oregon—do not. Many states have lower sales tax rates or no tax at all on some food, other goods, and many services such as medical care, education, and most professional services. This renders the sales tax base narrow in most states.

■ **Other dedicated taxes.** Dedicated taxes produce revenue streams that are earmarked for a particular purpose and therefore not available for general budgeting to support the full range of agencies, programs, and services provided by the government. Dedicated financing may be conducive to the fiscal sustainability of a new LTSS program given state balanced budget requirements, which make funding a large new program out of general revenue challenging. However, statutory earmarks can be overridden by changes in the law,

and they are even ignored in some cases, which makes meeting the challenge of fiscal sustainability more difficult.

■ **Provider fees:** Fees from care providers—hospitals, nursing homes, managed care plans, and health facilities—are currently a revenue source for 49 state Medicaid programs.⁵⁷ States could charge LTSS providers a percentage of payments made to them for services and earmark this revenue for the new LTSS program. However, it should be noted that the LTSS service infrastructure is not yet developed enough to meet current needs, so that imposition of a provider fee may prove very difficult in many states.

■ **Estate Tax.** Estate taxes are levies on the net value of the assets of a deceased person prior to their distribution to heirs. Thirteen states currently have an estate tax. However, these states exempt between \$1 million and \$11.2 million in assets from

⁵⁷ American Action Forum, “Medicaid Provider Fees Explained,” June 16, 2014, <https://www.americanactionforum.org/insight/medicaid-provider-fees-explained/>.



their estate tax, so that the vast majority of estates are not subject to this tax. Moreover, those that are subject to it pay the rate (often gradually increasing with asset size, up to a maximum rate in some states of 20 percent) only on the value of assets above the exemption threshold. Estate taxes have been rolled back significantly since 2001, both on the state and federal levels, and they can be fairly easily avoided.⁵⁸

- **Property surtax.** A property tax is a tax on real property (land and buildings) or personal property (e.g., business equipment or noncommercial motor vehicles). All states have property taxes, but the tax is primarily levied by cities, counties, and school districts rather than by states. Hence property taxes are, typically, not a major source of state revenue (New Hampshire being a notable exception).⁵⁹ Moreover, 44 states have either a statutory or constitutional limit on property taxes.⁶⁰

- **General revenues:** General revenues are revenues raised by government from all sources not earmarked for specific purposes. They may include revenues from a state income tax, corporate income tax, sales tax, or excise taxes (although not all states have each of these). Medicaid, the main public program paying for

LTSS in the U.S. today, is funded (jointly by states and the federal government) predominantly from general revenues. Its funding is based on a federal formula that pays states a percentage of their qualifying expenditures; that percentage varies by state (with states having lower per capita income receiving more).

- **Premiums:** While social insurance programs do not have risk-related premiums as in private insurance, they may have flat or income-related premiums. In a new LTSS program, seniors and/or beneficiaries of any age could be charged premiums either scaled to age or on a community-rated basis. Moreover, higher-income people could be charged more, or all could pay the same. Exemptions or subsidies could be considered for those with low income.

Funding Considerations

Several criteria should be considered in choosing one or more revenue sources to fund a new LTSS program.

- **Size of tax base.** The smaller the base of the revenue source chosen, the higher the rate will need to be. At the state level, among the taxes available to policymakers, income taxes (where applicable) have the largest base, followed by payroll taxes.

⁵⁸ The Urban Institute, "Estate and Inheritance Taxes, 2018" (State and Local Backgrounders), <https://www.urban.org/policy-centers/cross-center-initiatives/state-local-finance-initiative/state-and-local-backgrounders/estate-and-inheritance-taxes>; Chye-Ching Huang and Chloe Cho, "Ten Facts You Should Know about the Federal Estate Tax," Center on Budget and Policy Priorities, October 30, 2017, <https://www.cbpp.org/research/federal-tax/ten-facts-you-should-know-about-the-federal-estate-tax>.

⁵⁹ The Urban Institute, "Property Taxes" (State and Local Backgrounders), <https://www.urban.org/policy-centers/cross-center-initiatives/state-local-finance-initiative/projects/state-and-local-backgrounders/property-taxes>.

⁶⁰ Iris J. Lav and Michael Leachman, "State Limits on Property Taxes Hamstring Local Services and Should Be Relaxed or Repealed," Center on Budget and Policy Priorities, July 18, 2018, <https://www.cbpp.org/research/state-budget-and-tax/state-limits-on-property-taxes-hamstring-local-services-and-should-be>.

■ **Fiscal sustainability.** In LTSS programs, a long time typically elapses between when individuals begin making contributions and when they receive benefits. One of the goals of a program is to provide plan participants with peace of mind during this period, and if a program is fiscally sustainable, participants have the assurance that promised benefits will be there when they need them. Ideally, revenues should be set to meet projected benefit costs over at least a 75-year window, with experience reviews at specified intervals (e.g., every five years). Under a new program, states will face a choice between committing to certain benefit levels and, if necessary, adjusting revenue to fund those levels, or setting revenue and adjusting benefits to match the available funds. Using multiple and diverse financing sources can make a program's revenue stream more stable, while also making each revenue component smaller. On the other hand, using only one revenue source simplifies the financial management and administration of the program. A combination of dedicated funds and general revenues might be used. If the earmarked funds are sufficient for benefits, they can be the sole source of financing. If they are insufficient, general funds can be used to cover the deficit while the earmarked funding is adjusted. General revenues could also be used to make up shortfalls in projected income from fund investment returns, or to subsidize the contributions of low-income participants or those who are outside the workforce.

■ **Political sustainability.** Contributory social insurance programs have proven far more politically resilient than programs funded out of general revenues. Their funds are strictly separated from government budgets and cannot easily be used for other purposes. In contrast, general revenues may be used for any purpose, and funds for any specific need, such as an LTSS program, would be subject to reallocation each year in the annual appropriations process. In addition, in a social insurance program, contributors tend to feel that they have earned a right to benefits if the insured risk transpires, creating a strong constituency to sustain the program.⁶¹ However, Medicaid is an example of a general revenue-funded program that has proven remarkably resilient; since its enactment, it has seen major expansions to children and (in many states) childless adults. Still, it was one vote short of being significantly cut in 2017, highlighting the political vulnerability of social programs funded by general revenues.

■ **Affordability;** A universal program needs to be affordable even for low-income participants. Otherwise, it will contribute to their financial hardship. A modest payroll tax, whereby workers contribute a fixed percentage of their earnings, can by definition not exceed a small fraction of a worker's income. Some social insurance programs provide subsidies funded from general revenues for those who cannot afford contribution payments.

⁶¹ Xenia Scheil-Adlung, "Long-Term Care Protection for Older Persons: A Review of Coverage Deficits in 46 Countries," Working Paper No. 50, International Labour Organization, https://www.researchgate.net/publication/282249506_Long-term_care_protection_A_review_of_coverage_deficits_in_46_countries.

■ **Connection with program benefits.**

People tend to be more willing to pay particular taxes if the money goes to a particular purpose they find worthwhile—see, for example, the popular acceptance of Social Security and Medicare taxes. Having a revenue stream (whether from a payroll tax or some other source) dedicated to a new LTSS program would likely increase buy-in for the program and the taxes used to fund it. Buy-in can also be enhanced if a revenue source is related in some way to the purpose it is used for, and several types of sources are connected to LTSS. For example, provider fees on businesses supplying LTSS services, which would benefit from an increase in revenue from the new program, would fit this criterion. So would a tax on the value of a home to help finance LTSS services so that people could age in place.

A conceptual case can be made for using an estate tax to fund LTSS benefits. It

would allow people to protect part of their estate from the largest unfunded liability threatening it—major LTSS costs. Today, many people tap into their assets—by withdrawing from their 401(k), selling their home, or taking out a reverse mortgage—to pay for LTSS. Some completely exhaust their assets. For example, one study found that among nursing home entrants, housing wealth steadily declined over a six-year period, resulting in a median housing wealth of zero within six years after entry.⁶² In other cases, after a person has received Medicaid LTSS benefits, a state may put a lien on their estate and reclaim the cost of some of those benefits after their death. If a modest estate tax were enacted with a low threshold, it could ensure that a broad range of households contribute to LTSS from their assets, while rendering it extremely unlikely that anyone—even someone with high LTSS needs—would deplete all their assets paying for LTSS.

⁶² Sudipto Banerjee, “Effects of Nursing Home Stays on Household Portfolios”, EBRI Issue Brief No. 372, July 31, 2015, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2088936.



Other possible funding sources, not discussed here, include excise taxes (e.g., state taxes on alcohol and tobacco, which are sometimes used to fund health care and education spending), taxes on business income and tourism (which fund Hawaii's Kūpuna Caregivers program), and lottery funding (used by Florida to address nursing home liability issues). "Sin" and lottery taxes are highly regressive.

A modest estate tax could ensure that a broad range of households contribute to LTSS from their assets, while making it extremely unlikely that anyone would deplete all of their assets to pay for LTSS.

Pay-As-You-Go vs. Prefunding

As noted earlier, a key decision is whether a new program is to be financed on a PAYGO basis or prefunded. A **prefunded system** invests the contributions of current workers and pays future benefits out of the assets generated. Therefore, it cannot immediately pay out benefits for currently eligible individuals, but rather must accumulate monies for many years before benefits can be paid. This leaves workers who are above a certain age when a program is first implemented (transition cohorts) excluded from the benefits of the program. On the other hand, prefunding future benefits lowers the tax burden on current workers, as funds can grow through investment. This is true, however, only insofar as the monies collected are segregated or earmarked for the exclusive

purposes of the program. A prefunded system also has more time to adjust to demographic shifts like the aging of the population.

In a **PAYGO system**, the program pays current benefits out of current contributions, and the future benefits of current workers will be paid for out of future contributions. While a PAYGO system can pay out benefits soon after it starts collecting contributions, the contribution rate would likely need to be higher than in a prefunded approach, where benefit payouts are deferred. This is because in a PAYGO system the fund would not earn investment income (which could help fund benefits) and because benefit payouts would occur sooner.

A state could take a mixed approach, using PAYGO and prefunding for different populations. For example, a prefunded program in which workers vest over time could be used for future benefits, while a PAYGO program could be used for those currently needing LTSS. In this approach, social insurance contributions could finance the prefunded benefits, while general revenues or a dedicated tax could fund benefits of the transition cohorts. Those already retired but not yet needing LTSS could participate in the program by paying premiums.

A mixed system could be complex to financially administer because the size of the prefunded and PAYGO components would change over time (with the prefunded component growing and the PAYGO component shrinking as people age). On the other hand, a mixed system would be able to pay benefits to currently eligible individuals while at the same time prefunding future



benefits. A mixed approach also has the potential to garner broad public support because it gives those currently needing LTSS some level of benefits while phasing in potentially more generous benefits for those who will need them in years to come.

As noted previously, another approach would be to rely on Medicaid LTSS to provide benefits (funded by general revenue) for the transition cohorts. This approach would have to take into account Medicaid's limitations—it requires individuals to deplete their assets and provides limited access to home-and community-based care.

LTSS Funding in Practice

In choosing a revenue source for a new LTSS program, it is helpful to consider how some major existing and proposed LTSS programs are—or would be—paid for, both in the U.S. and abroad, as shown in Table 2. The table also identifies the scope of coverage corresponding to each revenue source, as well as whether the system is financed on a prefunded or PAYGO basis.

A mixed approach also has the potential to garner broad public support because it gives those currently needing LTSS some level of benefits while phasing in potentially more generous benefits for those who will need them in years to come.

TABLE 2: Some U.S. and International Programs and Proposals for Financing LTSS

	Revenue Source	Scope of Coverage	PAYGO or Prefunded
Medicaid program	General revenues	Means-tested	PAYGO
Washington State*	Payroll tax on all earned income	Universal	PAYGO with limited prefunding
Cohen-Feder proposal**	From age 40 onward: Payroll tax on all earned income (split between employers and employees)	Universal (after income-related waiting period)	Prefunded
Germany	Payroll tax on earned income (split between employers and employees) up to a cap of €4,425 (\$5,100)/month; Pensioners pay full contribution; Childless workers pay supplementary contribution; Unemployment Insurance pays contributions for unemployed	Universal	PAYGO with limited prefunding
Japan	50% contributory (payroll tax [split between employers and employees] for those age 40-64 and modest income-related premiums for those age 65+)	Universal for 65+ and for age 40-64 with aging-related disability (e.g., dementia)	PAYGO
Netherlands	Contributory for institutional care and 24-hour home care (employee payroll tax on earned income up to cap of €3,280 (\$4,009)/month) with general revenue funding for other home care and LTSS	Universal	PAYGO
United Kingdom	General revenues	65+ only, means-tested	PAYGO
France	General revenues with smaller social insurance component	Universal 60+, strict disability criteria (3 ADLs), benefit levels inversely related to income	PAYGO
Taiwan	Increases in estate, gift, and tobacco taxes; general revenues	Near-universal***	PAYGO

*For a description of the Washington State program, see p. 156 of this chapter.

**A proposal by Marc Cohen of the University of Massachusetts at Boston and Judith Feder of the Urban Institute and Georgetown University would combine back-end (catastrophic) LTSS benefits with gap-filling private LTC insurance to ensure comprehensive protection, focused on middle-income people. For a fuller description, see Appendix III, as well as Marc Cohen, Judith Feder, and Melissa Favreault, "A New Public-Private Partnership: Catastrophic Public and Front-End Private LTC Insurance," Urban Institute, February 1, 2018, <https://www.urban.org/research/publication/new-public-private-partnership-catastrophic-public-and-front-end-private-ltc-insurance>.

***Taiwan's program covers people with disabilities age 49 and under, people with mild or severe dementia age 50 and older, and frail seniors 65 and older.

Sources: Francesca Colombo et al., "Help Wanted? Providing and Paying for Long-Term Care," OECD Health Policy Studies, 2011, <https://doi.org/10.1787/9789264097759-en>; Heinz Rothgang, "Social Insurance for Long-Term Care: An Evaluation of the German Model," Social Policy & Administration, Vol. 44, No.4, August 2010; Howard Gleckman, "Long-Term Care Financing Reform: Lessons from the U.S. and Abroad," The Commonwealth Fund, February 2010; KPMG, "Other Taxes and Levies," January 1, 2018, <https://home.kpmg.com/xx/en/home/insights/2011/12/Netherlands-Other-taxes-and-levies.html>; Deloitte, Tax@Hand, April 25, 2017, <https://www.taxathand.com/article/6752/Taiwan/2017/Changes-to-Long-Term-Care-Services-Act-Approved;More-Inclusive-Long-Term-Care-Plan-Approved,Taiwan-Today,September-30,2016,https://taiwantoday.tw/news.php?unit=2,6,10,15,18&post=102478>; Japan External Trade Organization, "Japan's Social Security System," https://www.jetro.go.jp/en/invest/setting_up/section4/page9.html.

As Table 2 shows, there is a variety of financing approaches in public LTSS programs (existing and proposed). One evident pattern is that existing programs tend to be pay-as-you-go because of the political challenges of introducing a system that fails to cover those currently in need, such as today's seniors or individuals under age 65 with disabilities.

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Section VI.

**COMPARING THE
COST OF DIFFERENT
STRUCTURAL
OPTIONS BY
FINANCING SOURCE**

While our discussion so far has focused on choices in program design, what likely looms largest for policymakers is the question of cost. That is, how much will it cost to finance a program, and what will this cost mean for those required to contribute to it? To answer these questions, we engaged the Actuarial Research Corporation to estimate what it might cost to pay for some illustrative programs of different types and ensure their fiscal solvency for a 75-year period, based on current knowledge of service utilization, the tax base, and expected demographic trends. To facilitate comparisons across major program types (e.g., front-end coverage, back-end coverage, etc.), we held constant many other program parameters (such as the structure and amount of the daily benefit and the benefit eligibility criteria). The estimates are expected to cover all benefit payments and expenses over the 75-year period under PAYGO financing. The programs are modeled as if they will be implemented nationally; however, a state program might cost more or less than the national estimate because of demographic and economic factors specific to the state.

In Table 3 we show the tax rate on workers required for three program structures, each of which reimburses the costs of covered services up to a daily benefit of \$100 and has the same benefit eligibility criteria (the same required level of functional or cognitive impairment). The Washington Front-End Plan pays benefits up to a total amount of \$36,500 (whether claimed all during one year or over a beneficiary's lifetime). What we call the "Home Health Program" pays benefits to participants

who meet eligibility thresholds but continue to live in the community (not a facility such as a nursing home). For this plan we model benefits payable over three different time periods: 365 days of services (\$36,500 maximum), 730 days of services (\$73,000 maximum), and an unlimited duration or dollar amount of benefits. The Cohen-Feder Catastrophic or Back-end Plan pays benefits only after an individual has satisfied the benefit eligibility criteria for two years.⁶³ Due to their vesting requirements, the Washington and Cohen-Feder models collect income for a period of time before any benefits are paid out and so have a degree of prefunding.

The tax rate that would be charged for each program is estimated for four different tax bases: (1) on the Social Security tax base (earnings up to an annual cap); (2) on the federal income tax base (income with no cap); (3) on the combined Medicare payroll (earnings without a cap) and Additional Medicare Tax on high earners (on income over \$200,000 single/\$250,000 married) tax bases; and (4) on the combined Medicare payroll, Additional Medicare Tax on high earners, and Medicare Net Investment Income Tax (paid on certain investment income by high earners) tax bases.

What likely looms largest for policymakers is the question of cost. That is, how much will it cost to finance a program, and what will this cost mean for those required to contribute to it?

⁶³ A proposal similar to the Cohen-Feder design was put forward at the federal level by Rep. Frank J. Pallone (D-NJ) in 2018. It will likely be introduced as a bill in Congress in 2019. (For analysis of the 2018 proposal, see Howard Gleckman, "A New Congressional Proposal for a Medicare Long-Term Care Insurance Benefit," *Forbes*, June 13, 2018, <https://www.forbes.com/sites/howardgleckman/2018/06/13/a-new-congressional-proposal-for-a-medicare-long-term-care-insurance-benefit/#733864b0737b>.)

TABLE 3: Tax Rates Required to Fund Some LTSS Programs, for Different Tax Bases
75-Year Rates Based on a \$100 Daily Benefit*

LTSS Program	Social Security Payroll Tax Rate	Income Tax Rate	Medicare Tax (if payroll tax only)		Medicare Tax (if payroll & investment income tax)		
			Payroll tax rate	Additional rate on earnings above \$200k/\$250k	Payroll tax rate	Additional rate on earnings above \$200k/\$250k	Investment income tax Rate
Washington Front-End	0.75%	0.58%	0.59%	0.18%	0.56%	0.17%	0.74%
Home Health, \$36,500 Benefit Max	1.08%	0.83%	0.85%	0.26%	0.81%	0.25%	1.06%
Home Health, \$73,000 Benefit Max	1.73%	1.33%	1.37%	0.42%	1.29%	0.40%	1.70%
Home Health, Unlimited Benefit Max	4.03%	3.11%	3.19%	0.99%	3.02%	0.94%	3.96%
Cohen-Feder Catastrophic	0.74%	0.57%	0.58%	0.18%	0.55%	0.17%	0.72%

Source: Edward Armentrout and Gordon Trapnell, "Actuarial Report on Long-Term Care Financing Proposals," Unpublished Report produced for the National Academy of Social Insurance, October 2018.

*The tax rate needed to assure fiscal solvency for a 75-year duration, that is, a projection period from 2018 to 2092, is calculated so that the present value of income (taxes) is sufficient to cover the expected benefits and expenses.

The Washington State and Cohen-Feder plans have very similar costs, and the required tax rates are nearly the same across the different tax bases. However, although they both pay a \$100 daily benefit (reimbursement for covered service expenses up to \$100 per day), the average total benefit received under the front-end Washington plan is less than under the back-end Cohen-Feder plan, but

the Washington plan pays benefits to more individuals. The Home Health Program is more expensive, because it is PAYGO covering those who are currently disabled, and the difference in cost is of course greater for versions that pay benefits for a longer period.

In thinking through program choices, policymakers may have in mind a certain level



of taxation that they believe is acceptable and politically feasible. It may be helpful to compare these three programs by assuming the same tax rate across all programs and estimating the daily benefit amount that this rate could sustain. Figures 9 through 11 show the estimates of daily benefit amounts that could be supported by each program under a 0.50%, 0.75%, and 1.00% tax rate across each of the tax base options.

As shown in these figures, across all tax rate levels modeled, the Washington front-end and the Cohen-Feder catastrophic back-end programs support higher daily benefits over the 75-year projection period for a given tax rate, although they will also provide fewer person-days of benefits compared to the other programs. Moreover, the analysis shows that, on average, the income and Medicare payroll tax bases yield greater revenues for the same tax percentage than do the other potential tax bases.

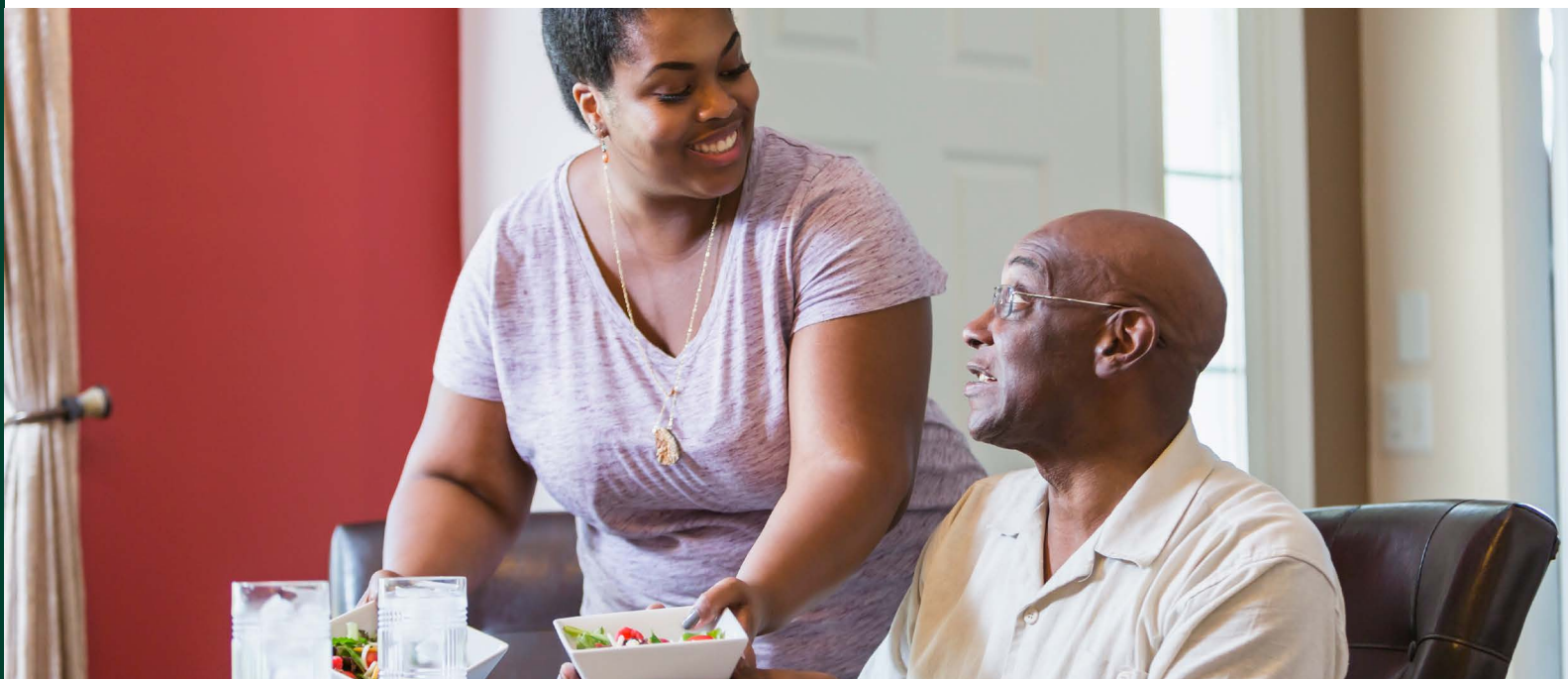
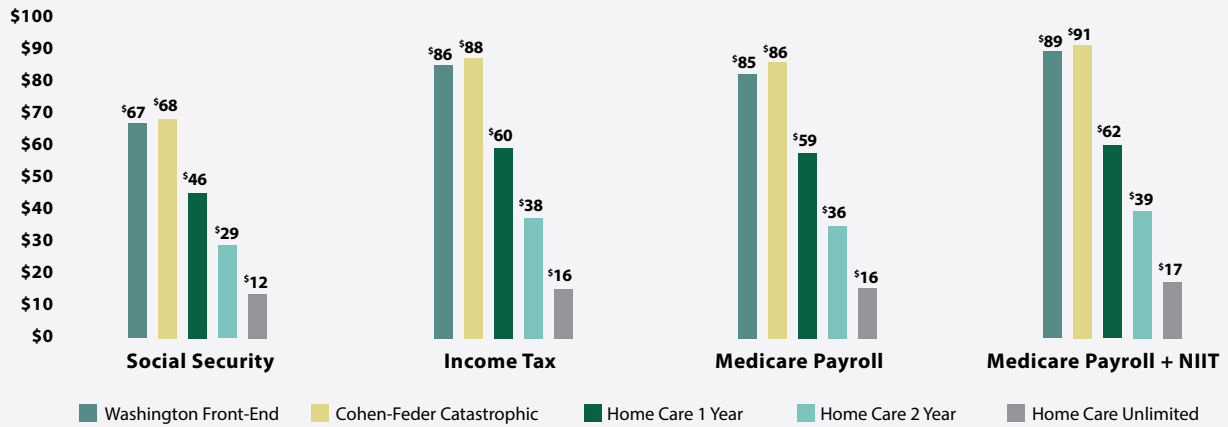


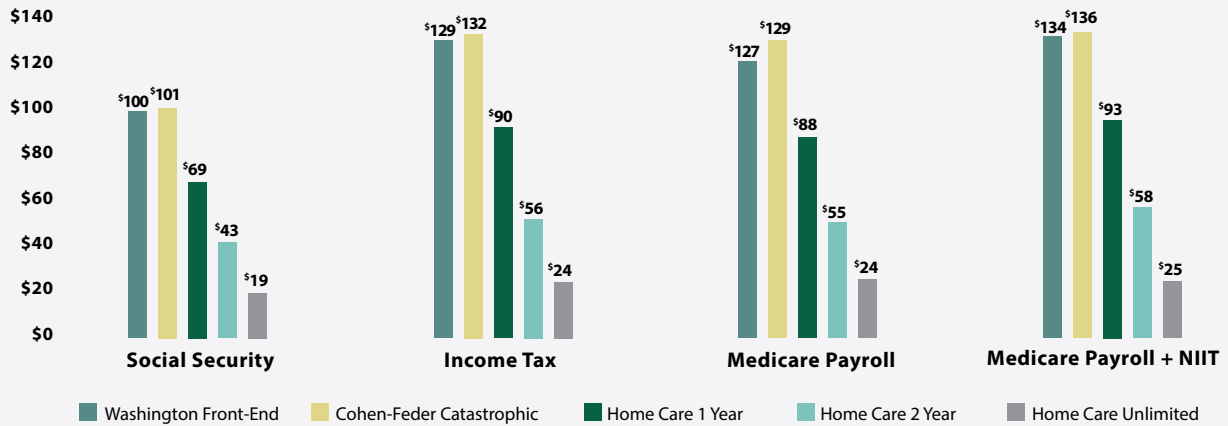
FIGURE 9: Daily Benefit for a 0.50% Tax Rate by Financing Source and Program Type



Source: Edward Armentrout and Gordon Trapnell, "Actuarial Report on Long-Term Care Financing Proposals," Unpublished Report produced for the National Academy of Social Insurance, October 2018.

Note: Medicare Payroll and Payroll + NIIT tax rates are set at 0.5% for the base payroll tax. High earnings and NIIT are set relative to the base payroll tax.

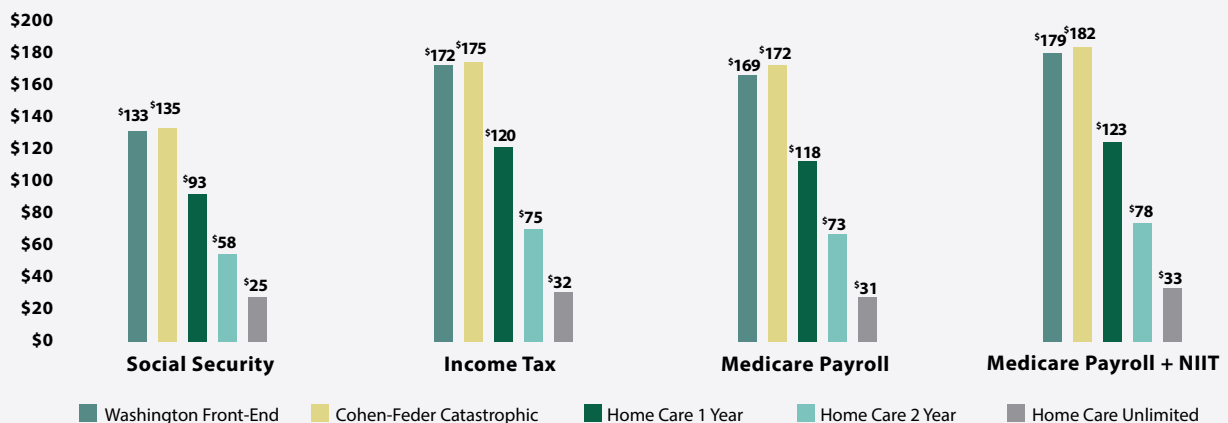
FIGURE 10: Daily Benefit for a 0.75% Tax Rate by Financing Source and Program Type



Source: Edward Armentrout and Gordon Trapnell, "Actuarial Report on Long-Term Care Financing Proposals," Unpublished Report produced for the National Academy of Social Insurance, October 2018.

Note: Medicare Payroll and Payroll + NIIT tax rates are set at 0.5% for the base payroll tax. High earnings and NIIT are set relative to the base payroll tax.

FIGURE 11: Daily Benefit for a 1.00% Tax Rate by Financing Source and Program Type



Source: Edward Armentrout and Gordon Trapnell, "Actuarial Report on Long-Term Care Financing Proposals," Unpublished Report produced for the National Academy of Social Insurance, October 2018.

Note: Medicare Payroll and Payroll + NIIT tax rates are set at 0.5% for the base payroll tax. High earnings and NIIT are set relative to the base payroll tax.

Section VII.

**INTEGRATION WITH
CURRENT LTSS
PAYMENT AND
DELIVERY SYSTEMS**

States that establish a new LTSS program will need to make decisions about the integration of the program with other payers and benefits, as discussed in this section.

Coordination of Benefits with Other Payers

One key issue is who will be the primary and who will be the secondary payer. (The secondary payer pays benefits only for services not covered by the primary payer.) By law, Medicaid is the payer of last resort for its beneficiaries,⁶⁴ so Medicaid would be the secondary payer for any LTSS services also covered by a new state program. Regarding private long-term care insurance policies, they, too, include a coordination of benefits provision designed to prevent duplication of coverage and overpayment (that is, a beneficiary receiving benefits from two payers for the same service).⁶⁵ States will need to determine whether there should be a coordination of benefits provision in the new LTSS program, and if so, how it should be structured.

Federal Medicaid Funding Issues

A new program should be structured so that the state will not lose federal Medicaid

matching dollars. In one approach, the new program could be designed to cover LTSS services or populations not (or not fully) covered by the state's Medicaid program. For instance, many state Medicaid programs do not fully cover home- and community-based services (either throughout the state or in some areas), and a new program could emphasize filling this gap, thereby complementing Medicaid. The unsuccessful Maine Universal Home Care ballot initiative, for example, authorized the Board creating the program to "design the program to reduce the amount of unmet need and to supplement and not supplant existing programs."⁶⁶

A new program should be structured so that the state will not lose federal Medicaid matching dollars.

Alternatively, states could seek a federal waiver allowing the new program to operate as the secondary payer to Medicaid. However, it is unclear whether such a waiver would conform with Medicaid's Third-Party Liability regulations.⁶⁷ Moreover, such a provision

⁶⁴ Code of Federal Regulations, Title 42 Public Health, https://www.ecfr.gov/cgi-bin/text-idx?SID=25d5f81f5390085e084f2454df1ef87d&mc=true&node=sp42.4.433.d&rgn=div6#se42.4.433_1140.

⁶⁵ Private insurers can make coverage changes to existing LTCI policies to accommodate a new state LTSS program and avoid duplication of benefits if the changes favor the policyholder, but not if they do not. Companies are likely to make such changes. In the future, private policies that seek to coordinate with an LTSS social insurance program or to fill gaps in it will have to define which payer is primary and which is secondary.

⁶⁶ Maine Legislature, IB0003, https://legislature.maine.gov/legis/bills/bills_128th/billtexts/IB000301.asp.

⁶⁷ It is unclear whether such a waiver could or would be approved. Medicaid's Third-Party Liability regulations state that they are implementing Sections "1902(a)(25), 1902(a)(45), 1903(d)(2), 1903(o), 1903(p), and 1912" of the Social Security Act. The Section 1115 waiver authority is only valid for items in Section 1902. In theory, anything flowing from Sections 1903 and 1912 cannot be waived, but 1902(a)(25) and (45) could be waived for a demonstration that promotes the objectives of Medicaid and is budget-neutral for the federal government. A state seeking such a waiver could argue that the substantive requirement is really in Section 1902 (not in 1903 and 1912), which can be waived. (Government Publishing Office, Electronic Code of Federal Regulations, December 20, 2018, <https://www.ecfr.gov/cgi-bin/text-idx?SID=25d5f81f5390085e084f2454df1ef87d&mc=true&node=sp42.4.433.d&rgn=div6>.)

would need to be structured in a way that required benefit coordination with Medicaid only for beneficiaries already on Medicaid, rather than requiring all new program beneficiaries to prove that they are not eligible for Medicaid, which would place a heavy bureaucratic burden on the new program.

Finally, states could seek a waiver to retain projected federal matching dollars as some state spending on LTSS shifts from Medicaid to the new program, on the grounds that the new program promotes the objectives of Medicaid and would be budget-neutral for the federal government.⁶⁸ With such a rationale, Massachusetts was able to secure a waiver in the late 1990s and has renewed that waiver twice since then. Washington State's recently enacted Long-Term Care Trust Act instructs its Department of Social and Health Services state to request any necessary waivers in this regard.⁶⁹

⁶⁸ Ibid.

⁶⁹ State of Washington Legislature, H-1732.1, 2019, <http://lawfilesexternal.wa.gov/biennium/2019-20/Pdf/Bills/House%20Bills/1087-S2.pdf>.

⁷⁰ Another issue to be resolved will be whether benefits paid by the program are considered income for the purpose of SSI eligibility.

Another issue: States contract with private-sector health plans to provide managed LTSS to their Medicaid populations. If some beneficiaries of the new LTSS program are on Medicaid and enrolled in one of these private plans, will the LTSS program pay their benefits directly to the plan? If so, there is a risk of losing federal Medicaid matching dollars. Here, too, a waiver may be necessary.

Are Program Benefits Income?

Another question: Would benefits paid by a new LTSS program be considered income for the purpose of Medicaid eligibility?⁷⁰ Some sources of income are exempt for eligibility purposes, and a state could seek a waiver to exempt the new program's benefits. States will also want to seek clarification from tax experts on whether benefits paid by the new LTSS program would, like most private LTCI



benefits, be considered tax-qualified, and so not treated as taxable income.⁷¹

Policymakers are looking for ways to contain health care spending growth, and there is a growing body of evidence that access to LTSS and integration and coordination of LTSS with medical care can both improve the quality of care and significantly reduce care costs, especially for high-need, high-cost individuals (with multiple chronic health conditions and functional limitations). For instance, in coordinated systems of integrated care, such as the Minnesota Senior Health Option (MSHO) for individuals dually eligible for Medicare and Medicaid (“dual eligibles”), those living in both nursing homes and the community had fewer hospital stays and fewer preventable hospitalizations and emergency room visits.⁷² Similarly, dual eligibles in Massachusetts’ Senior Care Options program experienced fewer hospital days and fewer nursing home placements than comparable dual eligibles in a fee-for-service environment.⁷³ Enrollees in the Program of

All-Inclusive Care for the Elderly (PACE)—which provides comprehensive preventive, primary, acute, and long-term care and social services to adults 55 or older with insurance through Medicare and/or Medicaid who have chronic conditions and functional and/or cognitive impairments—experienced fewer hospitalizations but more nursing home admissions.⁷⁴ Other efforts at acute and long-term care integration are underway across the country.⁷⁵ States implementing a new LTSS social insurance program should consider how the new LTSS benefit could be integrated into their existing LTSS—and acute care—delivery systems, as a way to both hold down costs and improve the care and quality of life of state residents.

There is a growing body of evidence that access to LTSS and integration and coordination of LTSS with medical care can both improve the quality of care and significantly reduce care costs, especially for high-need, high-cost individuals.

⁷¹ The basic question would be whether benefits of the new LTSS program pay for “qualified long-term care services” as defined by the IRS, and whether other requirements for tax-qualified status are met by the program. A ruling from the IRS may be needed, although current language allows for a “state-maintained plan” to receive tax-qualified status. While this was intended for state-provided long-term care coverage paid from individual premium contributions (e.g., the CalPERS Long Term Care Program), it is useful to note that this reference to a state-maintained plan currently exists within the IRS ruling for tax qualified long-term care.

⁷² Wayne L. Anderson, Sharon K. Long, and Zhanlian Feng, “Effects of Integrating Care for Medicare-Medicaid Dually Eligible Seniors in Minnesota,” *Journal of Aging and Social Policy*, July, 2018, DOI: 10.1080/08959420.2018.1485396.

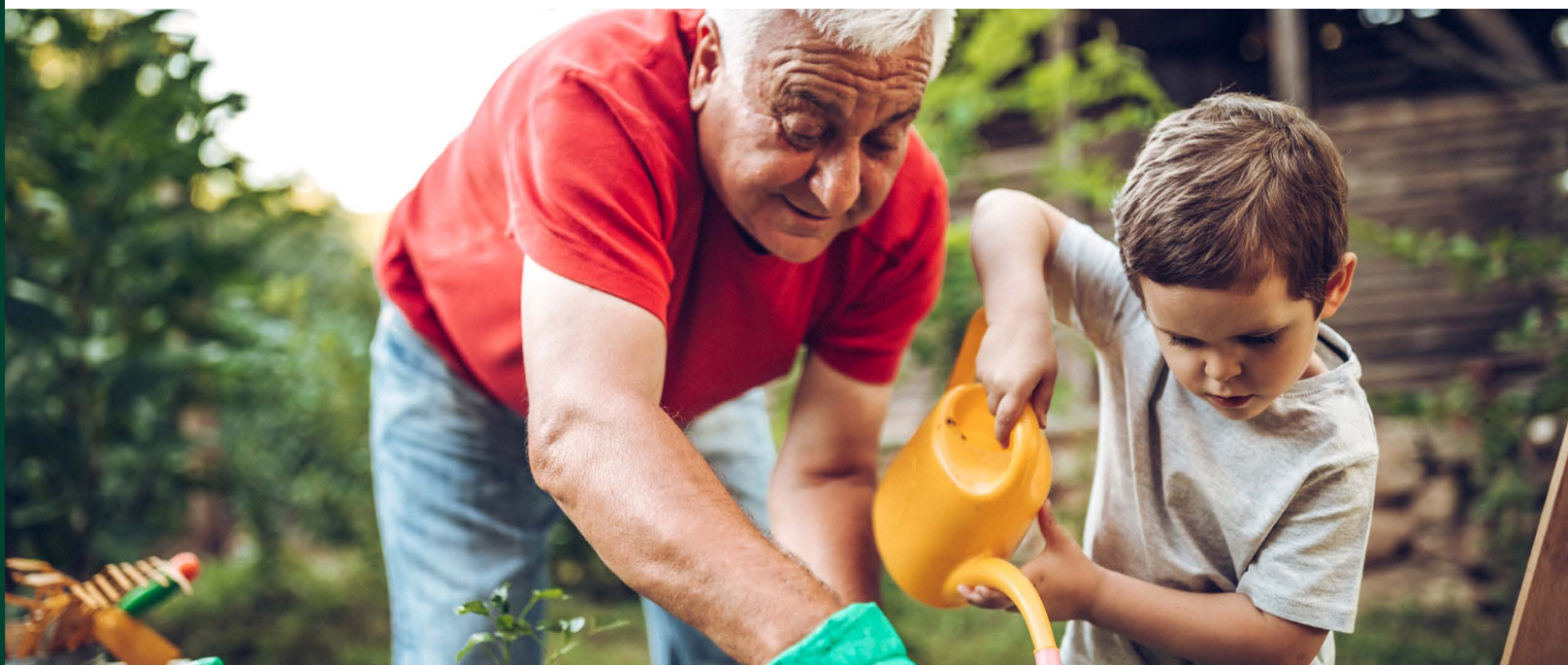
⁷³ Robert J. Master, “Commonwealth Care Alliance: Design Features to Promote Improved Care Delivery,” Presentation to the National Academy of Medicine Workshop on High-Need Patients, July 7, 2015, <http://www.nationalacademies.org/hmd/~media/Files/Activity%20Files/Quality/VSRT/2015-07-07/RobertMaster.pdf>.

⁷⁴ Arkadipta Ghosh, Cara Orfield, and Robert Schmitz, “Evaluating PACE: A Review of the Literature,” U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, 2014, <http://aspe.hhs.gov/basic-report/evaluating-pace-review-literature>.

⁷⁵ Medicare Payment Advisory Commission, “Managed Care Plans for Dual-Eligible Beneficiaries,” 2019, http://medpac.gov/docs/default-source/reports/jun18_ch9_medpacreport_sec.pdf; Medicaid and CHIP Payment and Access Commission (MACPAC), “Managed Long-Term Services and Supports: Status of State Adoption and Areas of Program Evolution,” 2019, <https://www.macpac.gov/publication/managed-long-term-services-and-supports-status-of-state-adoption-and-areas-of-program-evolution/>.

As states introduce a new LTSS social insurance program, they should be mindful of how such a program relates to existing public and private LTSS and health insurance and delivery systems. The landscape of health and long-term care integration is undergoing rapid change, and an LTSS social insurance program should be designed in a manner that can easily evolve with that transformation. As a state proceeds to adopt a new program, it should seek advice from LTSS experts, experts in Medicaid law, managed LTSS plans, and state and federal administrators on best practices for integrating new LTSS benefits with the existing health and long-term care infrastructure.

As a state proceeds to adopt a new program, it should seek advice from LTSS experts, experts in Medicaid law, managed LTSS plans, and state and federal administrators on best practices for integrating new LTSS benefits with the existing health and long-term care infrastructure.



Section VIII.

IMPLEMENTATION CONSIDERATIONS

NATIONAL
ACADEMY
OF SOCIAL
INSURANCE

Pre-Implementation Analyses

There are a number of analyses states will want to consider before program implementation, to prepare for an appropriate and successful program launch. Two of the most important are the following:

■ **Build or buy?** One of the first decisions a state must make is whether it will build the capabilities it needs to run the entire program itself or contract out (through competitive bidding) some program components to one or more third-party entities with expertise. States already face a similar choice for state employee health insurance, managed LTSS, and other programs. A state can begin by assessing the capabilities of existing state systems and programs to accommodate required program functions (discussed below). A state needs to determine whether these capabilities currently exist in a single entity or in several entities with a well-established record of working together. The more closely aligned current programs and department functions are with the new program's requirements, the better able a state will be to implement the program on its own. If the state has a logical and strategically identified implementation leader, but lacks an obvious supporting infrastructure, an outsource approach could be a viable alternative.

■ **Provider adequacy.** While providing funding to consumers to help them pay

for LTSS is very important, if sufficient numbers and types of LTSS providers are not available and accessible, consumers will still find it difficult to obtain the care they need. States may need to address problems in their service infrastructure so that when program monies are infused into the system, the providers will be in place and prepared to meet program objectives. For example, if an expanded program of LTSS coverage cannot be handled by the current care workforce, perhaps the new initiative could include a component supporting incentives, training, and certification to expand the workforce. A state might also forgive student loans for those engaged in care or training. And recent studies have shown that even small increases in the minimum wage can attract more workers into the LTSS workforce.⁷⁶ In seeking to identify systems capacity and access issues, specific concerns regarding the needs of family caregivers, workforce challenges, and more, state policymakers could start by reviewing AARP's Long-Term Services and Supports State Scorecard, which provides detailed ratings and rankings for each state across a wide variety of domains affecting the service delivery system.⁷⁷

States may need to address problems in their service infrastructure so that when program monies are infused into the system, the providers will be in place and prepared to meet program objectives.

⁷⁶ Joshua M. Wiener, Wendi Elkins, and Michael Lepore, "Impacts of Potential Minimum Wage Increases on Assisted Living and Continuing Care Retirement Communities," RTI International, September 2017, <https://www.theceal.org/images/reports/RTI-CEAL-Minimum-Wage-Report-2017-FINAL.pdf>.

⁷⁷ "Long-Term Services and Supports State Scorecard," AARP, 2019, <http://www.longtermscorecard.org/>.

Framework for Implementation

Regardless of the program structure adopted, there is a series of implementation activities that will be necessary to ensure program success. The primary implementation activities include:

- Program startup
- Program administration
- Program monitoring, evaluation and modification

Program Startup

To help guide program startup activities, a state may consider the creation of a temporary or permanent entity (e.g., Implementation Oversight Council) that coordinates program implementation over a multi-year period. That entity might consist of all the state agencies involved in implementation and actuarial and insurance experts, as well as stakeholders, such as representatives from provider and consumer groups. Some of the primary startup activities are the following:

- **Raising awareness** about the program among consumers, employers, LTSS providers, and other stakeholders. Stakeholders will need to be educated about what the program means for them—both what they have to “give” and what they are likely to “receive.” It is important to build public understanding of how the program works, who will benefit, under what circumstances benefits will be paid, what is and is not covered, how benefits will be provided, how the program is funded, and any other issues that stakeholders or the public might have concerns about.

Indeed, stakeholder input and support are critical as early as the program design phase. To obtain broad political support, the program must address the needs and wants of stakeholders while at the same time maintaining affordability and program feasibility.

- **Enrollment.** For the types of programs discussed in this report, the presumption is that enrollment is automatic for those



who meet eligibility criteria. Thus, there needs to be a well-defined process for verifying that these criteria have been met. Also, there must be clear ways to communicate to individuals about their program status, and to make information accessible and accurate when an individual needs benefits. Importantly, the state needs to decide which existing agencies will handle which of these functions, or whether a separate state entity needs to be created to administer them, or whether some functions should be contracted out.

It is important to build public understanding of how the program works, who will benefit, and many other matters.

- **Provider credentialing.** If the program reimburses LTSS providers for services rendered to participants, providers must meet certain requirements (e.g., licensure, capacity, staffing, and others) to be reimbursed. These requirements must be clearly stipulated. A program may credential providers in advance—that is, in order to be admitted as participants in the program providers must show that they meet these standards—or the program may verify that providers meet the standards only at the time they submit a claim. Credentialing in advance places a greater burden on program administrators and providers. It may also limit the providers from which consumers can choose. On the other hand, if credentialing only occurs at the time of claim, the burden

falls more on consumers; they must understand the requirements providers must meet, because if they use a provider that is not eligible, the program will not pay reimbursement. In contrast, if the program simply pays participants a cash benefit, credentialing may not be required. However, even in this case there may be a desire to provide guidance to consumers about which providers may be preferred or most appropriate to meet various care needs.

- **Program documents and contracts** must be developed to ensure transparency and program controls. Approaches can vary, but the program may have a coverage agreement or program explanation document; this identifies the terms of coverage to be provided to beneficiaries and specifies what constitutes a covered service, the duration of coverage, and the conditions under which benefit eligibility will be re-assessed or coverage will end. This coverage document would also set forth the terms and conditions under which an individual would no longer be eligible to participate in the program (e.g., leaving the state for a certain number of years) and how they could re-enter the program if eligibility is lost. If participating providers are under contract to the program, provider contracts would need to be developed, along with a process for reviewing, renewing, modifying, or discontinuing them. If outside vendors will be used for program functions, requests for proposals (RFPs) need to be developed, issued, and evaluated. Once selections are made, vendor contracts need to be developed.



Program Administration

The critical components associated with administering a social insurance program for LTSS likely do not differ from those currently performed by private long-term care insurance companies. A brief description of key administration functions includes:

- **Provider/service verification.** A program that reimburses LTSS providers for services would require state vetting of providers to safeguard program integrity. A program that pays a cash benefit to participants would require little or no provider credentialing, but given the complexities of the LTSS service system, a state may want to consider making care coordination and counseling services available. If benefits are paid to family caregivers, a state may want to require some minimal level of training and a program provider ID in order to ensure a minimum level of quality. Overall, a
- program will need to balance affordable care and provider choice with consumer safety and quality assurance.
- **Enrollment processing** includes new enrollments, disenrollments, and re-enrollments (in accordance with the rules of the program regarding maintaining coverage, portability when leaving the state, and conditions that cause enrollment eligibility to end or be reinstated). Processing new enrollments means ensuring that consumers satisfy requirements for participation in the program, both at the outset and over time.
- **Tax/premium collection and management** encompasses collecting revenues and, for a prefunded program, establishing and managing the dedicated LTSS fund. Actuarial expertise is needed (and may be obtained from a vendor) to oversee claim and investment activity, monitor the adequacy of the fund, and

identify actions needed to maintain the health of the fund. A predetermined schedule of financial performance should be established so that any adjustments to contributions or benefit levels required to ensure program sustainability can be made in a timely manner.

■ **Benefit eligibility determination.**

Participants applying for benefits must be assessed to determine whether they meet the program's benefit eligibility requirements, and there must be a workforce that is trained to equitably and objectively make this determination. States will be able to rely on the HIPAA criteria for functional and cognitive loss, a proven set of assessment tools and technologies, and trained personnel familiar with the use of these tools. A set of issue papers published by the SCAN Foundation in 2011 to assist the U.S. Department of Health and Human Services in implementing the Community Living Assistance Services and Supports (CLASS) Act provide helpful guidance for states in this regard.⁷⁸ In addition to initial assessment, there must be protocols for timely reassessment of beneficiaries who are likely to improve. A reassessment timeframe is typically established at the time of the initial claim, based on the nature of the underlying condition and the likelihood of recovery or change. Finally, a transparent and easily understood appeals process needs to be defined. The National Association of Insurance Commissioners

(NAIC) has developed a set of consumer protection standards related to appeals and grievances which offers a strong framework (along with procedures and specific language) for states to consider.⁷⁹

■ **Benefit payment.** If the program reimburses providers for services, systems will be needed to confirm that the provider and the service are eligible for reimbursement under the program, and to verify the amount of expense incurred. For programs with cash benefits, procedures will be needed for making payments to participants or (if assignment of benefits is allowed) directly to providers. For either type of program, there must be a way to confirm that the claimant is benefit-eligible. Explanation of benefits statements help ensure that both program administrators and beneficiaries can keep track of how benefits have been used and the value of remaining benefits.

■ **Care coordination** can be helpful to beneficiaries and their families as they navigate a complex LTSS service delivery system. Care coordinators can help beneficiaries determine their care needs, find appropriate providers, identify less costly alternatives to paid care (e.g., home modifications, voluntary community-based services, and others), and train and support family caregivers. A state LTSS program may or may not include care coordination; it may be offered to participants as an option, or it may be mandatory. Mandatory care

⁷⁸ The SCAN Foundation, "CLASS Technical Assistance Brief," 2011, <http://www.thescanfoundation.org/class-technical-assistance-briefs-0>.

⁷⁹ National Association of Insurance Commissioners, "Long-Term Care Insurance Model Regulation," https://www.naic.org/documents/cmte_b_sthp_ltcg_related_mo641.pdf.

coordination or counseling may be appropriate for cash benefit programs. (This is the approach of the federal “Cash and Counseling” program that is being implemented in 15 states.⁸⁰) A state may build care coordination capability itself or find a third-party vendor.

- **Program integrity** refers to efforts to monitor and address fraud, waste, and abuse. In a program that reimburses for services, it must be verified that providers are credentialed and that they are actually providing the services for which they bill at the frequency with which they bill. In both reimbursement and cash benefit programs, it must be verified that beneficiaries are in fact eligible for benefits, both initially and over time. This involves determining that a disability exists and that any recovery is reported in a timely manner. The state may also want to ensure that individuals are receiving the care they need (e.g., not

having their benefit misappropriated by family or caregivers), and that they are receiving safe and appropriate care.

Ongoing Monitoring of Sustainability and Program Evaluation

One of the lessons that can be gleaned from the experience of private long-term care insurance companies is that it is extremely challenging to estimate the costs of a specific set of benefits and requirements and the premiums that will be needed to fund it. When a state LTSS program is prefunded and expected to pay benefits well into the future, fiscal sustainability of the program is subject to a variety of trends that are difficult to project. And while this may be less of an issue with a PAYGO approach, there is still enough variability in service use and need to necessitate close monitoring of program revenues (premiums and/or taxes) and expenses (benefit payouts and administration).

⁸⁰ Lori De Milto, “Cash and Counseling,” Robert Wood Johnson Foundation, February 28, 2015, <https://www.rwjf.org/en/library/research/2013/06/cash---counseling.html>.





One of the lessons that can be gleaned from the experience of private long-term care insurance companies is that it is extremely challenging to estimate the costs of a specific set of benefits and the premiums that will be needed to fund it.

Consequently, periodic reviews of the program's financial status should be built into the implementation plan to ensure that, as experience unfolds, policymakers can be apprised of any emerging threats to the program's long-term financial sustainability. This will also help to build confidence in the program, which is particularly important for ensuring political support over time.

In addition, while it is not essential, it is useful to conduct periodic program evaluations to assess the effectiveness of

the program's design in meeting its stated objectives. For this, the parameters against which the program would be evaluated and the timeframe for evaluation would ideally be established in advance. Prior to program implementation, the systems for collecting the data needed for evaluation and the method of evaluation (e.g., outside contract or other approach) would also need to be identified. Metrics for evaluation might include the number of participants receiving benefits, access to care in the least restrictive setting, timely payment of claims, accuracy of claim payments, satisfaction ratings of consumers and caregivers, measures of quality of home-and community-based care based on measures (developed by the National Quality Forum⁸¹ and others), consumer and provider satisfaction, complaint rates, and others. Areas of program improvement could be identified, with clear plans laid out for implementing program changes based on evaluation results.

⁸¹ National Quality Forum, "Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement," September 2016, http://www.qualityforum.org/Publications/2016/09/Quality_in_Home_and_Community-Based_Services_to_Support_Community_Living__Addressing_Gaps_in_Performance_Measurement.aspx.

Section IX.

CONCLUSION



With the need for LTSS projected to rise in the coming years and the availability of family caregivers projected to decline, there will be a growing need for formal, paid LTSS. LTSS is expensive, however, and most Americans cannot afford to pay for it out of pocket. This is true not only for people with lifelong LTSS needs, but also for most of those whose needs begin in old age. The majority of people approaching retirement today lack sufficient savings to maintain their standard of living after they quit working, even without accounting for health and LTSS costs.

Even for Americans who can afford to save for LTSS, it would not be efficient to do so. While the risk of needing LTSS is universal, it is also unpredictable, difficult to plan for, expensive, and a threat to retirement security—all characteristics that could be addressed through risk pooling, that is, insurance. Moreover, the primary public payer for LTSS—the Medicaid program—is unlikely

to be able to adequately address this growing need. It is a targeted program available only to those who have low income and assets or who spend almost all their assets on care. And for those who meet its strict financial and functional eligibility criteria, Medicaid guarantees access only to nursing home care, not home care. Taken together, these individual and public challenges argue for a new approach to financing and, more specifically, one based on principles of insurance. A universal social insurance program option is a potentially efficient way to mitigate the financial risk associated with LTSS and meet a host of other systemic objectives important to families.

This report has taken a deep dive into what it might mean for a state to introduce a new universal, state-based LTSS social insurance program and the programmatic design features and tradeoffs that must be considered. In 2019, Washington State

enacted one version of such a program: a front-end benefit available shortly after onset of need, providing a fixed amount of support over a beneficiary's lifetime, funded by a modest employee contribution. To make LTSS more affordable and accessible for their residents, policymakers in other states could follow suit and avail themselves of one of the range of viable structural design and financing options described in this report. Such options could enable those in need of care to remain at home longer and retain their autonomy. They also would give people the peace of mind of knowing that they will have access to the care they need as they age, without burdening their spouse or children. Proactive policies could lessen the financial pressure on state Medicaid budgets, reduce care burdens on families, and also support significant job creation in one of the fastest-growing sectors of the economy—personal care and home health care.

Given the lack of federal action in this area, and the enormous social good that could result from addressing this problem, it is not surprising that a growing number of states are considering such an approach.

Proactive policies could lessen the financial pressure on state Medicaid budgets, reduce care burdens on families, and also support significant job creation in one of the fastestgrowing sectors of the economy—personal care and home health care.



Appendices

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Appendix I

ADDITIONAL CONSIDERATIONS IN STRUCTURING AN LTSS PROGRAM

Benefit Amount

How much a program pays in benefits affects both its cost and state residents' perceptions of its value. LTSS social insurance programs are designed to cover a portion of LTSS costs; there is currently no program in the world that covers all costs for all levels of need. A program pays a daily or weekly benefit; as mentioned, the beneficiary could be paid a flat dollar amount, or their incurred expenses could be reimbursed up to the benefit amount. Either way, the benefit amount can be set to cover roughly a certain portion of either nursing home care or home care. For instance, a program might set a dollar amount that is roughly equal to 50 percent of the average nursing home daily charge in the state. Or the benefit might be based on 75 percent of the average cost of home and community-based services. A benefit intended to cover most of the cost of nursing home care will be higher than one designed to cover most home care costs, since facility costs are usually higher. (Nursing homes provide room and board and round-the-clock care, while many people receive home care for only a few hours a day.)

Of course, beneficiaries' care costs will vary widely, depending on the type and frequency of the services they receive. One person might need continuous supervision or 24-

There is currently no program in the world that covers all costs for all levels of need.

hour personal care, while another might only require help for an hour or two once or twice a day. Costs will also vary by location within a state. If the program has a relatively low benefit based on home care, it will provide all beneficiaries with some help, but it may cover only a small portion of the expenses of those with the greatest needs (generally those in a facility). However, some argue that the benefit should reflect only LTSS costs, not the room and board costs of facilities. A state could have two benefits, a higher one for those in a facility and a lower one for those being cared for at home. This adds some complexity but enables a program to better meet individual needs.

It must also be considered whether and how benefit amounts will be increased over time to account for the rising costs of care. Benefit amounts could be automatically adjusted by a fixed rate each year. (The annual inflation rate in long-term care costs has historically been around 3 percent.) Alternatively, they could be periodically adjusted to reflect actual increases in LTSS costs, or increases could be

linked to the consumer price index, a home care worker wage index, or other indices that are published consistently.

Benefit Eligibility Triggers

An LTSS program must identify objective, reliable, and easily measured criteria for when someone qualifies for benefits. There is a prevailing standard of significant LTSS need that meets this test, is required for federally tax-qualified LTCI policies, has been used in the private LTCI market for more than 25 years, and is consistent with HIPAA definitions. Under this standard, individuals qualify for benefits when they need substantial assistance from another person to perform two or more activities of daily living (ADLs) and this is expected to last at least 90 days, or when they have a severe cognitive impairment. However, some state Medicaid programs cover certain home and community-based services for those with a lower level of impairment (such as the inability to perform only one ADL), while others restrict certain LTSS benefits to those meeting a higher standard (such as loss of three or more ADLs or a severe cognitive impairment.)

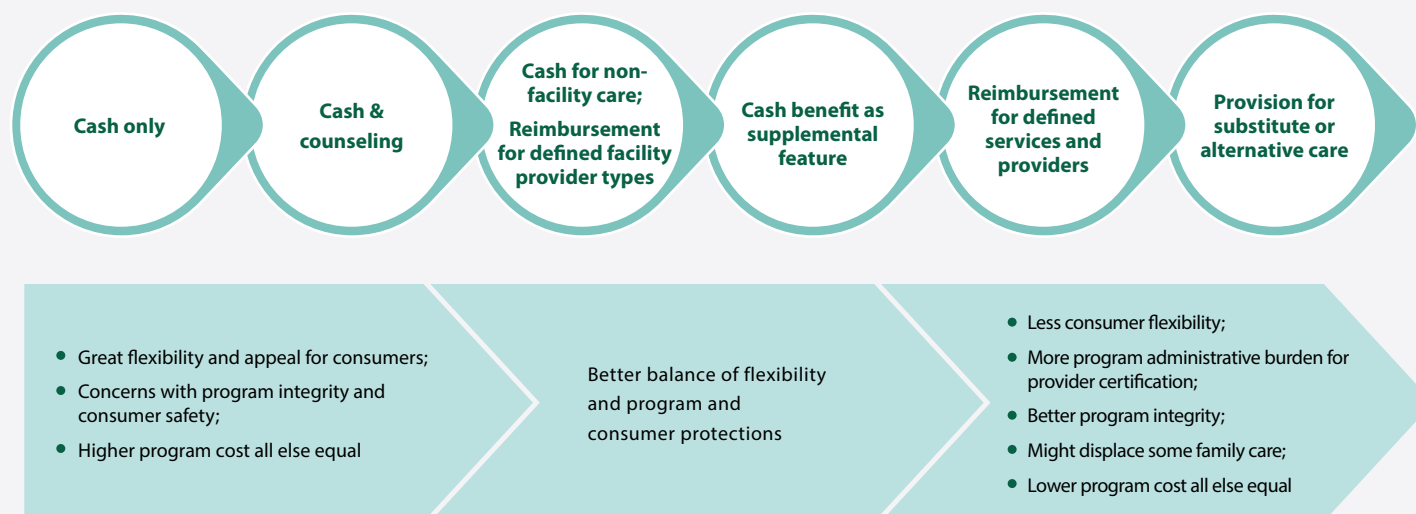
A program could pay a higher benefit to those with a greater need for care (such as those unable to perform more ADLs). Indeed, most existing LTSS social insurance programs around the world differentiate benefits in some way based on the level of need. Such an approach would provide benefits more in proportion to each beneficiary's actual need. However, it would necessitate significant investment to achieve the administrative sophistication required to precisely assess each beneficiary's level of need.

Comparing Cash Benefits and Service Reimbursement

In this report we have discussed two models of benefit payment: cash benefits paid to participants who qualify as disabled and reimbursement of incurred expenses for qualified services, up to a preset limit. As shown in the figure below, there is actually a continuum of choices, with many options between the “all cash” and “all service reimbursement” approaches. Private LTCI insurers have paid benefits under all the options shown below, and policymakers can draw on their experience to better understand the implications of these approaches for pricing, program integrity, administrative burden, and consumer flexibility and choice. The cash payment model normally requires only the documentation of a qualifying disability, without regard to services used or expenses incurred. However, variations of the cash model may require beneficiaries to receive counseling on the most appropriate services and providers for their needs, or to receive care in accordance with a plan developed by a care manager. Cash benefits maximize the ability of beneficiaries to choose the services and providers they prefer, including ones without any certification or licensure. However, there are concerns about the safety or appropriateness of care, particularly for beneficiaries who are vulnerable because

There is actually a continuum of choices, with many options between the “all cash” and “all service reimbursement” approaches.

FIGURE 12: The Continuum of Benefit Payment Choices



of a cognitive impairment or when there is potential for elder financial abuse. All else being equal, a cash benefit approach also costs more, because benefits are paid for each day of disability, even if services are not needed every day. A cash approach avoids some administrative expenses related to provider credentialing and verification of services delivered, but it incurs other administrative costs associated with frequent and personalized benefit eligibility determinations.

The reimbursement model affords participants less flexibility than the cash model. They cannot spend their benefit money on anything they please—it goes to reimburse allowable expenses. These are defined up front, based on the types of providers and services covered (e.g., nursing home, assisted living facility, home health care agency, home care agency, respite care, hospice care, etc.). However,

given that participants typically enroll in an LTSS program years if not decades before they use providers, there is typically some flexibility, allowing reimbursement of care or provider types that emerge after the policy or program begins. For the same reason, participants are not limited to any network of providers—they can usually use any licensed and/or certified provider of a covered type of care. A program may also reimburse care provided by family members or other unpaid caregivers, provided certain conditions are met. There are variations on the reimbursement model, as shown in the figure. A program might reimburse for some services (such as facility care) but pay a cash benefit for others (such as home care or unpaid caregivers).

The reimbursement model has higher administrative costs than the cash model; costs are incurred in confirming that providers and services are eligible, reviewing

bills, issuing explanations of benefits, and keeping track of accounts. However, access to care notes and service records may limit the expense of determining and recertifying benefit eligibility. On the other hand, benefit costs are lower under the reimbursement model. Paying benefits only on days when expenses are incurred is less costly, and reimbursement also may reduce incentives to utilize the system.



Appendix II

ELIGIBILITY FOR MEDICAID LTSS

As discussed in Section III, to qualify for Medicaid on the basis of disability or age (65 and older), as most of those seeking Medicaid LTSS coverage do, applicants must meet both income and asset (resource) criteria. That is, they cannot have countable assets above a certain very low amount, and they must have low income (or spend most of their income on their care while on Medicaid). These financial eligibility rules vary by state (within federal requirements).

Financial eligibility for Medicaid has traditionally been linked to eligibility for cash assistance (welfare) programs, so that only the very poor can qualify. To qualify for Medicaid based on disability or age, applicants must often meet the standards for receiving Supplemental Security Income (SSI). For 2018, SSI recipients must have monthly countable income at or below \$750 for an individual or \$1,125 for a couple, about 74 percent of the federal poverty level (FPL). As for assets, applicants typically can have no more than \$2,000 in countable resources

(\$3,000 for a couple). Furthermore, federal law allows states to use even more restrictive financial eligibility criteria, and several states do so.⁸² On the other hand, some states offer LTSS coverage to those with incomes—and, in some cases, assets—above the SSI thresholds.⁸³ For example, states have the option to expand coverage to individuals who require institutional-level care and have income up to 300 percent of the SSI Federal Benefit Rate (roughly 222 percent of FPL); 44 states have adopted this option.⁸⁴

Many middle-income people who do not meet these restrictive financial requirements when they first need long-term care nonetheless eventually receive Medicaid LTSS coverage.

It should also be kept in mind that many middle-income people who do not meet these restrictive financial requirements when they first need long-term care

⁸² Section 209(b) of the 1972 amendments to the Social Security Act allows states to use their own more restrictive criteria to determine Medicaid eligibility for seniors and people with disabilities, in lieu of granting eligibility for Medicaid coverage to all individuals who qualify for SSI benefits. Eleven states have adopted this waiver option—some using disability criteria, some using financial criteria. (Kaiser Family Foundation, “Total SSI Beneficiaries, 2017,” State Health Facts, 2019, <https://www.kff.org/medicaid/state-indicator/total-ssi-beneficiaries/>.)

⁸³ For detailed information on income eligibility thresholds for seniors and people with disabilities by state, see Medicaid and CHIP Payment and Access Commission, “Medicaid Income Eligibility Levels as a Percentage of the Federal Poverty Level for Individuals Age 65 and Older and Persons with Disabilities by State, 2017,” MACStats: Medicaid and CHIP Data Book, December 2017, <https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-37.-Medicaid-Income-Eligib-Levels-as-a-Percentage-of-the-FPL-for-Individuals-Age-65-and-Older-and-Persons-w-Disabilities-by-State-201.pdf>.

⁸⁴ Medicaid and CHIP Payment and Access Commission, “Eligibility for Long-Term Services and Supports,” <https://www.macpac.gov/subtopic/eligibility-for-long-term-services-and-supports/>.

nonetheless eventually receive Medicaid LTSS coverage. They spend their countable assets on care until they have only \$2,000 left. (They can keep non-countable assets, which often include their home.) In most states they can qualify even if their income is above the required levels provided that, while on Medicaid, they spend all but a small portion of their income on their care. There are also allowances that preserve income and assets for a Medicaid applicant's spouse, so that he or she is not left with nothing to live on. As noted previously, some middle-income people may transfer liquid assets to their children well in advance—typically five or more years—of needing LTSS, so that they can qualify for Medicaid when the need arises. However, little is known about the magnitude of this practice and there is little empirical evidence to support the notion that it is widespread.

In addition to satisfying categorical and financial eligibility criteria, those applying for Medicaid LTSS coverage must also meet federal and state functional or clinical eligibility criteria. There is significant variation among state Medicaid programs, particularly with regard to eligibility for home and community-based services (HCBS). Moreover, meeting financial eligibility requirements for Medicaid HCBS coverage is not a guarantee that an individual will be approved to receive coverage. States have a great deal of flexibility in how they structure access to HCBS.

There is significant variation among state Medicaid programs, particularly with regard to eligibility for home and community-based services (HCBS).

Working-age people with disabilities may qualify for Medicaid LTSS coverage through other avenues. For example, if an SSI recipient with a severe impairment re-enters the workforce and their earnings exceed the maximum allowed, federal standards require states to maintain their Medicaid coverage. Adult children with disabilities (over the age of 18) who lose SSI eligibility on becoming eligible for Social Security benefits due to the retirement, death, or disability of their primary caregiver must still be eligible for Medicaid coverage. Federal standards also require states to cover working people with disabilities who are eligible for Medicare Part A (due to receipt of Social Security Disability Insurance benefits) whose earnings are under 200 percent FPL and whose assets are below twice the standard for SSI. In addition to these federally required standards, states have a variety of additional options to expand the reach of Medicaid coverage for people with disabilities.



Designing a State-Based Social Insurance Program for Universal Family Care

2019

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Preface

ABOUT THE CHAPTER

This chapter explores state-level social insurance solutions to the growing challenges families face in meeting their care needs across generations while still making ends meet. It is the culminating chapter of this report, elaborating policy options for the design of a Universal Family Care program that would provide early child care and education (ECCE) benefits, paid family and medical leave (PFML), and long-term services and supports (LTSS) through one integrated care insurance fund. It does not offer policy recommendations but instead identifies key decision points for states to consider in crafting a program, elaborates a range of illustrative approaches states could adopt, and analyzes tradeoffs among these approaches. This analysis was developed during a year of deliberations by a Study Panel Working Group of 10 policy experts with a variety of perspectives. It was informed by the work of the broader Universal Family Care Study Panel of 29, and it builds on the analysis of the previous three chapters on ECCE, PFML, and LTSS policy. This chapter can be read independently, but the reader may wish to consult the previous chapters for more in-depth analysis of those policy domains. While addressed primarily to state policymakers, this report may also be of interest to providers, advocacy organizations, and administrators, as well as to any person interested in these issues.

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EXECUTIVE SUMMARY

Gaps in our care infrastructure make it difficult for many workers to juggle the needs to earn a living and to provide care for family members. Similarly, people needing time off work to recover from an illness or injury, as well as those needing long-term services and supports (LTSS) to cope with a disability (either lifelong or in old age), often find that today's patchwork of programs falls short.

Our early child care and education (ECCE) and LTSS systems are fragmented and means-tested, limited to serving only a fraction of even poor and low-income Americans. The broad middle class has inadequate care options and support. Paid family and medical leave (PFML)—which makes it possible for workers to care for a family member, bond with a new child, or recover from a medical condition without significantly compromising the family finances—is available in only a handful of states. Providers of ECCE and LTSS are poorly compensated, which limits the size and skills of the care workforce and affects the quality and reliability of care. Against this background, an integrated, holistic approach to family care needs over the lifespan merits consideration; such an approach also could address the needs of care workers, who are disproportionately women and people of color and face their own family care challenges.

Universal Family Care (UFC) is a policy designed to strengthen our care infrastructure to meet families' changing care needs over time. It would make an affordable, integrated care system available to all. Everyone would both contribute to and benefit from a single "care insurance fund." National programs

including Social Security and state programs such as PFML have successfully used this social insurance model. In this report, we focus on state-level policy options, although such an approach could be adopted at the federal level as well.

The UFC insurance fund would cover ECCE, PFML, and LTSS needs when they arise, and provide benefits to families through a single access point. In crafting a UFC program, states will need to make design choices on a variety of issues, including the level of comprehensiveness regarding who is covered and for what, the sources of funding, eligibility requirements, benefit adequacy, and qualifying events. To understand tradeoffs in design choices, we present four illustrative UFC designs, each expressed as packages of ECCE, PFML, and LTSS benefits. The choices vary primarily by their benefit generosity and by whether the program is funded solely by contributions or also by additional revenues to achieve universal coverage. Once a state has decided upon a structural design approach, choices remain concerning the degree of internal UFC integration across its ECCE, PFML, and LTSS components, as well as the relationship of UFC benefits to existing ECCE programs and Medicaid LTSS.

As states weigh how to help families cope with managing work and family, encourage greater labor force participation, improve the quality of jobs in the rapidly expanding care sector, and assist families with care costs, UFC holds the potential to address these challenges in a holistic way.

Section I.

**INTRODUCTION:
THE CASE FOR
RETHINKING OUR
FRAGMENTED,
MEANS-TESTED
APPROACH TO
CARE POLICY**

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Caring for family members can give us some of the most meaningful and joyful experiences of our lives. But gaps in the current care infrastructure mean that these experiences are often overshadowed by the struggle to both earn a living and provide care for children, parents, or other family members. Similarly, people needing time off work to recover from an illness or injury, as well as those needing long-term services and supports (LTSS) to cope with a disability (either lifelong or in old age), often find that today's patchwork of supports falls short.

Families have always coped with the risk of needing to receive or provide care—whether for children, those coping with illness or injury, or people with functional or cognitive support needs. Yet the share of families with a stay-at-home caregiver has sharply declined in recent decades. Most of today's families with children need all parents' earnings to make ends meet; 64 percent of mothers bring in at least one quarter of family earnings, including 41 percent who bring in half or more.¹ For many families, the care risk has become unmanageable, or manageable only at significant cost in terms of family members' health, well-being, income, and careers.

Purchasing paid services to relieve the burden on family caregivers is expensive and unaffordable for many families. These family care challenges are now being exacerbated by the aging of the Baby Boomers and the growing shortage of family caregivers, as the growth in persons 80 and older far outpaces the growth in potential caregivers ages 45-64.²

Our systems for providing affordable early child care and education (ECCE) and LTSS are fragmented and limited to those with low income, leaving the broad middle class to muddle through with inadequate care options and supports. Paid family and medical leave (PFML)—which makes it possible for workers to care for a loved one, bond with a new child, or recover from a medical condition without significantly compromising the family finances—has been enacted in only seven states (California, Connecticut, Massachusetts, New Jersey, New York, Rhode Island, and Washington) and the District of Columbia.³ At the same time, child care and long-term care jobs are poorly compensated, which limits the size and skills of the care workforce as well as the quality and reliability of care.⁴ To address these challenges, policymakers might consider a comprehensive approach to meeting the caregiving needs of families

¹ Sarah Jane Glynn, "Breadwinning Mothers Continue to be the U.S. Norm," Center for American Progress, May 10, 2019, <https://www.americanprogress.org/issues/women/reports/2019/05/10/469739/breadwinning-mothers-continue-u-s-norm/>.

² Donald Redfoot, Lynn Feinberg, and Ari Houser, "The Aging of the Baby Boom and the Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers," AARP Public Policy Institute, August 2013, <https://www.aarp.org/home-family/caregiving/info-08-2013/the-aging-of-the-baby-boom-and-the-growing-care-gap-AARP-ppi-ltc.html>.

³ PFML is currently available in California, New Jersey, New York, and Rhode Island, and is awaiting implementation in Connecticut, the District of Columbia, Massachusetts, and Washington.

⁴ Robert Espinoza, "Workforce Matters: The Direct Care Workforce & State-Based LTSS Social Insurance Programs," PHI, 2019 (Forthcoming); Nina Dastur, Indivar Dutta-Gupta, Laura Tatum, Peter Edelman, Kali Grant, and Casey Goldvale, "Building the Caring Economy: Workforce Investments to Expand Access to Affordable, High-Quality Early and Long-Term Care," Creative Commons, 2017, http://www.georgetownpoverty.org/wp-content/uploads/2017/05/Building-the-caring-economy_hi-res.pdf.



across their lifetimes. The needs of care workers themselves—who are disproportionately women and people of color—and their families should also be considered within such a framework. This concluding chapter of the report analyzes policy options for states interested in Universal Family Care (UFC), a proposal for a new, integrated social insurance program to support families in coping with the risk of needing to provide or receive care across generations. Family members would contribute to a care insurance fund out of their earnings, from their first job onward, and receive ECCE, PFML, or LTSS benefits when they need them.⁵ (Policy options for these three components of UFC were analyzed in depth in the previous chapters and will be examined in the context of UFC in Section III of this chapter.) The chapter will present four policy options for Universal Family Care, and explore the tradeoffs among them.

Universal Family Care is a proposal for a new, integrated social insurance program to support families in coping with the risk of needing to provide or receive care across generations. Family members would contribute to this program from their first job onward and receive ECCE, PFML, or LTSS benefits when they need them.

UFC is a policy designed to strengthen our care infrastructure to meet the growing and changing needs for care supports of families across the income spectrum. The goal is to create an affordable, integrated care system

⁵ In social insurance, “contributions” are taxes earmarked for a specific program. The vehicle is typically a payroll or income tax. [Theodore R. Marmor, Jerry L. Mashaw, and John Pakutka, *Social Insurance, America’s Neglected Heritage and Contested Future* (Los Angeles: Sage, 2014)].

available to all families, replacing today's fragmented, means-tested patchwork of programs. Everyone would contribute into one care insurance fund, and everyone would be eligible to benefit from the risk protections provided by the fund. UFC would build on proven social insurance approaches utilized in national programs like Social Security and Medicare Part A (Hospital Insurance) and state programs like PFML (enacted in seven states and the District of Columbia) and LTSS (enacted in Washington State in 2019). As in Medicare, contributions would be made out of all earnings, and benefits would be portable across jobs.

This chapter begins with an analysis of deficits in our current policy approaches and how UFC could address them. It then explores key decision points for states considering reimagining their care infrastructure, presents and evaluates four illustrative approaches to UFC design, and concludes with a discussion of key issues in program integration (both internally and in relation to existing programs) and implementation.

The Status Quo Is Costly to Those in Need of Care, Family Caregivers, and the Economy

Today, most families pay for care when it is needed, often when they can least afford it. For instance, families often need child care supports relatively early in their careers—

when work histories are often shorter and earnings lower—and LTSS when people are retired and perhaps living on a fixed income. Lack of access to paid family and medical leave can be costly as well—a person may lose wages or even have to quit their job to take time off for a serious medical condition, pregnancy, surgery, or injury, or to provide care to a loved one experiencing one or more of these health issues.

Early child care and education—particularly high-quality, center-based programs—is well beyond the means of many families.⁶ On average, families with a four-year-old in a legally operating child care facility can expect to pay roughly \$9,000 annually for center-based care or around \$8,300 for home-based care.⁷ For a toddler (age 1-3), the annual cost of center-based care rises to around \$10,000, and for an infant (age 0-1) to roughly \$11,600. These figures vary widely across states, and they do not take into account additional expenses for extra services such as extended or flexible hours. The average cost of ECCE represents 10 percent of the average earnings of married co-parent households with minor children and over one-third (37 percent) of the earnings of the average single parent.⁸ Based on standards established by the U.S. Department of Health and Human Services, child care should take up no more than seven percent of a family's income to be considered affordable. By this measure, high-quality ECCE is unaffordable for many American families.⁹

⁶ Elise Gould and Tanyell Cooke, "High-Quality Child Care Is Out of Reach for Working Families," Issue Brief #404, Economic Policy Institute, 2015, <https://www.epi.org/files/2015/child-care-is-out-of-reach.pdf>.

⁷ Child Care Aware of America, "The U.S. and the High Cost of Child Care: 2018 Report," 2018, <http://usa.childcareaware.org/advocacy-public-policy/resources/research/costofcare/>.

⁸ Ibid.

⁹ Office of Child Care (OCC), Administration for Children and Families (ACF), Department of Health and Human Services (HHS), "Child Care and Development Fund (CCDF) Program," 2016, <https://www.federalregister.gov/documents/2016/09/30/2016-22986/child-care-and-development-fund-ccdf-program>.



A lack of paid leave is costly for workers needing to provide care to their aging parents, children, or other family members, or to take time off to receive care themselves. The federal Family and Medical Leave Act of 1993 (FMLA) gives many U.S. workers the right to *unpaid*, job-protected time off to provide or receive care. But because of restrictive eligibility requirements, roughly 40 percent of workers are excluded entirely from FMLA coverage, and those who are covered often cannot afford time away from work without any compensation.¹⁰ No national policy provides or mandates that workers receive paid family or medical leave, although seven states

(California, Connecticut, New Jersey, Rhode Island, New York, Washington, Massachusetts) and the District of Columbia have enacted their own PFML programs.¹¹ Only 39 percent of civilian workers have short-term disability insurance (paid medical leave),¹² and only 17 percent have paid leave for caregiving, through an employer-provided benefit.¹³

Long-term services and supports most often are needed for less than two years, but they are expensive. Among the roughly half of Americans 65 and older who will have significant LTSS needs, the average total cost will be \$266,000 in today's dollars, and

¹⁰ Jacob Alex Klerman, Kelly Daley, and Alyssa Pozniak, "Family and Medical Leave in 2012: Technical Report," Cambridge, MA: Abt Associates, Revised April 2014, <http://www.dol.gov/asp/evaluation/fmla/FMLA-2012-Technical-Report.pdf>.

¹¹ Ibid.

¹² Bureau of Labor Statistics, "Table 16. Insurance Benefits: Access, Participation, and Take-Up Rates, Civilian Workers, March 2018," U.S. Department of Labor, 2019, <https://www.bls.gov/ncs/ebs/benefits/2018/ownership/civilian/table16a.htm>. "Civilian workers" are defined by the Bureau of Labor Statistics as all private industry and state and local government workers. Federal government, military, and agricultural workers are excluded.

¹³ Bureau of Labor Statistics, "Table 32. Leave Benefits: Access, Civilian Workers, March 2018," U.S. Department of Labor, 2019, <https://www.bls.gov/ncs/ebs/benefits/2018/ownership/civilian/table32a.htm>.

a little more than half of that will have to be paid out of pocket.¹⁴ Some younger people with disabilities have lifelong LTSS needs and expenses. The affluent can pay for LTSS out of their income and savings; a few people (only about seven percent of adults 50 or older) have private long-term care insurance.¹⁵ Those in the broad middle class either forgo paid care (relying on family members to be available to provide care), pay for it out of limited income and savings until they deplete their assets and qualify for Medicaid, or simply forgo needed care altogether. If a person goes on Medicaid, they must contribute most of their income to their LTSS costs, and they may be forced to enter a nursing facility instead of staying at home because they cannot access Medicaid's limited home and community-based services benefits.

Because of the gaps in our care infrastructure, many family caregivers have to muddle through with inadequate supports. Caregiving has historically been an undervalued activity,¹⁶ typically carried out by women, and this has had many negative effects on individual and family well-being. Family caregivers face a range of risks to their personal well-being, from social isolation to damage to their immediate and long-term financial

security, careers, and health.¹⁷ Professional care workers face substantial challenges as well, including low wages, limited potential for professional growth, exclusions from traditional employment benefits, difficult working conditions, and often long hours and unpredictable scheduling.¹⁸

Universal Family Care Takes a Holistic, Integrated Approach

UFC encompasses ECCE, PFML, and LTSS benefits, but it is more than the sum of these parts. It is not based on the administrative logic of combining these programs, but rather takes a holistic approach to families' care experiences, which change over time. While ECCE, PFML, and LTSS are typically siloed in public debate and social policy, families often experience them as overlapping and interrelated. For instance, a parent may be coping with their own medical needs while also caring for a child or aging family member with long-term care needs.

UFC encompasses ECCE, PFML, and LTSS benefits, but it is more than the sum of these parts.

¹⁴ Melissa Favreault and Judith Dey, "Long-Term Services and Supports for Older Americans: Risks and Financing Research Brief," Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Washington, D.C., February 2016, <https://aspe.hhs.gov/basic-report/long-term-services-and-supports-older-americans-risks-and-financing-research-brief>.

¹⁵ Life Insurance and Market Research Association (LIMRA), "Combination Products Giving Life Back to Long-term Care Market," 2017, https://www.limra.com/Posts/PR/Industry_Trends_Blog/Combination_Products_Giving_Life_Back_to_Long-term_Care_Market.aspx.

¹⁶ Paula England, "Emerging Theories of Care Work," *Annual Review of Sociology*, Vol. 31, August 2005, <https://doi.org/10.1146/annurev.soc.31.041304.122317>.

¹⁷ National Academies of Sciences, Engineering, and Medicine, *Families Caring for an Aging America* (Washington, DC: The National Academies Press, 2016).

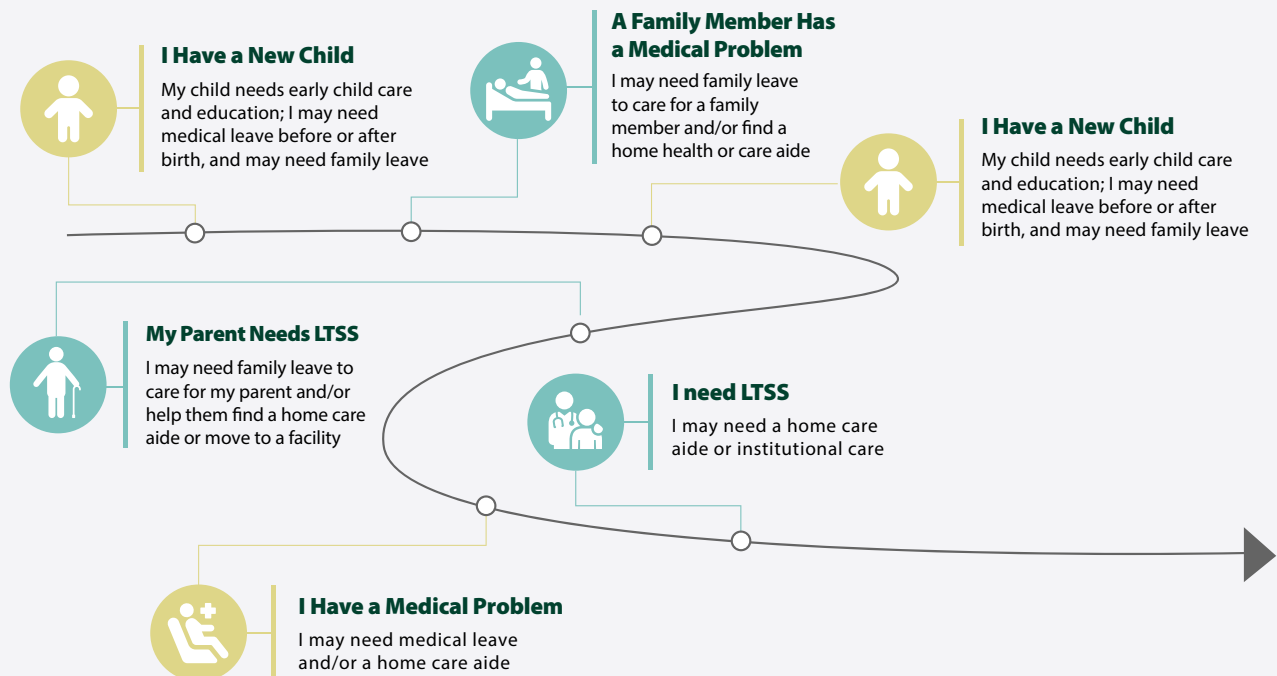
¹⁸ Nina Dastur, Indivar Dutta-Gupta, Laura Tatum, Peter Edelman, Kali Grant, and Casey Goldvale, "Building the Caring Economy: Workforce Investments to Expand Access to Affordable, High-Quality Early and Long-Term Care," Creative Commons, 2017, http://www.georgetownpoverty.org/wp-content/uploads/2017/05/Building-the-caring-economy_hi-res.pdf.

The **Sandwich Generation** is made up of people providing both elder and child care at the same time. Roughly one in six working adults (nearly 25 million people) is providing care for a family member over 65, and more than one in four of these people (27.5 percent) care for children as well. A majority of these family caregivers are middle-aged, but nearly a quarter are millennials (age 15-34).¹⁹ Some adults leave the workforce entirely because they cannot manage the competing demands of work and caregiving.

UFC is a holistic program, providing a one-stop shop—a single user access point (discussed in depth in Section IV)—for a broad range of family

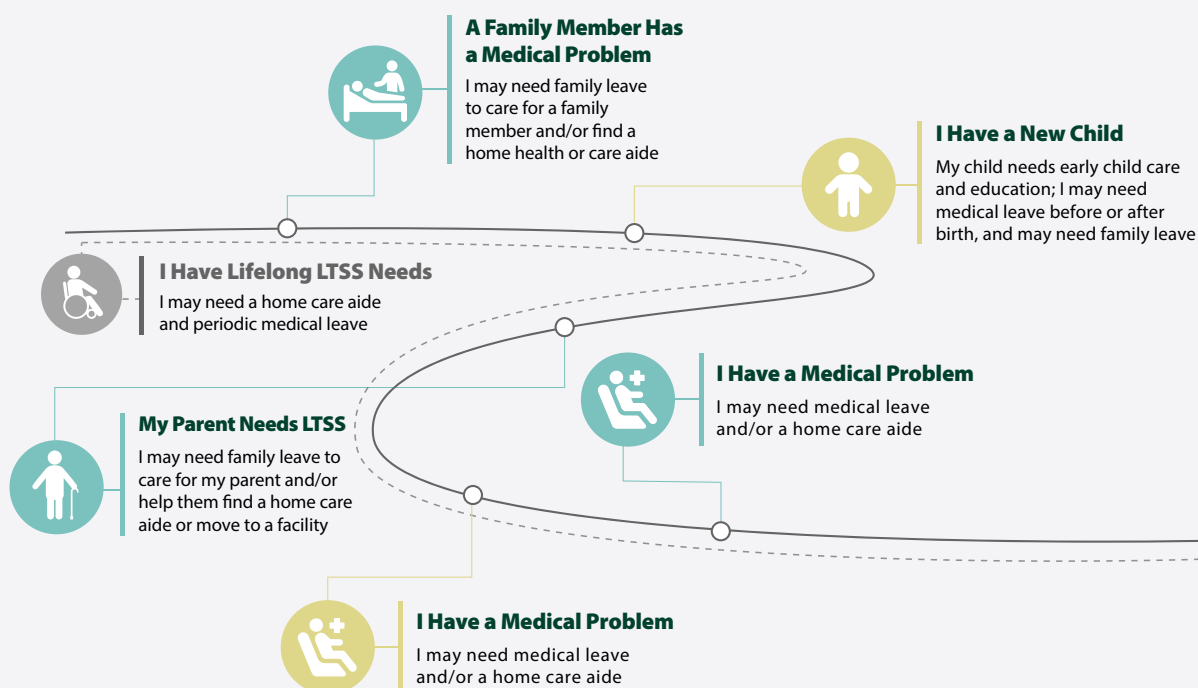
care supports over the life course. While the timing and duration of each family’s care needs differ, Figure 1 represents a common scenario.

FIGURE 1: Care Needs Across the Life Course: A Typical Scenario



¹⁹ U.S. Department of Labor, *Navigating the Demands of Work and Eldercare* (Washington, DC, 2016), http://digitalcommons.ilr.cornell.edu/key_workplace/1602.

FIGURE 2: Care Needs Across the Life Course: A Scenario with Lifelong LTSS Need



At various points across the life course, an individual may need early care and education for a child; time off from work to recover from an injury, surgery, or other medical condition; time off to care for a family member with a serious health problem; LTSS for a spouse, parent, or family member with a disability; and/or LTSS for their own functional and/or cognitive impairment in old age. And for some people, an ongoing and permanent need for LTSS is added to the scenario from the onset of a disability (Figure 2).

The holistic approach of UFC also takes into account the fact that a family's needs for different kinds of care are interrelated. Care involves a nexus of people and relationships: the person needing care or support, the

family caregiver(s), the care worker(s), the person managing the care, and family members who receive less time and attention from the primary caregiver or care worker as a result of the care they provide. Addressing the needs of one person can reduce some of the pressure on the others. A parent is relieved when a child has access to affordable

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day care. A child's welfare is improved when a parent can afford to take time off work to bond with a new baby or provide care when the child is sick. A family caregiver of a person with LTSS needs is supported when that person has access to paid care.

A parent is relieved when a child has access to affordable day care. A child's welfare is improved when a parent can afford to take time off work to bond with a new baby or provide care when the child is sick. A family caregiver of a person with LTSS needs is supported when that person has access to paid care.



Esmerelda is a young Sandwich Generation caregiver who lives at home with both her mother, who has schizophrenia, and her two-year-old daughter.

“I’m home full time with basically two toddlers, and it’s overwhelming. My family doesn’t see caregiving as work because there’s no money coming in. If I had some income, I could hire someone to take care of my mom. I could get back on my feet and go back to school.”

She does not manage her own or her family members’ care needs in isolation, but rather must cope with the intersecting challenges of caring for two other dependents, while also trying to establish a footing in the labor market. A program that streamlines supports for child care, elder care, and paid family leave in one program would enable Esmerelda to secure the quality care they need and get a job or even start a career. It would free her from the endless loop of providing care, filling out forms, and meeting activity requirements for public assistance.

The Advantages of Addressing a Broad Range of Caregiving Needs in One Integrated Program

While discrete programs that address one type of care are helpful, an integrated approach encompassing the entirety of the care nexus would be far more effective in supporting families. Today, the provision of and payment for care is highly fragmented. Different care needs are targeted by a range of programs, each with differing age-based, financial, and clinical and functional eligibility criteria. And each type of care need is further fragmented within itself. Young children may be eligible for different ECCE programs simultaneously or successively. In Medicaid, home and community-based services (HCBS) are treated very differently from institutional care. Even within HCBS, people with intellectual and developmental disabilities are often served by different waiver programs than are older adults—even when they are in the same family—creating a labyrinth of bureaucratic confusion. Eligibility for ECCE and LTSS can change quickly with shifts in family income (and for Medicaid LTSS, assets). All of this fragmentation has unintended consequences and often obliges families needing care to navigate and overcome multiple bureaucratic hurdles.

While discrete programs that address one type of care are helpful, an integrated approach encompassing the entirety of the care nexus would be far more effective in supporting families.



Leah works full-time as a marketing manager. She is the 30-year-old mother of a two-year-old son, and is currently pregnant. She is also a part-time caregiver for her 78-year-old father, who has serious health issues. She worries that care for her dad has taken her away from her son.

"I've been spending less time with him and missing out on those moments I would love to catch ... I'm the only child of immigrant parents, so care is all on me. Caring for my dad has brought on a lot of stress and frustration. Having someone to step in, even just to walk with him or offer him advice, would strengthen our relationship and make a world of difference."

A one-stop approach would ease this burden. Universal Family Care would enable all families to access care supports from one program rather than through a series of means-tested, bureaucratic processes. Family members would contribute to UFC from their first job onward and sign up for benefits the first time they need care. From then on,

when family care needs arise, they could re-engage the program in a less burdensome way, much like Americans deal with Social Security or traditional Medicare. (Recall that Social Security, like Universal Family Care, covers multiple risks in one overarching program: the financial risks of disability, retirement, and death of a breadwinner. Medicare also covers various types of health care risks and benefits in one program: the need for physician care, hospital care, prescription drugs, and others.)

A one-stop approach would ease this bureaucratic burden. Universal Family Care would enable all families to access care supports from one program rather than through a series of means-tested, application processes.

Creating one integrated program in place of a balkanized set of programs would also streamline program administration, and this could result in efficiencies and savings. There is a core set of functions in all care benefit programs: collecting contributions, managing program finances, determining eligibility, certifying providers, tracking claims, making payments, and ensuring program integrity, to name a few. Administrative costs are almost always lower when one integrated program handles these core functions.

In addition, an integrated program can enable a state to address several facets of a problem, not just one part of it. Just as legislating

universal pre-K does not work in practice unless accompanied by policies to ensure the supply of well-trained pre-K teachers, providing LTSS benefits does not guarantee that people's needs will be met effectively without establishing and enforcing job quality standards and investing in workforce training. And trained care workers will be unable to provide reliable care unless they have access to ECCE, PFML, and LTSS for their own family members.

In sum, from the perspective of both families' care experiences and public administration, there are synergies in addressing the multifaceted and longitudinal care nexus holistically. In the following sections of this chapter, we discuss how such an integrated policy could be designed.

Why Adopt a Universal Social Insurance Approach?

Programs targeting low-income people, like most of today's ECCE and LTSS programs (see discussion in Chapters 1 and 3), can provide critical assistance to their beneficiaries. However, a universal, social insurance approach has advantages.²⁰

Social insurance programs address the needs of not only those with low income, but also the broad middle class. The rationale for such a universal approach is that the need or "risk" being insured against is a normal part of social or biological life for everyone, not just those with low income. Social insurance programs are typically funded by contributions (dedicated taxes) from workers

²⁰ Social insurance programs can be structured to be universal only for those who have contributed or can include additional provisions rendering them universal for all residents. These issues are discussed in Sections III and IV.



and/or their employers, rather than from general revenues. For several reasons—contributors are also beneficiaries, benefits are seen as “earned,” and people across the income spectrum benefit—there tends to be broad buy-in among citizens²¹ and social cohesion is fostered. As a result, universal social insurance programs have, empirically, been able to generate far greater revenue than programs targeting those with low income, both in aggregate and per enrollee or beneficiary.²²

Because social insurance programs typically have dedicated contributory financing held in a trust fund and so do not have to compete with other programs for limited general revenues, they tend to be fiscally and politically stable. This is an important consideration for a program like Universal Family Care, which is designed to enable

families to make long-term decisions about family formation, child care, and elder care.²³ Another advantage of a social insurance approach is that families can qualify for care supports without having to file extensive paperwork to prove that they have low income and assets.²⁴ This also means that there are few “income cliffs” (which create perverse work or earnings incentives) or “asset cliffs” (which give rise to complex and inefficient “spend down” strategies).

A middle ground, known as *targeted universalism*, seeks to meet the objectives of targeted programs while maintaining the advantages of universal ones.²⁵ Funding is broad-based and often contributory, but progressive elements are built into the benefit design and/or funding mechanism. In simple terms, everyone contributes and benefits, but those with higher income pay

²¹ Theda Skocpol, “Targeting Within Universalism: Politically Viable Policies to Combat Poverty in the United States,” in Paul E. Peterson and Christopher Jencks, eds., *The Urban Underclass* (Washington, DC: Brookings Institution, 1991); Theodore R. Marmor, “Beneath the Surface. Social Insurance and American Health Care: Principles and Paradoxes,” *Journal of Health Policy, Politics, and Law*, Vol. 43, No. 6, December 2018, DOI 10.1215/03616878-7104419; Robert Greenstein acknowledges that universalistic approaches engage the political support of broader constituencies but notes that targeted programs, if designed well, can also endure and grow over time, giving as examples Medicaid, the Earned Income Tax Credit, and the Supplemental Nutrition Assistance Program (Food Stamps). Robert Greenstein, “Universal and Targeted Approaches to Relieving Poverty: An Alternative View,” in Paul E. Peterson and Christopher Jencks, eds., *The Urban Underclass* (Washington, DC: Brookings Institution, 1991).

²² This is true, for example, of both Social Security compared to Supplemental Security Income, and Medicare compared to Medicaid. “Fast Facts and Figures about Social Security, 2018,” Social Security Administration, September 2018, https://www.ssa.gov/policy/docs/chartbooks/fast_facts/index.html; Kaiser Family Foundation, “Medicaid Spending per Enrollee,” <https://www.kff.org/medicaid/state-indicator/medicaid-spending-per-enrollee/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>; Kaiser Family Foundation, “Medicare Spending per Enrollee,” <https://www.kff.org/medicare/state-indicator/per-enrollee-spending-by-residence/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>; Centers for Medicare and Medicaid Services, “NHE Fact Sheet,” <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html>.

²³ For an in-depth discussion of the conceptual foundations of social insurance, see Theodore R. Marmor, “Beneath the Surface. Social Insurance and American Health Care: Principles and Paradoxes,” *Journal of Health Policy, Politics, and Law*, Vol. 43, No. 6, December 2018, DOI 10.1215/03616878-7104419.

²⁴ While eligibility is not means-tested in universal programs, benefit levels are, in some cases, related to income. For example, ECCE benefits can be structured in relation to family income, and paid leave benefits are a percentage of prior income.

²⁵ Theda Skocpol, “Targeting Within Universalism: Politically Viable Policies to Combat Poverty in the United States,” in Paul E. Peterson and Christopher Jencks, eds., *The Urban Underclass* (Washington, DC: Brookings Institution, 1991).



more, and those with greater need receive more. In such an approach, a program can be well-resourced and politically sustainable, but also do the most good for those most in need of support.

Targeted universalism seeks to meet the objectives of targeted programs while maintaining the advantages of universal ones. Funding is broad-based and often contributory, but progressive elements are built into the benefit design and/or funding mechanism.

A social insurance approach to UFC would be considered targeted universalism if its financing and/or benefits were, on the whole, progressive. An example of progressive social insurance financing is the Medicare Part A (Hospital Insurance) tax base, which requires a higher contribution on earnings above a certain level and includes investment income. Similarly, Medicare Parts B and D are funded by contributions based on income level, supplemented by general revenues (which themselves are progressively financed). In most ECCE program designs, the benefit would equal the cost of care minus seven percent of household income, so that lower-income families would receive greater benefits than higher-income families. Most PFML program designs utilize a benefit formula with bend points and a benefit maximum; that is, they replace a higher share of wages for low-income workers than for middle- or high-income workers, rendering the benefit

formula progressive (see Chapter 2, Table 1, pp. 94-99). And because people with lower income at age 65 have, on average, greater need for LTSS than do higher-income individuals, they tend to receive more LTSS benefits.²⁶

If one compares a social insurance approach to a private insurance approach, the former tends to be more affordable for the consumer than the latter, for several reasons. First, social insurance pools risk—and spreads the cost of coverage—across the entire workforce or population. This means that low-risk and high-risk individuals are all in the same risk pool, lowering per-person costs compared to a voluntary private insurance approach, which is vulnerable to adverse selection. Second, social insurance programs typically calculate contributions as a percentage of income, while private insurance bases premiums on the severity of a person's risk of needing care. And third, in social insurance there are limited or no marketing, sales, or underwriting expenses.

Why UFC Could Be Pursued at the State Level

Universal Family Care could be introduced at the state or federal level. Doing so at the federal level could make integration with

existing programs easier and also avoid complications in covering those who live in one state and work in another, or who move from one state to another. However, the states are the focus of this report, both because the challenges to state-level UFC adoption are navigable (see Sections IV and V), and because the states have a key role to play in social policy innovation.

States led the way in creating social insurance protections in Workers' Compensation, Unemployment Insurance, and Paid Family and Medical Leave.²⁷ Washington State recently passed the nation's first LTSS social insurance program. Moreover, state and local governments have decades of experience administering ECCE and LTSS programs. They already perform functions such as defining and assessing benefit eligibility, certifying qualified providers, and reimbursing providers. States have a wealth of knowledge and experience that can easily be built on as a Universal Family Care program is designed and implemented. Finally, a UFC social insurance program with dedicated financing would fund much of a state's paid LTSS needs, relieving pressure on its Medicaid budget, which is funded by general revenues.²⁸ Thus, there is no reason to believe that states must "sit on their hands"

²⁶ Melissa Favreault and Judith Dey, "Long-Term Services and Supports for Older Americans: Risks and Financing Research Brief," Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, February 2016, <https://aspe.hhs.gov/basic-report/long-term-services-and-supports-older-americans-risks-and-financing-research-brief>.

²⁷ Four states—California, New Jersey, New York and Rhode Island—operate PFML social insurance programs, and four more jurisdictions—Connecticut, the District of Columbia, Massachusetts, and Washington—have recently enacted PFML programs that are currently awaiting implementation. For in-depth descriptions of these programs, see Chapter 2.

²⁸ Universal Family Care would reduce Medicaid spending over the long term. A back-end or comprehensive (with no time limit on benefits) LTSS program would reduce Medicaid LTSS spending by 32 or 35 percent, respectively, by 2070, compared to currently projected spending. Melissa M. Favreault, Howard Gleckman, and Richard W. Johnson, "How Much Could Financing Reforms for Long-Term Services and Supports Reduce Medicaid Costs?," The Urban Institute, February 2016, https://www.thescanfoundation.org/sites/default/files/how_much_could_financing_reforms_for_ltss_reduce_medicaid_costs_feb_2016.pdf.

and wait in the absence of federal solutions; in fact, they have particularly relevant capacities to successfully put forward such an approach.

How Much Would a UFC Program Cost?

In-depth modeling of the cost and impact of UFC policy at the state and federal levels will be undertaken in late 2019 using the

illustrative UFC policy packages discussed in Section III of this chapter. For this report, we have developed preliminary estimates of the social insurance contribution or tax rate which might be required to fund a sample UFC program, using a range of possible tax bases (Table 1). These are ballpark estimates at the national level for a set of program components for which dollar cost estimates are publicly available today.

TABLE 1: Estimated Tax Rate Required to Fund a Universal Family Care Program, for Different Tax Bases

Universal Family Care Program LTSS: Front-end coverage PFML: FAMILY Act ECCE: NAS Illustrative Package	Social Security Payroll Tax Base	Income Tax Base	Medicare Tax Base				
			(Payroll Only)		(Payroll & Investment)		
			Payroll	Additional rate on earnings above \$200k/\$250k	Payroll	Additional rate on earnings above \$200k/\$250k	Investment income
	2.02%	1.48%	1.55%	0.66%	1.44%	0.61%	2.56%

Source: Edward Armentrout, Actuarial Research Corporation (ARC) based on cost estimates from ARC, IMPAQ International/Institute for Women's Policy Research, and the National Academies of Sciences, Engineering, and Medicine.²⁹

²⁹ Estimates are national, based on national costs and tax bases; individual states will vary. Total UFC program costs are in constant 2016 dollars, based on the sum of separate cost estimates for each component of the program. The financing estimates here are illustrative for the purpose of quantifying the possible cost of a UFC program. They are the best available estimates and fall within the range of program designs described in Chapters 1, 2, and 3 of this report. For LTSS, a 75-year cost estimate produced by ARC for the front-end coverage option described in Chapter 3 of this report is used. For ECCE and PFML, single-year estimates are used. For ECCE, the cost estimate is from the Illustrative Package elaborated in: National Academies of Sciences, Engineering, and Medicine, "Transforming the Financing of Early Care and Education," 2018, <https://doi.org/10.17226/24984>. For PFML, the cost estimate is for The Family and Medical Insurance Leave Act from Table 3 in: IMPAQ International and Institute for Women's Policy Research, "Estimating Usage and Costs of Alternative Policies to Provide Paid Family and Medical Leave in the United States," Issue Brief—Worker Leave Analysis and Simulation Series, January 2017, <https://www.dol.gov/asp/evaluation/completed-studies/IMPAQ-Family-Leave-Insurance.pdf>.

Based on these preliminary estimates, the contribution level required to fund benefits could, in most program designs, be around 1.5 percent of earnings for most workers, with a higher rate on individual earnings above \$200,000 (or \$250,000 for couples). If contributions were structured as a flat rate on all earnings, the rate could be about two percent.

To elaborate on one option shown in the table: If the UFC package used above (middle-of-the-road in benefit cost and adequacy) were funded from the tax base of the Medicare payroll tax, the contribution rates required could be 1.55 percent of earnings plus an additional 0.66 percent of earnings above \$200,000 (individual)/\$250,000 (couple). With this contribution structure, a family with the median household income of \$61,372 would pay an annual contribution of \$951 (about \$79/month).³⁰ But if this family needs a home health aide, the median annual cost is around \$50,000, and if they need child care, the average annual cost for children under four is nearly \$10,000.³¹ And while the UFC program would not cover all these expenses, it would pay a substantial portion. (The ECCE benefit would pay costs in excess of seven percent of household income, and a front-end LTSS benefit would likely pay a maximum lifetime amount of around \$36,500 in today's dollars.) The advantage of the social insurance principle is clear: Workers pay in

small amounts out of every paycheck across their careers, and in times of need, they are able to draw on the program to receive valuable care supports.

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How Would a UFC Program Affect Families, Workers, and the Economy?

Leaving the status quo care infrastructure intact—that is, “doing nothing”—could be the most economically and socially costly option available to policymakers. Our current arrangements leave workers and their families largely to fend for themselves when care needs arise. This has pernicious effects on child development, adult labor force participation, family economic security, health, and quality of life.

High-quality ECCE programs can have lasting effects on a child's long-term educational achievement,³² socio-emotional development,³³ lifetime earnings, and

³⁰ Median household income was \$61,372 in 2017. U.S. Census Bureau, “Income and Poverty in the United States: 2017,” September 12, 2018, <https://www.census.gov/library/publications/2018/demo/p60-263.html>.

³¹ The median annual cost of a home health aide was \$50,336 in 2018. Genworth, “Cost of Care Survey 2018,” <https://www.genworth.com/aging-and-you/finances/cost-of-care.html>; Child Care Aware of America, “The US and the High Cost of Child Care: 2018 Report,” 2018, <http://usa.childcareaware.org/advocacy-public-policy/resources/research/costofcare/>.

³² For a review of the literature on the impact of early childhood education, see: Sneha Elango, Jorge Luis García, James J. Heckman, and Andrés Hojman, “Early Childhood Education,” 2015, <https://heckmanequation.org/assets/2017/01/FINALMoffitt-ECE-Paper2015.pdf>.

³³ James J. Heckman, “Schools, Skills, and Synapses,” *Economic Inquiry*, Vol. 46, No. 3, 2008, http://jenni.uchicago.edu/papers/Heckman_2008_EI_v46_n3.pdf.



Leaving the status quo care infrastructure intact—that is, “doing nothing”—could be the most economically and socially costly option available to policymakers.

likelihood of incarceration.³⁴ Estimates of the return on investment in high-quality ECCE programs range from \$4 to \$16 for every dollar spent.³⁵ In the District of Columbia, the introduction of universal pre-K resulted in sizeable increases in labor force participation among disadvantaged mothers (and others).³⁶

Together, UFC’s ECCE and PFML benefits could make it easier for younger adults to start a family without falling off the career ladder. In 2018, the birthrate in the United States fell to a 32-year low, despite a prolonged period of economic recovery and growth. While the causes of this decline are multiple, the high cost of child care along with the need of most families for the income of all working-age adults to make ends meet could be a factor.³⁷ Access to affordable child care and paid leave could tip the balance in some couples’ decisions about whether and how many children to have.

³⁴ Arthur Rolnick, “Investing in Early Childhood Development Is Smart Economic Development,” *The Science of Early Brain Development: A Foundation for the Success of Our Children and the State Economy: First Edition*, Wisconsin Family Impact Seminars, 2014, https://www.purdue.edu/hhs/hdfs/fii/wp-content/uploads/2015/07/s_wifis32report.pdf.

³⁵ Ibid.

³⁶ Rashid Malik, “The Effects of Universal Preschool in Washington, D.C.: Children’s Learning and Mothers’ Earnings,” Center for American Progress, 2018, <https://www.americanprogress.org/issues/early-childhood/reports/2018/09/26/458208/effects-universal-preschool-washington-d-c/>.

³⁷ Brady E. Hamilton, Joyce A. Martin, Michelle J.K. Osterman, and Lauren M. Rossen, “Births: Provisional Data for 2018,” National Center for Health Statistics, May 2019, <https://www.cdc.gov/nchs/data/vsrr/vsrr-007-508.pdf>.

With regard to LTSS, nearly 70 percent of the cost of the home and community-based care of those turning 65 today will be paid out of pocket by families³⁸—often at a time when they are least able to afford it. A social insurance mechanism would spread this cost out over the lifespan, making it much easier for those needing LTSS to stay at home and avoid or delay institutionalization. New research suggests that in the coming years, for middle-class seniors, public LTSS supports such as those UFC would provide could be the difference between being able to afford to age in place and impoverishing themselves or spending down their assets to qualify for Medicaid—which could also mean having to go into a nursing home prematurely.³⁹

For middle-class seniors, public LTSS supports such as those UFC would provide could be the difference between being able to afford to age in place and impoverishing themselves or spending down their assets to qualify for Medicaid—which could also mean having to go into a nursing home prematurely.

While improving ECCE, PFML, or LTSS policies individually would take significant pressure off families facing caregiving challenges, Universal Family Care would go further. Because it takes a holistic approach to the interdependent family care nexus, it would provide families with supports that give them more freedom to choose how to cope with their care challenges in ways that fit their needs, preferences, and constraints across generations. This could improve their well-being in terms of work and earnings, health, and quality of life. It could do so both when people are providing care and when they are receiving it. Specifically, UFC holds promise to:

- Reduce families' vast unmet need for affordable care supports;
- Increase labor force participation and wages among people providing care as well as some of those receiving care (e.g., people with disabilities, people with temporary but serious illnesses or injuries);
- Empower families to address their care needs in an integrated fashion through whichever combination of ECCE, PFML, and LTSS makes the most sense for them;
- Provide peace of mind to families long before care is needed, compared to the status quo where many dread the prospect of high child care or long-term care costs;

³⁸ Melissa Favreault and Judith Dey, "Long-Term Services and Supports for Older Americans: Risks and Financing Research Brief," Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, February 2016, <https://aspe.hhs.gov/basic-report/long-term-services-and-supports-older-americans-risks-and-financing-research-brief>.

³⁹ Caroline F. Pearson, Charlene C. Quinn, Sai Loganathan, A. Rupa Datta, Beth Burnham Mace, and David C. Grabowski, "The Forgotten Middle: Many Middle-Income Seniors Will Have Insufficient Resources for Housing and Health Care," *Health Affairs*, Vol. 38, No. 5, April 24, 2019, <https://doi.org/10.1377/hlthaff.2018.05233>. See Chapter 3 of this report for a full discussion of Medicaid LTSS.



- Facilitate quality care as well as quality jobs in this fast-growing sector of the labor force by infusing funds into our care systems;
- Reduce poverty and financial shocks in families needing health care and caregiving; and
- Increase transparency, quality, and accountability in ECCE and LTSS service provision by fostering a beneficiary community that spans the income spectrum, as exists for other universal contributory programs like Medicare.⁴⁰

⁴⁰ The extent to which UFC would achieve many of these plausible outcomes will be explored in further research. As noted above, microsimulation modeling of the cost and impact of various UFC designs will be conducted in late 2019. Further research will be conducted as well on issues such as workforce implications, challenges to achieving universal coverage, strategies for covering 1099 income, integration with existing programs, and administrative implementation.

Section II.

**OVERVIEW
OF KEY UFC POLICY
DESIGN ELEMENTS
AND CONSIDERATIONS**



The policy vision of Universal Family Care is a new, integrated social insurance program to support families in coping with the risk of needing to provide or receive care across the lifespan, to which everyone contributes and from which everyone is eligible to benefit. This vision can be operationalized in a variety of ways. States seeking to adopt Universal Family Care will ultimately choose a policy design that best matches their goals, preferences, and constraints.

Key decision points in UFC policy design include:

- A choice between two high-level structural design approaches—contributory (a self-funded program, where only contributors may receive benefits) or comprehensive (a program

with additional funding sources beyond contributions, where coverage is extended beyond contributors);

- A choice of financing approaches; and
- Three program “dials”—eligibility requirements, benefit generosity, and qualifying events—that can be calibrated to meet a state’s needs.

These dials can be turned up or down, making the program more or less expansive (in terms of people covered and/or benefits) and correspondingly more or less expensive. Each of the decision points explained in this section will constitute a building block for the construction of the four illustrative UFC policy constellations discussed in Section III.

FIGURE 3: Contributory Social Insurance Approach



Structural Design

There are two basic program structures: a contributory and a comprehensive approach.

Contributory approach. In the contributory social insurance design, payroll contributions (paid by the employee, the employer, or both) are pooled into a dedicated insurance fund that covers those who have contributed (Figure 3).

While covering a large majority of the population, a purely contributory program (without any additional provisions) will leave out those who do not (for various reasons) contribute to it. This includes people who are outside the formal paid labor force (because they have a disability or family caregiving responsibilities, or for some other reason), as well as those who retired before the program began and so could not contribute to it. Also excluded are those who have contributed to the program, but not long enough to meet

the eligibility requirements (discussed below). Examples of a contributory social insurance design are Social Security, Medicare Part A (Hospital Insurance), Washington State’s new LTSS program, and most state PFML programs. A key feature of a contributory social insurance design is that the program’s revenue is held in trust. The trust fund generally must balance income and outgo. For example, the Social Security Trust Funds do not have authority to draw on general revenues to make up for any current funding shortfall, nor can they borrow from the General Fund or the public.⁴¹ Similarly, existing state PFML programs are self-funded: States monitor projected program income and outgo, and they generally ensure that sufficient trust fund balances are maintained to cover at least three to six months of benefit payments and administrative costs; to keep the programs in balance over time, states may adjust up or down the payroll contribution rate or the taxable maximum, or in some cases, the maximum weekly benefit.⁴²

⁴¹ Congressional Research Service, “Social Security: The Trust Funds,” May 8, 2019, <https://fas.org/sgp/crs/misc/RL33028.pdf>.

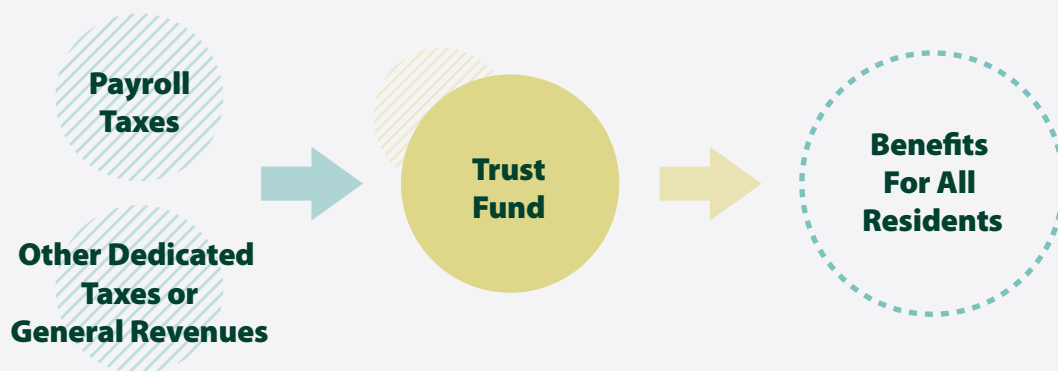
⁴² Department of Legislative Services, “Report of the Task Force to Study Family and Medical Leave Insurance,” December 1, 2017, <http://dls.maryland.gov/pubs/prod/HHS/2017-Report-of-the-Task-Force-to-Study-Family-and-Medical-Leave-Insurance.pdf>; for one state’s PFML trust fund forecast and management process see: State of California Employment Development Department, “Disability Insurance (DI) Fund Forecast,” May 2019, https://www.edd.ca.gov/About_EDD/pdf/edddiforecastmay19.pdf.

The advantage of this contributory trust-fund approach for a new UFC program is that it would cordon off the program from the rest of the budget. This would mean both that UFC would be insulated from competition with other programs for funding and that the program's spending would not negatively affect the rest of the state's budget. (In fact, UFC might result in savings in some existing programs like Medicaid and so relieve pressure on the budget.) In other words, a contributory UFC program would bring in new revenue to fund its benefits, and it could only spend what it takes in. At the same time, because the program would not have to compete with other state programs for limited revenue in annual appropriations battles, contributors would have some degree of confidence that they could count on UFC's LTSS benefits in their long-term LTSS planning. On the other hand,

a disadvantage of the contributory trust-fund approach is that in times of greater need the trust fund might not have sufficient resources to cover projected benefits. In that case, either benefits would have to be cut or the payroll tax rate increased. However, such situations could be avoided through actuarial forecasting and planning, whereby the tax rate is set to cover projected expenditure over a longer time horizon.

Comprehensive approach. In a comprehensive program design, all residents of the state are eligible for benefits from the program, regardless of whether or how much they have contributed to it. The comprehensive design is generally anchored in contributory social insurance but also includes funding from other dedicated taxes or general revenues, which are used to cover those who have not contributed (Figure 4).

FIGURE 4: Comprehensive Approach



For each of these two basic approaches, we will present (in Section III) a “core” version with modest benefits, and a more generous “expanded” version. This will yield four structural design options: Core Contributory, Expanded Contributory, Core Comprehensive, and Expanded Comprehensive.

Financing

There are two issues related to financing: choice of funding source(s), and—for LTSS benefits—use of a prefunded or pay-as-you-go approach.

Funding Sources

Potential sources of revenue include (but are not limited to):

- **Payroll contributions.** Workers and/or their employers contribute a share of their earnings to the UFC Trust Fund. Earnings from self-employment or contract work can be subject to contributions at the same rate as regular employment

earnings. Payroll contributions can be purely proportional, where the same rate is paid on all earnings; they can be regressive, where the same rate is paid on all earnings up to a cap, with no contributions due on earnings above the cap; or they can be progressive, where a higher rate is levied on earnings above a certain threshold. (The latter is the payroll contribution approach in Medicare, where earnings above \$200,000 per person or \$250,000 per couple are taxed at a higher rate.)

Payroll contributions can be purely proportional, where the same rate is paid on all earnings; they can be regressive, where the same rate is paid on all earnings up to a cap, with no contributions due on earnings above the cap; or they can be progressive, where a higher rate is levied on earnings above a certain threshold.



■ **Taxes on investment income.** A tax may be levied on unearned (investment) income, typically only for individuals or households with income above certain levels. An example is the Medicare Net Investment Income Tax, which levies a tax on investment income of those with modified adjusted gross income (MAGI) above \$200,000 (for individuals) or \$250,000 (for couples) (thresholds not indexed for inflation).

■ **Premiums.** While social insurance programs do not typically charge premiums, a UFC program might allow or require those who have not contributed to the system for the minimum period of time to qualify for coverage by paying premiums. This might include both those who have not had enough paid employment and those who retired before they could meet contribution requirements. Premium amounts would not vary according to the risk a person presented (as in private insurance) but would be community rated (with all paying the same). As a variation, a higher rate could be charged on those with higher incomes, and exemptions or subsidies could be provided to those with low incomes. Examples of this approach: Some people with insufficient work histories to qualify for Medicare Part A pay community-rated premiums for Part A coverage; all Medicare beneficiaries pay premiums to cover part of the cost of Parts B and D.

■ **General revenues.** A state could supplement social insurance contributions and/or premiums with general revenues, as in Medicare. The additional funding could

make it easier to provide more expansive coverage or benefits. However, general revenue funding is subject to annual appropriations battles and highly vulnerable to cuts. Funding a UFC program entirely from general revenues would constitute social assistance, not social insurance.

■ **Income surtax.** States could levy a surtax on their income tax base and dedicate the revenue to the new UFC program. However, income tax bases differ by state, and seven states have no income tax.⁴³

■ **Other dedicated taxes.** A state could supplement social insurance contributions and/or premiums with other dedicated taxes as well. A state could earmark a portion of the revenue from another source (e.g., sales tax, estate tax, property tax, corporate tax, or excise tax), or levy a surtax on one of these revenue sources for UFC. This would arguably be less vulnerable to annual appropriations battles than general revenue funding, but dedicated tax revenue could still be unpredictable, particularly if the tax were based on sales of a specific type of commodity or on property value.

Prefunding vs. PAYGO

As discussed in Chapter 3, there are two basic approaches to funding benefits:

■ In a *prefunded* system, current contributions are invested to pay for future needs. Typically, participants must contribute to the system for a minimum number of years before they are eligible for benefits.

⁴³ The states without an income tax are Alaska, Florida, Nevada, South Dakota, Texas, Washington, and Wyoming. New Hampshire and Tennessee have a tax only on investment income, not earnings.



- In a *pay-as-you-go* (PAYGO) system, current contributions pay for the benefits of those who need them now. Usually in PAYGO, participants are eligible for benefits very soon after the program is established. (The implications of these two choices are examined in Chapter 3, pp. 171-73 and pp. 185-88.)

Whether a contributory or comprehensive structure is chosen for a UFC program, PAYGO will generally be used for ECCE and PFML benefits. In a contributory program, LTSS benefits will usually be prefunded. In a comprehensive program, a PAYGO or hybrid approach could be used for LTSS. In a hybrid system, contributions could be used to fund benefits for those who have contributed, and other funding sources (such as a dedicated tax or general revenues) would pay for those who need benefits but have not met the contribution requirements.

Eligibility Requirements

A contributory UFC program would generally have work and/or earnings requirements. That is, to be eligible for benefits, an individual must have worked and paid into the program for a minimum period of time. However, the requirement is typically quite different for ECCE, PFML, and LTSS benefits, and a UFC program could have different rules for each.

- ECCE benefits would have no contribution requirement (even in a contributory program), following the National Academies of Sciences' consensus report recommendation that children's access to ECCE not be contingent on the employment status of their parents.⁴⁴
- In existing state PFML social insurance programs, workers must have earned a

⁴⁴ La Rue Allen and Emily P. Backes (eds.), "Transforming the Financing of Early Care and Education," Committee on Financing Early Care and Education with a Highly Qualified Workforce, 2018, <https://www.nap.edu/catalog/24984/transforming-the-financing-of-early-care-and-education>.

certain amount of money and/or worked a certain number of hours or weeks over roughly the previous year (for detailed information, see Table 1 in Chapter 2).

- In LTSS social insurance programs, the required contribution period is usually much longer. In Washington State’s new program, workers must contribute for a total of 10 years (without any interruption lasting five or more consecutive years), or three of the past six years.

A comprehensive UFC program, designed to cover all state residents, would not have eligibility requirements beyond state residency of some duration. However, a state taking this approach would need to decide how immigration status would affect eligibility. A program could, for example, cover all lawful permanent residents (both U.S. citizens and noncitizens) or even include undocumented immigrants. The fact that immigrants provide a large portion of ECCE and LTSS services is an argument for including them in coverage. Nearly one fifth (18 percent) of the ECCE workforce and nearly one quarter (23.5 percent) of long-term care workers are foreign born.⁴⁵

Benefits

Policy options

For each of the three components of UFC, the previous chapters outlined a core menu of policy options.

ECCE

1. **Comprehensive universal early child care and education.** This approach places ECCE on par with primary and secondary school education by entitling all children access to publicly funded early care and education.
2. **Employment-based, contributory early child care and education.** This entitles all children to early care and education if their parent(s)/guardian(s) are sufficiently attached to the labor force.
3. **Universal early child care and education subsidy.** This entitles all families to a subsidy to cover a portion of the cost of early care and education for their children.

PFML

1. **Universal, contributory social insurance program, exclusive state fund.** Throughout their careers, all workers contribute to a state social insurance fund—out of which all benefits are paid—in return for an earned benefit should a PFML need arise.
2. **Contributory social insurance program with regulated private options.** Employers are required to offer a certain level and type of coverage and to comply with specified anti-discrimination and other consumer protections. Employers are free to choose between utilizing the state fund, self-insuring, or purchasing a private plan for coverage.

⁴⁵ Leah Zallman, Karen E. Finnegan, David U. Himmelstein, Sharon Touw, and Steffie Woolhandler, “Care for America’s Elderly and Disabled People Relies on Immigrant Labor,” *Health Affairs*, Vol. 38, No. 6, June 2019, <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05514>; Maki Park, Margie McHugh, Jeanne Batalova, and Jie Zong, “Immigrant and Refugee Workers in the Early Childhood Field: Taking a Closer Look,” Migration Policy Institute, April 2015, <https://www.migrationpolicy.org/research/immigrant-and-refugee-workers-early-childhood-field-taking-closer-look>.

- 3. Employer mandate.** Employers are obligated to provide paid leave benefits directly to their workers, either by self-insuring or by purchasing private coverage.

LTSS

- 1. Front-end coverage.** Benefits begin to be paid as soon as someone becomes disabled (or after a brief waiting period of, for example, 30 or 90 days), but they last only for a limited time (such as a year or two) or only up to a total dollar amount.
- 2. Back-end (catastrophic) coverage.** Benefits begin only after someone has been disabled for an extended period (such as two or three years).
- 3. Comprehensive coverage.** Benefits are paid during the entire period of need.

Cross-cutting the three benefit types, there are two key aspects of benefit design to consider: the structure of the benefit and its generosity.

Benefit structure. The design of a UFC program's benefits can best be thought of as a spectrum that runs from a cash benefit to service reimbursement.⁴⁶

- **Cash benefit.** An amount is paid directly to a beneficiary, which they can use to pay for the services and providers they choose.
- **Service reimbursement (in-kind benefit).** An amount is paid to a provider for services delivered to the beneficiary. Typically, to receive benefits from the

program, a provider must be a covered provider—they must register with a state agency and meet certain requirements for qualifications, care quality, and reporting.

In either case, benefits could cover all or a portion of the cost of care. While these two approaches may seem fundamentally distinct, benefits for ECCE or LTSS could be designed to fall anywhere along the spectrum between them.⁴⁷ (PFML, by its nature, must be a cash benefit.) For instance, a voucher (subsidy) might be given to a beneficiary (a cash benefit), but they could only be permitted to spend it on a covered provider (as in reimbursement).

Registering and monitoring providers—and reimbursing for costs incurred—places a greater administrative burden on the state, but it also gives the state a greater opportunity to improve the quality of care and care jobs. A pure cash benefit gives beneficiaries more autonomy in choosing services and providers, but the state has less control over how the money is spent. A program's benefit design will have substantial implications for the program's utility for beneficiaries, cost, and public buy-in. Given the differences in ECCE, PFML, and LTSS, different benefit designs for each may be appropriate. These issues are discussed in depth in the previous chapters.

Adequacy of benefits. Benefit levels will be a strong driver of both a UFC program's effectiveness in addressing families' care needs and the cost of the program. States could also choose to make benefits progressive—that is, provide greater benefits to those with greater need—in various ways.

⁴⁶ A third type of benefit is direct public provision, as in the case of state-run pre-K education.

⁴⁷ For an in-depth discussion of this issue, see the Chapter 3, pp. 213-15.

For instance, for ECCE, beneficiaries could be required to pay only up to a certain percentage of their household income on services (e.g., the seven percent deemed affordable by the Department of Health and Human Services), with the program covering the remainder of costs. In many PFML designs, those with lower incomes have a higher percentage of their wages replaced during leave. For LTSS, those with higher incomes could receive a lower benefit or be required to pay a greater portion of care costs.

Qualifying Events

A qualifying event is something that must occur for a beneficiary to be eligible for benefits. Each component of a UFC program will have different qualifying events, since each addresses a different need.

Early Child Care and Education. Benefits are available for any child below the current age of universal access to formal education in the state (which varies by state from four-year-old preschool to first grade).

Paid Family and Medical Leave. Most PFML programs in the United States have some or all of these qualifying events:

- A person has a child, adopts a child, or receives a foster child in placement.
- A person requires care for a serious health-related need (including those

related to a physical or mental illness, injury, disability, or medical condition) or services and supports related to incidence(s) of domestic violence, sexual assault or abuse, and/or stalking.

- A family member needs substantial or ongoing functional support for a physical or mental illness, injury, disability, or medical condition, or support for a safety concern such as domestic violence, sexual assault or abuse, and/or stalking.
- A family member is deployed on active military service or has been notified of an impending military deployment abroad.

Long-Term Services and Supports. States will have two primary decision points:

- What level of functional limitation is required? The need for an institutional level of care, as for Medicaid LTSS benefits in most states? The less stringent criteria used by some state Medicaid programs? The HIPAA benefit triggers used in most private long term care insurance plans—loss of functional capacity in two or more activities of daily living and/or severe cognitive impairment? Or something else?
- Will persons of all ages with LTSS needs be eligible, or only those above a certain age?

Section III.

ILLUSTRATIVE APPROACHES TO UNIVERSAL FAMILY CARE

NATIONAL
ACADEMY
OF SOCIAL
INSURANCE



In crafting a Universal Family Care program, states will need to make design choices with regard to the high-level structural approach (contributory vs. comprehensive), funding source(s), and the program “dials” of eligibility requirements, benefit adequacy, and qualifying events. Each state will make these choices within the context of its unique needs, preferences, and constraints.

To clarify and facilitate these choices, we present here four illustrative approaches to UFC design, each expressed as packages of ECCE, PFML, and LTSS benefits. The policy components specified in the benefit packages below are shorthand descriptions of ECCE, PFML, and LTSS policies elaborated in full in the previous chapters; they are presented here in brief in order to offer a quick overview and comparison of the four illustrative approaches. In practice, UFC will be an integrated care insurance program that is more than the sum of its ECCE, PFML, and LTSS parts. In Section IV, we will discuss alternative approaches to achieving UFC program integration across these three benefit domains.

The four UFC approaches include two versions of the contributory model and two versions of the comprehensive model. In each case, we present a core version and a more generous—and costly—expanded version. We offer these four illustrative approaches not as policy recommendations, but to demonstrate how UFC can be designed in practice and what tradeoffs different design choices entail.

Across these policy packages, there are tradeoffs involved in turning the dials up or down for various design elements. As eligibility is dialed up closer to universality, the program becomes more widely available but also more costly (assuming a fixed level of benefits per beneficiary). As benefits become more generous, they provide more support for more families—making care more affordable for them—but this, too, makes the program more expensive. Funding approaches include a payroll contribution (whether proportional or progressive) or a payroll contribution supplemented by general revenues or other earmarked taxes of some sort. A program fully funded by payroll contributions would have dedicated—and likely more stable—funding,

but it would, barring additional provisions, leave out some people. Finally, all the choices in program design—particularly with regard to benefit structure—will also have substantial impact on the administrative simplicity or complexity of the program.

In sum, decisions about how these various dials and decision points are calibrated can have a significant impact on the degree to which the program achieves and balances its myriad goals. Those goals will vary for different states, political ideologies, and individual policymakers, but they are likely to include most or all of the following: universality of coverage, adequacy of benefits, fiscal sustainability, political sustainability, and administrative simplicity.

In this section, then, we will present:

- A general discussion of the contributory approach;
- The two contributory models (core and expanded);
- A discussion of the comprehensive approach; and
- The two comprehensive models (core and expanded).

Below we elaborate four illustrative approaches to UFC design: two contributory packages, followed by two comprehensive packages. Table 2 begins this discussion with an overview of key features of these four approaches.

TABLE 2: Key Features of Illustrative Approaches to Universal Family Care

		Contributory UFC		Comprehensive UFC	
		Core	Expanded	Core	Expanded
Funding: Payroll contributions levied on:		All earned income	Medicare payroll tax base (higher rate on earnings > \$200k/\$250k)	Medicare total tax base (including investment income), plus retiree premiums	Medicare total tax base plus retiree premiums and general revenues
Program Structure					
ECCE	Universal subsidy	X	X		
	Comprehensive			X	
	Comprehensive (w/ no parental contribution)				X
PFML	Universal contributory	X	X	X	X
	Job protection	X	X	X	X
	Stipend for family caregiver				X
LTSS	Front end coverage	X			
	Back end coverage		X		
	Comprehensive			X	X



The Contributory Approach: General Comments

The contributory approach most closely matches classic social insurance. This model has a long track record at the national level (e.g., Social Security) and is the design approach for all existing state PFML programs⁴⁸ as well as the new LTSS program in Washington State. Such programs provide earned benefits, where workers contribute to the program throughout their careers and in return receive coverage. Payroll contributions are traditionally paid jointly by workers and their employers, though many existing state PFML programs, as well as the Washington State LTSS program, are funded entirely by worker contributions.

A drawback of this approach is that people who do not contribute for at least a certain period of time do not qualify for benefits. This includes people who have not sufficiently participated in

paid employment (because they are disabled, left the workforce to provide unpaid care labor for a child and/or family member, or for some other reason) as well as those who retired before or shortly after the program was established. To give some examples of contribution requirements: In most existing state PFML programs, people must have worked a certain period of time or achieved a certain amount of earnings over roughly the previous year.⁴⁹ The FAMILY Act, a proposal for a federal PFML program, has a much stricter requirement: It bases benefit eligibility on the work history requirements of Social Security Disability Insurance, which can be expressed in simplified terms as 10 years of work and contribution history, five of which occurred in the last 10 years (with younger workers needing considerably fewer credits to qualify).⁵⁰ Washington State's new LTSS program requires ten years of work, with no more than five years' interruption (or three of the past six years).

⁴⁸ The only exception is Hawaii's program, but it is not a PFML program; it provides paid medical leave only. See Chapter 2 for more detail on existing PFML programs.

⁴⁹ These periods/amounts vary by state. See Table 1 in Chapter 2 for existing state program provisions.

⁵⁰ Social Security Administration, "How You Earn Credits," 2019, <https://www.ssa.gov/pubs/EN-05-10072.pdf>.

Note that, in the two contributory models presented here, there is no contribution requirement for ECCE—benefits are available to all children under school age, regardless of their parents’ work history. Note also that it is inherent in the logic of PFML programs to make benefits available only to those engaged in paid employment, i.e., to replace earnings only for those who had earnings during the preceding period. (However, a *comprehensive* UFC program could be designed to provide a stipend to family caregivers whether they are formally employed or not. An example of such a program is the Veterans Administration’s Caregiver Support Program, which provides stipends to primary family caregivers providing personal care services to an eligible veteran.⁵¹)

How many people would be left out of a contributory program because they do not meet the work/contribution requirements?

This would, of course, depend on what those requirements were, and precise data for most eligibility requirements is lacking. A universal PFML program based on the FAMILY Act’s strict eligibility criteria would likely cover around three-quarters of workers.⁵² Most existing state PFML programs, which have a lower eligibility hurdle, cover a larger share of workers. A study of one contributory LTSS program proposal estimated 96 percent of all adults would enroll in the program, but did not project how many would meet the work requirements.⁵³

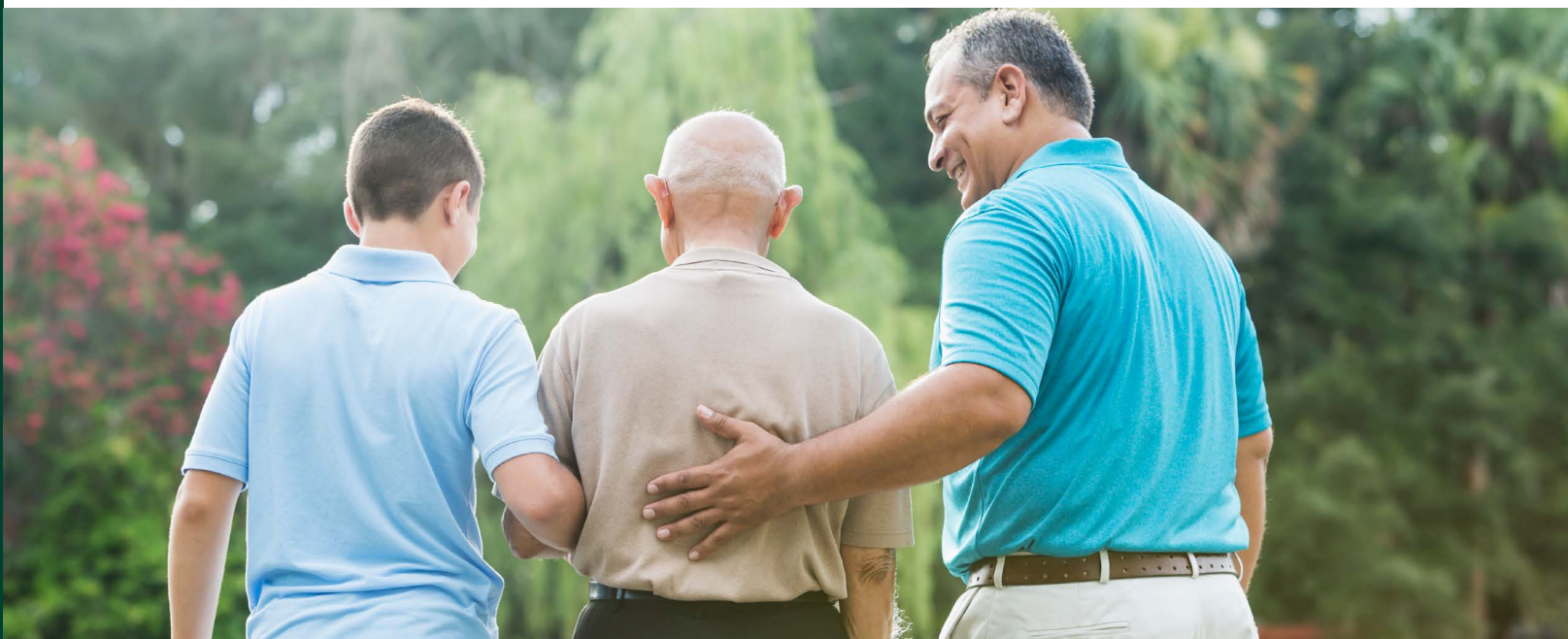
Those who do not qualify for a contributory UFC program’s LTSS benefits could apply for Medicaid LTSS, which has generous benefits but is fragmented and means-tested and lacks guaranteed access to home care.⁵⁴ For those who do not qualify for PFML because they are not engaged in paid employment, there is no national backstop program.

⁵¹ “VA Caregiver Support,” U.S. Department of Veterans Affairs, <https://www.caregiver.va.gov/>, accessed May 5, 2019.

⁵² “Facts and Figures about Social Security, 2018” Social Security Administration, https://www.ssa.gov/policy/docs/chartbooks/fast_facts/2018/fast_facts18.html, accessed May 6, 2019.

⁵³ Melissa Favreault, Howard Gleckman, and Richard W. Johnson, “How Much Could Financing Reforms for Long-Term Services and Supports Reduce Medicaid Costs?” The Urban Institute, February 2016, <https://www.urban.org/sites/default/files/publication/77476/2000603-How-Much-Could-Financing-Reforms-for-Long-Term-Services-and-Supports-Reduce-Medicaid-Costs.pdf>.

⁵⁴ For a detailed discussion of Medicaid LTSS, see Chapter 3, pp. 160-64.



Illustrative Approaches to Universal Family Care

1A: Core Contributory



This is a classic social insurance approach. PFML and LTSS benefits are available to those who have worked and contributed for a certain period of time, but not to those who have not. ECCE benefits are available to all children under school age. Benefits are modest but sufficient for many people.

Financing:

- Exclusive source: a proportional (flat-rate) payroll contribution on all earned income
- Partially prefunded (for LTSS benefits)

ECCE coverage (see Chapter 1, Universal subsidy, pp. 50-53)

- **Eligibility and qualifying events.** Available to all children below the age of formal entry into public education.

- **Benefits.** Subsidy—an amount is paid directly to a qualified ECCE provider on behalf of an eligible family. The amount of the subsidy could be the same for all children or higher for lower-income families.

PFML coverage (see Chapter 2, Exclusive state fund, pp. 109-10)

- **Eligibility.** Must have worked and contributed for at least 820 hours in four out of the five quarters before applying for paid leave.
- **Qualifying event.** Need to take time off work to care for a seriously ill family member, or for one's own illness or injury, or to bond with a new child (including fostered and adopted children).
- **Benefits.** From 50 to 80 percent of earnings (higher for lower-paid workers).⁵⁵ An individual can take up to 12 weeks at a time and up to 16 weeks in a year.⁵⁶

⁵⁵ For workers paid 50 percent or less of the state average weekly wage (AWW), the weekly benefit is 80 percent of the worker's AWW. For workers paid more than 50 percent of the state AWW, the weekly benefit rate is 80 percent of the worker's AWW up to 50 percent of the state AWW, plus 50 percent of the worker's AWW that is more than the state AWW. The maximum weekly benefit is 64 percent of the state AWW.

⁵⁶ If a worker experiences a pregnancy-related serious health condition that results in incapacity, they can take up to 14 weeks at a time and up to 18 weeks in a year.

LTSS coverage (see Chapter 3, Front-end coverage, pp. 173-76)

■ **Eligibility.** To be eligible, workers must contribute for a total of 10 years (without any interruption lasting five or more consecutive years), or three of the past six years. As a result, those who do not participate in the paid workforce, have retired, or are near retirement would not be eligible for benefits. This means that people of all ages who currently have disabilities would not be eligible for benefits until and unless they were able to accumulate a sufficient work history.

■ **Qualifying event.** HIPAA criteria (widely used in private long-term care insurance): inability to perform at least two activities of daily living (ADLs) without substantial assistance and/or severe cognitive impairment. Waiting period: Benefits begin 30 days after meeting these criteria.

■ **Benefits.** \$100/day, up to a total lifetime amount of \$36,500. (This lasts at least one year but can last longer if a lower daily benefit is claimed or benefits are not claimed for every day.) Amount increased annually by three percent to account for rising costs.

Policy Assessment of Approach IA: Core Contributory UFC

Universality of coverage: This package would vastly expand the share of the population with access to paid care supports. However, because of the work/contribution requirements (except for ECCE), it would fall short of universal coverage.

Adequacy of benefits: Overall benefits are modest but adequate for many. The ECCE

benefits are modest but sufficient to render ECCE affordable for the majority of households. The PFML benefits are comparable to existing state programs and adequate. For LTSS, everyone with a significant need would receive some benefits during the initial period of need; those with longer periods of need would have to pay out of pocket after benefits expire until they qualify for Medicaid LTSS benefits, unless they have private LTC insurance. (Those on Medicaid at the onset of LTSS need would be eligible for the UFC LTSS benefits as well; for a discussion of benefit integration with Medicaid, see Chapter 3, pp. 195-96.)

Fiscal sustainability: Program cost is modest compared to the other three illustrative approaches. The tax base (all earnings) is very broad, and the prefunded approach to LTSS benefits enhances the UFC program's overall fiscal sustainability, since it gives the program time to accumulate assets before paying out those benefits.

Political sustainability: This approach would likely garner wide support. First, like all UFC program designs, it provides benefits to a broad population, without means-testing. Second, benefits are "earned," which resonates positively in the U.S. political culture. Third, it does not put any demands on state general revenues.

Administrative simplicity: A contributory social insurance approach to UFC could draw on administrative practices in a number of other contributory social insurance programs at the federal and state level (e.g., Social Security, Unemployment Insurance, Medicare, etc.). PFML contributions and benefits would be straightforward to administer in this program design, as it is similar to the exclusive state fund approach to PFML discussed in Chapter 2. However, the administration of

ECCE and LTSS benefits would require the development of some new capabilities. If a higher ECCE benefit is to be paid to lower-income families, income will have to be determined and confirmed. States would also need to approve and monitor child care and education providers for their eligibility to receive service reimbursement. To alleviate that administrative complexity, states could use the same provider list they already have in place for other programs, such as the Child Care and Development Block Grant. For LTSS, states would need to conduct assessments of claimants to determine if they satisfy the HIPAA criteria; this would require modification of existing processes, given that state Medicaid programs use different qualifying triggers.



Illustrative Approaches to Universal Family Care

1B: Expanded Contributory



This is a more expansive package than the Core Contributory. It includes all of the features of the Core Contributory package plus some additional benefits and expanded eligibility. An important difference is that LTSS coverage is back-end instead of front-end.

Financing:

- Exclusive source: payroll contribution on all earnings, with a higher rate on earnings above \$200,000/individual or \$250,000/couple (the Medicare payroll tax base). Thus, this financing is more progressive than that of the Core Contributory package.
- Partially prefunded (the LTSS component)

ECCE coverage (see Chapter 2, Universal subsidy, pp. 50-53)

Same as in the Core Contributory package.

PFML coverage (see Chapter 2, Exclusive state fund, pp. 109-10)

Same as in the Core Contributory package, except:

- Benefit levels are higher. Benefits replace from 50 to 90 percent of earnings (higher for lower-paid workers).⁵⁷ An individual can take up to 12 weeks of family leave and 20 weeks of medical leave at a time, and up to 20 weeks total in a year.

LTSS coverage (see Chapter 3, Back-end coverage, pp. 173-76)

- **Eligibility.** The work and contribution requirement is less stringent than in the

⁵⁷ For workers paid 50 percent or less of the state average weekly wage (AWW), the weekly benefit is 90 percent of the worker's AWW. For workers paid more than 50 percent of the state AWW, the weekly benefit rate is 90 percent of the worker's AWW up to 50 percent of the state AWW, plus 50 percent of the worker's AWW that is more than the state AWW. The maximum weekly benefit is 90 percent of the state AWW.

Core Contributory package (a total of six years, or two out of the last four), making it easier for those nearing retirement when the program is enacted to become eligible. In addition, those over 65 who retired before qualifying can opt into the UFC LTSS benefits by paying premiums, as in Medicare Part A (Hospital Insurance) today.

- **Qualifying event.** As in the Core Contributory package, the HIPAA criteria (widely used in private long-term care insurance): inability to perform at least two activities of daily living (ADLs) without substantial assistance and/or severe cognitive impairment.
- **Benefits.** \$100/day, indexed at three percent per year. Coverage is “back-end”: There is no lifetime limit on total benefits, but benefits begin only after a person has met the HIPAA criteria for two years. In other words, beneficiaries must finance their own LTSS for the first two years, making this coverage targeted to those with “catastrophic” needs and costs.

Policy Assessment of Approach IB: Expanded Contributory UFC

Universality of coverage: This package would achieve modestly broader coverage than the Core Contributory package because more people are able to meet the shorter LTSS work and contribution requirement.

Adequacy of benefits: As in the Core Contributory package, ECCE benefits are modest but could be sufficient to make ECCE affordable for a majority of households. The back-end LTSS coverage would, on average, pay roughly twice as much in total lifetime benefits to those who qualify for benefits as the front-end benefit in the Core Contributory package, because there is no cap on the duration of benefits. But families would have to pay for their own LTSS for the first two years, and many would not need care long enough to qualify for benefits.

Fiscal sustainability: With its broad tax base and partial prefunding of the LTSS benefit, this package should be fiscally sustainable. However, the costs of the back-end LTSS coverage, with its unlimited duration of benefits, will be less predictable than front-end coverage, especially as life expectancy and the need for LTSS increase over the years.

Political sustainability: Like the Core Contributory approach, this expanded package should garner broad support because benefits are earned and general revenues are not drawn on. In addition, the back-end LTSS benefit creates a market for front-end private long-term care insurance products, which promises to not only neutralize potential political opposition from the insurance industry but also potentially win its support.

Administrative simplicity: The administrative issues here are the same as for the Core Contributory package.



Comprehensive Approach: General Comments

A comprehensive program would be built on a foundation of social insurance, but with additional funding to cover those who have not contributed to the system. It would cover anyone who had a care need (qualifying event), whether or not they had contributed and regardless of how long, and would provide generous benefits. It is based on the belief that those who have not contributed at a particular point in their lives may do so in the future, and seeks to offer LTSS coverage to older adults and people with disabilities even if they retired before they could contribute or have not

participated for a sufficient period of time in the paid workforce.

The costs of such a program would be higher than the two approaches discussed thus far, but the percentage of the population covered would be higher as well, and the degree to which the program allows families to affordably meet their care needs would be equal to or greater than the preceding approaches. Funding to supplement payroll contributions could come from a dedicated tax of some sort or general revenues. An alternative approach would be to levy a payroll tax rate higher than that required to cover the cost of coverage for those who meet the work and/or contribution requirements.

Illustrative Approaches to Universal Family Care

2A: Core Comprehensive



This approach is anchored in social insurance but aims to cover not just all workers but all residents. Eligibility is not tied to work or contributions to the system.

Financing:

- Payroll contributions on all earnings, with a higher rate on earnings above \$200,000/individual or \$250,000/couple (the Medicare payroll tax base)
- A tax on investment income of those with income higher than the above thresholds (the Medicare Net Investment Income tax base). This feature makes the financing of this program more progressive than the others previously discussed.
- The rates levied would be modestly higher than needed to cover the contributing population in order to finance coverage of those without paid employment.
- LTSS benefits would be funded on a pay-as-you-go (PAYGO) basis, rather than prefunding.

- Those 65 or older who have not contributed to the program for at least 10 years would pay premiums (at the same rate as the social insurance contribution from workers) to help fund their coverage.

ECCE coverage (see Chapter 1, Comprehensive universal, pp. 43-45):

As with the contributory packages, all children are eligible. In addition:

- Parents pay only up to seven percent of household income for care; the program pays all additional costs.
- Local school systems use state funds for both school-based and other qualified programs (or funding is divided between school systems and collaboratives of community-based programs that function as part of the public system).

PFML coverage (see Chapter 2, Exclusive state fund, pp. 109-10):

Same as in the Expanded Contributory package, with the addition of:

- Stipends for primary family caregivers not in the workforce (calculated similarly to the VA Primary Family Caregiver Stipend).

LTSS coverage (see Chapter 3, Comprehensive coverage, pp. 173-76):

- **Eligibility.** Everyone is covered, including those already retired (if they opt in and pay premiums) and those of any age who already need LTSS.
- **Qualifying event.** The HIPAA criteria (widely used in private long-term care insurance): inability to perform at least two activities of daily living (ADLs) without substantial assistance and/or severe cognitive impairment. Waiting period: Benefits begin 30 days after meeting these criteria.
- **Benefits.** \$100/day, indexed at three percent per year. Benefits begin 30 days after meeting the HIPAA criteria and last as long as needed.

Policy Assessment of Approach 2A: Core Comprehensive

Universality of coverage. Comprehensive UFC achieves near universal coverage. It covers not only those who are working but also those outside the paid labor force. It immediately covers people of all ages with disabilities.

Adequacy of benefits. The benefits of this UFC package are far more generous than those of the two contributory packages.

LTSS benefits begin with the onset of LTSS need and last as long as the need persists. This would be enormously helpful to people with lifelong disabilities. The availability of stipends for primary family caregivers is another feature that could be critical to many families with disabilities.

Fiscal sustainability. Overall, this comprehensive package would be more costly than the two contributory packages because of the greater population coverage and the unlimited duration of LTSS benefits. This unlimited duration and the PAYGO approach to LTSS would also render actuarial modeling of the package's cost less certain. However, collection of LTSS premiums from older adults would contribute to the fiscal sustainability of the program. The costs of expanding access to comprehensive ECCE for children under the age of entry into the formal education system would be substantial and initially somewhat unpredictable, although some states have experience in this regard on which the new program could draw.

Political sustainability. Political support for universal public education has, by and large, stood the test of time, and there is a strong case for extending this system to ECCE, given its benefits for children, families, and society at large. Seniors are a strong political constituency; allowing them to opt into LTSS coverage is likely to garner their powerful support.

Administrative simplicity. It will be administratively challenging to cover people who are outside the paid labor market, including family caregivers.

Illustrative Approaches to Universal Family Care

2B: Expanded Comprehensive



This approach includes all of the features of the Core Comprehensive package but has more generous benefits—notably free ECCE.

Financing:

All the funding sources of the Core Comprehensive, plus:

- General revenues would be drawn on to help fund the cost of covering those not in the workforce.

ECCE coverage (see Chapter 1, Comprehensive Universal program, pp. 43-45):

ECCE is handled quite differently than in the other packages. Instead of offering subsidies to help parents pay for ECCE, the state would provide ECCE free-of-charge, without requiring any family contributions, like public primary and secondary education.

PFML coverage (see Chapter , Exclusive state fund, pp. 109-10):

Same as in the Core Comprehensive package.

LTSS Coverage (see Chapter 3, Comprehensive coverage, pp. 173-76):

Same as in the Core Comprehensive package, except:

- After two years of receiving benefits, the daily benefit amount would be increased by 25 percent; after four years, by another 25 percent. This is designed to cover the increase in need for LTSS services that typically occurs over time.

Policy Assessment of Approach 2B: Expanded Comprehensive

Universality of coverage: Same as in the Core Comprehensive package.

Adequacy of benefits: This is the most generous UFC benefit package of the four discussed here. ECCE would be free, and LTSS benefits would increase over duration of need.

Fiscal sustainability: This is the most costly of the four UFC designs presented here, and it shares many of the fiscal sustainability challenges of the Core Comprehensive approach. However, the diversity of revenue sources, reducing the amount of revenue needed from each source, is likely to enhance fiscal sustainability.

Political sustainability: A comprehensive, generous UFC design will foster a broad base of loyal constituents. The high cost of the program could make it a political target, however. Moreover, the partial reliance on general revenue funding could subject the program to budget cuts in periods of state fiscal crisis.

Administrative simplicity: The administrative challenges in this package would be similar to those in the Core Comprehensive package—but somewhat more modest, because offering free ECCE to all, instead of income-related subsidies, would be administratively less complex.

Comparing the Four Packages: Tradeoffs

Each of these four stylized policy approaches to Universal Family Care makes a series of tradeoffs among universality of coverage, adequacy of benefits, fiscal and political sustainability, and administrative simplicity—see Table 3.

TABLE 3: Illustrative Approaches to Universal Family Care: Policy Assessment

Structural Design		Universality of Coverage	Benefit Adequacy	Funding Source: Payroll Tax on:	Fiscal Sustainability	Political Sustainability	Admin. Simplicity
Contributory	Core (1A)	All who contribute for a certain period of time	Low	Earnings (no cap)	High	High	High
	Expanded (1B)		Medium	Medicare Payroll Tax Base	High	High	High
Comprehensive	Core (2A)	Near universal	Medium	Total Medicare Tax Base plus retiree premiums	Medium	High	Low
	Expanded (2B)		High	Total Medicare Tax Base plus retiree premiums and general revenues	Low	Medium	Low



A contributory social insurance program would go far in mitigating most families' care risks and give them peace of mind about their future care needs. It could be of moderate cost or more expensive, depending on what benefits a state offered. Because it would be self-funded through a dedicated payroll tax, the program's cost would be politically less challenging than programs competing for funding with other state budget priorities. As a result, it would likely have high political sustainability (akin to Social Security and Medicare).

A comprehensive UFC program would cover virtually everyone with moderate or generous benefits, depending on a state's program design. It would be more expensive than the contributory approach, but with dedicated funding for most of its benefits, it would be politically more sustainable than purely general-revenue funded programs (which compete for resources in appropriation battles year after year). Medicare Part B and Part D are examples of programs that

derive some of their political resiliency from being at least partially contributory (their political sustainability also benefits greatly from having seniors, a politically powerful constituency, as their main beneficiaries).

Both of these structural design approaches have a big advantage over the status quo: They pool resources and risk across most or all of the population, and across the life course, rather than leaving those needing care to cope with the financial cost of that need when it arises.

The illustrative packages discussed in this section have been presented to demonstrate four plausible ways ECCE, PFML, and LTSS policies could be integrated into a holistic UFC program, and to discuss the tradeoffs that must be considered when making design choices. Based on their own unique needs, preferences, and constraints, states can develop other UFC policy constellations as well.

Section IV.

INTEGRATION CONSIDERATIONS

NATIONAL
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UFC is designed to be a highly integrated program—a “one-stop shop” for families seeking care supports, a single place where they can access benefits for ECCE, PFML, and LTSS. Yet, such a program is not without policy design challenges. Two of the most prominent are how these three distinct benefit types will be integrated into a unified program and how the new program will relate to existing ECCE programs and Medicaid LTSS.

Integration Within Universal Family Care

The first integration question policymakers must answer is this: How closely integrated will UFC’s ECCE, PFML, and LTSS components be, with regard to funding, benefits, and administration? They might choose a highly integrated, moderately integrated, or loosely integrated approach. These approaches are distinguished by whether key program functions reside within a single agency and

whether funding streams are managed by a single or multiple agencies.

Note that some of the policy options for standalone ECCE, PFML, and LTSS programs discussed in the preceding chapters cannot be integrated into a UFC program. Specifically, PFML designs with an employer mandate or private opt-outs—private insurance or employer self-insurance—are not consistent with an integrated UFC program predicated on one insurance contribution (perhaps supplemented by other revenues) funding three types of benefits. (For this reason, those policy options were not included in this chapter.)

Highly Integrated Approach

There is a core set of functions in all care benefit programs: collecting contributions, managing the trust fund, determining

eligibility, certifying providers, tracking claims, making payments, and ensuring program integrity, to name a few. Administration would be more streamlined and efficient (likely resulting in lower administrative costs) if the core competencies necessary to perform these program functions resided in a single state agency rather than across multiple agencies.

In the most integrated form of UFC, a single UFC Care Insurance Fund would fund ECCE, PFML, and LTSS benefits. A single agency would collect contributions (and/or other revenue) into this trust fund, manage the fund, determine eligibility, track claims, make payments, and monitor program integrity. Only the certification of providers would need to be conducted by the state agencies with expertise in different areas, namely those already responsible for certifying providers for a state's existing ECCE and LTSS benefits.

This approach would also streamline the user experience by enabling families to access a range of care supports from one program rather than three. Families would have a single access point—one “door” to knock on, whether that be the physical door of the administrative home of UFC, a web app (discussed in Section VI), or a hotline. Family members would contribute to UFC from their first job onward and sign up for benefits the first time they needed care supports. From then on, when family care needs arose, they could re-engage the program using their UFC membership number (akin to a Social Security number), rather than having to start from scratch each time in applying to a separate program.

A highly integrated program would yield a whole that is greater than the sum of its parts. With an integrated program interface—for instance, through a web app—family members could apply for and track the status of their own and their family members' ECCE, PFML, and LTSS benefits in one place. For example, someone caring for an elderly parent could help their parent apply for LTSS benefits and at the same time apply for their own PFML benefits (perhaps to help the parent transition to acceptance of a home health aide), tracking the status of both benefits in one web app. Additionally, beneficiaries could access ancillary care supports that transcend any one of the three major benefit types (if a state chose to provide them). For example, a highly integrated UFC program would be better positioned to offer a care advisor (a toll-free number) to help families find information and resources to cope with their care needs (which often involve more than one major benefit type) or guidance about long-term care planning.

A highly integrated program would yield a whole that is greater than the sum of its parts.

However, a single, integrated UFC program would need to balance the short-term horizon of ECCE and PFML benefit administration with the long-term solvency horizon of LTSS benefit administration. For PFML benefits, most existing state programs use a one-year time horizon, adjusting payroll



tax rates from year to year as needed to pay benefits. For LTSS benefits, on the other hand, a 75-year time horizon helps ensure the stability of payroll contribution rates over the long term; this is the actuarial approach taken in the new Washington State LTSS program, for example. However, a highly integrated UFC approach, with one trust fund, could accommodate these distinct horizons by either partially prefunding expected LTSS benefits or by projecting expenses and contribution rates for all three types of benefits over a medium (25- or 50-year) or long-term (75-year) horizon.

Moderately Integrated Approach

In a moderately integrated program, there would still be one overarching administrative umbrella, but more of the functions—such as program integrity enforcement—would

be conducted by the state agencies already responsible for existing ECCE and LTSS benefits. There would still be one revenue stream, but it would be allocated to two or three funds. PFML benefits would be administered with a dedicated trust fund (as they are now in most states), either separately from or combined with the financial administration of the ECCE benefits. LTSS benefits would be financially administered through a separate, dedicated LTSS fund, to better accommodate the 75-year horizon of LTSS actuarial planning. Payroll contribution rates for the LTSS trust fund could be set for a 75-year time frame and periodically adjusted to maintain long-term solvency, while rates for the PFML and ECCE trust funds (or a combined fund) could be adjusted from year to year to maintain one-year solvency. A model for this moderately integrated approach is the Social Security system, which

has one overarching administration and one payroll contribution but allocates part of that contribution to an Old Age and Survivors Trust Fund and part to a Disability Trust Fund.

An advantage of having separate trust funds within UFC is that this could foster greater fiscal accountability within each trust fund. A disadvantage is that it could create an opposition in public discourse between ECCE, PFML, and/or LTSS benefits. This has been the case in recent years within Social Security, where opponents of the program have seized on differences in the solvency projections of the old-age and disability trust funds to pit the needs of people with disabilities against those of the elderly. For care supports, creating such a political vulnerability makes even less sense, given that families can experience multiple needs at a single point in time.

Loosely Integrated Approach

A loosely integrated UFC program would be like a moderately integrated one in that a state would have one revenue stream allocated into three separate trust funds, each of which would be separately managed. However, administration would be more decentralized than in the moderate approach. Not only would the state agencies currently responsible for child care benefits and Medicaid manage certification of service providers and approval of beneficiary qualifying events for the ECCE and LTSS benefits within UFC, but they might also determine coverage eligibility (satisfaction of work and contribution periods), track claims, make payments, and monitor program integrity.

To fulfill the promise of UFC, the program should have a non-bureaucratic, easily

navigable user experience. A family member applying for benefits should be able to apply to one and the same program whether ECCE, PFML, or LTSS supports are needed. The degree of internal program integration is likely to affect that user experience. That said, certain factors or constraints in a state may mitigate against a high degree of UFC program integration. These will be discussed below.

Integration of UFC with Existing Programs

Every state has existing ECCE and LTSS benefits. From the perspective of state administrators, integration with these existing programs is an important issue, for a significant amount of state and—more importantly—federal funding is at stake. Finally, several states have existing PFML programs; their integration into UFC entails distinct challenges.

Integration with Existing ECCE Programs

There is a range of ECCE programs currently in place—Head Start and Early Head Start, the Child Care and Development Block Grant (CCDBG) program, and state-run preschool programs in most states—and states will need to plan carefully to integrate UFC’s ECCE benefits with them. With the exception of a handful of universal preschool programs, these existing ECCE programs are serving only a fraction of the children who are eligible, primarily due to insufficient funding. A new infusion of ECCE funding from a state UFC program would (depending on program design) allow states to serve all children in the designated age group, not just a small percentage of those in need. UFC could achieve universal ECCE coverage most cost-effectively

by structuring benefits in such a way as to leverage and complement existing funding.⁵⁸

States must determine how beneficiaries and/or service providers will be able to “blend,” “braid,” and “layer” funding from the new UFC program with that of existing programs in order to efficiently expand access to affordable care. “Blending” refers to combining funds from different sources into one pot without allocating and tracking expenditures by funding source. “Braiding” refers to coordinating different funding sources, allocating revenues and tracking expenditures by funding source.⁵⁹ “Layering” refers to supplementing one source of funding (e.g. federal funding for a specific component of ECCE) with one or more others (e.g., new ECCE funding through UFC) in such a

way that if one source of funding is rescinded, the other layers remain functional.⁶⁰

States may seek to align any quality standards and requirements of the new UFC program’s ECCE benefits with those of existing federal programs, so as to facilitate the blending and braiding of funding. To this end, states would benefit from collaborating directly with federal program administrators from the outset of any effort to introduce universal ECCE through UFC. This could also help streamline administration and render the program more navigable for families.

All but seven states now have state-funded preschool programs.⁶¹ These programs are extremely heterogeneous in their design

⁵⁸ La Rue Allen and Emily P. Backes (eds.), “Transforming the Financing of Early Care and Education,” Committee on Financing Early Care and Education with a Highly Qualified Workforce, 2018, <https://www.nap.edu/catalog/24984/transforming-the-financing-of-early-care-and-education>.

⁵⁹ Child Care State Capacity Building Center, “Layering or Blending and Braiding Multiple Funding Streams,” accessed January 28, 2019, <https://childcareta.acf.hhs.gov/systemsbuilding/systems-guides/financing-strategically/maximizing-impact-public-funding/blending-braiding-funding>.

⁶⁰ Manuela Fonsceca, “Braiding, Blending, and Layering Funding Sources to Increase Access to Quality Preschool,” PDGTA State Technical Assistance Report, 2017, <https://pdg.grads360.org/services/PDCService.svc/GetPDCDocumentFile?fileId=26705>.

⁶¹ Allison H. Friedman-Krauss, W. Steven Barnett, G.G. Weisenfeld, Richard Kasmin, Nicole DiCrecchio, and Michelle Horowitz, *The State of Preschool 2017: State of Preschool Yearbook*, National Institute for Early Education Research (NIEER), Rutgers Graduate School of Education, 2018, http://nieer.org/wp-content/uploads/2018/04/YB2017_Executive-Summary.pdf.



and objectives.⁶² Most prioritize low-income children, with eligibility based not only on age but on a state-specified income level. Since each state's preschool design is a product of its own constraints and preferences, it is likely that the ECCE benefits in a new UFC program would build on the existing preschool program architecture while making coverage universal. However, some states may find it easier to replace their existing preschool programs with a new, universal ECCE benefit design under the umbrella of UFC.

Integration with Existing PFML Programs

Seven states and the District of Columbia already have an existing PFML program, and they will need to decide whether to integrate it completely into the new UFC program (for example, through one central system of collecting contributions, tracking eligibility, and administering claims) or leave it as a discrete component of a loosely integrated UFC program. Two complications arise here.

First, some states allow some employers who meet certain conditions to opt out of the PFML program if they provide paid leave that meets the statutory requirements—by purchasing insurance or paying for it themselves (self-insurance). This includes New York and, to a lesser extent, New Jersey, California, Washington, Massachusetts, and Connecticut. The extreme case is Hawaii, where the entire paid medical leave system is based on an employer mandate—employers must provide paid leave either through private insurance or self-insurance. If a state wants to incorporate PFML into an integrated UFC program, it must

eliminate such private opt-outs. UFC is a social insurance program in which one contribution by a worker and/or their employer funds (in whole or in part) all three care benefits (ECCE, PFML, and LTSS). Neither an employer mandate nor a PFML system with private opt-outs is compatible with this. All of every UFC contribution by a worker and/or their employer needs to be pooled to fund all three care risks: ECCE, PFML, and LTSS.

Second, in some states, the existing PFML program includes an employer contribution. In the District of Columbia, the PFML program is entirely employer funded; in Washington State, employers share the cost with employees; and in New York and New Jersey, employers share the cost of the temporary disability insurance (paid medical leave) component of the PFML system. Integration of these states' PFML systems into a new state UFC program would be easiest if the UFC program had the same financing approach as the state's existing PFML system. This is by no means necessary, however. A state could also simply keep the existing PFML program's benefit structure but fund it in a new way, out of the UFC revenue stream (also a payroll contribution with or without supplemental funding).

All states, whether they have an existing paid leave program or not, will need to decide how the new UFC program's PFML benefits will interact with existing employer plans. While most do not, some employers offer some paid family leave and/or temporary disability insurance coverage to their employees, even in the states without any statutory requirement to do so. A new state UFC program could allow

⁶² Ajay Chaudry, "The Promise of Preschool Education: Challenges for Policy and Governance," in *The Current State of Scientific Knowledge on Pre-Kindergarten Effect* (The Brookings Institution and Duke University Center for Child and Family Policy, 2017).



employers to provide “top-up coverage”—that is, a plan that would supplement the PFML benefits of the state UFC program. Such coverage might last longer than state benefits or cover a higher percentage of lost earnings.

Integration with Medicaid LTSS

By law, Medicaid is the secondary payer—it pays benefits only for Medicaid-covered services not (or not fully) covered by private insurance or a new social insurance benefit like UFC. Hence for LTSS beneficiaries in a UFC program who have sufficiently low income and assets to qualify for Medicaid LTSS, UFC would pay first, then Medicaid would pay any covered expenses not paid by UFC.

On one hand, this would result in a reduction in Medicaid spending, which the state partially funds, and therefore bring about savings for the state. (For example, actuaries estimate that when the new LTSS social insurance program created by Washington State’s Long-Term Care Trust Act is fully mature in 2052, it will achieve \$470 million (in 2018 dollars) in federal and state Medicaid savings that year.⁶³ The savings are equal to the amount of UFC LTSS benefits expected to be received by people who would qualify for Medicaid.) But on the other hand, because Medicaid is partially funded by the federal government (at least half, and more for poorer states), this could also mean that states would lose federal dollars. There are two possible solutions to this problem:

⁶³ Milliman, “2018 Feasibility Study of Policy Options to Finance Long-Term Services and Supports in the State of Washington,” Prepared for Washington Department of Social and Health Services (DSHS), ESSB 6032, Section 206(34), September 24, 2018, https://apps.leg.wa.gov/ReportsToTheLegislature/Home/GetPDF?fileName=WA%20LTSS%202018%20Feasibility%20Study_83c07ada-0ba4-4797-8798-3fec9e582043.pdf.

- A state could seek a federal waiver allowing the new UFC program to operate as the secondary payer to Medicaid. However, as discussed in Chapter 3, it is unclear whether such a waiver would conform with Medicaid's Third-Party Liability regulations. Moreover, such a provision would need to be structured in a way that required benefit coordination with Medicaid only for beneficiaries already on Medicaid, rather than requiring all new UFC LTSS beneficiaries to prove that they are not eligible for Medicaid. The latter would place a heavy bureaucratic burden on the new program.
- Alternatively, a state could seek a waiver to retain projected federal matching dollars as some state spending on LTSS shifts from Medicaid to the new UFC program, on the grounds that the new program promotes the objectives of Medicaid and would be budget-neutral for the federal government.⁶⁴ With such a rationale, Massachusetts was able to secure a waiver in the late 1990s and has renewed that waiver twice since then. Washington State's recently enacted Long-Term Care Trust Act similarly instructs its state Department of Social and Health Services to request any necessary waivers in this regard.⁶⁵

Washington State presents a unique integration situation. It has a universal PFML program and is the only state with a universal LTSS program. It thus already has two of the three building blocks of UFC. Furthermore, in

2019, the state passed one of the country's most comprehensive ECCE policy frameworks, the Washington Child Care Access Now Act. It would cap family child care expenses at seven percent of family income for families meeting the income eligibility thresholds for subsidized child care, subject to available funding. It also establishes the goal of achieving universal child care access for all Washington families by 2025.⁶⁶ As a result, the step from its current care policy infrastructure to UFC would be the smallest of any state in the country. Introducing UFC would enable the state to achieve its goal of universal ECCE coverage. To get from the state's current care support systems to UFC, it would need to align—or pool—its funding approaches for ECCE, PFML, and LTSS benefits. Currently, its ECCE benefits are funded by general revenues, its PFML program is funded by both employers and employees, and its LTSS program is funded solely by employees. The state would also need to pursue some level of administrative and user-interface integration of the three care support systems.

Washington State presents a unique integration situation. It has a universal PFML program and is the only state with a universal LTSS program. Furthermore, in 2019 the state passed one of the country's most comprehensive ECCE policy frameworks.

⁶⁴ Government Publishing Office, *Electronic Code of Federal Regulations*, December 20, 2018, <https://www.ecfr.gov/cgi-bin/text-id.x?SID=25d5f81f5390085e084f2454df1ef87d&mc=true&node=sp42.4.433.d&rgn=div6>.

⁶⁵ State of Washington Legislature, H-1732.1, 2019, <http://lawfilesexst.leg.wa.gov/biennium/2019-20/Pdf/Bills/House%20Bills/1087-S2.pdf>.

⁶⁶ State of Washington Legislature, SB-5436, 2019, <http://lawfilesexst.leg.wa.gov/biennium/2019-20/Pdf/Bills/Senate%20Bills/5436.pdf>.



A Final Challenge: All Who Contribute Must be Eligible for Benefits

A final challenge faces new UFC programs: Since all workers will be contributing to the program, all must have access to benefits when they have a qualifying care need. No one should be denied UFC benefits because they qualify for another program due to their low income. For instance, a family should not be denied UFC ECCE benefits because they are eligible for Head Start/Early Head Start; people should not be denied UFC LTSS benefits because their income and assets are so low they qualify for Medicaid LTSS. If this occurred, they would be paying an insurance contribution to a program whose benefits they are effectively not eligible to receive. This would be highly regressive social policy, as those with low income would be paying

for benefits for the middle class but getting nothing themselves. It is possible, however, to structure UFC benefits so that they layer on top of existing programs, and so that existing funding is leveraged. Policymakers should plan carefully to ensure that UFC is not reinforcing existing inequality in access to care supports and that low-income beneficiaries, in particular, are better off in UFC—on a net basis after considering contributions and benefits—than in the status quo.

See the previous chapters for more in-depth discussion of integration issues. As a state proceeds to adopt a new UFC program, it should seek advice from policy experts in these domains, legal experts, and administrators of existing state and federal programs.

Section V.

IMPLEMENTATION CONSIDERATIONS

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There are a variety of issues states will need to consider before and during implementation of a UFC program.

Pre-Implementation Phase

Trust Fund Board

A state could establish a Trust Fund Board representing care recipients, care workers, care providers, family caregivers, and state administrators, among others. Such a board could oversee implementation of the program and, after implementation, review its operations at periodic intervals. It could advise the state on measures to help ensure that the program not only serves beneficiaries well but also takes into account the needs of care workers and care providers. These measures could relate to provider standards, workforce investment and training, services covered, inflation adjustment, or any other program challenges that arise over time.

Administrative Design

A state will need to decide where the new UFC program will be housed—whether in an existing agency or agencies or in a new agency dedicated to UFC.

Administrative structures vary across states, but in most states the different types of benefits provided by UFC are administered by distinct entities. For example, in Washington State, ECCE benefits are administered by the Department of Children, Youth, and Families (DCYF); the PFML program by the Employment Security Department (ESD); and Medicaid LTSS benefits through the Department of Social and Health Services (DSHS). In addition, the state's new LTSS social insurance program (not restricted by Medicaid's Single State Agency Rule⁶⁷) is administered across three agencies. ESD collects worker contributions and deposits them into the program's trust

⁶⁷ Government Publishing Office, *Electronic Code of Federal Regulations*, 42 CFR §431.10 - Single State Agency, May 13, 2019, <https://www.law.cornell.edu/cfr/text/42/431.10>.



fund. DSHS determines benefit eligibility and pays out benefits. The Health Care Authority tracks claims (how much of a person's total lifetime benefit amount they have received), monitors program integrity, and establishes rules for coordination of benefits with Medicaid, Medicare, and private LTSS insurance. All three agencies are instructed to collaborate to realize program efficiencies and provide beneficiaries with a well-coordinated experience.⁶⁸

A state adopting a highly or even moderately integrated model for UFC will need to assign responsibility for overseeing the program to a core entity. This could be a unit within an existing state agency, a new agency dedicated to UFC, or a combination of existing agencies. It would likely be responsible for (at a minimum) managing

the trust fund(s), determining benefit eligibility, tracking claims, making payments to providers, and creating and maintaining a beneficiary user interface (a web app and hotline for learning about the program and applying for benefits).

In a loosely integrated UFC program, administration would be more decentralized. The agencies currently responsible for Medicaid and child care benefits would not only manage certification of service providers and approval of beneficiary qualifying events for the ECCE and LTSS benefits within UFC, but also might determine benefit eligibility (satisfaction of work and contribution periods), track claims, make payments, and monitor program integrity. To take the example of Washington State, a UFC entity could be

⁶⁸ State of Washington Legislature, H-1732.1, 2019, <http://lawfilesexternal.leg.wa.gov/biennium/2019-20/Pdf/Bills/House%20Bills/1087-52.pdf>.

established within ESD that collects worker contributions, manages the trust funds, creates a public-facing user interface, and administers PFML benefits, while DSHS and DCYF could manage virtually all aspects of ECCE and LTSS benefits.

Creating a new agency to administer all three components of Universal Family Care in an integrated fashion would bring certain efficiencies. But at the same time, this approach would create redundancies in relation to existing administrative structures, particularly with the agencies administering child care and Medicaid LTSS programs.

Raising Awareness and Promoting Enrollment through Education and Outreach

The experiences of existing PFML programs and the Affordable Care Act have shown how important education and outreach are in the early years of a new social program. Between the time a program is enacted and when it goes into effect, it is critical that resources be committed to informing residents about its benefits. If not, many residents (particularly those with limited education or English proficiency) who contribute to the program directly or indirectly may fail to claim benefits for which they are eligible. It is particularly important that outreach extend across cultural and

linguistic barriers and into all geographic areas of a state, and be carried out through a broad range of channels and media.

Building Up the Provider Workforce

Direct care workers (home health aides, personal care aides, and nursing assistants⁶⁹) already make up the second largest occupational group in the United States (with 4.3 million workers) and one of the fastest growing. (The number of home health aides is projected to increase by 47 percent between 2016 and 2026, and the number of personal care aides by 39 percent.⁷⁰) But the care workforce will need to continue growing rapidly in the coming years to meet the needs of an aging society, characterized by greater numbers of elders and fewer family caregivers. And with passage of a UFC program, the demand for care workers would likely increase even more, as states seek to provide their residents access to affordable, quality ECCE and LTSS.

Jobs for direct care and child care workers are generally characterized by low compensation and other indicators of low-quality employment.⁷¹ This is a problem for a number of reasons: It undervalues the important work of caring for our loved ones, threatens the economic security of millions of workers, leads to high turnover in the care workforce, undermines recruitment into the field, and threatens the quality of care provided.

⁶⁹ PHI, “Who Are Direct Care Workers?,” 2011, <https://phinational.org/wp-content/uploads/legacy/clearinghouse/NCDCW%20Fact%20Sheet-1.pdf>.

⁷⁰ Bureau of Labor Statistics, “Employment Projections: Occupational Separations and Openings, Projected 2016-2026,” <https://www.bls.gov/emp/tables/occupational-separations-and-openings.htm>.

⁷¹ Robert Espinoza, “Workforce Matters: The Direct Care Workforce & State-Based LTSS Social Insurance Programs,” PHI, 2019 (Forthcoming); Nina Dastur, Indivar Dutta-Gupta, Laura Tatum, Peter Edelman, Kali Grant, and Casey Goldvale, “Building the Caring Economy: Workforce Investments to Expand Access to Affordable, High-Quality Early and Long-Term Care,” Creative Commons, 2017, http://www.georgetownpoverty.org/wp-content/uploads/2017/05/Building-the-caring-economy_hi-res.pdf.



Consequently, UFC legislation would be incomplete if it enacted care benefits but failed to include provisions to strengthen the care workforce, incentivize improvements in job quality, and stimulate job growth. There are a variety of measures states can take to build the care economy, such as ensuring care workers have minimum wage, benefit, and labor protections, and making investments in workforce development and ongoing education, training, and career pathways.⁷² An advantage of such measures is that, because care work is not outsourceable and is needed throughout a state, they could bolster job growth across the state and thereby strengthen the state and local economies, particularly in rural areas that are often underserved by ECCE and LTSS providers.

Covering Workers Who Live and Work in Different States

A state enacting UFC will need to decide whether coverage of individuals is to be based on whether they *work* in the state or *reside* in the state. How do current ECCE, PFML, and LTSS programs deal with this issue?

- In all state ECCE programs, which are funded by general revenue, residency is the basis for benefits.
- In all existing state PFML programs, coverage is tied to the state of employment.

⁷² Nina Dastur, Indivar Dutta-Gupta, Laura Tatum, Peter Edelman, Kali Grant, and Casey Goldvale, "Building the Caring Economy: Workforce Investments to Expand Access to Affordable, High-Quality Early and Long-Term Care," Creative Commons, 2017, http://www.georgetownpoverty.org/wp-content/uploads/2017/05/Building-the-caring-economy_hi-res.pdf.

- To be eligible for Washington State’s new LTSS social insurance program, a person must have fulfilled the contribution requirements by *working* in the state for a number of years and also must be *residing* in the state at the time of receiving care.⁷³

A principle that can guide a state in deciding this issue is fairness in terms of who pays for the program and who benefits from it, and this will differ for contributory and comprehensive UFC models.

- In a contributory social insurance design, which is funded by contributions from employees and/or employers (not all residents), basing eligibility on state of employment appears to be the most equitable approach. Those who contribute are covered, whether they live in or out of the state; those who do not contribute are not covered, whether living in or out of the state. This option also reduces confusion for businesses, as they do not need to treat employees in the same workplace differently based on where they live. And employers are already accustomed to this model for other existing programs at the state level, such as Unemployment Insurance, Workers’ Compensation, and paid leave programs.
- In a comprehensive UFC design, funding comes not just from worker contributions but also from dedicated taxes or general revenues paid by all residents of the state. Therefore, all residents should be eligible for benefits. In addition, the state would

need to provide coverage to those living outside the state but working in it and contributing to the UFC system.

Regardless of which approach a state chooses, it will have to consider how a UFC program will affect workers and employers involved in employment across state lines. There is precedent for coordination between states on issues such as wage and claim record-sharing, taxation agreements, and even coordinated policy efforts (e.g., in-state tuition reciprocity between Wisconsin and Minnesota⁷⁴).

Coordination among states in developing UFC policies and administering programs could reduce the administrative burden on state agencies, employers, and employees alike.

Covering Self-Employment

Policymakers will need to determine whether and how a new UFC program covers nonstandard employment arrangements—that is, earnings from a source other than W2 wages, such as self-employment or independent contract work. Henceforth we will refer to all such work as *self-employment*. Some social insurance programs, such as Workers’ Compensation, have not traditionally covered self-employment work and income, because there is no identifiable employer. Other social insurance programs, like Social Security and Medicare, do cover the self-employed, but require them to pay both the employee and employer contributions, which can be a significant burden on low- or even many middle-income workers.

⁷³ Workers become eligible for benefits after a contribution period of a total of 10 years (without any interruption lasting five or more consecutive years) or three of the past six years. (State of Washington Legislature, H-1732.1, 2019, <http://lawfilesexternal.wa.gov/biennium/2019-20/Pdf/Bills/House%20Bills/1087-S2.pdf>.)

⁷⁴ See: Minnesota Office of Higher Education, 2017, <https://www.ohe.state.mn.us/mPg.cfm?pageID=121>.



In introducing a UFC program, a state should give careful consideration to how it will treat self-employment income. If such income is not subject to contributions and not counted in determining a person's eligibility, two problems arise:

- Some people spend most of their lives self-employed; they would not meet the program's work and contribution requirements and would not be eligible for benefits.
- Some people spend much of their lives self-employed, either part-time or full-time, but have enough regular employment to be eligible for UFC benefits. They qualify for the same benefits as those who were in regular employment all their lives, but they pay contributions on only part of their lifetime income, while the latter pay contributions on 100 percent of theirs.

For these reasons, automatically including all self-employment would best meet the goals of universal coverage and equitable funding.

A compromise approach is automatically including the self-employed but allowing them to opt out. But this also has problems:

- Some of those self-employed who opted out would have done so without fully understanding the risks and costs of needing ECCE, PFML, or LTSS, and could have significant unmet need when care risks transpired.
- Some people who opted out would qualify for benefits based on a period of regular employment, but (as described above) they would not pay contributions on a large part of their income (their self-employment earnings).
- Those who were more likely to need ECCE, PFML, or LTSS benefits would be more likely to stay in the UFC program, and those less likely to have such a need would be more likely to opt out (in what is called adverse selection). This would weaken the program's finances.

If a state received contributions on self-employment income and also required employer contributions, how would the employer portion be collected for the self-employed? A state might simply make up that money from another source, such as general revenues. Another solution could be to have employers contribute a percentage of all payments made to independent contractors to the UFC fund. Massachusetts' new PFML program will require such payments, for example, but only for businesses where self-employed workers make up more than half of the workforce. Workers in these businesses will be covered automatically and be required to pay the employee contribution.⁷⁵

Implementation Phase

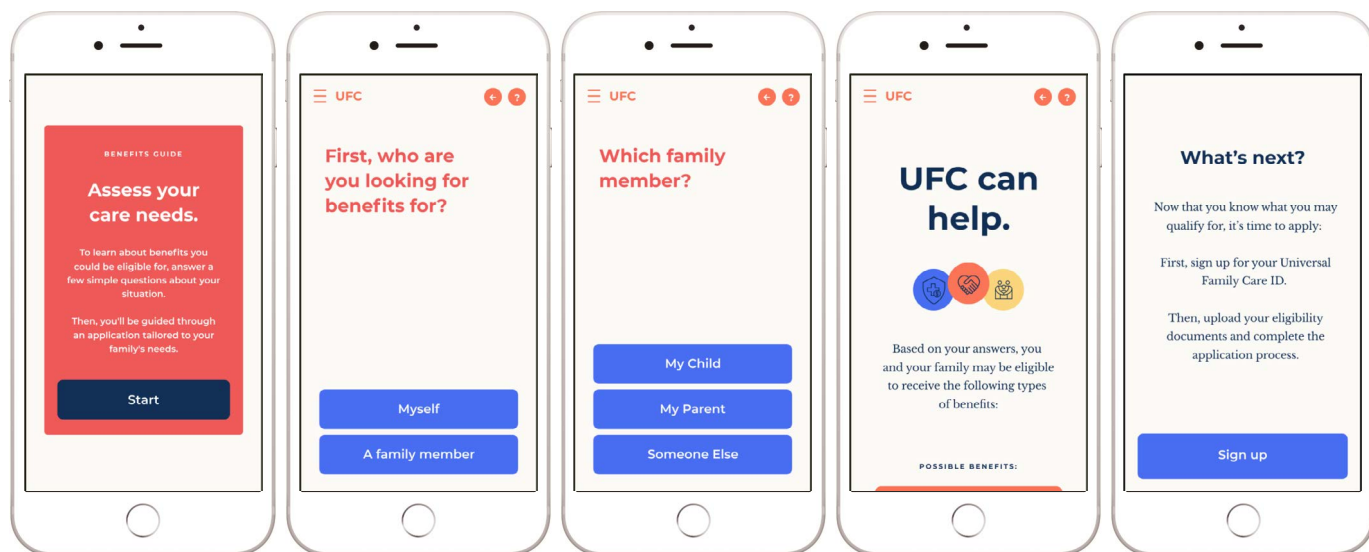
Integrated User Experience

To maximize take-up for UFC benefits and to ease the bureaucratic burden on family caregivers, policymakers will want to design

the program's user experience to be accessible. Ease of access to program information and simplicity of interaction with program administration are critical to ensuring that all people who pay into the system can feasibly benefit from it. One way to achieve this would be through a user-friendly web app, an example of which is presented in Figure 5.

When a family member first seeks to claim benefits from the UFC program, they should be able to obtain general information about benefits they may be eligible for, answer a few simple questions about their care situation, and then be guided through a preliminary application tailored to the family's care needs. Based on their answers to the questions, the claimant should be able to determine more specifically what types of benefits they may be eligible for. They would then need to apply formally for benefits—ideally, this could be done by simply uploading the required eligibility documentation.

FIGURE 5: An Integrated User Experience Grounded in Family Needs



⁷⁵ Sherry Leiwant, Molly Weston Williamson, and Julie Kashen, "Paid Family and Medical Leave & Self-Employment," Brief 1 of *Constructing 21st Century Rights for a Changing Workforce: A Policy Brief Series*, *A Better Balance*, 2018, <https://www.abetterbalance.org/resources/report-constructing-21st-century-rights-for-a-changing-workforce-a-policy-brief-series/>.



In addition, applicants should be able to learn about benefits other family members involved in the care situation may be eligible for. For example, a person seeking to claim paid family leave to care for a parent with dementia should be told about the potential availability of benefits for a home care aide for the parent. Those using the web app should also be able to access a list of ECCE or LTSS providers in their area. In short, the web app should be a one-stop shop grounded in the family's holistic, integrated care experience.

Once a beneficiary signs up for benefits the first time, from that point forward, as subsequent family care needs arise, they should be able to re-engage the program through the web app in a non-bureaucratic way.

Quality Assurance

A state may want to use a new UFC program to take measures to improve the quality of ECCE and LTSS. One way to do this would be to include funding for training of care workers and/or development grants for providers. Another would be to mandate quality standards through provider credentialing. See Chapters 1 and 3 for a detailed discussion of these issues.

Ancillary Supports and Services

A UFC program can serve as a “chassis” to which ancillary services and supports beyond traditional ECCE, PFML, and LTSS benefits can be added. For example, many family caregivers feel alone in facing their

family's care challenges and find themselves having to make key decisions about the care of a child or an aging parent without adequate information or guidance. A UFC program could offer a care advisor (a toll-free number) to help families find information and resources to cope with their care needs (which often involve more than one major benefit type). The program could also offer guidance about long-term care planning. Finally, a state could consider negotiating discounts for UFC beneficiaries with private service providers like ride-share companies or meal delivery services.

Ongoing Program Administration

The administration of a UFC program will involve a variety of ongoing activities. To mention a few considerations:

- Enrollment in the program would be automatic for all workers.
- If the program has any work history requirement to become eligible for benefits, or any waiting period after a qualifying event before benefits are payable, this will need to be tracked.
- Both program participants and service providers must be able to quickly and

easily receive information about an individual's benefit eligibility status; program participants could access this information through a web app (discussed above).

- A state must either manage the program's finances directly or contract out management and sustainability monitoring of the Trust Fund.
- A state will need to establish procedures for monitoring and ensuring program integrity. Here, states can likely draw on agency expertise in administering existing ECCE and LTSS programs. In approaching program integrity, states will want to balance concerns for quality with respect for the autonomy of families and care recipients.
- A state may want to conduct periodic program evaluation to assess the effectiveness of the program's design in meeting its stated objectives.

For more detailed discussion of the issues involved in implementing ECCE, PFML, and LTSS benefit systems, see the preceding chapters of this report.

Section VI.

CONCLUSION

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Families have always coped with the risk of needing to receive or provide care—whether care for children, people with disabilities, older adults with functional or cognitive impairments, family members with a serious illness or injury, or one’s own health needs. But the share of families with a stay-at-home caregiver has sharply declined in recent decades, as most families now need earnings from all working-age adults in the household to make ends meet. At the same time, the number of older people needing LTSS is growing with the aging of the Baby Boomers. Paid care services—whether for children, elders, or people with disabilities—are expensive and unaffordable for many families.

Today, support for families is highly fragmented and largely limited to those with very low income and assets. The vast majority of people with care needs are not eligible for public ECCE or LTSS benefits, and most Americans do not live in a state that has a

PFML program. For those who are eligible, eligibility can change quickly with changes in family income and assets.

Universal Family Care would enable all families to access care supports, not just those with low incomes. They would do so through a one-stop shop with straightforward eligibility requirements, rather than a series of bureaucratic applications for different means-tested programs. UFC would provide ECCE, PFML, and LTSS benefits, but would be more than the sum of these parts. Family members would contribute to UFC from their first job onward and sign up for benefits the first time they need care. From then on, when family care needs arise, they could re-engage the program in a less burdensome way, as with Social Security or traditional Medicare.

A state’s decision to bolster its care infrastructure through UFC will highlight the need to develop its care workforce as well. In

rolling out a UFC program, states will benefit from workforce investments. The mechanism of provider credentialing through UFC can be leveraged to ensure the new employment created by the program results in quality jobs providing quality care to our children, seniors, and people with disabilities.

The policy vision of UFC can be achieved in a variety of ways. This report has outlined two high-level structural approaches—contributory and comprehensive—and presented illustrative benefit packages for core and expanded versions of each. A state seeking to adopt UFC will ultimately choose a policy design that best matches its own unique goals, preferences, and constraints. In so doing, it will calibrate the program dials of eligibility requirements, qualifying events, and benefit generosity. The common denominator in all approaches to UFC is that everyone contributes into one care insurance fund (or funds), and all contributors benefit

from the risk protections provided. Some states may choose to go further and extend coverage to all residents—even those who have not been able to work and contribute—by supplementing contributory funding with other dedicated taxes or general revenues.

If a UFC program were funded—as is Medicare—by a payroll tax on all earnings, with a higher rate on earnings above \$200,000 (\$250,000 for a married couple), a preliminary estimate of the contribution rate required from the typical household to fund a middle-of-the-road package is about \$79 a month (more detailed modeling will be conducted in late 2019). In return for paying this amount throughout their working lives, when a family was faced with the need for costly child care or LTSS, the family would receive benefits worth up to tens of thousands of dollars, as well as partial wage replacement when a family member needed to take time off from work to provide



or receive care. In other words, as in all social insurance, workers would pay in small amounts out of each paycheck and receive substantial help in times of need.

Many states are now weighing how to better equip families to cope with the challenges of managing work and family. We face a series of challenges: most families need the income of all working-age adults to make ends meet, yet the care infrastructure to enable family caregivers to work is fragmented and limited; female labor force participation is much lower in the U.S. than its peer nations; our birthrate is at a 32-year low; care jobs are poorly compensated, often resulting in low-quality care; and the next generation of seniors is ill-prepared to pay for their expected LTSS costs. UFC holds the potential to address these challenges in a holistic way: to make high-quality early care and education available to all children, thereby providing a solid foundation for our country's next generation; to empower family caregivers to flexibly manage work and care in ways they consider most efficient and beneficial; to facilitate the growth of quality jobs for the care workforce; to provide peace of mind to an aging population regarding the ability to age in place; and to make it easier for younger people with LTSS needs to work if they are able to do so.

